Current State of Research and Implementation of the INTERMED-model

Frits J Huyse MD PhD FAMP
Consultant Integrated care
Amsterdam, The Netherlands
Disclosure

Consultant integrated care

Trainer of the INTERMED-method
Objectives INTERMED Foundation

Stimulate integrated care for the complex medically ill

Development of related software
### INTERMED FOUNDATION

#### Council
- Frits Huyse, The Netherlands
- Fritz Stiefel, Switzerland
- Joris Slaets, The Netherlands
- Wolfgang Söllner, Germany
- Barbara Stein, Germany
- Roger Kathol, USA
- Elena Lobo, Spain
- Gundula Ludwig, Switzerland
- Corine Latour, The Netherlands

#### Advisors
- John Lyons, USA
- Cheri Lattimer (CMSA), USA
- Jeroen Bos, The Netherlands

[www.INTERMEDfoundation.org](http://www.INTERMEDfoundation.org)

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Huyse, Lyons, Stiefel, Slaets, De Jonge ea
Models of integrated care

According to Smith integrated care plans for complex patients should describe:

• how all relevant bps-factors will be assessed
• how a formulation is made why patient becomes ill in this way at this time
• the way in which management will be formulated and executed, including plans for linking, monitoring, advocacy and outreach
• the role of the person performing case management
• the way patient will be involved in this process

IM-model of integrated care

- Interview-based (15 to 20 minutes)
- Patient-oriented
- Health risks/Health needs assessment, which leads to actions
- Preventive, proactive and decision support
- Visualized risks- and needs assessment (grid)
- Enhancement of interdisciplinary communication

www.intermedfoundation.org
Clinical data

Clinical anchorpoints

Scoring of Variable

Action levels

Remarks:
Patient had a period of depressed mood after the separation of his wife during which he was not able to work.

Question description:
Psychological - History - Psychiatric dysfunction
- Unknown
- 0 No psychiatric dysfunction
- 1 Psychiatric dysfunction without clear effects on daily functioning
- 2 Psychiatric dysfunction with clear effects on daily functioning
- 3 Psychiatric admission(s) and/or permanent effects on daily functioning

Psychiatric dysfunction
- 0 = No vulnerability nor need to act
- 1 = Mild vulnerability and need for monitoring or prevention
- 2 = Moderate vulnerability and need for treatment or inclusion in treatment plan
- 3 = Severe vulnerability and need for immediate action or intensive treatment
Patient-oriented Health Risk- Health Needs assessment (IM CAG v6)

Date: 09-10-2009
Patient ID: 1234567
Name: P Stijfjes
Date of Birth: 02-12-1932
Gender: Male
IM-Complexity Score: 32

Reason for admission: Emergency admission for deterioration of M Parkinson

Biological Risks

Since 2003 patient is known with progressive M Parkinson for which he had successful deep brain stimulation in 2008. However he gradually deteriorated as the balance between cognition and movement became delicate. Moreover since 1999 patient suffers Diabetes Mellitus due to excess weight (BM>28) for which he uses oral anti-diabetics. In the past half year patient had 3 episodes of a urinary tract infection. Possibly resulting from an enlarged prostate. Yet the evidence is not yet conclusive and patient is still seen by a urologist.

Due to his overweight and his Parkinson patient is hardly able to walk. In combination with the current confusion he is not able to take care of himself. Patients’ blood sugar level in the morning is increased (15 mmol) and in addition there are signs of a urinary tract infection. The confusion and nightly unrest might be a result of a recent medication change to prevent increasing stiffness now complicated by a bladder infection and a deregulation of blood sugars.

Psychological functioning

Patient is not a person who can manage problems well. He is inclined to ignore or postpone them. His wife informed us that this is related to a stay in a Japanese camp in the 2nd world war with his mother whilst his father was forced to labor on the Burma Railroad. After the war his father had serious emotional outbursts, which influenced patient and turned him in a conflict avoiding person. Patient is smoking 3 cigars and drinks 3-5 whiskey's at night in order to sleep. In the seventies patient suffered for an episode of depression after the death of his father. He had ambulant treatment (psychotherapy). Nevertheless as he was psychological not able to function in his job, he got illness compensation at the end of his career.

