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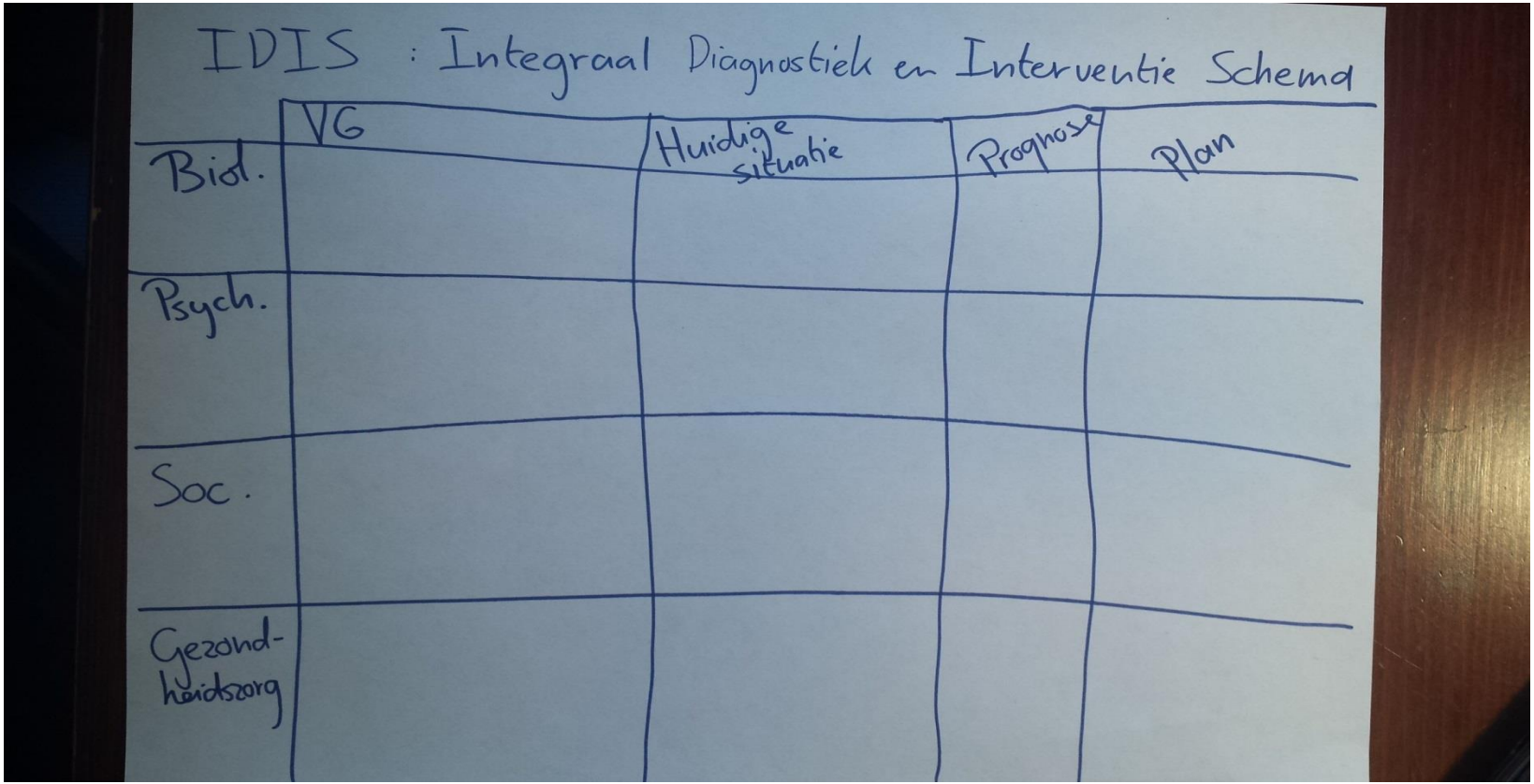
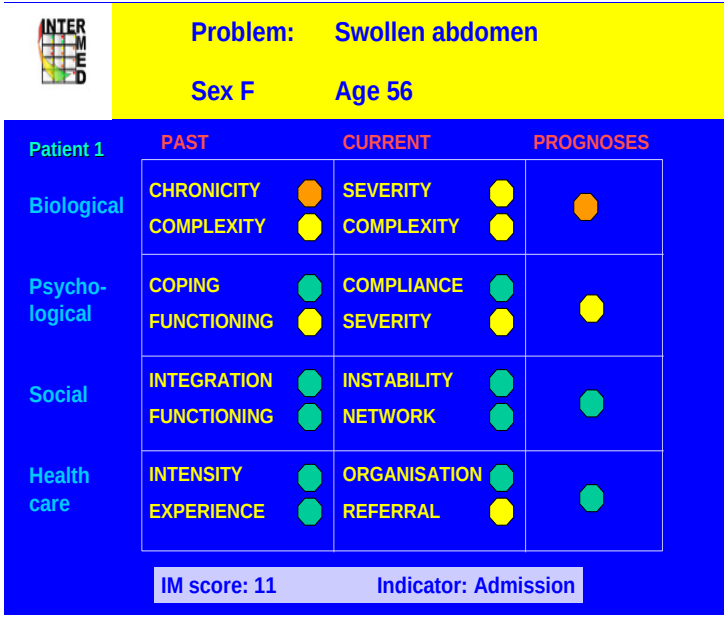
Using the Intermed in patient care to implement integrated care: failures, successes, lessons learnt.

