International Education Seminar Report

Dr. Pauline Pariser, Dr. Samir Sinha

Toronto University, Canada

October 20[Fri]-27[Fri], 2017, Toyama University

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International Education Seminar 国際教育セミナー

Dr. Pauline Pariser
Associate Professor,
Department of Family and Community Medicine,
University of Toronto
(トロント大学地域家庭医療学講座准教授)

Dr. Samir Sinha
Associate Professor of Medicine,
Health Policy, Management and Evaluation,
University of Toronto
(トロント大学健康政策管理評価講座准教授)

2017.10.20(Fri)
17:30-19:00

臨床講義室1 通訳付き！

University of Toronto

Dr. Pauline Pariser

Family Medicine in Canada
カナダの家庭医療について

Dr. Samir Sinha

Acute care of elderly in hospital
病院における高齢者急性期医療

University of Toronto !

Toronto General Hospital !

主催&お問い合わせ
とやま総合診療イノベーションセンター(CIGM) (076-415-8867)
総合診療部

平成29年10月20日（金）17:30-19:00

国際教育セミナー「カナダの家庭医療について」、「病院における高齢者急性期医療」

Dr. Pauline Pariser, Dr. Samir Sinha

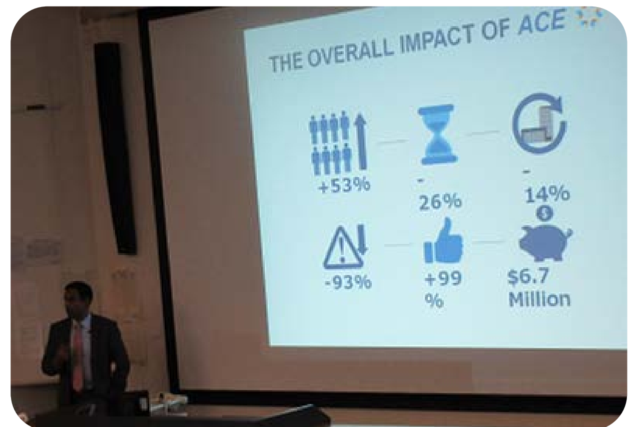
＜山城先生からPauline Pariser 先生をご紹介＞

＜Pauline Pariser 先生＞

＜熱心に聴講される医師、研修医、学生のみなさん＞

＜英語のスライドと日本語訳のスライドを並べて＞

＜Samir Sinha 先生＞



＜Q&Aタイム＞

＜山城先生ご挨拶＞

国際教育セミナー 参加人数

日時　平成29年10月20日（金）17:30-19:00

講師　Dr. Pauline Pariser, Dr. Samir Sinha

場所　臨床講義室1

参加者　26人

【学内】 19人　（人）

医学部教員	8
医学科学生	6
看護学科学生	1
薬学部学生	1
他職員	3

【学外】 7人　（人）

富山市まちなか診療所	2
富山赤十字病院	1
済生会高岡病院	1
金沢医科大学病院	1
氷見市民病院	1
亀田ファミリークリニック館山	1

Family Medicine in Canada

Pauline Pariser
Primary Care Lead, University Health Network
Primary Care Lead, Mid-West Toronto
Associate Professor, Department of Family and Community Medicine, University of Toronto

Family Medicine in Canada
家庭医療inカナダ

Pauline Pariser
Primary Care Lead, University Health Network
Primary Care Lead, Mid-West Toronto
Associate Professor, Department of Family and Community Medicine, University of Toronto

Outline

- History of Family Medicine in Canada
- Training Program
- Structure of Family Medicine Practice
- Funding Models
- Toronto International Program in Family Medicine

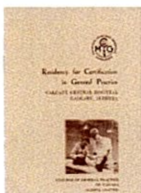
Outline概略

- History of Family Medicine in Canada
  家庭医療の歴史
- Training Program
  研修プログラム
- Structure of Family Medicine Practice
  家庭医療の実践
- Funding Models
  財源
- Toronto International Program in Family Medicine
  家庭医療のトロント国際プログラム

History of Family Medicine

College of Family Physicians of Canada - 1954

First Residency Programs – 1966 –University of Calgary and Western University, London, Ontario

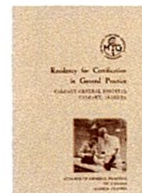


First Certification Exam - 1969

History of Family Medicine
家庭医療の歴史

College of Family Physicians of Canada – 1954
1954年に学会が創設

First Residency Programs – 1966 –University of Calgary and Western University, London, Ontario
1966年に最初の研修プログラム開始（カルガリーウエスタン大学）



First Certification Exam – 1969
1969年に最初の資格試験

The Four Principles of Family Medicine

- **The Family Physician is a skilled clinician**
  Competent in patient-centered clinical method
- **Family Medicine is a community-based discipline**
  Mobilizes resources and skilled at collaborating
- **The Family Physician is a resource to a defined practice population**
  Views practice as "population at risk" providing proactive care
- **Patient-physician relationship is central to the care**

The Four Principles of Family Medicine
家庭医療の4原則

- **The Family Physician is a skilled clinician**
  Competent in patient-centered clinical method
  患者中心の診療の方法を修得している
- **Family Medicine is a community-based discipline** Mobilizes resources and skilled at collaborating
  地域基盤の診療。資源の利用と協働
- **The Family Physician is a resource to a defined practice population**
  Views practice as "population at risk" providing proactive care
  限られた患者層への資源で、リスクの高い患者への診療
- **Patient-physician relationship is central to the care**
  患者医師関係がケアの中心

Training in Family Medicine

- Rotations in Family Medicine in 2nd and 3rd year medical school.
- Post-graduate Residency - 17 medical schools
  - 2 years
  - optional 3rd year for focused practice: e.g. Emergency medicine, Hospitalist program, Low-risk obstetrics, Care of the elderly, Palliative Care, etc.

Primary Care Faculty and Residents publish in peer reviewed Canadian Family Physician journal.

Training in Family Medicine
家庭医療の研修

- Rotations in Family Medicine in 2nd and 3rd year medical school. 医学部2年生と3年生は家庭医療をローテート
- Post-graduate Residency - 17 medical schools卒後研修
  - 2 years 2年間
  - optional 3rd year for focused practice: e.g. Emergency medicine, Hospitalist program, Low-risk obstetrics, Care of the elderly, Palliative Care, etc. 3年目の選択研修：救急、ホスピタリスト、産科、老年医学、緩和医療

Primary Care Faculty and Residents publish in peer reviewed Canadian Family Physician journal.
カナダ家庭医療学会誌

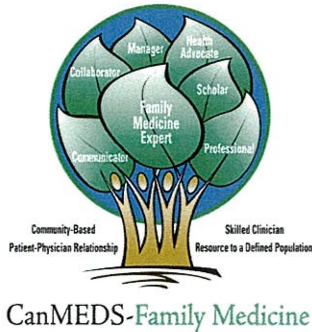
Triple-C Competency Based Curriculum - 2010

- Comprehensive : Standardized training Family Medicine Programs so graduates can practice anywhere in Canada
- Continuity: continuity of patient-doctor relationship and continuity in the learning environment
- Centered in family medicine – training takes place in family medicine clinics – and content – based on best evidence in primary care

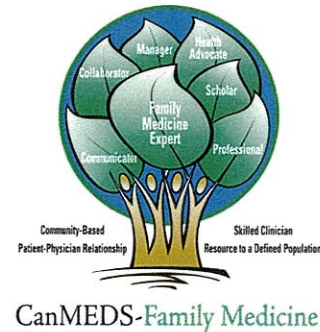
Triple-C Competency Based Curriculum – 2010
3Cコンピテンシー基づくカリキュラム

- Comprehensive : Standardized training Family Medicine Programs so graduates can practice anywhere in Canada
  包括性
- Continuity: continuity of patient-doctor relationship and continuity in the learning environment
  継続性
- Centered in family medicine – training takes place in family medicine clinics – and content – based on best evidence in primary care
  家庭医療・プライマリケア中心

CAN-MEDs Competencies:
informs curriculum and evaluation at the undergraduate, graduate and post-graduate levels



CAN-MEDs Competencies:
informs curriculum and evaluation at the undergraduate, graduate and post-graduate levels
CAN-MEDコンピテンシー：卒前、卒業時、卒後レベル



Structure of Family Medicine Practice

25,000 MDs in Ontario-11,900 MDs in Family Medicine

Mostly independent providers

Single Payer: Bill government directly for each service or are paid by capitation

Many have their own clinic or work in teams.

Structure of Family Medicine Practice
家庭医療診療の構造

25,000 MDs in Ontario-11,900 MDs in Family Medicine オンタリオ州医師25,000人-家庭医11,900人

Mostly independent providers ほとんど独立医師

Single Payer: Bill government directly for each service or are paid by capitation 1つの保険機関

Many have their own clinic or work in teams.
多くはクリニックを所有し、チームで診療

Primary Care: Patients' First Point of Contact

Solo Primary Care Physician	Family Health Team	Community Health Centre	Walk-in Clinic	Tele health Nurse

Secondary Care: Need referral from Primary Care

Specialist	Mental Health	Home & Community Care	Long-term Care	Rehabilitation Services

Tertiary/Quaternary Care: Hospital Care

Specialists arrange elective admissions, admit patients from ED. Patients can self-refer to the Emergency Room

Primary Care: Patients' First Point of Contact
プライマリケア：患者の初期診療

Solo Primary Care Physician	Family Health Team	Community Health Centre	Walk-in Clinic	Tele health Nurse

Secondary Care: Need referral from Primary Care二次ケア

Specialist	Mental Health	Home & Community Care	Long-term Care	Rehabilitation Services

Tertiary/Quaternary Care: Hospital Care三次ケア：病院

Specialists arrange elective admissions, admit patients from ED. Patients can self-refer to the Emergency Room

Primary Care Structure

- $13.7 billion spent on primary care, the second largest health care expense
- Usually the first point of care for patients

Solo Family Doctor Office	Traditional Primary Care: a family doctor's office with a single doc
Family Health Team	Team: MDs, RNs, social workers, pharmacists, etc collaborating in the care of population
Telehealth	For inquiries when cannot reach primary care- run by RNs
Walk In Clinics	For patients without primary care or who cannot easily access MD
Community Health Centres	For high-needs pop. Team based primary, social and community care

Primary Care Structure
プライマリケアの構造

- $13.7 billion spent on primary care, the second largest health care expense 13.7兆カナダドルをプライマリケアへ、2番目に多い
- Usually the first point of care for patients 初めの診療の場

Solo Family Doctor Office	Traditional Primary Care: a family doctor's office with a single doc
Family Health Team	Team: MDs, RNs, social workers, pharmacists, etc collaborating in the care of population
Telehealth	For inquiries when cannot reach primary care- run by RNs
Walk In Clinics	For patients without primary care or who cannot easily access MD
Community Health Centres	For high-needs pop. Team based primary, social and community care

Funding Models

Fee-for Service: Many family physicians paid set fees per office service provided

Comprehensive Care Models – in Ontario 83% of family physicians practice in one of these models:

•Developed as part of primary care reform to improve infrastructure and performance

•Commit to comprehensive primary care with after-hours services

Funding Models診療報酬

Fee-for Service: Many family physicians paid set fees per office service provided 出来高払い

Comprehensive Care Models – in Ontario 83% of family physicians practice in one of these models:
統合ケアモデル

•Developed as part of primary care reform to improve infrastructure and performance
プライマリケアのリフォームとして発展

•Commit to comprehensive primary care with after-hours services
統合的プライマリケア

Models include

➢ Community Health Centres – serve disadvantaged populations, family physicians are salaried

➢ Family health Networks – blended capitation model with financial incentives for meeting preventative care indicators

➢ Family Health Teams – similar blended capitation with incentives but with the addition of multidisciplinary teams

➢ Family Health Groups – fee for service but with bonuses

Models include下記のモデル

➢ Community Health Centres – serve disadvantaged populations, family physicians are salaried
地域ヘルスセンター:生活困窮者を対象として、雇われ医師

➢ Family health Networks – blended capitation model with financial incentives for meeting preventative care indicators
家庭医療ネットワーク:予防ケア指標に合わせたインセンティブ

➢ Family Health Teams – similar blended capitation with incentives but with the addition of multidisciplinary teams
家庭医療チーム:多職種連携チーム

➢ Family Health Groups – fee for service but with bonuses
家庭医療グループ:出来高制はボーナス

Guiding Assumptions

- We all have something to learn
- We all have something to teach
- We are all adult learners
- We are all accountable to a range of "others" …and primarily to ourselves.
- We have a great common potential

Guiding Assumptions前提条件

- We all have something to learn学習
- We all have something to teach教育
- We are all adult learners成人教育
- We are all accountable to a range of "others" …and primarily to ourselves.責任性
- We have a great common potential潜在性

Program Objectives

By the end of the program participants will be able to:

1. Critically present **the role and potential impact of primary care and family medicine** in achieving health and wellbeing globally.
2. Describe **key enablers and challenges** in the establishment of effective family medicine in Canada and abroad (including policy, training and care delivery models).
3. Identify (and possibly engage in) **key strategies** to advance family medicine in their local settings including key collaborations.