Patient has always been able to cope with the recommendations provided by his doctors for the treatment of his Parkinson and diabetes, except for his diet. The internist even thought that he controlled his blood sugars more often than needed. In the past half year the blood sugar control deteriorated probably due to the decline of his cognition. In the past week there is an increase of patients confusion. When his family is in the neighborhood he is quiet and cooperative. During the 1st night of his hospitalization patient was agitated and confused, as he had no idea where he was. Patient was in need for sedative medication.

Social circumstances

Patient had an administrative function at a publisher. He got compensation for continuous conflicts with his superiors. Afterwards he worked as a volunteer at Amnesty International, yet with limited success. Afterwards he was focusing on the cultivation of orchids. However in the past year this became impossible due to his physical restrictions. His grandchildren are currently the main source of leisure. Though patient attempts to avoid conflicts, contact with man are often complicated and might every now and then contribute to aggressive outbursts.

Patient lives with his wife in a 3-rooms apartment on the 1st floor without elevator. His wife indicates that in the past 3 months things went out of control and due to her arthritis she is quite concerned whether or not she will be able to manage even with additional care. Patient and his wife have good relations with their 3 children, who manage socially well. They are ready and available for help when needed. In addition patient’s wife is socially well networked with friends who are willing and capable to help.

 Provision of care

Patient is well insured, lives close to health providers, and is a native English speaker with an Irish background. The contact with doctors has always been good. However recently there was a conflict with the urologist. First patient had to wait an hour and he was out in 10 minutes. Yet this does not seem to have influenced his general attitude towards health personnel.

In addition to the general practitioner who they trust, an internist for the diabetes and overweight, the neurologist see patient for the Parkinson and recently an urologist. The care among the specialists and the general practitioner is communicated through letters. The general practitioner is the first person to contact.
Prognoses and treatment plan

Biological risks

The options of treatment for patients M Parkinson became very restricted as they led to confusion. Patient is severely inhibited by the physical complications of the Parkinson and the overweight. As there are currently deregulations of the blood sugar and the bladder infection, these are probably the components that can best be influenced. As such they their immediate treatment is crucial to patients risk of death followed by the adjustment of the Parkinson medication.

Goals

- Stabilize physical condition to such a level that self-care becomes an option
- Detailed insight in mechanism of delirium and its prevention
- Analyze and stabilize urological problem

Actions

- Physiotherapy to improve condition and walking capacity
- Delirium diagnostics
- Delirium prevention
- Consult internist and urologist

Psychological functioning

There are clear signs of a delirium. The main issue is to find an appropriate balance between his physical and psychological functioning.

Goals

- Improve level of cognition
- Prevent complications resulting from agitation
- Find balance between cognition and movement

Actions

- Consult psychiatrist
- Consult geriatrician

Social circumstances

Though a return to home might still be an option, the chance that in the nearby future a nursing home is required seems considerable.

Goals

- Rehab towards prolonged stay in own circumstances
- Plan nursing home in 3 month

Actions

- Involve partner and family
- Coach partner with Social Work
- Involve transfer nurse

Provision of care

The risk and need management plan needs to be supported by active preventive care management, including coordination- and communication of care.

Consultant(s)

- Active transfer to OP care

Coordination

- Prepare multidisciplinary meeting
- Transfer treatment to ambulant team
16 risk variables + 4 vulnerabilities (B, P, S, HC)

- Chronicity
- Diagnostic Dilemma
- Symptom Severity/Impairment
- Diagnostic/Therapeutic Challenge
- Barriers in Coping
- Psychiatric Dysfunction
- Resistance to Treatment
- Psychiatric Symptoms
- Job and Leisure Problems
- Social Dysfunction
- Residential Instability
- Poor Social Support
- Access
- Treatment experience
- Organization of Care
- Coordination of Care

Predictor of negative outcomes, such as:
- HbA-1C
- LOS
- QoL
- Psychopathology
- Death

N = 1050
- Diabetes
- MS
- ESRD
- Gen Internal Med
- Neurology
- Rheumatology
- Pulmonology
- Psych C-L service
Complexity profiles of populations

Predictor of negative outcomes, such as:
- HbA-1C
- LOS
- QoL
- Psychopathology
- Death

