COMPLEX care for COMPLEX patients in a COMPLEX time

Pat Rich

"One problem per visit" is becoming a frequent mantra from providers trying to manage the increasing complexities of patients in primary care. With a shortage of physicians, nurses and excessive patient loads, many family physicians at walk-in clinics feel pressured to adopt this philosophy.

This trend reflects the very real issue of the growing complexity of care that many patients require and the demands this places on a physician's time.

For instance, patients are being discharged into the community quicker after hospital stays for surgery or major illness. Although it has been determined that patients can recover just as well — if not better — in their familiar home environment, many of these patients are often sicker than in the past.

UNE clientèle aux besoins de plus en plus lourds exerce des pressions énormes sur les médecins, constate le SNM 2007. Quelque 80 % des médecins répondants affirment que la complexité des besoins de leurs patients est un grand facteur de pression sur leur temps. Les médecins de famille et les omnipraticiens sont touchés un peu plus que les autres spécialistes, à la hauteur de 84 % et 75 % respectivement. D'autres facteurs — comme la prise en charge de patients atteints de problèmes chroniques ou de multiples morbidités, les patients vieillissants et les attentes accrues des patients — ont aussi une incidence sur la journée du médecin. Le manque de spécialistes en gériatrie, le vieillissement des effectifs médicaux et les pénuries de médecins et de personnel infirmier se font sentir au moment où le système de santé devient lui aussi plus complexe. Les patients arrivent à l'hôpital plus malades, en ressortent plus rapidement et ont besoin d'un suivi multidisciplinaire plus détaillé et coordonné. «Lorsqu'on passe plus de temps avec des patients dont l'état est complexe, cela signifie que l'on voit moins de patients dans une journée», affirme le Dr Stewart Cameron, professeur agrégé à l'Université Dalhousie à Halifax. Dans nombre de cas, toutefois, les régimes de rémunération des médecins n'ont pas suivi cette nouvelle réalité.

In the hospital, the intensity of illness is greater because the hospital tends to discharge patients sooner to open beds for newly diagnosed or sicker patients. This practice encourages recovery at home or elsewhere in the community, but it also increases the complexity of care required by family physicians in the community because patients are making the transition from one care setting to another so much more rapidly.

At the same time, many health care professionals are acknowledging the epidemic of chronic disease and the need to apply models of chronic disease prevention and management. These models require a interdisciplinary approach and are intended to manage various facets of a disease that will be with the patient for life.

Add to this the growing number of so-called "frail elderly" who have more than one disease and require much more complex care.

In the National Physician Survey (NPS), the most frequently cited factor increasing the demand on physicians' time was the increasing complexity of the patient caseload. Overall, 80% of physicians identified this as an issue, with the pressures being felt somewhat more by FP/GPs — 84% versus 75% of other specialists.

Other factors related to the complexity of care were also identified in the NPS as placing significant demands on physician time.

- The management of patients with chronic diseases and conditions — 73% (82% of FP/GPs and 64% of other specialists)
- Increasing patient expectations — 70% (75% of FP/GPs and 65% of other specialists)
- An aging patient population — 69% (80% of FP/GPs and 58% of other specialists)

Specialists who deal with older patients with more complex conditions see the current system as woefully inadequate to deal with their demands.

In a presentation to the Standing Senate Committee on Social Affairs, Science and Technology in November 2001, Dr. Kenneth Rockwood, professor of geriatric medicine at Dalhousie University, Halifax, wrote that "health care professionals are taught to listen to patients, examine them carefully and order special investigations, judiciously based on what is learned from the history and physical examination. The professionals are taught that patients with more than one problem should have each one addressed in the same manner.

"However, what we are learning in geriatric medicine is that this tried and true approach does not work for frail older adults, who have multiple, interacting, medical and social problems.

"Their 'overall problem' is not simply the sum of their individual ones; you cannot intervene on just one problem without it affecting the others. It is important to pay attention to large, overarching issues that often are seen as being outside the scope of traditional medical concern."

In an interview, Rockwood said people are slowly coming to acknowledge this reality, although he adds, "it's frustrating. It's often 1 step forward and 2 steps back."

He says chronic disease management models usually do not deal well with patients who have multiple problems. Such models, he says, tend to focus on "their" illness, rather than take into account interactions between various conditions.