Program Objectives
プログラムの目的

By the end of the program participants will be able to:
プログラム終了時には次のことができるようになる

1. Critically present **the role and potential impact of primary care and family medicine** in achieving health and wellbeing globally. プライマリケアと家庭医療の役割と潜在的影響力
2. Describe **key enablers and challenges** in the establishment of effective family medicine in Canada and abroad (including policy, training and care delivery models).
家庭医療を支え、挑戦する
3. Identify (and possibly engage in) **key strategies** to advance family medicine in their local settings including key collaborations. 重要な方略を理解する

Program Content

The program is structured around four content domains:

•Foundations of Family Medicine and Canada's health care system;
•Life-long learning, tools and supports;
•Pillars and Enablers of Academic Family Medicine;
•Site Visits & Observership.

Program Content
プログラムの内容

The program is structured around four content domains:4つの内容

•Foundations of Family Medicine and Canada's health care system; 家庭医療とカナダの医療制度の理解
•Life-long learning, tools and supports; 生涯教育
•Pillars and Enablers of Academic Family Medicine; アカデミック家庭医療の中心的存在と推進者
•Site Visits & Observership.サイトビジットと見学

Program Structure

- Interactive didactic sessions
- Site visits
- Focused mentorship & Special Interest
- Observership
- Reflection

Program Structure
プログラムの構造

- Interactive didactic sessions講義
- Site visitsサイトビジット
- Focused mentorship & Special Interestメンターシップ
- Observership見学
- Reflection振り返り

Examples of Course Content

Canada's health care system

Caring for Complex Patients

Care of the elderly/homecare

Electronic medical record

Generalism

Palliative Care

Quality Improvement and Research in Family Medicine

Examples of Course Content
コース内容の例

Canada's health care systemカナダのヘルスケアシステム

Caring for Complex Patients複雑な患者のケア

Care of the elderly/homecare高齢者/在宅ケア

Electronic medical record電子カルテ記載

Generalism総合性

Palliative Careプライマリケア

Quality Improvement and Research in Family Medicine質指標と研究

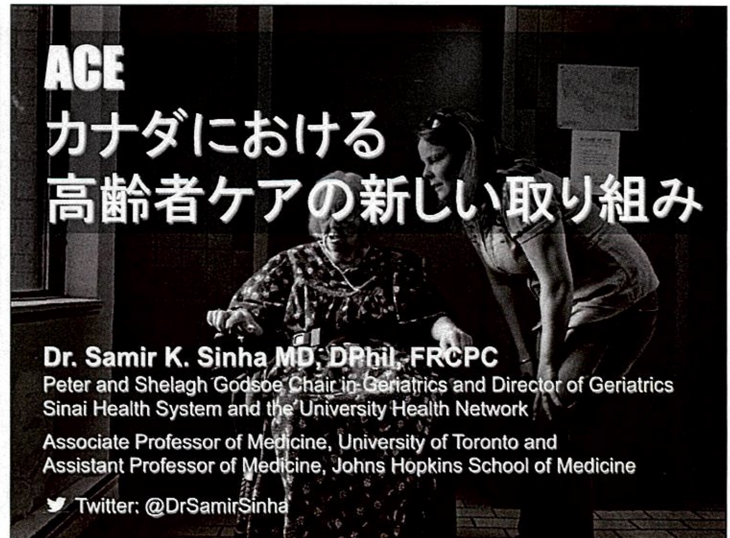
Save the Date!

April 23 – May 4, 2018
Toronto, Canada

Arigato Gozaimasu

Save the Date!
予約してね！
April 23 – May 4, 2018
Toronto, Canada

Arigato Gozaimasu
ありがとうございます



Presentation Objectives

- Demonstrate how current care delivery paradigms are problematic and require an elder friendly approach
- Appreciate how the evolving policy context in Canada is enabling an elder-friendly approach.
- Introduce the **Acute Care for Elders (ACE) Strategy** as a care model that can deliver better patient and system outcomes.

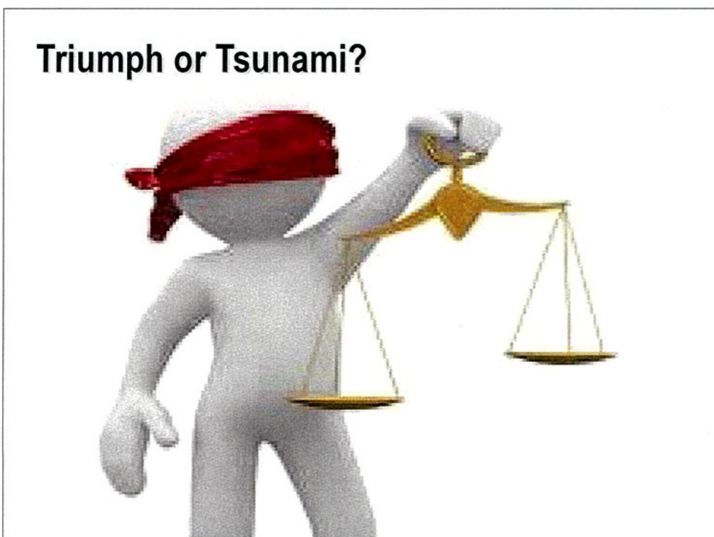
Presentation Objectives　発表の目的

- Demonstrate how current care delivery paradigms are problematic and require an elder friendly approach

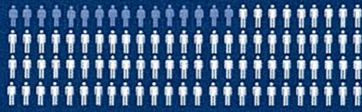
  今の高齢者医療には問題がある
- Appreciate how the evolving policy context in Canada is enabling an elder-friendly approach.

  新政策が高齢者に優しいケアを可能にしつつある
- Introduce the **Acute Care for Elders (ACE) Strategy** as a care model that can deliver better patient and system outcomes.

  ACE （高齢者向け急性期ケア戦略）の紹介



CANADA'S POPULATION |



16. 9% = 65+

カナダ人口の16.9%が65歳以上

CANADA'S POPULATION |

16. 9% = 65+

CANADIAN
HOSPITALIZATIONS |

入院患者の42%が高齢者

CANADIAN
HOSPITALIZATIONS |

OVERALL DAYS IN HOSPITAL |

全入院日数の59%を高齢者が占める

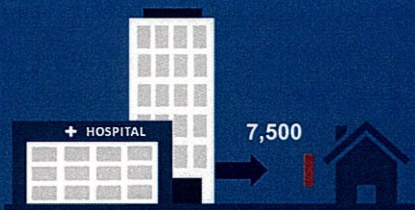
OVERALL DAYS IN HOSPITAL |

OLDER USERS
OF HEALTHCARE |

高齢者（医療保険利用者の10%）が
医療費の60%を使っている

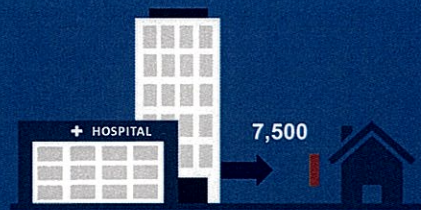
OLDER USERS
OF HEALTHCARE |

CANADIANS STUCK
EACH DAY IN HOSPITAL | ✚

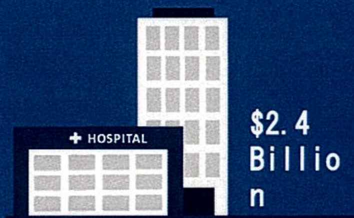


行くあてがなく、病院に留まる人
（退院待機患者）7,500人/日

CANADIANS STUCK
EACH DAY IN HOSPITAL | ✚

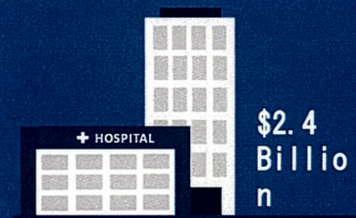


ANNUAL COST OF WAITING
TO GO ELSEWHERE |



退院待機患者にかかるコスト
24億加ドル/年

ANNUAL COST OF WAITING
TO GO ELSEWHERE |

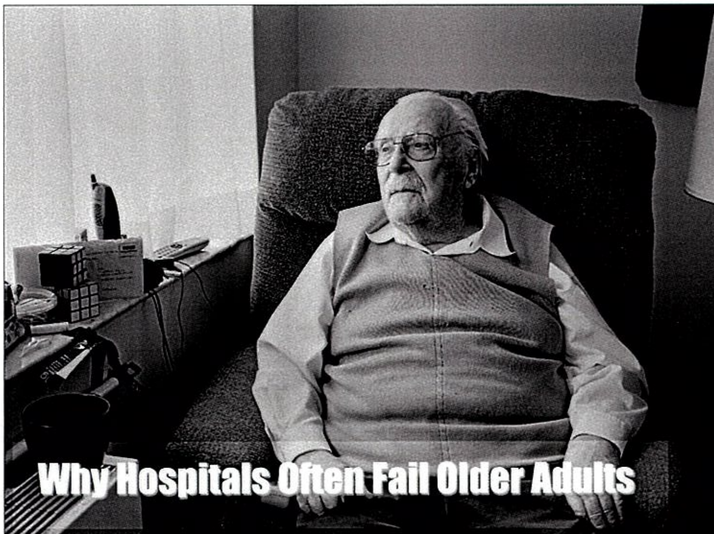


Canadian Health Care 101

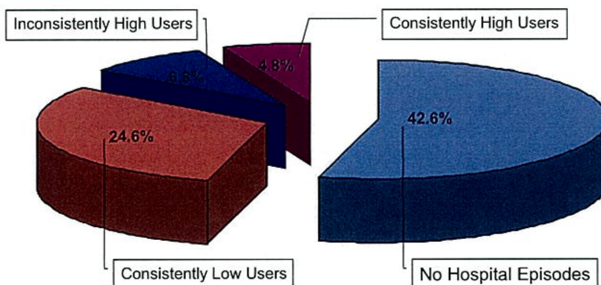
- Canada administers a universal health care system financed by taxation, and free at the point of service.
- Each of the 13 provincial and territorial governments administers services as per the Canada Health Act.
- Hospital Care and Physician Services are fully covered, Home and Long-Term Care is heavily subsidized but limited, Medications and Dental Care is only covered for the poor and the elderly.
- Canada does NOT run a Comprehensive Health Care System Similar to Most Western European Nations.

Canadian Health Care 101　カナダの医療101

- Canada administers a universal health care system financed by taxation, and free at the point of service.
  国の医療費は税金で賄われ、病院での支払いは無料
- Each of the 13 provincial and territorial governments administers services as per the Canada Health Act.
  各州はカナダ保健法に従って医療を提供
- Hospital Care and Physician Services are fully covered, Home and Long-Term Care is heavily subsidized but limited, Medications and Dental Care is only covered for the poor and the elderly.
  入院通院費は全額カバー/長期ケアは主に助成金（限定的）/薬剤費と歯科治療は貧困層と高齢者のみカバー
- Canada does NOT run a Comprehensive Health Care System Similar to Most Western European Nations.
  カナダは西欧諸国の様な包括的ケアシステムを運営していない

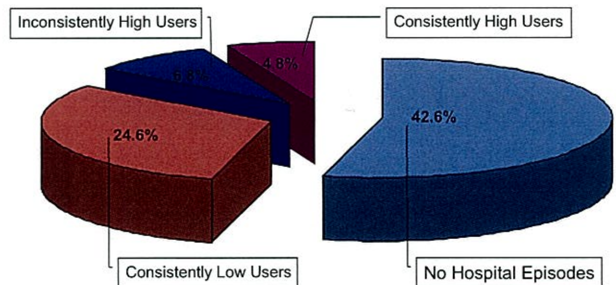


Ageing and Hospital Utilization in the 70+



- Only a ***small*** proportion of older adults are consistently extensive users of hospital services *(Wolinsky, 1995)*

Ageing and Hospital Utilization in the 70+ 70歳以上の高齢化と病院利用



- Only a ***small*** proportion of older adults are consistently extensive users of hospital services *(Wolinsky, 1995)*
  持続的に病院を利用する高齢者は**ごく一部**である

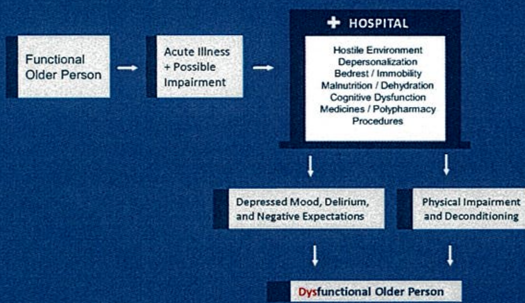
What Defines our Highest Users?

- Polymorbidity
- Functional Impairments
- Social Frailty

What Defines our Highest Users?
高利用者を定義するものは何か？

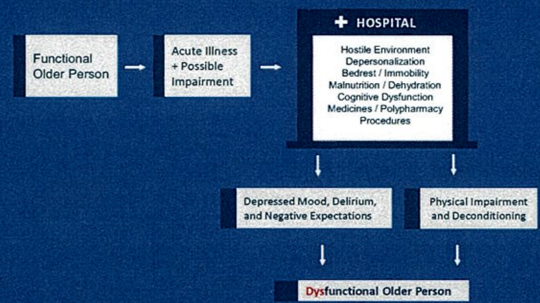
- Polymorbidity　多重不全（多疾患に罹患）
- Functional Impairments　機能低下
- Social Frailty　社会的脆弱

THE HAZARDS OF HOSPITALIZATION



Palmer et al., 1998 (Modified)

THE HAZARDS OF HOSPITALIZATION
入院に伴う危険



Palmer et al., 1998 (Modified)

16° Toronto

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Opinion / Commentary

Ontario hospitals unprepared for aging population

The province's cash-strapped health system needs to start planning now for the challenges ahead.