Huyse Farewell to C-L? JPR 2009
“While systems can be broken down into parts which are interesting from themselves the real power lies in the way the parts come together and are interconnected to fulfill some purpose”

“As soon as interconnections can be identified and the powers of the underlying dynamics can be understood, a given situation can often be perceived as less chaotic or even meaningful and a controlled approach becomes possible”

Paul Plsek
Chasm report and in “Complexity Science”: Series of articles in the BMJ 2001
A targeted psychiatric intervention in the complex medically ill identified by means of the INTERMED: A RCT
Stiefel FC ea Psychotherapy and Psychosomatics 2008;77:247-256
Effects on prevalence (%) of major depression (MINI)

A targeted psychiatric intervention in the complex medically ill identified by means of the INTERMED: A RCT
Stiefel FC ea Psychotherapy and Psychosomatics 2008;77:247-256
A targeted psychiatric intervention in the complex medically ill identified by means of the INTERMED: A RCT
Stiefel FC ea Psychotherapy and Psychosomatics 2008;77:247-256
Integrated Care for the Complex Medically Ill

**The INTERMED model**

**Type of patient**
- Distress
- Short episode of illness
- Mid acute illness

- Chronic illness
- Moderate to serious illness

**Complex Patients**
Multi-morbidity, including psychiatric
Multiple health care providers
Psychological-, social- and financial deregulations

**% Insured of health plan**

**Costs of insured**

- Low
- Medium
- High

**Complexity management**

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected low (IM&lt;10)</td>
<td>No action</td>
<td>Patient self-management</td>
</tr>
<tr>
<td>Potential existence (IM&gt;10)</td>
<td>Monitor for complexity with indicators</td>
<td>Primary care provider Care Manager (CM)</td>
</tr>
<tr>
<td>15-25</td>
<td>Analyze complexity through IM assessment, Reduce complexity through focusing on interactions</td>
<td>Collaborative care</td>
</tr>
<tr>
<td>25-30</td>
<td>Specialized Risk and Need analyses and TX planning</td>
<td>Referral to ambulant team</td>
</tr>
<tr>
<td>&gt;30</td>
<td>Intensive integrated care Specialized Risk and Need analyses and TX planning</td>
<td>Consider Psych-Med Unit to stabilize, make a plan and arrange a team</td>
</tr>
</tbody>
</table>

**Problems management**

**Disease management**

**Complexity management**
The INTERMED method is designed
- to facilitate integrated patient-oriented health care for complex patients
- though an action-oriented decision-support tool for clinicians
- which stimulates interdisciplinary communication

**COMPLEX PATIENTS**

**COMPLEXITY OF CARE**

**HEALTH CARE UTILISATION**

Reference

Related auto generated letter

**PATIENT-CENTERED**  **INTEGRATED CARE**  **ACTION ORIENTED/DECISION SUPPORT**

Goals of the Stichting INTERMED Foundation
Webservice

- ISO-norms, including https
- Creation of visualization
- Formulation and evaluation of
  - Goals
  - Actions
- Letter
- Repetitive risk assessment
- Definition of outcomes
- Repetitive outcome assessment
- Uniformity of data in collaborative research
Current state
Languages

- English
- German
- French
- Spanish
- Italian
- Dutch
- Norwegian
- Japanese in process
- Portugueze in process

Research

- Geriatric Epidemiological study
- Epidemiological hospital study
- Geriatric health service study
- IM Self Assessment
- Pediatric IM
- Transplant
- High Utilizers
- General hospital
- Emergency room

Wild Söllner
Lobo
Slaets Schuurmans
Ferrari Zdrojewski Stiefel Huyse
Cohen Lyons Kathol
Ludwig
CMSA Beacon Health NY
Kishi

Germany
Spain
NL
It Su NL
Canada NL US
Aus Su It Es
USA
Japan
Austria/Singapour

Clinical application

- Rehabilitation     Su, NL
- Neurology         NL
- Oncology          NL
- Primary Care      NL

Curriculum application

- HVA (School of Nursing) NL
Implementation

• SUVA (rehab) )¹ Swiss
• Experimental implementation rehab (2) NL
• Primary care center geriatric patients NL
• Department of oncology NL
• Department of neurology NL

