Multidisciplinary Teamwork in Musculoskeletal Conditions

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MSK multidisciplinary teamwork

- No different to any MDT approach
- Coordination of care versus episodic, single discipline approach
- Strategies to create and engage team
- Includes variety of NGO’s and community based care supports
- Ideally shared patient records
Why is teamwork important?

- People rarely have a single care provider and/or single health issue

- A strong MDT within a Musculoskeletal model of care helps us:
  - Be person focused and holistic
  - Recognise, assess and respond to the presence of other co-morbidities
  - Integrate care with other health clinicians, not act as an MSK “silo”
Musculoskeletal Care

- MSK disease inextricably linked to other chronic health issues.
  - 1 or more co-morbidities: 87%
  - 2 or more co-morbidities: 64%
  - 3 or more co-morbidities: 39%  (OACCP, 2012)

- MSK recognition in NSW long overdue
  - Specific disease approaches e.g. cardiac, diabetes, often ignore primary MSK limitation
  - Failure to identify other chronic disease risk factors in MSK patients
Chronic Care Management

The “elements of chronic care”:

- Maximise health outcomes and QOL
  - Evidenced based care and interventions
  - Promotion of self-management
  - Behaviour change strategies
  - Health coaching

- Care underpinned and supported by MDT

Ref: NSW Health Chronic Care Program
Benefits with MDT

- Care planning – individual, personalised ✓
- Point of entry for referral and assessment ✓
- Screening and coordination ✓
- Monitoring of intervention ✓
- Empowerment and self-management ✓
- Focus on consultation ✓
- Joint decision making with person/carer ✓
Benefits with MDT

- Holistic approach ✓
- Consistent messaging ✓
- Health Coaching - person focused goals ✓
- Success measured by:
  - access to evidenced based interventions ✓
  - individual health outcomes ✓
  - achievement of goals ✓
What do people needing Chronic Disease Management look like?
Case Study: Mr J

▲ 63 yr old male
▲ Presented 6/52 ago with 8/10 lower back pain and 9/10 radiating right leg pain
▲ 25 years since initial LBP; injury with fall at work
▲ Not working since 1998
▲ OA Lumbar Spine; Knees
Case Study: Mr J

PMHx:
- CVD; AMI in Queensland ~3-4 years ago, 2x Stents; still occasional angina
- Poorly controlled T2DM (BGL range 11.5 -16)
- HT (BP ↑ed lately to 160/90; ↑ed medication)

Mobility / Exercise Tolerance
- Maximum 80m last 12-18 months (pain)
- Increasingly housebound
Case Study: Mr J

- BMI = 39.7 (↑16kg last 12 months)
- Waist Circumference = 142cm
- Social Hx: married; recently moved back from Qld with wife; now primary carer for 3 grandchildren (aged 6, 8, 11)
- Depression / Anxiety / Fear Avoidance
- *Dissatisfied, disheartened with current care*
What care does Mr J need?

- MDT Chronic Care Management
- Presenting problem (OA) is SIGNIFICANT and is RELATED to his current health issues and overall lifestyle risk factors
Who has been involved in Mr J’s care?

- General Practitioner
- Cardiologist x 2
- Previous Cardiac Rehab
- Endocrinologist x 2
- Diabetic Educator
- Rheumatologist
- Physiotherapist
Multidisciplinary planning

In essence:
- Agreed goals
- Partnerships to coordinate care
- Support individual to actively participate
Who is in Mr J’s “team”?

- Physiotherapist – create and engage team
  ▲ Exercise Prescription, coaching support

- GP - recognised as coordinator of care
  ▲ Mood, Medication, encourage Physical Activity benefits (CVD, HT and T2DM)

- Rheumatologist – specialist follow up
  ▲ OA Hip (X-rays); Ortho Surgeon referral; Support for CCP links
Who is in Mr J’s “team”?

- Wife/Carer and his Grandchildren
- Diabetes Clinic, Dietitian or NGO’s?
  - Previous education packages and input – reinforced options available
- Others?
  - Orthopod, Cardiologist and Endocrinologist
  - Arthritis and/or Diabetes Groups
  - Psychologist
Challenges for MDT

- Connecting evidenced based care with actual care delivery
  - GP’s as care coordinators lack time
  - Funding models support episodic care
  - Access to health professionals difficult

- Changing how clinicians ‘do business’
  - Online assessment and record keeping
  - Person driven, not episodic and practitioner driven
Has it made any difference?

- Outcomes at 6/52
  - Walking program - 500m/day with W/stick
  - LBP 2/10; No radiating leg pain; Hip ~ ISQ
  - Medication review with GP
  - BGL’s now range - 5.5 to 8.1
  - Waist Circumference decreased 4cm
  - Improved HT control (last 140/80)
  - Improved mood++ and family interaction
Has it made any difference?

▲ Ortho Specialist: ? fit for surgery if required
▲ Transition to community based programs
  ● Commenced Hydro 1x/wk
  ● Diabetes Australia

▲ “I took the kids to the show and walked for hours. Gee I was a bit sore, but it was worth it!”
▲ “Pop is not just sitting in his chair now Nan, he’s coming out to play with us!”
Any Questions?