CARLOS OSORIO / TORONTO STAR Order this photo

Over the past decade, Ontario hospitals have become the most efficient in Canada, write Samir Sinha and Anthony Dale. But enormous challenges lie ahead.

By: Samir Sinha Anthony Dale

With the provincial government set to table its budget on Thursday, much of the public discussion to date has focused on the future of alcohol sales and power generation in the province. While these issues are very important, we must not lose sight of other priorities — particularly how best to care for Ontario's aging population.

While Ontario hospitals have not received an inflationary funding increase over the last three years, the province's 149 public hospitals have been working very hard to adapt to meet the needs of patients. Hospitals have worked hard to help the government meet its financial objectives by improving operating efficiencies and reducing costs while also

Inside the Star

Police offer up stations for Kijiji and Craigslist transactions

Toronto supply teacher caught on Twitter sleeping on the job

16° Toronto

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COMMENTARY

Opinion / Commentary

Ontario hospitals unprepared for aging population

オンタリオの病院は高齢者に対応していない

Over the past decade, Ontario hospitals have become the most efficient in Canada, write Samir Sinha and Anthony Dale. But enormous challenges lie ahead.

By: Samir Sinha Anthony Dale

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- NEW Bittersweet moment for winner of controversial Canada 150 logo-design contest
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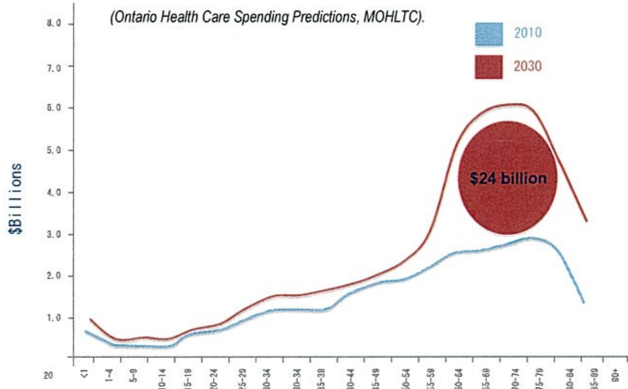
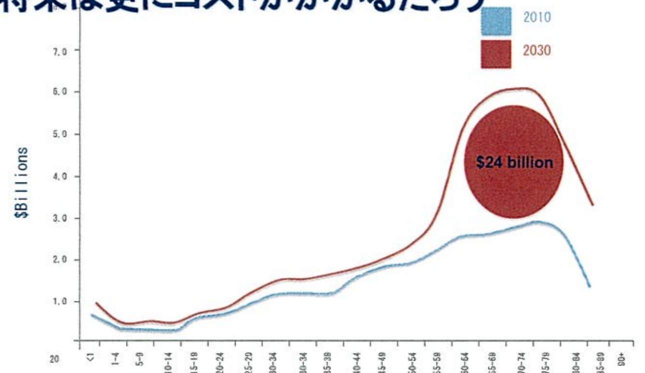
Our Future Will Cost Us More…



Our Future Will Cost Us More…
将来は更にコストがかかるだろう



Our Dilemma

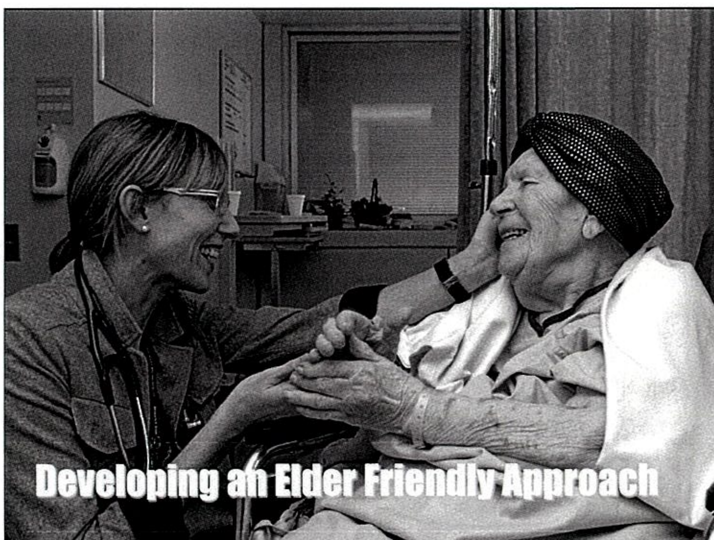
The way in which our cities, communities, and our health care systems are currently designed, resourced, organised and delivered, often disadvantages older adults with chronic health issues.

As Canadians and Japanese Individuals, our Care Needs, Preferences and Values are evolving as a society, with increasing numbers of us wanting to age in place.

Our Dilemma 私達のジレンマ

The way in which our cities, communities, and our health care systems are currently designed, resourced, organised and delivered, often disadvantages older adults with chronic health issues.
現代社会は慢性疾患を持つ高齢者にとって不利

As Canadians and Japanese Individuals, our Care Needs, Preferences and Values are evolving as a society, with increasing numbers of us wanting to age in place.
カナダも日本も高齢化に向けてケアの改善に取り組んでいる



Acute Care for Elders (ACE) Strategy

- Redesigns or establishes new and better sustainable interprofessional team-based approaches.
- Requires a shift in traditional thinking that underpins the administration and culture of most care organizations.
- Is not adverse to identifying risk factors and needs and in intervening early to maintain independence.
- Requires a relentless focus on monitoring and evaluating its outcomes to support continuous quality improvement

Acute Care for Elders (ACE) Strategy 高齢者のための急性期ケア戦略

- Redesigns or establishes new and better sustainable interprofessional team-based approaches.
  新しい、より持続的なチーム医療の再設計
- Requires a shift in traditional thinking that underpins the administration and culture of most care organizations.
  保健医療組織の思考転換
- Is not adverse to identifying risk factors and needs and in intervening early to maintain independence.
  リスクと需要の特定、独立維持のための早期介入
- Requires a relentless focus on monitoring and evaluating its outcomes to support continuous quality improvement
  品質改善のための持続的なモニターと評価

The Elder Friendly Hospital™ Model

These dimensions work together to minimize functional decline, promote safety, and mitigate adverse social and medical outcomes.

(Parke et al, 2001).

The Elder Friendly Hospital™ Model 高齢者に優しい病院モデル

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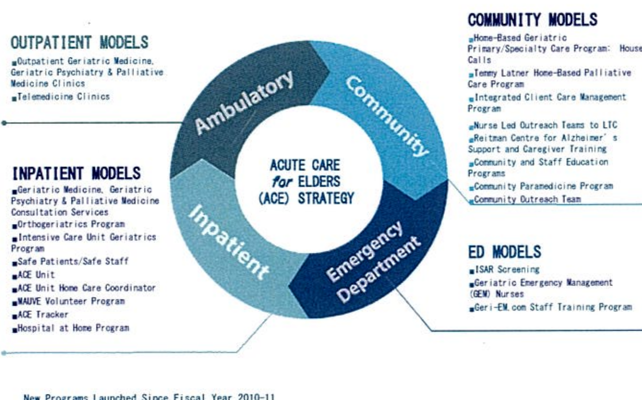
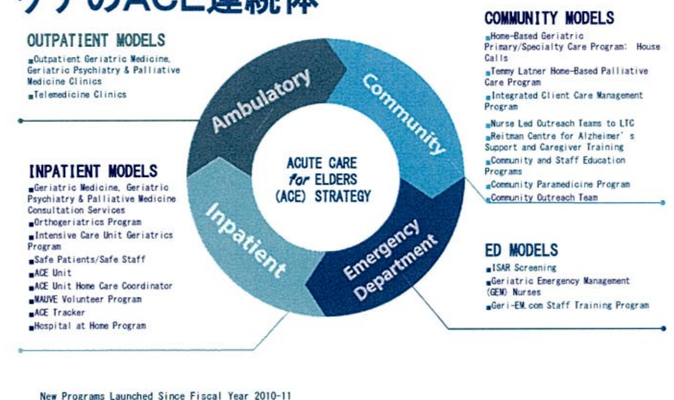
THE *ACE* CONTINUUM OF CARE



New Programs Launched Since Fiscal Year 2010-11

THE *ACE* CONTINUUM OF CARE ケアのACE連続体



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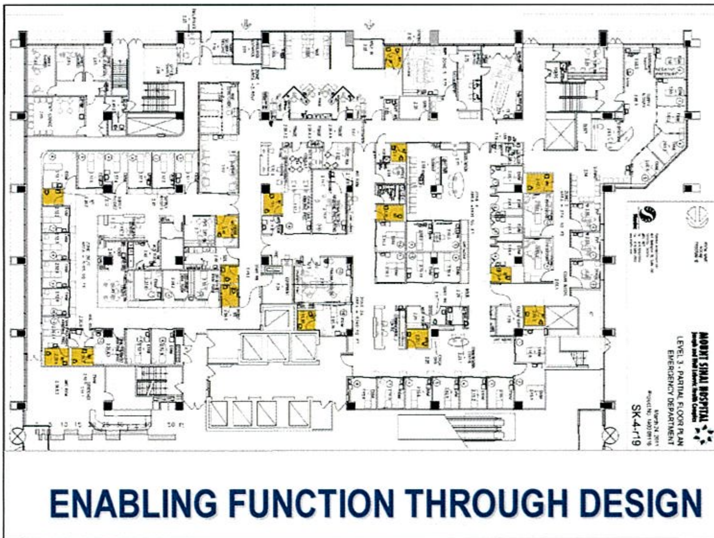
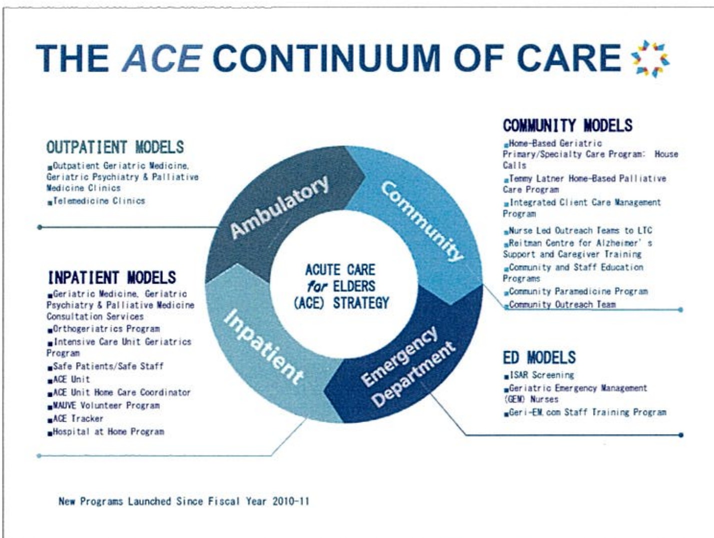

ENABLING FUNCTION THROUGH DESIGN

機能的なデザインへの取り組み


THE ACE CONTINUUM OF CARE
OUTPATIENT MODELS
Outpatient Geriatric Medicine, Geriatric Psychiatry & Palliative Medicine Clinics
Telemedicine Clinics
INPATIENT MODELS
Geriatric Medicine, Geriatric Psychiatry & Palliative Medicine Consultation Services
Orthogeriatrics Program
Intensive Care Unit Geriatrics Program
Safe Patients/Safe Staff
ACE Unit
ACE Unit Home Care Coordinator
MAUVE Volunteer Program
ACE Tracker
Hospital at Home Program
Ambulatory
Community
Inpatient
Emergency Department
ACUTE CARE for ELDERS (ACE) STRATEGY
COMMUNITY MODELS
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Temmy Latner Home-Based Palliative Care Program
Integrated Client Care Management Program
Nurse Led Outreach Teams to LTC
Reitman Centre for Alzheimer's Support and Caregiver Training
Community and Staff Education Programs
Community Paramedicine Program
Community Outreach Team
ED MODELS
ISAR Screening
Geriatric Emergency Management (GEM) Nurses
Geri-EM.com Staff Training Program
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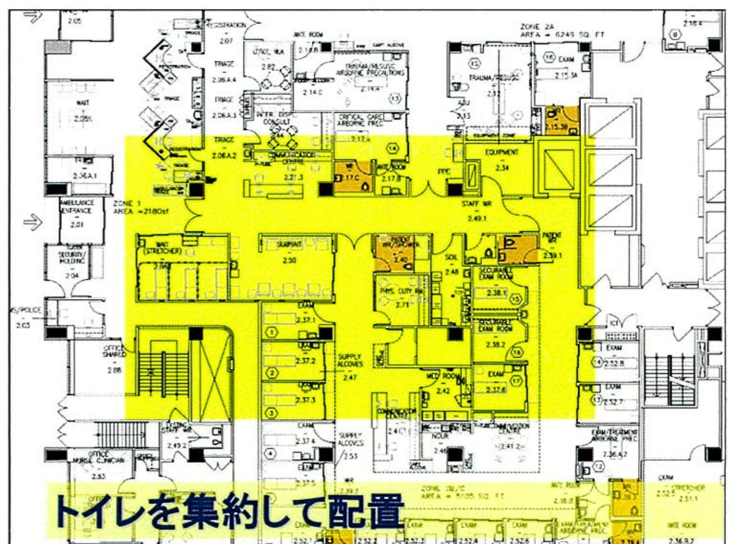
トイレを集約して配置

