Establishment and Achievements of Complex Care Clinic

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Problem: It's difficult enough when an adult is suffering from a long-term medical condition. But when the patient is a child, the emotional strain is far more profound. As a parent, you want the best possible care without depriving your child of the physical, emotional and intellectual development that is so much a part of their formative years.

Over the last three decades, medical advances and innovative technologies have resulted in allowing growing numbers of children living with complex, multi-system disorders who rely upon long term, intensive support from numerous health care providers, specialties and organizations. Coordination of care of these children and their families is extremely challenging and, if not prepared well, leads to long waits, untimely delays, fragmented communication, inadequate planning, dissatisfied patients, families and providers as well as poor health outcomes and inefficient and costly use of health care resources. The Department of Pediatrics recognized the gaps and challenges that exist in HMC's current system, and in collaboration with the HMC/SickKids Partnership Project, developed an innovative, effective and efficient model for serving medically fragile children and their families. The model proposed to enhance coordination of complex care by establishing a shared management model. Such a model fostered a collaborative partnership with multidisciplinary team members whose vision was to provide "Excellence in coordination of care for children with complex, chronic medical needs."

AIM & OBJECTIVES: Aim and objectives was realized through the establishment of three key components:

- Improving the quality of life and health status of children with complex medical conditions and their families.
- Maximizing time out of hospital and decrease avoidable hospitalizations, days in hospital, inefficient, unnecessary or avoidable ambulatory clinic visits, and emergency department visits.
- Creation of a "Multidisciplinary Team" to provide comprehensive, coordinated family centered care to children and their families. The team coordinates care for the whole family and integrates services and care across practitioners using an evidence-based approach.

Background

Impression of the term "Complex Care" in pediatrics:

- A coordinate care that bridges the gaps in the care of children with multiple medical issues. Many aspects of care.
- It involves multi-organ dysfunction and its management involving multidisciplinary team of nurses, physicians, allied health worker, dietitian
- Provide requirements for chronic patients who need special care
- Care for patients with more than 2 diseases/diagnoses, like CP cases with complicated needs
- Providing highly specialized care accessible to the clientele we serve
- Team looking after special needs children
- Complex care in pediatric is improvement of quality of care for patient – successful care for patient
- Complex care is a therapeutic approach in a transition of health care system, it is a multidisciplinary approach to the needs of a patient/child having complex behavior needs.

Importance in having an interdisciplinary team in a complex care program:

- Helps the patient to realize the best advice from various specialty experts at one point in time
- It helps the members to receive a firsthand information and treatment strategies from all the other professionals involved in the care of the patient
- To promote the level of treatment, to supply special needs for these patients
- Patient will not lose time in attending different clinics at different times, patient will be seen in one day
- Time saving for patient and team, better coverage of patient problems from all perspectives, integrated and full plan of care
- Better communication, better services
- This will help parents and caregivers and provide service of high quality for these clients
- Interdisciplinary team in a complex care program provides the best care and gives the easy care

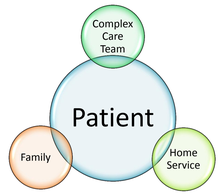
Benefits to having a complex care clinic

- Many, many, parents as partners in the care/satisfaction, bridge the gaps in the care of these patients, better communication, less medical errors,
- Following up the patients after discharge from the hospital, to be reference for the patients if they face any problems with their child
- Patient will be seen in one clinic in one day, patient plan of care will be discussed with all the required health care workers and patient /family
- Time saving for both sides, more advanced and better plan of care than only an individual's plan of care
- Access for better healthcare system in Qatar
- To reduce no. of visits/appointments for parents
- To care clients by a qualified team
- Successful care for patient, easy follow up for patient and parents
- Patient/family - it is easy for team to have a follow up, can come to the clinic in one sitting. I think for this they will not neglect their follow up to monitor

METHODS

- Methods used to meet to achieve the vision are following
- Established ***"Shared Management Model"*** of practice supporting interprofessional, collaborative care and treatment planning, and provision of coordinated services as close to home as possible for children who require ongoing complex care management.
- Provision of a designated ***"Complex Care Navigator"*** for each patient and their family to help lead their care, empower them to navigate the system and serve as a liaison for advice, co-ordination, and management of service delivery. The navigator will have access to specialized services in the tertiary care center including sub-specialty and allied health professional consultations.
- Provision of a designated "***Complex Care Social Worker***" for patients and families to advocate, support and counsel them in acquiring needed social and financial resources to help manage the complex requirements of the child's care needs.
- 4. Creation of an "***Interprofessional Practice Team***" to provide comprehensive care to patients.
- 5. Management of "***Information Technology***" and development of a data base that would include a critical summary of patient information and up to date care plans to help track services provided, issues encountered, medications and treatments administered as well as other key data that would help determine the efficacy of program interventions.

- **ideal model for a complex care program**



CONCLUSIONS

- Complex care team's commitment to treating the individual can make the difference between a child simply recovering, and also developing intellectually and socially. Our pediatric care program has been specifically created to serve medically-complex and medically-fragile infants and children. The pediatric unit is designed for optimum monitoring but, just as important, provides and environment that is nurturing, stimulating and encourages socialization.
- While most of the children in our program are technology-dependent and require specialized pulmonary care, our complex pediatric care services cover a wide array of other medical conditions. Services include a developmental pediatrician, pediatric pulmonologist, respiratory therapists, pediatric nutrition, pediatric nurses and certified nursing assistants well as therapeutic recreation and physical, occupational and speech therapists. We also provide case management, social work and educational services, as well as regular on-site consultation by an array of pediatric sub specialists.
- Because there is nothing more important to a child than knowing their family is there for them, we keep family members intimately involved in the care process. Together, we formulate and agree to treatment and therapy plan

- The multidisciplinary team responded to the needs of the patient and family by putting increased emphasis on family centered care. The core value of family centered care is the active involvement of patients and their families in the decision making about individual treatment options. Constant coordination and communication among all participants in a patient's treatment is encouraged between team members and the patients and their families. The patient experience is enhanced as the clinic focuses on treating the whole person through exercise programs (OT & PT), access to social work, dieticians, and other long-term needs of each patient.
- There are several surveys' that have been designed to measure patient satisfaction. The validated tool that the Complex Care Team chose to measure patients' perspectives of hospital care was the Family-Professional Partnership Scale. The aim of the survey is to understand how the parents felt about any member of the team who works with them and their child. All parents / primary care givers are encouraged to participate in the survey.
- Here are the graphical presentation of patient survey results