To be started
• CL-service and PMU in university hospital NL

Implementation
Critical factors

• Team decision
  – Not an instrument but a model of integrated care
• Positioning in clinical process
• Multidisciplinary rounds
• Coordinator
• Outcome guided care
Current research

- Geriatric epidemiological study  Germany
- Geriatric health service studies (1-2)  NL
- Multicenter inpatient outcome prediction study (3)  Spain
- CMSA-Beacon Health case management study  USA
- Field-testing of IM CAG Self assessment  Swiss, It, NL, Spain
- Field-testing of Pediatric IM CAG (PIM)  Canada (USA, NL)
- Emergency room outcome prediction study  Austria, (Singapour)
INTERMED Use in U.S.

- Roger Kathol, Cartesian Solutions Minneapolis Minnesota, council INTERMED Foundation

- Case Management Society of America (CMSA) directed by Cheri Lattimer Little Rock Arkansas
Integrated Health Management Training

CMSA’s Integrated Health Management Training Program helps clinical delivery and managed care organizations improve their assessment and treatment of medically complex patients, specifically individuals who face both physical and mental/behavioral health challenges.

Many patients suffer from mental illness along with other physical disease states. Often, these mental illnesses go untreated leading to additional problems for patients. For example, failure to treat depression can prevent proper treatment of other medical conditions as the patient lacks the motivation or desire to improve their health. This problem is less a matter of clinical indifference and more a reflection of the division that has occurred between physical health and mental health within the US healthcare system. Physical health care managers (e.g. nursing case managers, physicians, pharmacists, etc.) lack specific training in how to identify and coordinate treatment of mental and physical health problems. Rather, they focus solely on assisting with physical disease states. Likewise, mental health care managers (e.g. nurses, social workers, psychiatrists, etc.) often do not have the physical health background to coordinate treatment or relate mental health care to physical disease states that occur in patients with complex conditions where a mental health issues are but one aspect.

To address this critical issue, CMSA has partnered with INTERMED Foundation, a leader in integrated health assessment, and Cartesian Solutions, a consulting organization with extensive experience in advising companies in how to improved integrated health delivery, to launch the Integrated Health Management Training Program. This detailed program consists of four interrelated consulting and training steps:

Integrated Case and Disease Management Training Program
June 14-15, 2009

Sheraton Phoenix Downtown
340 N. 3rd Street
Phoenix, AZ 85004

Training Fees:
CMSA Member: $499
Non-Member: $699

Register

Held in conjunction with the CMSA Annual Conference in Phoenix, AZ.

"Many times since our training I have implemented the concept of integrated health with our case managers. I feel that I learned so much that I can apply to my daily practice. I would recommend the training program to anyone..."
The Integrated Case Management MANUAL

Assisting Complex Patients Regain Physical and Mental Health

Roger G. Kathol
Rebecca Perez
Janice S. Cohen
Description
An ideal reference guide for case managers who work with complex, multimorbid patients, *The Integrated Case Management Manual* helps readers enhance their ability to work with these patients, learn how to apply new evidence-based assessments, and advocate for improved quality and safe care for all patients. This text encourages case managers to assess patients with both medical and mental health barriers to improvement in order to coordinate appropriate integrated health interventions and treatment planning.

Built upon the goals and values of the Case Management Society of America (CMSA), this manual guides case managers through the process of developing new and important cross-disciplinary skills. These skills will allow them to alter the health trajectory of some of the neediest patients in the health care system.

**Key features:**
- Tools and resources for deploying an Integrated Health Model (physical and mental health treatment) to the medically complex patient
- Complexity assessment grids: a color-coded tool for tracking patient progress and outcomes throughout the trajectory of the illness
- Methods for building collaborative partnerships in emerging models of care delivery within multidisciplinary health care teams
- Strategies for using an integrated case management approach to improve efficiency, effectiveness, accountability, and positive outcomes in clinical settings
- Guidance on connecting multi-disciplinary teams to assist with health issues in the biological, psychological, and social domains to overcome treatment resistance, reduce complications, and reduce cost of care
INTERMED Use in U.S.