HIGH RISK SCREENING AND IDENTIFICATION TOOLS

Table 6.1 ISAR Screening Questions (Warburton et al. 2004)

Question	Response	Score
1. Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis	Yes No	01 00
2. In the last 24 hours, have you needed more help than usual?	Yes No	01 00
3. Have you been hospitalized for one or more nights during the past six months?	Yes No	01 00
4. In general, do you have serious problems with your vision, that cannot be corrected by glasses?	Yes No	01 00
5. In general, do you have serious problems with your memory?	Yes No	01 00
6. Do you take six or more different medications every day?	Yes No	01 00

IDENTIFICATION OF SENIORS AT RISK - **ISAR** *(McCusker et al., 1999)*

≥ 2 = Predicts Functional Decline, Recidivism, Institutionalization

HIGH RISK SCREENING AND IDENTIFICATION TOOLS
高リスク群のスクリーニングと確認ツール

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KEEPING CONNECTED TO BETTER MANAGE CARE AND TRANSITIONS

ICCP Patient Alert Notification - Message (Plain Text)

From: root@mshcmapp1.mtsinai.toronto.on.ca [adm@mtsinai.on.ca] Sent: Thu 2013/01/24 1:24 PM

To: MSH - ICCP Patient Notification

Cc:

Subject: ICCP Patient Alert Notification

```
Patient                was registered in Emergency on 2013/01/24 at 13:17.
This is an ICCP Pilot patient.

MRN: 805-145-401
Name:
Visit: 2013-395574
DoB: 1910/02/17
Location: Emerg Dept -  -
```

KEEPING CONNECTED TO BETTER MANAGE CARE AND TRANSITIONS
マネージケアとトランジションの連携維持

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SAFER PROTOCOLIZED CARE

Careset - ACE Admission Set

Improving Practice Standards for ACE and Other Patients

SAFER PROTOCOLIZED CARE

より安全なプロトコールに基づいたケア

Careset - ACE Admission Set

Improving Practice Standards for ACE and Other Patients

MOUNT SINAI HOSPITAL
ACE TRACKER
To improve the care of hospitalized elders

Example: *A 90 year old patient who has been admitted for 6 days and is currently delirious with a background history of cognitive impairment. They have a history of falls and have a high risk of falling according to their Morse Score of 75 and has urinary catheter in place. Patient has a low pain score of 1 and has not been prescribed or administered any BEERS medications but is still on 12 in total. PT, OT and SW are involved.*

Unclear if full delirium work-up has been completed with a proper medication review and if there is an opportunity to get rid of the catheter which will also pose a significant fall risk for them?

USING DATA TO DRIVE REAL-TIME CARE IMPROVEMENTS

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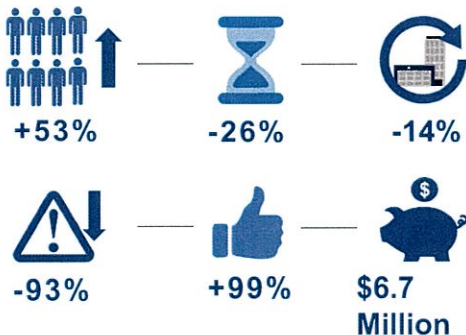
USING DATA TO DRIVE REAL-TIME CARE IMPROVEMENTS

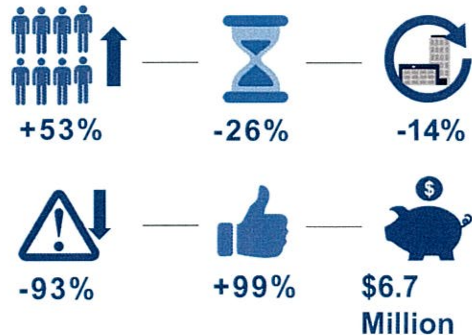
リアルタイムケアを推進するデータ利用

THE OVERALL IMPACT OF *ACE*



THE OVERALL IMPACT OF *ACE*

ACEの総合的効果



IMPLEMENTING *ACE* ACROSS NORTH AMERICA & BEYOND

Acute Care for Elders (ACE)

ACEの展開　北米全体、更に他地域へ

IMPLEMENTING *ACE* ACROSS NORTH AMERICA & BEYOND

Acute Care for Elders (ACE)

Canadian Foundation for Healthcare Improvement / Fondation canadienne pour l'amélioration des services de santé

Sinai Health System — HEALTHY AGEING AND GERIATRICS

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

18 TEAMS ACROSS 4 PROVINCES 〉 1 TERRITORY 〉 1 INTERNATIONAL SITE

1. Whitehorse General Hospital

1. National University Hospital of Iceland

1. Geraldton District Hospital
2. Halton Healthcare
3. Hamilton Health Sciences
4. London Health Sciences Centre
5. Montfort Hospital
6. Orillia Soldiers' Memorial Hospital
7. Queensway Carleton Hospital
8. Quinte Health Care
9. Scarborough Hospital
10. Thunder Bay Regional Health Sciences Centre
11. University Health Network
12. William Osler Health System

1. Horizon Health Network

1. CISSS Chaudières-Appalaches

1. Nova Scotia Health Authority - South Shore
2. Nova Scotia Health Authority - Central Zone

THE "*ACE*" COLLABORATIVE

4

Canadian Foundation for Healthcare Improvement / Fondation canadienne pour l'amélioration des services de santé

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THE "*ACE*" COLLABORATIVE
ACE 共同体

4

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A National Seniors Strategy for Canadians

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NATIONAL SENIORS STRATEGY

Independent, Productive & Engaged Citizens | Healthy and Active Lives | Care Closer to Home | Support for Caregivers

THE FOUR PILLARS SUPPORTING A NATIONAL SENIORS STRATEGY

Access | Quality | Value | Choice | Equity

THE FIVE FUNDAMENTAL PRINCIPLES UNDERLYING A NATIONAL SENIORS STRATEGY

JOIN THE CONVERSATION

87% of respondents in key ridings agree that federal political parties should make the issue of seniors care a top priority in the next federal election.

A National Seniors Strategy for Canadians　カナダ国家高齢者戦

Thank You

Samir K. Sinha MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System and the University Health Network

ssinha@mtsinai.on.ca
Twitter: @DrSamirSinha

Thank You
ご清聴ありがとうございました

Samir K. Sinha MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System and the University Health Network

ssinha@mtsinai.on.ca
Twitter: @DrSamirSinha

International Education Seminar
国際教育セミナー

2017.10.23(Mon)
17:30-19:00 臨床講義室1

Dr. Pauline Pariser
Associate Professor,
Department of Family and Community Medicine,
University of Toronto
(トロント大学地域家庭医療学講座准教授)

Dr. Samir Sinha
Associate Professor of Medicine,
Health Policy, Management and Evaluation,
University of Toronto
(トロント大学健康政策管理評価講座准教授)

University of Toronto

Dr. Pauline Pariser

IMPACT (Interprofessional Model of Practice for Aging and Complex Treatment) 地域医療での多職種連携モデル

Dr. Samir Sinha

Geriatrics program in Toronto
トロントの老年病プログラム

トロント大学からお招きします！
通訳付きです！
ぜひ、ご参加ください！

主催&お問い合わせ　とやま総合診療イノベーションセンター(CIGM) (076-415-8867), 総合診療部

国際教育セミナー 参加人数

日時　平成29年10月23日（月） 19:00-20:30

講師　Dr. Pauline Pariser, Dr. Samir Sinha

場所　臨床講義室1

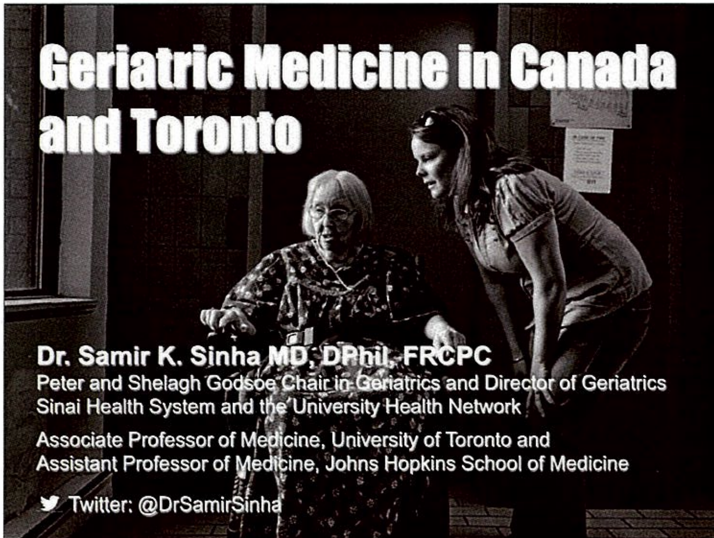
参加者　26人

【学内】 24人　（人）

医学部教員	13
医学科学生	8
他職員	3

【学外】 2人　（人）

富山市まちなか診療所	1
南砺市民病院	1

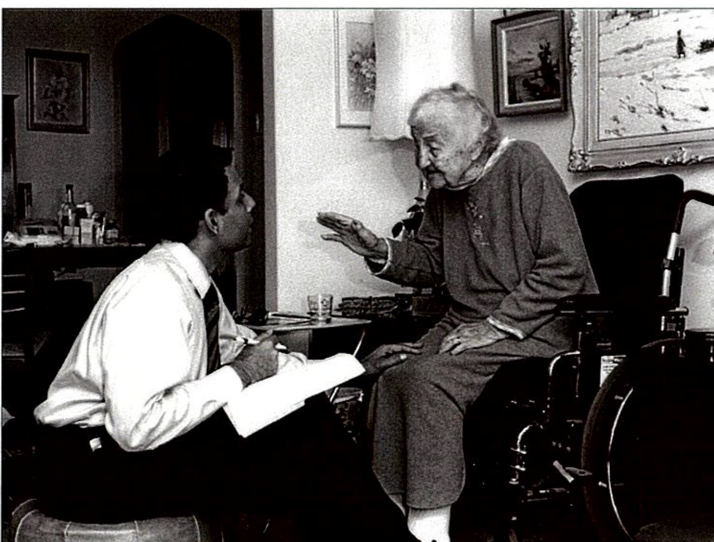


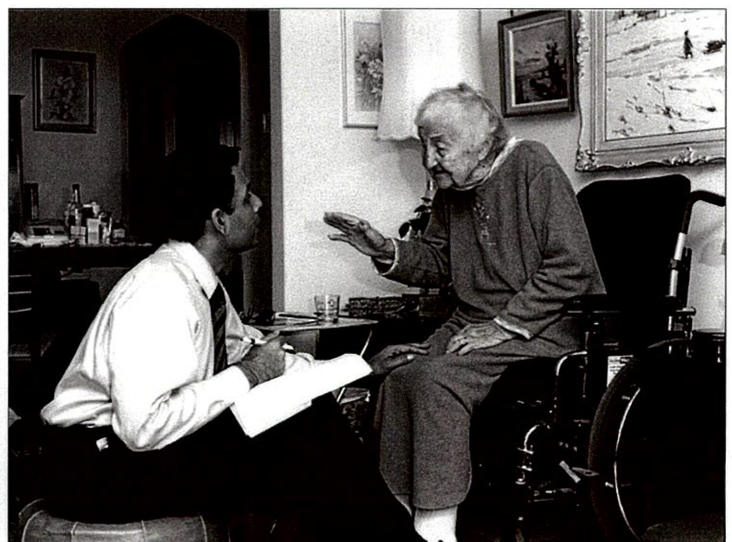
Presentation Objectives

- Describe the Role of Geriatric Medicine in Canada
- Outline the Training Required to become a Geriatrician in Canada
- Provide an Overview of Geriatrician Practice, Roles and Funding Models in a Variety of Settings

発表の目的

- カナダにおける老年医学の役割を説明する。
- カナダにおいて老年専門医になるために求められる研修の概要を説明する。
- 様々な場面における老年医の診療行為、役割、財政モデルについて説明する。





Geriatric Medicine: A Young Specialty

- Nascher coined the term Geriatrics in 1909 around an emerging area of medical practice.
- The American Geriatrics Society is founded in 1942, the British Geriatrics Society in 1947 and the Canadian Geriatrics Society in 1982.
- Geriatric Medicine has evolved differently in Britain, the United States and Canada.
- In the US, Geriatric Care can be practiced as a form of Primary Care, in Canada and Britain it is a secondary care specialty.

老年医学：新しい専門分野

- 老年医学と言う言葉は、1909年にNascherが、医療における新たな分野の一つとして用いたのが始まりである。
- 1942年にアメリカ老年医学会、1947年にイギリス老年医学会、1982年にカナダ老年医学会が設立された。
- 老年医学はイギリス、アメリカ、そしてカナダにおいて、それぞれ異なる道程で発展した。
- 老年医学は、アメリカではプライマリケア領域として、イギリス、カナダでは専門領域として研修することができる。

Training to Become a Geriatrician

- Geriatrics is not a mandated training rotation in Canadian medical schools.
- It is a 2 year Royal College Accredited Training Program that adjoins 3 initial core years of training in General Internal Medicine (GIM).
- Accredited Geriatricians can practice both GIM and Geriatrics for Adults 18+
- Most of the current training occurs in acute hospital and clinic based settings, but increasingly in home and long-term care and rehabilitation settings.