Rockwood says the ongoing shortage of geriatric specialists will mean the great majority of care for the frail elderly will be managed by family physicians and general internists. And for many of those physicians, who still bill on a fee-for-service basis, he says this care is "the moral equivalent of charity work" because of the time required.

But Dr. John Maxted, associate director of health and public policy for The College of Family Physicians of Canada, notes that "complexity of care is what family physicians excel in.

"FP/GPs look after the elderly, chronic disease patients and many complex patients in the community. It is part of our profession and training — even for those who have not had extra training, for example, in the care of the elderly."

But, he says, the increasing number of these patients requiring care is increasing the stress on these physicians, especially in a system that is also becoming increasingly complex.

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>
> *— Dr. Colin McMillan*

Rockwood says current research around care for elderly patients with complex problems is providing a mathematical basis for what may be seen as the "common sense" approach taken by geriatricians.

"For years what geriatricians concerned themselves with have been things like falls and confusion and function and social isolation. And we look at these from a disease perspective. It's not just common sense that when someone comes in and has 10 things wrong and we ask them if they can get out of bed and regard that very carefully and build solutions around helping them to get in and out of bed, this is more beneficial than solutions dealing with making sure that all of their lab values line up."

"If you think about it from an evolutionary standpoint, humans have evolved to have upright bipedal ambulation, divided attention, opposable thumbs and social interaction. So when these fail, they fail in terms of delirium and falls and impaired function and impaired social interaction. So, a lot of the things we have looked at are actually what you would do if you're going to look at a complex system on the verge of failure."

Dr. Chris Frank, current president of the Canadian Geriatrics Society, associate professor of family medicine at Queen's University, Kingston, and a family physician who has a special interest and extra training in care of the elderly, agrees that the number of elderly requiring complex care is growing and can be overwhelming for family physicians who have to provide this care.

Mark Holleron

He notes that discharging patients from hospital and transferring patients from hospital to long-term care are stressful situations for family physicians, especially when multiple medications are involved. Use of other specialized health care professionals, such as pharmacists and geriatric care managers, can help manage this transition.

Dr. Rody Canning, a Moncton pediatrician, says the growing complexity of care is not just restricted to the frail elderly. It creates challenges for those working in hospital as well as those providing care in the community.

"One of the things that we've seen over the last 15 years is an increasing shift to ambulatory care and correspondingly the reduced number of beds in hospitals, and that applies to all age groups and all conditions. Consequently, the majority of patients who get into hospital now and get a hospital bed are sicker when they got in than they were 15 years ago.

"In fact, many of the situations, which arise consequently, are because patients are on a multiplicity of medications and they come into the hospital with a very complicated medical history."

The converse is also true. As Dr. Colin McMillan, a cardiologist in Charlottetown notes, many heart attack patients are released from hospital much more quickly than in the past and this means their care is often more complex after they return home.

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Canning notes that the aging population is definitely affecting the demands on family physicians.

"In the ambulatory care setting, from the family physician's point of view, the aging population has had a huge impact and

we're seeing family doctors spending more and more time with elderly patients than with younger patients. Family doctors in many situations have had to restrict young families to 1 problem per visit in order to be able to devote more time to the more complicated cases, says Canning."

"Spending more time with complex patients means seeing fewer patients per day," says Dr. Stewart Cameron, associate professor of family medicine at Dalhousie University, Halifax.

"Unfortunately, governments sometimes continue to equate the number of encounters with care delivery. Even with alternate funding plans they may regard any reduction in the number of patient visits as reduced 'productivity.'"

Canning agrees that the shortage of trained geriatricians is a problem, although more family physicians are receiving special training in care of the elderly and helping to provide this type of care.

In Moncton, Canning notes, there is 1 fully trained geriatrician and 2 family physicians with special training in geriatrics. "The need is probably 3 to 3.5 times that. This is probably a microcosm of what it is right across the nation."

While the system continues to be plagued by physician shortages and more patients have multiple, chronic conditions and live longer, the demands of complex care are likely to continue to escalate over the next few years.

However, most of those interviewed agree that new primary care models providing collaborative care and paying physicians on a capita basis are better suited for providing the complex care many patients now require.

Pat Rich is editor of MD Pulse.