• Approximate total number of case managers trained in complexity assessment process as a part of CMSA integrated case management training: 100
  – Many system supervisors, consultants, and program leaders trained (testing the waters for their organizations)
  – Some front line case managers

• CMSA INTERMED software goes live (May 2010)

• Planned webinar training updates
INTERMED Use in U.S.

- Hudson Health Plan Experiment Top 2-3% users
  - Ten case managers trained onsite
  - Internal software implementation
- No other system level deployments at this time
- Isolated case managers
  - At least four independent case managers are using integrated case management in their work with patients—experience positive
  - Software availability in U.S. will help expand this
Future Plans

• Research
  – Identify partners to develop comparative studies
  – Seek Costeffectiveness research and foundation grant funds for research projects

• Training
  – Train adult organizational trainers to facilitate dissemination and deployment through CMSA (late 2010)
  – Develop and implement pediatric training program based on CM version (late 2010)
IM in Canada

Peadiatric INTERMED (PIM)

Operationalizing Biopsychosocial Case Complexity: The Examination of the Psychometric Properties of a Clinical Decision Making Tool with Children and Youth with Inflammatory Bowel Diseases

Dr. Janice S. Cohen, C. Psych.
Children’s Hospital of Eastern Ontario
Mental Health

About the Mental Health Program

The Mental Health Program provides a range of specialized mental health services for children and youth, including prevention, early intervention and more intensive diagnostic and treatment services. In partnership with the Royal Ottawa Mental Health Centre (Youth Program), a range of specialized psychiatric and mental health services are provided.

Specialized clinical services:

- Inpatient services, which include a 15-bed adolescent unit (ages 13-17) and a 10-bed children’s unit (ages 12 and under). Both units, located at CHEO, provide crisis stabilization, assessment and transitional care.

- Emergency Services, which provides psychiatric emergency, crisis intervention and urgent services. Services are provided in CHEO’s Emergency Department.

- Behavioural neuroscience consultation and liaison, which provides mental health consultation and intervention for children and youth who have both medical and mental health issues affecting treatment or recovery.
Basics of Communimetrics

1. “Just enough” reliable information
   - Psychometrics is designed for research
   - Clinimetrics is designed for clinical management
   - Communimetrics adds the facilitation of communication

2. Action levels
   - 0 No risk No need to act
   - 1 Slight risk Monitor
   - 2 Moderate risk Need to act
   - 3 Serious risk Need to act intensively or immediately

JS Lyons Communimetrics
in Huyse Stiefel eds Integrated Care for the Complex Medically Ill
Medical Clinics of North America Elsevier July 2006
Collaborators

- Project is an interdisciplinary collaboration
  - Dr. Janice Cohen, Psychology, Mental Health, CHEO
  - Dr. David Mack, GI, Paediatrics, CHEO
  - Dr. John Lyons, Mental Health Research, Provincial Centre of Excellence for Child and Youth Mental Health, CHEO
  - Dr. Frits Huyse, M.D., Ph.D., Associate Professor of Consultation/Liaison Psychiatry, University Medical Center Groningen
  - Dr. Derek Puddester, Psychiatry, Mental Health, CHEO
  - Dr. Joe Reisman, Paediatrics, CHEO
  - Dr. Mario Capelli, Mental Health Research, CHEO
  - Lynn Grandmaison-Dumond, Nursing, Palliative Care, CHEO
  - Dr. Lise Bisnaire, Autism Intervention Program, CHEO
Funding

• CHEO Research Institute
• 3-C Foundation of Canada
• CHEO Psychiatry Associates
• Provincial Centre of Excellence for Child and Youth Mental Health at the Children’s Hospital of Eastern Ontario
Rationale for Project

- Children with chronic illness heightened risk for development of mental health problems
- Children/youth with IBD at increased risk for psychosocial difficulties (e.g., decreased self-confidence, depression, anxiety)
- Emerging evidence that stress impacts on physiological process implicated in IBD
- Chronic illness impacts whole family system
  - Uncertainty about health outcomes
  - Daily hassles related to compliance with treatment regimens
  - Social, role and financial strains
  - Challenging to navigate complex systems of care
- Failure to address psychosocial issues places children at great risk for poor treatment adherence, increased service utilization and psychiatric co-morbidity
Objectives of Current Study

• Develop paediatric version of the INTERMED (PIM-CAG)
  – Literature review
  – Delphi survey of experts in the field
  – Pilot reliability study
Study Objectives (cont.)

