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CONFERENCE ABSTRACT

We have a TIP for You! - Serving Complex Patients through Telemedicine IMPACT PLUS TIP Case Conferences

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Context and Problem Statement: The number of Canadians with chronic conditions is growing. Often patients have serial visits with disconnected specialists and community providers, focused on single diseases not patient goals. Access to interprofessional resources and proactive coordinated care planning are needed to assist primary care providers address chronic disease burden and social determinants.

Description of Practice Change: Telemedicine IMPACT PLUS TIP, an innovative secure videoconferencing model, connects patients and their family physicians with interprofessional teams, internal medicine and psychiatry, for goal-directed care planning. An advanced practice community nurse prepares the patient and family physician, identifying what is important and key care concerns, and facilitates post-TIP care plan implementation.

Aim and Theory of Change: TIP leverages existing academic and family health teams to support complex patients and their solo family physicians in patient-present real-time planning.

Targeted Population: Family physicians are invited to refer "patients who keep them up at night" for synergistic problem-solving to address risk issues. The case conference includes the patient and family caregiver: helping focus everyone on what matters to the patient; ensuring the patient fully understands and commits to their plan; equipping family physicians with local resources; and boosting confidence in managing complexity.

Timeline: This program was launched in 2013 in three city regions and now involves 12 teams in all regions.

Highlights innovation, Impact and outcomes: Evaluations have shown exceptional levels of satisfaction:

97 % of team participants N = 227 found it effective

98% of GPs N = 65 would use this strategy again

100% of patients N = 74 would use again; 97% felt hopeful.

TIP was selected as the Ontario patient-centered chronic disease model for a national randomized control trial measuring impact on health care usage, qualitative measures and economic benefit. Early RCT findings show patients reported improvement on 4 patient self-management dimensions: Health Directed Behavior, Emotional Well being, Skill and Technique acquisition, and Social Integration and Support. Family physicians felt supported and reassured in their care of vulnerable patients. The interdisciplinary team members felt able to care for highly vulnerable patients and address determinants of health.

Sustainability: Sustainability requires referrals to this novel program. Direct patient advertisements, recruitment from hospital wards, and outreach to community coordinators and family physicians continue.

Transferability: Institutional commitment is essential for specialists and teams to continue to provide real-time support for family physicians and patients.

Conclusions/ Key findings: A coalition of providers across health sectors is now helping complex patients achieve what matters to them. The benefits are one-stop person-centred care enhancing patient function, supporting family physicians in complex care, and eventually reducing reliance on more expensive specialist/acute care.

Discussion: Using telemedicine, our care innovation has connected interprofessional teams to patients and families who struggle with complex medical and social problems, and their family physicians. Challenges include wireless technology in some city areas, and promoting this program with solo family physicians.

Lessons learned: The TIP nurse role is crucial in preparing for case conferences in advance, trouble-shooting the technology during the case conference, and providing follow-up.

Keywords: virtual interprofessional teams; synergistic care; patient-centred; provider-enhanced

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