CardioMetabolic Collaborative Clinic

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The Victoria Cardiometabolic Collaborative Clinic collaborative group of 6 specialist physicians (2 endocrinologists, 2 hepatologist and 1 cardiologist) focusing on different aspects of cardiometabolic disease. Our clinic has an innovative approach to chronic disease management including obesity and obesity related co-morbidities such as fatty liver disease and NASH, diabetes, hypertension, dyslipidemia, heart failure and overall cardiovascular risk education that uses a combination of specialist directed care and group visit educational programs in a collaborative fashion. We run a 12-week lifestyle program aimed at supporting healthy behavior change. This is delivered by a dietitian and GP via a virtual platform. We are also collecting data on this new model or care for quality assurance and for research purposes. There are students engaged in clinic research. We would like to expand on the education and monitoring aspects of these chronic disease and offer more opportunities to attend group visit on chronic different aspects of chronic disease management. The endocrinologists also run a bone health clinic and there would be the opportunity for the general practitioner to participate in the care of these patients as well.

We have the equipment to do in house ambulatory BP monitoring and would like to start or peripheral vascular screening clinic and a hypertension clinic. We do have an Ankle-Brachial blood pressure device for screening for peripheral vascular disease.

We are looking for a general practitioner to join our team to support the management of our patients. The general practitioner would be trained on how to manage specific areas of chronic disease management and be responsible for helping to develop and run additional group medical visits facilitated by nurses and other educators as appropriate. The GP role is not intended to be the primary care doctor for our patients but more a longitudinal caregiver focused on cardiometabolic health, practicing in concert with a supportive, high quality multidisciplinary specialist team.

Funding could be fee for service or for those interested a new to practice model for funding has been negotiated through the PCN network. This would allow for a more rational care based on the burden of illness and would provide the capacity for more time to be spent with those patients with more complex needs.

Patients would be referred to the practitioner by the specialist for specific monitoring. Many patients do not have a family practitioner, or their family practitioner may not have the time, resources or specialist support to engage in chronic disease monitoring of more complex patients. We are hoping to address this care gap.

There is no after-hours/on call needs however the practitioner would be asked to address patient questions in the field of cardiometabolic disease.

This would be a turnkey opportunity for anyone interested in walking into a well-managed clinic that is ready to support a general practitioner interested in obesity and obesity related disease management.

EMR: Oscar and Med Access

Remuneration: New to practice model funding will be obtained through the PCN Network.

Dates: September 2021 start