COMMENTARY

Building an integrated multidisciplinary care model for pediatric inflammatory bowel disease using institutional support

Daniel William

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ABSTRACT

While the bio psychosocial component of Inflammatory Bowel Disease (IBD) is now widely acknowledged by doctors, institutional managers, who make decisions about the funding of clinical programmes, are not always aware of the necessity for integrated multidisciplinary care. In this commentary, we highlight important factors to consider when gaining initial approval as well as strategies to maintain institutional support over time. We do this by drawing on our own experience in developing successful integrated care models within a division of Paediatric Gastroenterology (GI). We discuss the significance of presenting a compelling argument for the inclusion of a psychologist in pediatric IBD care, supporting an integrated model of care delivery, and addressing financial issues at the programme level. Additionally, we examine the advantages of gathering and disclosing programme data to back up the body of knowledge and/or theoretical hypotheses, demonstrate results, and develop additional value streams recognized by the institution (e.g., academic, reputational) in addition to the value to patients. Finally, moving from the theoretical to the practical while continuously framing debate for a nonclinical/administrative audience is necessary for success in gaining and sustaining institutional support. Although the procedure can take some time, it is ultimately worthwhile because it improves the experience of both patients and clinicians receiving care.

Key Words: *Interdisciplinary; Multidisciplinary bio psychosocial; Gastroenterology, psychology; Pediatrics; Integrated care and inflammatory bowel disease*

INTRODUCTION

An expanding corpus of research is showing that inflammatory bowel disease is bio psychosocial in origin . The bio psychosocial approach acknowledges that biological, psychological, and social (relationships, environment) components all interact to produce symptoms and disease activity. Clinicians may assume that it is obvious that each of these areas is a therapeutic target that must be addressed in order to give patients the best possible physical health and quality of life. They may also assume that this dynamic model makes it clear that the gastroenterology (GI) doctor and the psychologist should work together to provide routine *IBD* care. However, non-clinicians, who frequently make decisions regarding the resources supplied to clinical programmes, are not usually as aware of this need. In our experience, when deciding whether to support the growth of multidisciplinary and interdisciplinary clinics, administrators primarily ask two questions: What are the requirements of the patients, and what are the best ways to meet those needs? And what financial effects will the suggested practise model have? The first query is simpler, more empirically supported, and more consistent from health system to health system with regard to securing support for the formation of an IBD interdisciplinary programme. The second query focuses on a subject that is still developing and is initially partly reliant on the contracting and billing capabilities of a specific health system. In this article, we will address these concerns and discuss strategies for retaining support after winning initial acceptance. The lessons acquired can and should be applied to other pediatric subspecialty populations and clinical providers essential to their care, even though the focus of this discussion will be on pediatric IBD and the GI physician-psychologist relationship in IBD programmes. Real-world experience

Editorial Office, Journal of Nursing Research and Practice, Windsor, Berkshire

Correspondence: Daniel William, Editorial Office, Journal of Nursing Research and Practice, Windsor, Berkshire, e-mail: editor.jnrp@pulsusinc.com

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Making the case for inclusion of a psychologist in IBD care

The first step in winning support for include a psychologist in an IBD programme and developing a multidisciplinary clinic is to use the available literature to craft a persuasive argument for their inclusion in standard IBD therapy. The following serves as an illustration of how to use the present body of research to persuade an administrative leader of the significance of mental health in IBD, rather than serving as a complete assessment of the literature. The most important aspects to discuss are that psychological dysfunction is widespread in inflammatory bowel disease (*IBD*), that it affects symptoms, quality of life, and resource use, and that it may be treated, which in turn has a favorable effect on the course of the disease and expenses. Example of justification: Children with IBD are more likely to experience despair, anxiety, social isolation, and changed self-image. In reality, depression symptoms are present in almost 25% of adolescents with IBD, and the majority of these cases go undiagnosed without deliberate screening and evaluation. Internalizing symptoms are also linked to lower health-related quality of life in children with IBD, as well as higher pain frequency, severity, and effect. Depression is correlated with discomfort, diarrhea, and weight loss in teenagers with IBD. In general, stress is linked to symptom aggravation and relapse, especially in people who already have anxiety or depression.