老年医学専門医になるための研修

- カナダの医学部において、老年医学科での研修は必須ではない。
- 総合内科医（GIM）としての3年間の初期研修後に、2年間の公認研修プログラムがある。
- 老年医学専門医は老年医としてだけではなくGIMとして18歳以上の成人への診療行為を行うことができる。
- 現在、ほとんどの研修先は急性期病院もしくは診療所が基盤となっているが、在宅や長期療養、リハビリテーション施設での研修も増えている。

Geriatricians in Canada

- Being a relatively new specialty in Canada, there are currently only 250 Geriatricians out of 75,000 practicing physicians in Canada.
- In 2017, the number of Older Canadians > 65 began to outnumber Children < 15!
- Across Canada there are **<u>10x</u>** the number of Pediatricians as there are Geriatricians!

カナダの老年医

- 老年医学はカナダにおいて比較的新しい専門分野であり、75000人もいる開業医の中で、老年医は現在のところ、僅か250人しかいない。
- 2017年、ついにカナダでも、65歳以上の人口が15歳未満の人口を上回るようになった！
- しかし、カナダ全体で、老年医は小児科医の1/10しかいない！

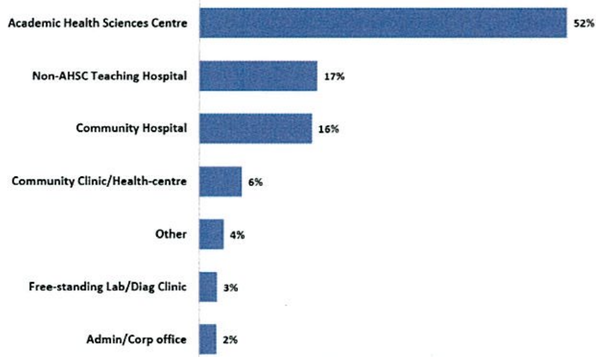
Geriatricians in Canada

- Only until recently, geriatrics remained unpopular due to *a lack of societal interest in the elderly, payment systems that disadvantaged geriatricians,* and *a lack of emphasis on this specialty in medical training programs.*
- This is starting to finally change!

カナダの老年医

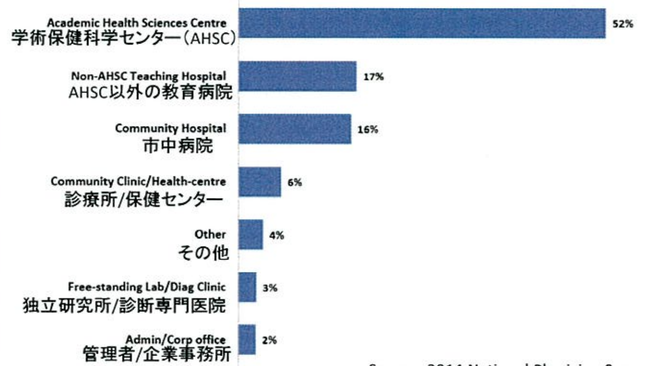
- 高齢者への社会的関心が欠けていること、老年医への不利な給与体系、そして臨床研修プログラムにおいて、老年医学の重要性が強調されてこなかったことから、最近に至るまで老年医学への人気は低迷したままであった。
- しかし、ついに変化する時がきた！

Where do Canadian Geriatricians Work?



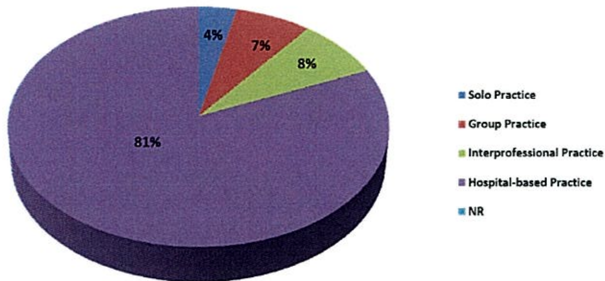
Source: 2014 National Physician Survey

カナダの老年医はどこで働いているのか？



Source: 2014 National Physician Survey

Where do Canadian Geriatricians Work?



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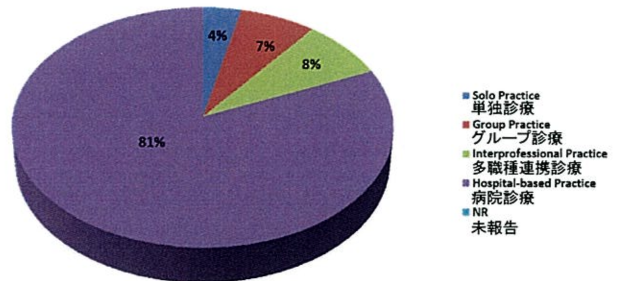
カナダの老年医はどこで働いているのか？



Source: 2014 National Physician Survey

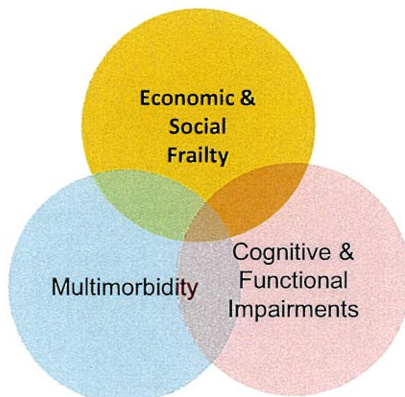
What Do Geriatricians Do?

- As specialists, we tend to work in interprofessional teams (nurses, social workers, therapists and pharmacists) to provide comprehensive geriatric assessments (CGAs)
- CGAs are holistic assessments provided in inpatient, outpatient, home and virtual settings that focus on *medical*, *cognitive and functional*, and issues that may be affecting an older person's independence.

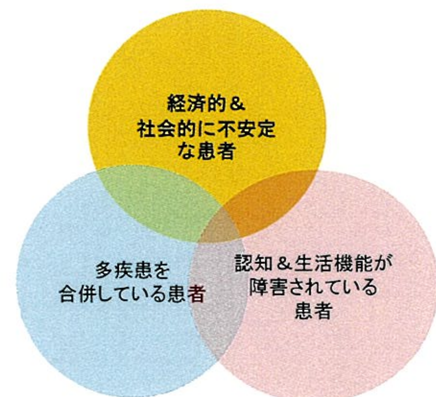
老年医は何をしているのか？

- 私たちは専門医として、高齢者総合的機能評価(CGAs)を供給するために、看護師、ソーシャル・ワーカー、理学療法師、薬剤師の方々と多職種連携チームを形成して働いている。
- CGAsとは、病院や外来、在宅、遠隔医療などの様々な状況における患者の医療状況、認知機能、生活機能にかかる問題点や、高齢者の独立を妨げる様々な問題点に対して供給される総合的な評価方法である。

What Defines our Highest Users?



老年医の対象患者とは？



What Do Geriatricians Do?

- As specialists, we tend to work in interprofessional teams (nurses, social workers, therapists and pharmacists) to provide comprehensive geriatric assessments (CGAs)
- CGA is defined as a multidisciplinary diagnostic process intended to determine a frail elderly person's **medical, psychosocial, and functional capabilities** and **limitations** in order to develop an overall plan for treatment and long-term follow up

老年医は何をしているのか？

- 私たちは専門医として、高齢者総合的機能評価(CGAs)を供給するために、看護師、ソーシャル・ワーカー、理学療法師、薬剤師の方々と多職種連携チームを形成して働いている。
- CGAは虚弱な高齢者に対する治療と長期療養への包括的な計画を立てるために、その高齢者を取り巻く**医療状況、心理社会的問題、機能的能力**や、その**制限**を決定することを意図し、多職種からの視点で診断していく過程と定義される。

An Opportunity for Intervention During Hospitalization

22 RCTs, 10 315 participants aged 65+ older, 6 countries, admitted to hospital (in emergency) who underwent CGA vs. usual care

OUTCOMES:

- ***More likely*** to be "living at home" (alive and in their own home)
  - At 12 months OR 1.16 (95% CI 1.05 to 1.28, p=0.003, NNT 33)
  - At 6 months OR. 1.25 (95% CI 1.11 to 1.42, p=<0.001, NNT 17)
- ***Less likely*** to be living in residential *care* (0.78, 0.69-0.88, p<0.001)
- ***Less likely*** to die or experience deterioration (0.76, 0.64 to 0.90; P=0.001)

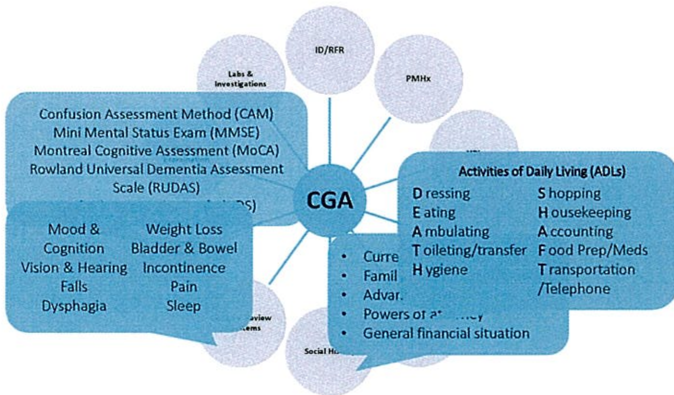
入院患者における調査結果

6カ国、合計10,315人の緊急入院を要した65歳以上の患者を対象に、CGAを用いて評価し治療した群と、通常の治療のみを行った群を比較した、22の無作為化比較対照試験(RCT)結果を示す。

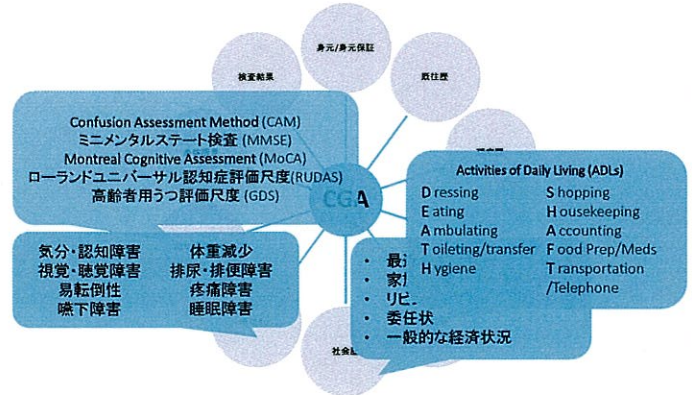
結果:

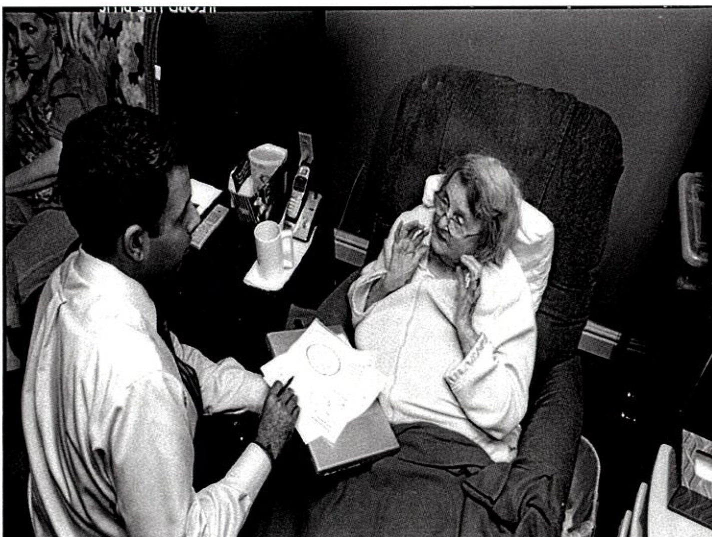
- ***自宅退院率が有意に高い***（生存して退院し自宅で生活する状態）
  - 12ヶ月後 OR 1.16 (95% CI 1.05 to 1.28, p=0.003, NNT 33)
  - 6ヶ月後 OR. 1.25 (95% CI 1.11 to 1.42, p=<0.001, NNT 17)
- ***老健施設への退院率は有意に低い*** (0.78, 0.69-0.88, p<0.001)
- ***病状悪化や死亡率が有意に低い*** (0.76, 0.64 to 0.90; P=0.001)