• Investigate psychometric properties of tool in population of children and youth with IBD
  – Relation of domain scores to other conceptually related measures
  – Relation of overall complexity index to Health Utilization Data
  – Intercorrelation of individual items
  – Inter-rater reliability

• Provide information about the psychosocial adjustment of children and youth with IBD
Eligibility Criteria

• Children between 8 and 17 diagnosed with Crohn’s or ulcerative colitis in the region (followed by CHEO’s IBD clinic)
• their parent(s) will also be asked to participate
• Goal is 175 participants (and their parents)
• As of June 30, 2010: 8 PIM Interviews completed, 18 more scheduled.
Study Protocol

• Child/youth and parents participate in semi-structured interview with research coordinator to obtain information to complete PIM-CAG
• PIM-CAG items will be completed by research coordinator following interview
• Second rater will also fill out PIM-CAG for 40 subjects to look at inter-rater reliability
• Completion of questionnaires by child/youth and parents
<table>
<thead>
<tr>
<th>Domain</th>
<th>Source of Information</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Child</td>
</tr>
<tr>
<td>Biological</td>
<td>• Functional Disability Inventory (FDI)</td>
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<tr>
<td>Psychological</td>
<td>• Children’s Depression Inventory (CDI)</td>
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<td></td>
<td>• Multidimensional Anxiety Scale for Children (MASC)</td>
</tr>
<tr>
<td>Social</td>
<td>• IMPACT III (Quality of Life)</td>
</tr>
<tr>
<td></td>
<td>• Functional Disability Inventory (FDI)</td>
</tr>
<tr>
<td>Family/Caregiver</td>
<td>• Pediatric Inventory for Parents (PIP)</td>
</tr>
<tr>
<td></td>
<td>• Family Inventory of Life Events and Changes (FILE)</td>
</tr>
<tr>
<td>Healthcare System</td>
<td></td>
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<tr>
<td><strong>ADDITONAL BIOLOGICAL (DISEASE INDICATORS) &amp; HEALTH SYSTEM UTILIZATION DATA</strong></td>
<td><strong>Date:</strong></td>
</tr>
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<tr>
<td><strong>Participant ID:</strong> ________________</td>
<td>M M D D Y Y</td>
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### DIAGNOSIS

| **Age at Diagnosis** | **YEARS** |
| **Time since Diagnosis** | **MONTHS** |
| **Activity Score of Diagnosis (PCDAI/PUCAI)** | **#** |
| **Family History of IBD in 1st degree relatives** | **YES** **NO** |
| **Family History of IBD in 2nd degree relatives** | **YES** **NO** |
| **Time from onset of symptoms until diagnosis** | **MONTHS** |

### DISEASE COURSE AND COMPLICATIONS

| **Number of Hospitalizations** | **#** |
| **Medication Adverse Events** | **#** |
| **Disease Adverse Events (refers to known complications with IBD)** | **YES** **NO** |
| **Number of Surgeries** | **#** |
| **Number of Concomitant Conditions** | **LIST** |

### TREATMENT REGIME

| **Number of pills/day (currently)** | **#** |
| **Number of Courses of Prednisone** | **#** |
| **Chemical Immunodulators (Methotrexate, Mercaptopurine, Azathiprine)** | **YES** **NO** |
| **Biological Immunodulators (Remicade, Humira)** | **YES** **NO** |

### HEALTH CARE UTILIZATION DATA

| **Number of CHEO services involved in child/youth’s care** | **LIST** |
| **Number of telephone calls to the GI clinic nurses** | **#** |
| **Number of extra appointments with the GI team (unscheduled/unplanned)** | **#** |
| **Number of visits to the emergency department** | **#** |
| **Number of admissions to the hospital** | **#** |
"Coordinated" study with INTERMED for the assessment of "complex patients" in medical wards: frequency, profiles, organization and quality of health care.