Given everything said above, it may not come as a surprise that a mental health diagnosis dramatically raises the number of emergency room visits and inpatient stays among young people with IBD. Anxiety and depression were found to be negatively connected with transition self-efficacy in a recent comprehensive review, which suggests that they may delay or prevent a successful transition to adult care. Understanding the connection between internalizing symptoms and IBD control appears to be crucial given the detrimental effects that psychological dysfunction might have on medication compliance. Several obstacles, including (but not limited to) the complexity of the treatment regimen in pediatric IBD, have a negative impact on adherence. The relationship between adherence obstacles and adherence appears to be moderated by emotional and behavioral functioning, with the lowest adherence seen in individuals with higher barriers and higher anxiety and/or depression. Depending on the measuring method, no adherence rates of 2 to 93% have been observed in young people with IBD and are linked to poor coping mechanisms, anxiety, sadness, and issues with family and social interactions. In turn, no adherence is linked to a rise in disease severity, a decline in clinical remission rates, a rise in the chance of relapse, and a rise in medical expenses. In summary, it is now understood that anxiety and/or depression are frequent in children with IBD and that they have an adverse impact on IBD symptoms and disease progression, adherence, quality of life, and transition efficacy/readiness.

Fortunately, there are methods for locating and successfully treating IBD patients who are at risk. The clinical course and health-related quality of life can be positively impacted by appropriate screening and treatment of anxiety and depression in children and adolescents with IBD. In children and adolescents with IBD and depression, psychotherapy lessens impairment, lessens depression, and improves general adjustment. It also lowers healthcare use, such as hospital admissions, ER visits, radiologic exams, and endoscopies. The adherence rate can be greatly increased by individually planned psychological treatment for non-adherence, which may include instruction in problem solving techniques and, in some situations, behaviour management, self-management, and education. The North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition and a task force of the Improve Care Now network have both endorsed the significance of routine psychosocial and adherence screening in children with IBD in light of this mounting evidence, setting the new standard for best practise and paving the way for psychological treatment to be routinely incorporated into clinical care.

Although it is crucial to communicate the extensive body of research that shows how essential it is for a psychologist to be a part of the healthcare team, as was done above, our experience has shown that gathering data to apply this research locally is frequently crucial. Data gathered from patients at your own clinic can help personalize the need for more holistic care. Before requesting permission to add psychology to the medical team, we would advise starting local screening (or any other discipline). In the end, a range of factors must guide the selection of certain screening tools: Topic areas to be screened, frequency of reassessment, availability of measures with strong psychometric properties within those areas, length of individual measures compared to the battery as a whole, cost of using individual measures as part of standard clinical care, administration and scoring logistics, and, last but not least, clinical utility.

In order to strengthen your argument, you may also be able to extract additional data from the electronic medical record (EMR) and integrate it with the screening results. For pediatric IBD, the impacts of anxiety, depression, and adherence could be examined in relation to EMR-based outcome indicators such, for instance, the population-level admission and length of stay rates for hospitals without the use of steroids. It will be simpler for you to "ask" for the inclusion of a psychologist in standard IBD care if you can demonstrate the impact of psychological and social factors on the symptoms, course, and associated costs of IBD in your own clinic's patient population.

Finally, we advise stressing that when we accept the duty to care for a patient with IBD, we also accept the duty to find and address all pertinent factors that may have an impact on the patient's outcome. In other words, you have an implied ethical responsibility to remedy the flaws found after screening patients. The body of existing research makes a compelling case for the inclusion of mental health screening and treatment in IBD programs, which will hopefully be strengthened by local data.

Justifying an integrated model for delivering care

When an administrator is persuaded that include a psychologist on the IBD healthcare team is essential for achieving the best possible illness outcomes, the question of how to do so in the most effective, economical, and patient-centered way remains unanswered. Why not, for instance, examine patients in the clinic and refer them to a psychologist if necessary? What are the benefits of an interdisciplinary programme where professionals also actively engage and share choices while taking into account the many elements influencing results versus a multidisciplinary programme where each expert contributes to the patient's care? For an in-depth discussion of various multidisciplinary care models, numerous methods have been used to determine the best care models from the perspectives of healthcare providers and patients. All of these methods unanimously support a "multidisciplinary" process, which in reality frequently refers to an integrated multidisciplinary or interdisciplinary approach to practise.