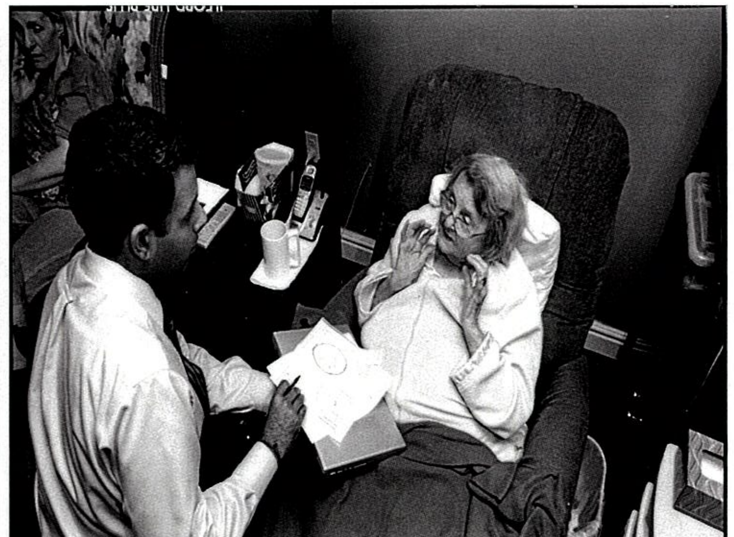
Components of a CGA



CGAの構成要素







Referral Reasons and Practice Settings

Common Reasons

- Dementia vs Delirium vs Depression
- Managing Functional Decline and Falls
- Diagnostic/Treatment Challenges
- Advice to Support Transitions to Outpatient, Community & Home-Based Services from Hospital and to Long-Term Care Settings from Home.
- Goals of Care & Disposition Planning

Practice Settings

- Hospital-Based (Acute and Rehab)
- Clinic-Based
  - General Geriatrics
  - Specialty Clinics (Memory, Falls etc)
- Home-Based ideally with Primary or Home Care Colleagues.
- Telemedicine or Virtual
  - Solo (Geriatrician Only)
  - Team-Based (IMPACT Clinic)

紹介理由と診療場面

一般的な紹介理由

- 認知症 vs せん妄 vs うつ病
- 機能低下・易転倒性の管理
- 診断/治療への挑戦
- 病院から外来、療養型病院への転院、あるいは在宅から長期療養型施設への移行をサポートする。
- 治療目標と退院計画

診療場面

- 病院（急性期・リハビリテーション）
- 外来
  - 総合老人外来
  - 専門外来（物忘れ、転倒予防等）
- 在宅（プライマリ・ケアや在宅医と）
- 遠隔医療
  - 単独（老年医単独）
  - チームベース（IMPACTクリニック）

Funding Models (Likely a Blend)

- **Fee-for Service:** Paid Set Fees per Service Provided – now based on time and specific activities for geriatricians.
- **Alternate Funding Plans**: Payments based on specific care and activity (capacity-building) thresholds.
- **On-Call Funding:** Stipend Based on Providing After-Hours On Call Services (mainly in hospitals)

財政モデル（組み合わされることが多い）

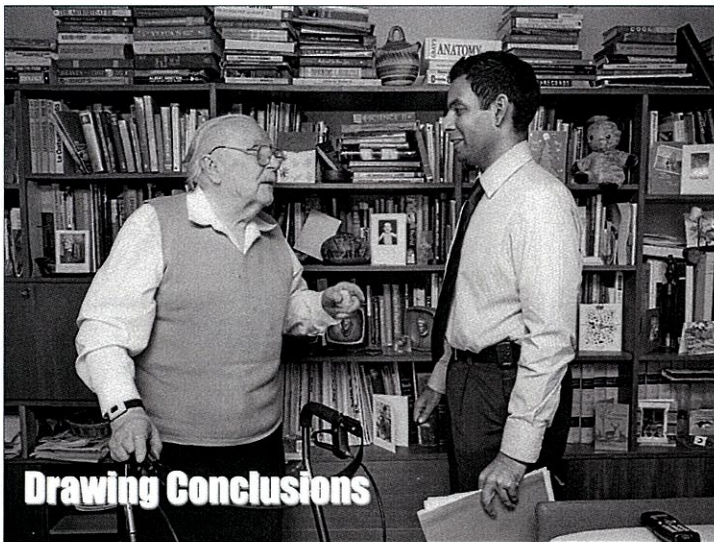
- **出来高払い制：実際に行ったサービスに応じて報酬が支払われる** – 現時点では老年医の診療行為と、その時間に基づいて支払われている。
- **代替資金計画**：特定のケアや能力育成型の活動閾値に基づいて支払われる。
- **オン・コール資金**：Stipend Based on Providing After-Hours On Call Services（時間外オン・コール業務提供に基づく給付金）が主に病院勤務者に対して利用されている。

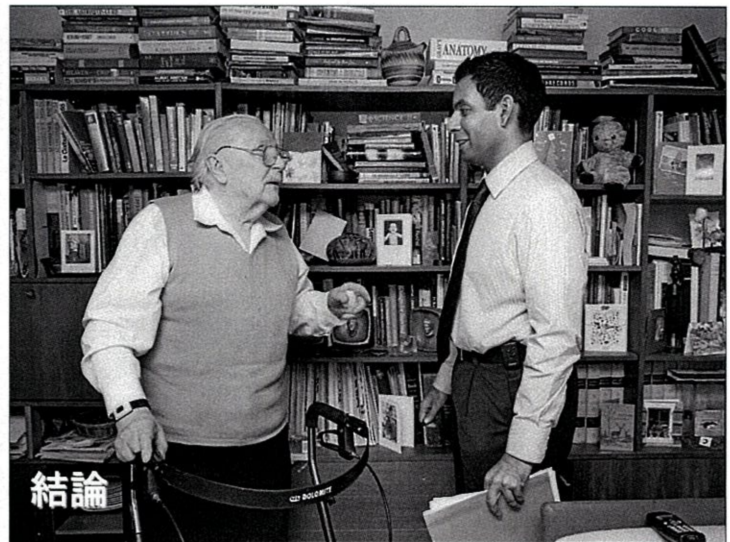
THE *ACE* CONTINUUM OF CARE

New Programs Launched Since Fiscal Year 2010-11
Programs To Be Launched in Fiscal Year 2015-16/2016-17

連続した高齢者への急性期ケア（ACE）

New Programs Launched Since Fiscal Year 2010-11
Programs To Be Launched in Fiscal Year 2015-16/2016-17





What Does the Future Hold?

- Geriatric Medicine and Psychiatry are now becoming recognized as valued specialties that will be essential to caring for an ageing population with specialist expertise.
- With increasing societal interest, payment reform and a growing emphasis on geriatrics in medical training – demand for training is on the rise.
- The Future is Bright for Geriatrics in Canada!

老年医学の未来はどうなるのか？

- 老年医学と老年精神科は、専門知識と経験とを要する高齢者ケアに対し、最も大切な要の存在であると認識され始めている。
- 社会的関心も高まりつつあり、給与体系の見直しとともに臨床研修の中で老年医学の重要性がより強調され、研修への要望も大きくなりつつある。
- カナダの老年医学の未来は、とても明るい！

Thank You

Samir K. Sinha MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System and the University Health Network

ssinha@mtsinai.on.ca
Twitter: @DrSamirSinha

ご静聴ありがとうございました

Samir K. Sinha MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System and the University Health Network

ssinha@mtsinai.on.ca
Twitter: @DrSamirSinha

Pauline Pariser MD CCFP FCFP
Associate Professor, Department of Family and Community Medicine
University of Toronto

Treating your patients with IMPACT: Integrated Care for Complex Patients

Pauline Pariser MD CCFP FCFP
ポーリーン・パリセラ
Associate Professor, Department of Family and Community Medicine
University of Toronto

Treating your patients with IMPACT:
IMPACTを用いた患者の治療
Integrated Care for Complex Patients
複雑な問題を抱える患者への統合ケア

Outline

- Integrated approach to managing complex patients
- Team-based consultation to support primary care physicians
- How this clinic addresses the Quadruple AIM:
  - Improves patient experience
  - Improves patient outcomes
  - Reduces costs
  - Improves physician experience

Outline　概要

- Integrated approach to managing complex patients
  複雑な問題を抱える患者に対する統合されたアプローチ
- Team-based consultation to support primary care physicians
  プライマリ・ケア医を支えるチームによる協議
- How this clinic addresses the Quadruple AIM:
  この診療の四つの目標
  - Improves patient experience　患者の経験をより良いものにする
  - Improves patient outcomes　患者の結果をより良いものにする
  - Reduces costs　経費を削減する
  - Improves physician experience　医師の経験をより良いものにする

Interprofessional Model of Practice for Aging and Complex Treatments

IMPACT PLUS is a comprehensive model of:

- Assessment
- Care
- Mentorship and training
- Inter-professional problem solving

Interprofessional Model of Practice for Aging and Complex Treatments
高齢者と複雑な問題を抱えた患者に対する専門職連携モデル

IMPACT PLUS is a comprehensive model of:
IMPACT PLUSは以下を含む包括的なモデル

- Assessment　考察
- Care　ケア
- Mentorship and training　指導と訓練
- Inter-professional problem solving 専門職連携による問題解決

The Problem:

Patients with complex co-morbidities

- 1-5% of the Ontario population
- 30-84% of health care costs

World wide

- 59% of 57 million deaths
- 46% of global burden of disease

WHO: Preventing Chronic Diseases: A vital investment. 2005.

The Problem:
問題点

Patients with complex co-morbidities
複雑な併存症を抱える患者

- 1-5% of the Ontario population オンタリオ市人口の1-5%
- 30-84% of health care costs 医療費の30-84%

World wide 世界的に

- 59% of 57 million deaths 5700万件の死亡の59%
- 46% of global burden of disease 全世界の疾患の46%

WHO: Preventing Chronic Diseases: A vital investment. 2005.

Broader Patterns

The 65+ age group:

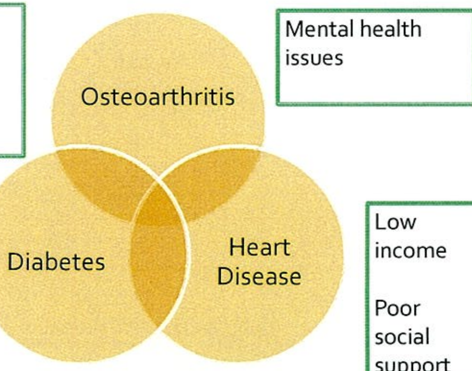
- fastest growing segment of Canadian population
- require treatment for 6.5 chronic illnesses, on average

Broader Patterns
幅広く傾向を見ると

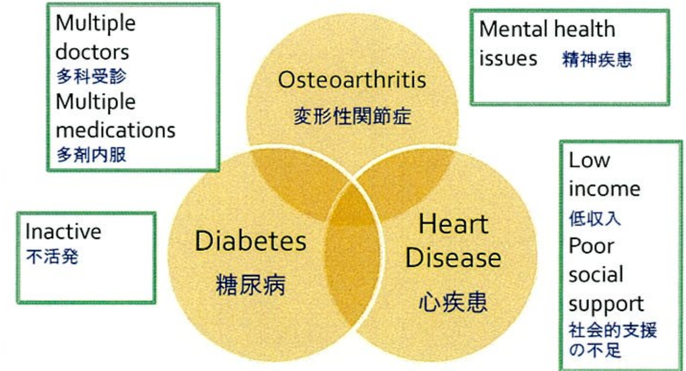
The 65+ age group: 65歳以上の高齢者グループは

- fastest growing segment of Canadian population カナダの人口で最も急速に増加している群
- require treatment for 6.5 chronic illnesses, on average 平均6.5個の慢性疾患の治療中

Typical Patient



Typical Patient
典型的な患者



Multiple Chronic Diseases: Challenges

- Clinical Practice Guidelines (CPGs) have a single disease focus
- CPGs often conflict with each other and between diseases
- Reliance on single disease CPGs = near total medicalization of patient's life

Multiple Chronic Diseases:多くの慢性疾患 Challenges 挑戦

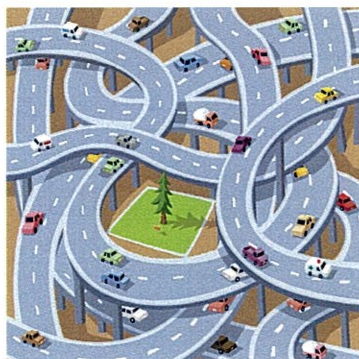
- Clinical Practice Guidelines (CPGs) have a single disease focus

  ガイドラインは一つの疾患に焦点を絞っている
- CPGs often conflict with each other and between diseases

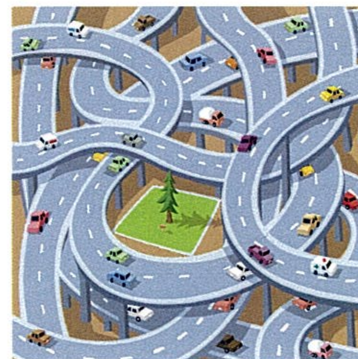
  ガイドラインは医師・患者間にも疾患同士にも葛藤を生じる
- Reliance on single disease CPGs = near total medicalization of patient's life

  一つの疾患を扱ったガイドラインに依存すると患者は一生薬を処方される

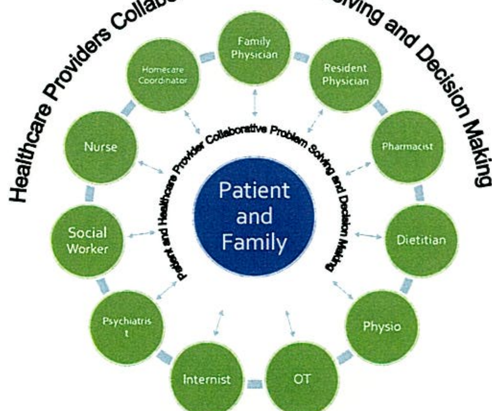
Too many specialist appointments
Too many tests....



