Bijlage H Aanvullende vragen auteurs

Werkwijze

Alle auteurs van de artikelen die geïncludeerd zijn in de systematische literatuuranalyse werden benaderd voor twee aanvullende vragen. De eerste auteur van het artikel werd benaderd, en indien er geen contactgegevens waren werd de laatste, of tweede auteur benaderd. Van de auteurs waarmee het gelukt is om contact te leggen, en gereageerd hebben, vatten wij de antwoorden samen. De twee vragen die gesteld werden, waren:

1. Is it possible to give an estimation of the time investment required for the different elements of your care intervention? [deze vraag werd alleen gesteld wanneer het antwoord niet te vinden was in het artikel]

2. Is the care intervention still in practice today? Why/why not?

Antwoorden

Pariser, P:

Pariser (2019) conducted a pre-post intervention study in the outpatient setting in Canada. They included 76 patients with three or more chronic conditions. Follow up time was not reported. The multidisciplinary assessment was embedded in the Telemedicine IMPACT Plus (TIP) care model. The care team consisted of a registered TIP nurse, the TIP team (specialists from psychiatry and internal medicine, a social worker, pharmacist, home care and community coordinator, other professionals based on patient's needs such as occupational therapist or dietitian), and the primary care physician (PCP). The dedicated TIP nurse met with the PCP and patient in advance to prioritize issues most important to the patient. The TIP nurse enhanced self-management and care coordination, aligned care and goals with appropriate reduction in medications and serial specialists consultations, and equipped the PCP with local resources. A clinical consultation using videoconference took place with the PCP in his office, the patient at home, and the TIP team present as well. The team developed recommendations that formed the nucleus of a coordinated care plan. The TIP nurse helped with follow-through of team's recommendations together with the patient's PCP. The TIP nurse invested 6.1 hours per patient on average (2.4 hour preintervention, 2.0 hour for intervention, 1.7 hour postintervention). The multidisciplinary conference lasted 1 hour.

"Yes, the care model is very much still in operation in the Greater Toronto and has now spread to provide multi-disciplinary case consultation for patients living in more remote areas outside of Toronto. We have shown qualitative benefits for complex patients who participate in virtual case consultation. Our care intervention is one of the few interventions that impacts people who are structurally marginalized, not meeting the social determinants of health. Our intervention shows that one multidisciplinary consultation can be more effective for vulnerable patients, where serial office visits often fall short. An example is a patient who frequented the emergency department 21 times in the six months prior to a multidisciplinary case consultation, with no repeat emergency department visits in the 6 months after the consultation. We also service patients who cannot go to multiple specialists' appointment, by bringing the specialist team to them, in the comfort of their own home. The care intervention is a cost-effective solution."

Bryk, J:

Bryk (2018) conducted a pre-post intervention study in the outpatient setting of a primary care facility in the United States. Super utilizers were enrolled in the study, defined by more than two inpatient admissions over the past 12 months and/or more than 6 emergency department (ED) visits over the past year, and answered 'yes' to the question: Would you like us to help you stay out of the emergency room and the hospital? Follow-up time was 6 months. The care team consisted of the primary care physician (PCP), nurse care manager, social worker, administrative assistant, psychologist who was collocated with the PCP, psychiatrist and other clinicians based on patient needs. The multidisciplinary assessment was embedded in an Enhanced Care Program (ECP). An initial intake appointment was conducted, which included a full medical and psychosocial assessment. An ECP care plan was created that addresses physical, mental, financial, environmental and

functional health. This was placed in the electronic medical record and could be updated by any member of the team at any time. The ECP provided co-management of mental illness by PCP, psychiatrist and psychologist. ECP provided walk-in clinic visits, home visits, was equipped for care of urgent issues such as emergent blood work, same day scheduling of imaging and procedures, 24/7 phone access to care manager. ED care plans were made to direct patient care to the ECP PCP for non-life-threatening conditions. The ECP also provided education (diabetes, diet, self-monitoring blood pressure) and delivery of medication by local pharmacy. ECP social worker assisted patients with medical costs. All patients were seen for routine checks at least monthly and contacted by their nurse care manager at least monthly. Cancer screenings for cervical, breast and colon cancer were reviewed at each patient encounter.

"As a primary care physician, I work fulltime for the care intervention, seeing patients from 8.45-3.30, 10-13 patients per day (approx. 30-40 min per patient), in addition to making many phone calls to patients (telemedicine visits). An intake appointment typically takes 1-1.5 hours, and the after visit review of charts/creation of care plan takes approximately 3 additional hours. There is a 24/7 on-call phone staffed by the nurse care managers with physician back up. The care intervention is still in practice because the team is very motivated due to the positive change we see the intervention has. We can't help them all – but the ones we do makes it all worth it."

<u>Chung, H:</u>

Chung (2013) conducted a pre-post intervention study in the outpatient, primary care setting in the United States. They included 79 patients with chronic illness (Diabetes Mellitus, coronary artery disease and/or chronic heart failure), at least one abnormal indicator (blood pressure >140/90, Hba1c >8, LDL>100) and comorbid depression (PHQ-9 score ≥ 10). Follow up time was after a minimum of 8 weeks. The care team consisted of a primary care physician (PCP), nurse, behavioral health manager (BHM), accountable care manager (ACM) who were experienced registered nurses, and a consulting psychiatrist. The multidisciplinary assessment was embedded in a "synergy program". In this program, cases were reviewed with a focus on medical indicators (blood pressure, Hba1c, LDL) and depression indicators (PHQ-9 score) as well as overall psychosocial function. The ACM did a psychosocial assessment by phone focused on chronic illness care, medication reconciliation and self-management approaches including motivational interviewing and behavioral activation. The ACM also coordinated with the PCP and other specialists on medical issues and assists with appointments. The BHM evaluated cases onsite and provided psychotherapy, he/she liaised with the psychiatrist and PCP. The PCP educated patients on depression diagnosis and the potential negative impact. The PCP also managed antidepressants with consulting psychiatrist reviews provided through the electronic medical record. If patients did not reach their treatment target or were complex, the psychiatrist provided an individual patient consultation. BHM and ACM documented on the same care management electronic record for coordination and information sharing.

"Basically, the intervention investment is a nurse who is trained to support patient self-management for depression, anxiety, alcohol and SUD; a mental health social worker who can provide behavioral health evaluation, and short term psychotherapy (usually CBT focused) but also able to support patient self-management for chronic illness (HTN, CAD, DM, etc) ; and a psychiatric consultant (MD or NP) who can make diagnostic evaluation for complex cases, and recommend psychopharmacology recommendations, usually to a PCP; if patients warrant , they may end up being transferred to permanent BH treatment. This team above probably manage 60-80 patients on a regular basis especially if there is digital support to the patients such as smartphone texting; measurement informed care, etc. The duration of this team-based approach is usually 4-6 months until we achieve some reasonable response and stability. It was continued up until our health system stopped managing older patients (age 50 and older) for which the health system had financial responsibility; as that was the major group that benefits from this type of intervention. At that point, with workforce reduction and with loss of financial accountability; it was decided to stop. The health system maintained collaborative care model which did not really focus on the medical issues. This approach was continued because of good behavioral health outcomes, and data showed overall reductions in emergency room visits and medical specialty care (data to be submitted)."