In a study using semi-structured interviews with IBD specialists, it was determined that contacts across subspecialty providers were of the utmost importance and that the ideal approach comprised sharing collective expertise in a formalized manner. An interdisciplinary coordinated structure was also endorsed by a systematic analysis of IBD care standards from the perspectives of healthcare providers and patients, which came to the conclusion that this approach was affordable.

Healthcare professionals and patients in the UK came to almost complete agreement that treatment should be delivered by a multidisciplinary team that meets frequently to discuss appropriate individuals. An integrated care model with a healthcare team that includes a psychologist was determined to be the best model by a recent systematic review. This model has been found to reduce hospital admissions, IBD surgeries, comorbidities, and both direct and indirect expenses. It is evident that both patients and providers support a care model that falls between integrated multidisciplinary, where providers work side by side with real-time meaningful communication/collaboration and interdisciplinary, where providers regularly see patients together.

Addressing program finances

Selling an integrated care vision can be difficult, especially when addressing a program's financial implications. The majority of IBD healthcare providers believe that lack of money is the biggest obstacle to implementing the best care approach. In addition to the many different reimbursement models that are currently in development, trends toward capitated care and shared risk models, and potential future reimbursement models focused on providing value to the patient, i.e., improved outcomes at lower costs are among the challenges. Although pay-for-service remains the main method of payment, healthcare providers must prepare for the transition to payment models that value high-quality care. Although it is outside the scope of the current article to address the many and evolving payment structures, we would want to highlight three points in advance of discussion of the programme proposal with administration: Create a thorough plan for the care model; create a business plan; and emphasise the necessity to evaluate finances as total inflow minus total outflow.

First, a thorough explanation of the optimal clinical care model enables management to comprehend staffing and resource requirements as well as strategies for maximizing effectiveness. Additionally, it offers the strong structure required for creating a business strategy because start-up costs and ongoing expenses can be estimated more precisely. A marketing strategy, anticipated revenue, and potential development into other areas should all be included in the company plan. Administrative decision-makers typically exhibit greater confidence when the clinical care model and commercial plan are more detailed. The need of identifying business partners in order to give administrationdata with credibility cannot be overstated. The clinical team should continue to be actively involved in business planning, though, to avoid data being derived from incorrect assumptions and to guarantee that they are accurate based on the clinical team's experience and plans. The business plan's forecasts can be made in a collaborative effort, which results in the most precise, significant, and reliable results. The financial evaluation of the ideal clinical care model should be framed as total revenue minus total expenses for the programme as a whole, diverting the discussion away from the evaluation of individual team members. This is likely the most crucial step in selling and maintaining an integrated care vision. An integrated care programme is likely to be destroyed by a careful review of individual team members due to the disparities in billing parameters, reimbursement rates, etc. amongst specialized providers. The bottom line will benefit from optimizing billing for individual team members, but considering the whole i.e., total inflow versus total outflow more effectively takes into account team time, especially when one team member can bill for a portion of the clinical service (e.g., time spent in non-face-to-face interdisciplinary collaboration) but another cannot. The entire initiative should be approved if its financial requirements are met, according to the government. If not, guidelines can be established and efforts can be made to balance the budget without sacrificing the best possible service. Integrated care models are well adapted to be the most cost-effective as more remuneration is capitated or based on the quality of results, indicating superior outcomes that cut costs and improve patient value.

CONCLUSION

Clinicians now debate how to effectively execute integrated care in practise rather than whether psychologists should be included as a crucial part of the IBD healthcare team. Although the purpose of this commentary was to discuss strategies for leveraging institutional support to create and sustain integrated multidisciplinary care models for Paediatric IBD and other GI populations, these actions and the lessons learned could equally well be used to create integrated programmes in other Paediatric subspecialties. First and foremost, the healthcare team must engage in a deliberate effort to educate administrative executives on the most recent research, regional patient needs, and best practises in order to secure the resources required to improve care and results. Direct evaluation of programme finances and value delivery are essential during both the original process and ongoing evaluation. Despite the fact that we have provided some guidance, it is crucial to do an evaluation that takes into account the institutional billing capabilities that are currently in place while also looking for ways to enhance billing procedures. Moving from the theoretical to the practical by gathering and applying local data to demonstrate need, outcomes, and value to the institution is necessary for success in gaining and sustaining institutional support. Although the procedure can take some time, it is ultimately worthwhile because it improves the experience of both patients and physicians receiving care.