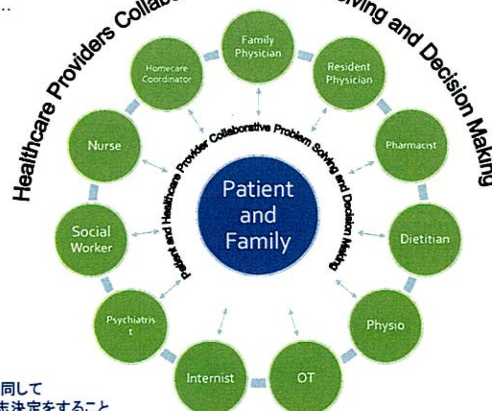
Too many specialist appointments 多すぎる専門医の予約
Too many tests.... 多すぎる検査



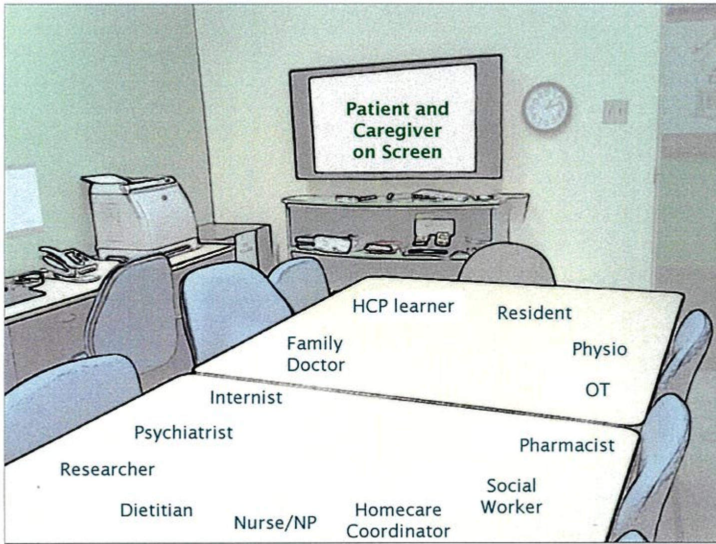
The Solution.....

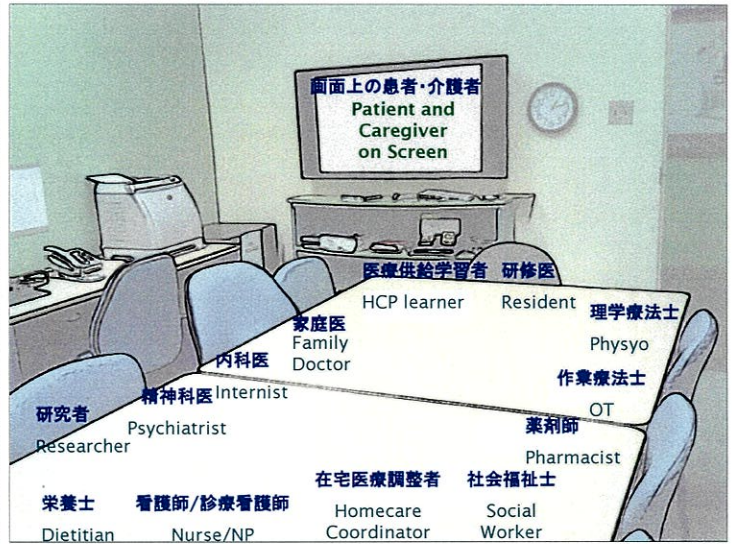


The Solution.....
解決策は.....



医療提供者が共同して
問題を解決し意志決定をすること





Telemedicine IMPACT Plus

Interprofessional Complex Care Clinics

Primary Care Physician
Patient
TIP Nurse
OTN Videoconferencing
Interprofessional Care Team
CCAC Coordinator
Dietitian
Psychiatrist
Social Worker
Internist/Geriatrician
Pharmacist
OT/Specialty Nurse

- A dedicated nurse prepares the case for the team and helps implement the plan
- Using Telemedicine TIP =a secure video conference

Telemedicine IMPACT Plus

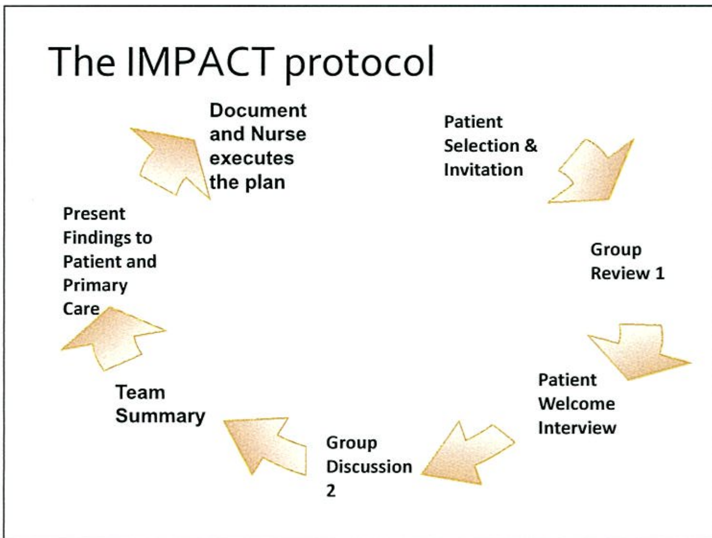
IMPACT Plus モデルを使用した遠隔医療

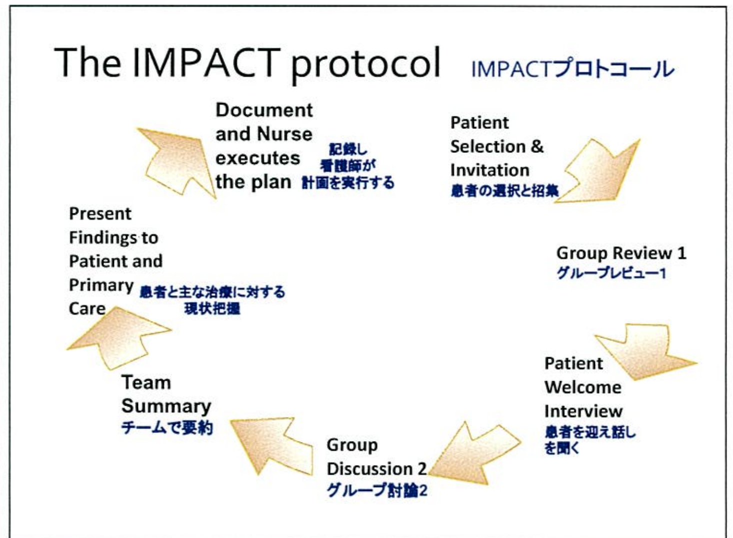
Interprofessional Complex Care Clinics

専門職が連携して複合的ケアを提供する診療

Primary Care Physician
Patient
TIP Nurse
OTN Videoconferencing
Interprofessional Care Team
CCAC Coordinator
Dietitian
Psychiatrist
Social Worker
Internist/Geriatrician
Pharmacist
OT/Specialty Nurse

- A dedicated nurse prepares the case for the team and helps implement the plan 担当看護師がチームの為に事例を準備し計画遂行を援助する
- Using Telemedicine TIP =a secure video conference
  IMPACT Plusモデルを使用した遠隔医療はセキュリティの高いビデオ会議





Relevance of General Internist Input

- "One Stop Shopping" -helps analyze co-morbid conditions
- Gives confidence to GPs. "You don't need to consult the cardiologist. Simply lower the dose of the beta-blocker."
- Simplifies treatment for multiple conditions
- Transfer of knowledge and modeling of clinical approach to other health professionals and trainees

Relevance of General Internist Input
総合内科医が関わる事の重要性

- "One Stop Shopping" -helps analyze co-morbid conditions
  「1か所に必要なサービスを集約させること」は併存症評価に有益である
- Gives confidence to GPs. "You don't need to consult the cardiologist. Simply lower the dose of the beta-blocker."
  総合診療医に自信を与える。「心臓専門医に紹介する必要はありません。ベータブロッカーの投与量を減らしさえすればよいのです。」
- Simplifies treatment for multiple conditions
  多様な状態に対して治療を単純化する
- Transfer of knowledge and modeling of clinical approach to other health professionals and trainees
  他の医療専門職や研修医に知識やモデル化した臨床方法を伝える。

Relevance of Psychiatric Input

- Chronic illness complicated by psychiatric co-morbidities
- Introduces theories and concepts of illness behavior
- Supports group process of team

Relevance of Psychiatric Input
精神科医が関わる事の重要性

- Chronic illness complicated by psychiatric co-morbidities
  精神科疾患が合併すると慢性疾患は複雑化する
- Introduces theories and concepts of illness behavior
  自分の病気を明らかにしようとする行動に関する
  理論と概念を導入する
- Supports group process of team
  チームの集団過程を支援する

Relevance of Community-based support

- Social worker and Homecare Coordinator part of the team
- Educate Family MD about community programs
- Make the connections for the patient:

eg. counselling programs, housing support, dietary services, homecare visiting.

Relevance of Community-based support 地域を基盤とした支援の重要性

- Social worker and Homecare Coordinator part of the team
  社会福祉士と在宅医療調整員もチームに加わる
- Educate Family MD about community programs
  家庭医に地域の取組みを教える
- Make the connections for the patient:
  患者のために繋ぎをする

eg. counselling programs, housing support, dietary services, homecare visiting.

カウンセリング、住宅支援、食事サービス、訪問診療などと患者を結ぶ

The Multi-Problem Patient

- A Different Approach:
  - "whole-person" approach: focus on *function* not *fixing*
  - Interactive communication / shared care between primary and specialty care.
  - One patient-centered treatment plan

The Multi-Problem Patient 多様な問題を抱える患者

- A Different Approach:
  異なるアプローチ
  - "whole-person" approach: focus on *function* not *fixing*
    「全人的」アプローチ：*修復するのではなく機能に*着目する
  - Interactive communication / shared care between primary and specialty care.
    相互にコミュニケーションを図る/プライマリ・ケア医と専門医でケアを分かち合う
  - One patient-centered treatment plan
    一人の患者を中心に治療計画を立てる

Does Collaborative Care Improve Outcomes?

Meta-analysis of interventions:

- positive effects on patient outcomes in mental illness and diabetes.

Qualitative data:

- Families and caregivers, primary care physicians feel supported

Does Collaborative Care Improve Outcomes? 連携したケアは結果を改善させるのか？

Meta-analysis of interventions: 介入のメタ分析

- positive effects on patient outcomes in mental illness and diabetes.
  精神疾患と糖尿病患者で好ましい効果があるとされている

Qualitative data:質的データ

- Families and caregivers, primary care physicians feel supported
  家族、介護者、プライマリ・ケア医は支援されていると感じている

Intended Outcomes

- Reduction in Emergency room visits
- Reduction in hospital admissions
- Reduction in the burden of care: Patients have many of their needs addressed in one visit
- ="ONE STOP SHOPPING" – increases efficiency (LEAN), decreases costs, improves patient experience

Intended Outcomes
予測される結果

- Reduction in Emergency room visits
  救急受診の減少
- Reduction in hospital admissions
  入院の減少
- Reduction in the burden of care: Patients have many of their needs addressed in one visit
  ケアの負担減少
- ="ONE STOP SHOPPING" – increases efficiency (LEAN), decreases costs, improves patient experience
  ワンストップショッピング―効率上昇、経費削減、患者経験の改善

Intended Outcomes (2)

Primary Care Providers

- Reduce burn-out – these are difficult patients to look after
- Comprehensive chart review
- Fewer office visits
- Care plan provides the way forward

Intended Outcomes (2)
予測される結果(2)

Primary Care Providers　プライマリ・ケア提供者にとって

- Reduce burn-out – these are difficult patients to look after
  燃え尽きるのを減らす―面倒みるのが難しい患者がいるので
- Comprehensive chart review
  包括的にカルテを見直す
- Fewer office visits　外来受診が少なくなる
- Care plan provides the way forward
  ケアプランがあれば前に進むことができる

Intended Outcomes

For patients:

- The patient's needs are considered: "What is important to you?"
- Patient is part of the solution – interacts with the whole team.
- Improved self-management of chronic condition

Intended Outcomes
予測される結果

For patients:　患者にとって

- The patient's needs are considered: "What is important to you?"
  患者のニーズが考慮される「あなたにとって何が重要か？」
- Patient is part of the solution – interacts with the whole team.
  患者は解決の一部となる　―　チーム全体と相互に作用する
- Improved self-management of chronic condition
  慢性疾患の自己管理が上手くなる

Intended Outcomes (3)

Team:

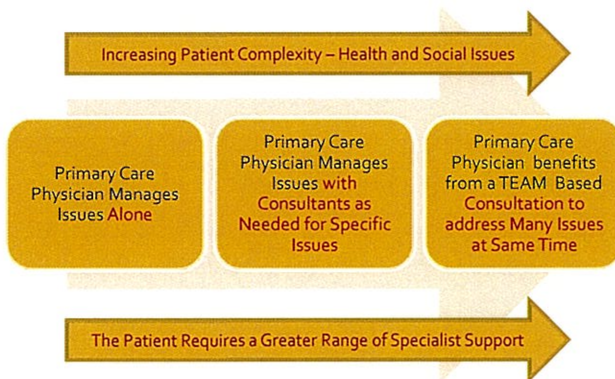
- Understanding each professional's scope of practice
- Transfer of knowledge & skills to other team members and to students