Proy. ETES – Instituto de Salud Carlos III – 2009-2010

Hospital Clínico – Zaragoza (E.Lobo, p.i.)
Hospital Doce de Octubre – Madrid (M.Navio)
Hospital Miguel Servet – Zaragoza (T.Ventura)
Objectives

- To document…
  - The frequency of complex patients (INTERMED criteria)
  - Differences in specific complexity parameters (above/ below IM cut-off point)
  - Inter-hospital differences → Causal hypotheses
  - Establish ground for intervention study
    - Early detection of complex cases
Methods

• 3 Spanish hospitals in the public health system covering a Health Area.

• Internal Medicine wards (≈350 patients each hospital)
Differences complex/non-complex: Parameters/ Instruments

• Mortality, re-admission, LOS, consultations, cognition, depression/anxiety, social problems, Quality of life, ER visits in the 30 days post-discharge:
  » IMCAG v6 (admission).
  » HADS, MMSE, SPQ, SF-36, CAGE, CIRS, Hospital records (discharge).
Hospital-specific sub-studies

• Patients’ satisfaction with health care (H.12 Octubre-Madrid)
  – SERQHOS (discharge)

• Capacity to give informed consent (H.Miguel Servet-Zaragoza)
  – CI-4 (discharge)

• Nurses’ evaluation of health needs (H.Clínico-Zaragoza)
  – GACELA – Virginia Henderson (discharge)
Study update

June, 2010

• Recruitment finished: 1000 patients (Admission).

• Frequency of complexity in H.Clinico Zaragoza: ≈38% above IM cut-off point.
IM in the Netherlands
HvA International

The Hogeschool van Amsterdam, University of Applied Sciences (HvA) is the largest inner-city institute for higher professional education in The Netherlands. HvA mainly offers bachelor degree programmes, but also has a number of (professional) master degree programmes. For students from HvA’s international partner institutes it is possible to study at HvA as an exchange student.
Handboek multidisciplinaire zorg


De gezondheidszorg wordt steeds meer geconfronteerd met problemen die de grenzen van de verschillende evelons en disciplines overschrijden. Vergrijzing van de populatie, met een forse toename van het aantal kwetsbare, veelal oudere, patiënten met multimorbiditeit vraagt om een samenhangende benadering waarbij de deskundigheid uit verschillende vakgebieden bij elkaar wordt gebracht: multidisciplinaire zorg.
In de sterk op specialisatie gerichte gezondheidszorg ontbreekt echter tot nu toe een kader om deze multidisciplinaire aanpak vorm te geven. Dit handboek, waarvan vrijwel alle hoofdstukken tot stand zijn gekomen door een multidisciplinaire samenwerking tussen artsen uit diverse disciplines, psychologen en juristen, is het eerste Nederlandstalige boek dat specifiek vanuit het perspectief van de zorgverlening aan kwetsbare patiënten en groepen is geschreven.
Het boek richt zich primair op de medicus practicus, ongeacht diens specialisme. Daarnaast richt het zich op psychologen en paramedische disciplines die in hun dagelijkse praktijk te maken hebben met multidisciplinaire samenwerking.
Stop met het DBC, laat artsen samenwerken

Wie aan meer dan één ziekte lijdt, komt door het DBC-systeem in de problemen: de artsen overleggen niet

Gepubliceerd: 23 juni 2010 13:12 | Gewijzigd: 24 juni 2010 08:39

Het huidige DBC-systeem zorg heeft geleid tot een fragmentatie met grote gevolgen voor patiënten met meer dan één ziekte.

Frits Huyse, psychiater np
Sven Danner, hoogleraar inwendige geneeskunde VUmc
Wouter van Ewijk, raad van bestuur (RvB) VUmc
Peter Huijgens, hoogleraar hematologie VUmc
Mark Kramer, hoogleraar inwendige geneeskunde VUmc
Kees Lemke, RvB GGNet
Betty Meyboom de Jong, voorzitter Nationaal Programma Ouderenzorg
Wouter Teer, RvB Delta Psychiatrisch Centrum
Rien Vermeulen, hoogleraar neurologie AMC
Chris van Weel, hoogleraar huisartsengeneeskunde UMC St Radboud
Joost Zaat, huisarts, adjunct hoofdredacteur Nederlands Tijdschrift voor Geneeskunde