Intended Outcomes (3)
予測される結果(3)

Team:　チームにとって

- Understanding each professional's scope of practice
  互いの職種の役割が理解できる
- Transfer of knowledge & skills to other team members and to students
  他のチーム員や学生と知識と技術を交流させる

Across the Continuum



Across the Continuum連続性を超えて

IMPACT PLUS in 6 easy steps

1. Selection of the right patient
2. Community nurse generates patient-centered problem list
3. Set up video-conference with the team and determine who will interview
4. Conduct the case conference
5. Document recommendations as part of a coordinated care plan
6. Community nurse helps patient/family and primary care provider implement the plan

IMPACT PLUS in 6 easy steps
6つの簡単なステップ

1. Selection of the right patient患者の選択
2. Community nurse generates patient-centered problem list患者中心のプロブレムリスト
3. Set up video-conference with the team and determine who will interviewビデオカンファレンス
4. Conduct the case conferenceケースカンファレンス
5. Document recommendations as part of a coordinated care plan推奨の記録
6. Community nurse helps patient/family and primary care provider implement the plan
   地域看護師は計画を開始する患者/家族/家庭医を援助する

Case Study:73 year old retired physician

1. Selection of Right Patient: CCC =Complex Co-morbid Conditions:

- Ischemic Cardiomopathy with ejection fraction<30%
- Atrial fibrillation with CHADs Score of 2
- Hyperlipidemia
- Gout
- Renal cell cancer
- IGA paraproteinemia
- Smoker
- Social isolation
- Short term memory loss – determine dementia vs. depression
- Sleep deprivation
- Irritable bowel syndrome

Case Study:73 year old retired physician
ケーススタディ：73歳退職医師

1. Selection of Right Patient: CCC =Complex Co-morbid Conditions:下記の複雑な併存疾患

- Ischemic Cardiomopathy with ejection fraction<30%
- Atrial fibrillation with CHADs Score of 2
- Hyperlipidemia
- Gout
- Renal cell cancer
- IGA paraproteinemia
- Smoker
- Social isolation
- Short term memory loss – determine dementia vs. depression
- Sleep deprivation
- Irritable bowel syndrome

Patient Centered Problem List

2.Community Nurse generates Patient-centered Problem list: What matters to the patient:

3 top concerns:

1. Coordinate services so patient manages at home – Patient wants better quality of life -to look after cat "Smoothie." Would like a scooter to increase his mobility/decrease social isolation.

2. Is patient developing dementia or are low mood and sleep disorder contributing to memory loss?

3. Improve medical management of generalized fatigue, CHF and abdominal bloating

Patient Centered Problem List
患者中心のプロブレムリスト

2.Community Nurse generates Patient-centered Problem list: What matters to the patient:
地域看護師が作成したプロブレムリスト

3 top concerns:トップ3の心配事

1. Coordinate services so patient manages at home – Patient wants better quality of life -to look after cat "Smoothie." Would like a scooter to increase his mobility/decrease social isolation.
家庭での管理ー猫の面倒、スクーターの使用

1. Is patient developing dementia or are low mood and sleep disorder contributing to memory loss?
認知機能低下

1. Improve medical management of generalized fatigue, CHF and abdominal bloating倦怠感、心不全や腹部膨満感の管理

Decide on Team Players

3. Who are the right people on the inter-professional team to interview and advise the patient? Note: Family Physician also attends

For: 1. Coordination of social services=social worker/ Behavioral resource outreach worker

2. Determination of dementia/depression/sleep disorder =psychiatrist and pharmacist

3. For medical management =geriatrician

Decide on Team Players
チームの決定

3. Who are the right people on the inter-professional team to interview and advise the patient? Note: Family Physician also attends
多職種連携チームでの中心は誰か：家庭医も参加する

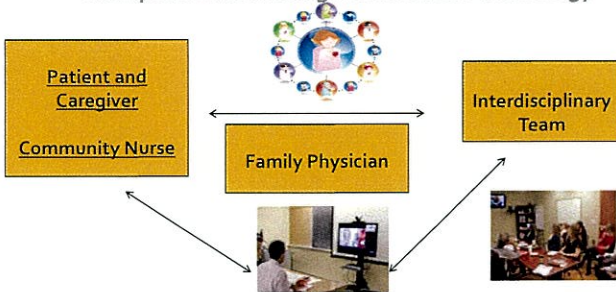
For: 1. Coordination of social services=social worker/ Behavioral resource outreach worker
社会支援の調整＝社会福祉士など

2. Determination of dementia/depression/sleep disorder =psychiatrist and pharmacist
認知症/うつ/不眠の評価＝精神科医と薬剤師

3. For medical management =geriatrician
医学的管理＝老年医学専門医

A 'Typical' 1 hour TIP Meeting

- Inter-professional case conference with patient, caregiver, and family doctor present
- Multiple locations using Telemedicine technology



A 'Typical' 1 hour TIP Meeting

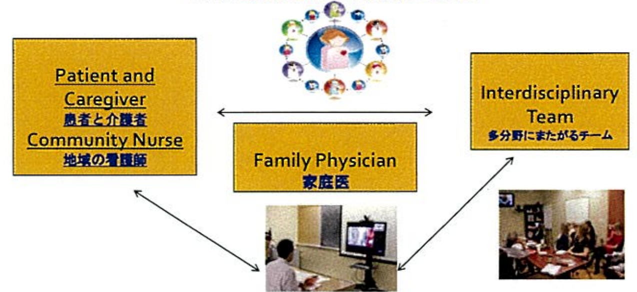
「典型的な」1時間のTIP会議

- Inter-professional case conference with patient, caregiver, and family doctor present

  患者、介護者、家庭医が参加する専門職連携事例検討会

- Multiple locations using Telemedicine technology

  遠隔医療技術を用いた多施設からの参加



Interview: Patient at home/team in hospital or clinic

4. Conduct the case consultation: Each provider interviews the patient and everyone problem solves together– done via secure videoconference

Interview: Patient at home/team in hospital or clinic面談

4. Conduct the case consultation: Each provider interviews the patient and everyone problem solves together– done via secure videoconference

ケースコンサルテーション：ビデオを通して一緒に解決する

Recommendations:

5. Document recommendations into coordinated care plan:

1.Referral made for occupational therapy assessment for scooter

2.Dementia vs: Depression – assessed as having mild cognitive impairment. SSRI/SSNRI – contraindicated.

Address sleep disorder – referral for sleep study, advised re: aids to increase relaxation and mindfulness. Librium discontinued with low dose Clonazepam recommended if necessary

Recommendations:推奨

5. Document recommendations into coordinated care plan:調整プランへの推奨の書類作成

1.Referral made for occupational therapy assessment for scooterスクーター使用のためにOTへ紹介

2.Dementia vs: Depression – assessed as having mild cognitive impairment. SSRI/SSNRI – contraindicated.

Address sleep disorder – referral for sleep study, advised re: aids to increase relaxation and mindfulness. Librium discontinued with low dose Clonazepam recommended if necessary

認知症vsうつ：SSRI/SSNRI禁忌、睡眠障害検査、リチウム中止、少量のクロナゼパム使用。

Recommendations (continued)

3. Medical issues:

- Referred to respirologist and for smoking cessation.
- Enhanced management of medications for CHF- e.g. Good = 92 kg – take 80 mg. Furosemide.
- To see dietician regarding NACL intake and address bloating.
- For fatigue: Sleep study, use of appropriate meds for insomnia, decreased social isolation and better management of heart failure to contribute to improved energy

Recommendations (continued) 推奨のつづき

3. Medical issues:医学的課題

- Referred to respirologist and for smoking cessation.
  禁煙のために呼吸器科医へ紹介
- Enhanced management of medications for CHF- e.g. Good = 92 kg – take 80 mg. Furosemide.
  心不全の管理
- To see dietician regarding NACL intake and address bloating.
  栄養管理
- For fatigue: Sleep study, use of appropriate meds for insomnia, decreased social isolation and better management of heart failure to contribute to improved energy倦怠感に対して、睡眠管理、孤立や心不全管理

Implementing the Recommendations

6. **Community Nurse helps patient and family physician implement the recommendations over the next 6 months**

Note: Family physician implemented all the recommendations within the first week post-TIP clinic

Implementing the Recommendations推奨の実行

6. **Community Nurse helps patient and family physician implement the recommendations over the next 6 months**
地域看護師は患者は家庭医が推奨を実行することを6か月以上支援する

Note: Family physician implemented all the recommendations within the first week post-TIP clinic
家庭医はTIPクリニック後の1週間で全ての推奨を実施する

Patient Outcomes

Patient Experience:

I wish we had this kind of service when I was practicing.

I am impressed at the level of knowledge the team has. This is true care coordination.

I did not think the team would address all my concerns. I was in awe when they touched on everything, even the fact that I was interested in having a scooter - that was mind-blowing for me.

Patient Outcomes 患者の結果

Patient Experience:患者の経験

I wish we had this kind of service when I was practicing.
このようなサービスができればよかった
I am impressed at the level of knowledge the team has. This is true care coordination.
チーム知識レベルに感銘、これが本当のケア連携
I did not think the team would address all my concerns. I was in awe when they touched on everything, even the fact that I was interested in having a scooter - that was mind-blowing for me.
全ての自分の心配事に対応しているわけではないが、スクーターにも興味をもったことは恐れ多く、うれしいことであった。

Patient Outcomes

3 Months Post-TIP Clinic:

•Saw respirologist and started on inhalers which has helped his shortness of breath

•Heart failure well-controlled

•Started smoking cessation program

•Still being assessed for scooter

•His clonazepam had to be changed to diazepam 2.5 mg

•Overall functioning better with less fatigue.

Patient Outcomes
患者の結果

3 Months Post-TIP Clinic: 3か月後

•Saw respirologist and started on inhalers which has helped his shortness of breath呼吸器科の治療開始

•Heart failure well-controlled心不全コントロール

•Started smoking cessation program禁煙外来

•Still being assessed for scooterスクーター調整

•His clonazepam had to be changed to diazepam 2.5 mg
服薬調整

•Overall functioning better with less fatigue.倦怠感改善

TIP OUTCOMES:

Since implementation in 2013:

- 95% of family physicians are satisfied with recommendations
- 92% of patients and caregivers feel confident their care will be better managed
- 538 patients have received TIP clinic
- 336 solo family physicians supported by TIP team and connected with new inter-professional resources

TIP OUTCOMES:結果

Since implementation in 2013: 2013年開始以来

- 95% of family physicians are satisfied with recommendations
  95%の家庭医が推奨に満足
- 92% of patients and caregivers feel confident their care will be better managed
  92%の患者と介護者がケアに自信を持った
- 538 patients have received TIP clinic
  538人がTIP外来を利用している
- 336 solo family physicians supported by TIP team and connected with new inter-professional resources
  336人の家庭医をTIPチームが支援し、新しい職種間連携に繋がっている

TIP Outcomes

IMPACT PLUS chosen for national RCT

to assess:

Costs, use of acute care services, patient outcomes and experience, quality of team-based care.

Early qualitative results: met needs of complex patients, all participants experienced benefit, offered full spectrum of Patient-centered Clinical Method.

TIP Outcomes結果

IMPACT PLUS chosen for national RCT
国のRCTに選ばれる

to assess:

Costs, use of acute care services, patient outcomes and experience, quality of team-based care.
コスト、急性期治療の利用、患者のアウトカムと経験、チームケアの質

Early qualitative results: met needs of complex patients, all participants experienced benefit, offered full spectrum of Patient-centered Clinical Method.
質的結果：複雑な患者のニーズ、経験の利益、患者中心の臨床

IMPACT Publications

- Bell SH, Tracy CS, Upshur RE; IMPACT Team. The assessment and treatment of a complex geriatric patient by an interprofessional primary care team. BMJ Case Rep. 2011 Mar 15;2011. doi:pii: bcr0720103154. 10.1136/bcr.07.2010.3154.
- Smirnova A, Bell SH, Tracy CS, Upshur RE. Still dizzy after all these years: a 90-year-old woman with a 54-year history of dizziness. BMJ Case Rep. 2011 Sep 13;2011. doi:pii: bcr0520114247. 10.1136/bcr.05.2011.4247.
- Medlock A, McKee E, Feinstein J, Bell SH, Tracy CS. Applying an innovative model of interprofessional team practice: The view from occupational therapy. Occupational Therapy Now. 2011 May/June;13(3): 7-9.
- Medlock A, McKee E, Feinstein J, Bell SH, Tracy CS. Applying an innovative model of interprofessional team practice: The IMPACT model in action. Occupational Therapy Now. 2011 November/December; 13(6): 28-9.
- Tracy CS, Bell SH, Nickell LA, Charles J, Upshur REG, on behalf of the IMPACT Team. The IMPACT clinic: an innovative model of interprofessional primary care for elderly patients with complex healthcare needs. *Canadian Family Physician* [in press].

IMPACT Publications文献

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Arigato Gozaimasu

For more information:

Dr Pauline Pariser
Pauline.Pariser @uhn.ca

Arigato Gozaimasu
ありがとうございます

For more information:

Dr Pauline Pariser
Pauline.Pariser @uhn.ca

CIGM

Center for innovation of general medicine in Toyama