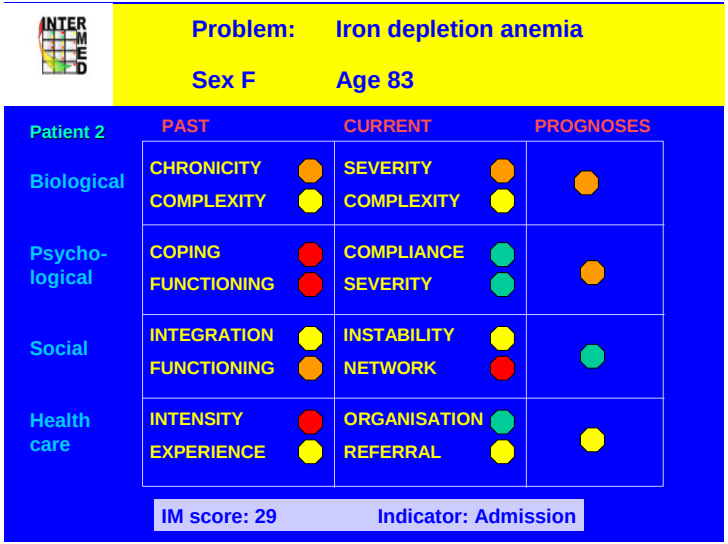
Annette Boenink, C-L Psychiatry


IDIS : Integraal Diagnostiek en Interventie Schema
VG
Huidige situatie
Prognose
Plan
Biol.
Psych.
Soc.
Gezond-heidszorg


Interned Chef

Visual Representation





IMSA

Assessment of Biopsychosocial Complexity and Health Care Needs: Measurement Properties of the INTERMED Self-Assessment Version

van Reedt Dortland, Arianne K.B. PhD; Peters, Lilian L. PhD; Boenink, Annette D. MD, PhD; Smit, Jan H. PhD; Slaets, Joris P.J. MD, PhD; Hoogendoorn, Adriaan W. PhD; Joos, Andreas MD, PhD; Latour, Corine H.M. PhD; Stiefel, Friedrich MD, PhD; Burrus, Cyrille MD; Guitteny-Collas, Marie MD; Ferrari, Silvia MD, PhD

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Questions

What can we learn from the experiences of working with the Intermed in health care?

Can these experiences guide the use of the IMSA?

Corine Eeltink, nurse-practitioner Hematology Vumc (Stem Cell Transplantation)

- Support of team leader nursing team
- Improve nursing anamnesis
- Anticipating patients health care needs
- Questionnaires and data ≠ information. Coloured profile works.
- Clinical population not very complex (well selected)
- Pilot with outpatients
- Future: EPR (epic) and education

“You certainly get an idea of what people want or are able to do”.

Basil Waldmann, team leader nursing team Neurology department

- Leadership
- Multidisciplinary (doctor – nurse) appears to be difficult – role for specialized nurses to pick up
- Discuss results of Intermed / IMSA with the patient
- Transmural role of “case-manager” from primary to tertiary care

More Dutch Experiences

- UMCG Internal Medicine ward Groningen
  - Used as nursing anamnesis tool to make care-plans
  - Coordination with doctors difficult
  - Uncertainty about EPR (epic)
- Centre for Body, Mind and health Tilburg
  - Patients somatic symptom disorder
  - Systematically use Intermed / IMSA
  - Discussed in MD team
  - Feedback to patient

Dutch experiences continued

- Mental health nurse specialists Amsterdam
  - They just start to use it
  - With difficult, hostile patients
  - Immediately sharing and discussing results with patients
  - Helpful in goal setting
  - Coloured profiles
- Primary care project Utrecht
  - Intermed validates subjective feeling of complexity
  - Scores in EPR as “care-risk”and discussed with patients
  - Additional items needed on financial situation of patient
  - Patients choose their own case-manager!
  - 4D model

	research			Patient care		
Freiburg	Hematooncology Prostate cancer			-	Resources interest	
Modena	Hiv colonoscopy			Liver transplant	MD team	
Nurnberg	Liver transplant			CL fast track emergency unit	Feedback to team Interviewer training	
Graz university	Emergency unit					
Nantes	Parkinson inpatients			Psychiatrist interviewer	Take complexity into account	
	Cardiology inpatients			Psychiatrist interviewer		
	IMSA endocrinology	Complexity and suicide risk (poster)		Plans to implement IMSA		
Lausanne Sion						

Conclusions / recommendations

1. “leadership” and enthousiasm
2. ICT support (EPR, app) desirable (but pencil/ paper/ hand coloring also works!)
3. Discuss results with patients
4. MD collaboration with somatic specialists is difficult → model with (empowered!) casemanager preferred?
5. Implementation is always local: encourage local varieties, but preference for additional questions leaving IMSA intact to allow for sharing data and experiences
6. Anyone interested can use it! IMSA can be a user-friendly tool for professionals and patients, (not primarily a research instrument.)
7. Implementing IMSA can contribute to transforming health care into personal care, taking into account the patients context but also his or her personal values in life.

More information:

www.intermedconsortium.com

And the final slide is Dutch again….

Council for health and Society
June 19th 2017

www.raadrvs.nl

en/item/no-evidence-without-context

Quote from the report summary

Evidence as the basis of good healthcare is therefore an illusion. In addition to external kno wledge, good and patient-oriented care requires other sources of knowledge that EBP und erutilises: clinical expertise, local knowledge, knowledge from the patients themselves, kn owledge of the context -
the living conditions and preferences of patients and the setting within which care is given –
and of the values that are involved. Because any decision involves a specific demand in a s pecific context, healthcare decision-making can be seen as an experiment in putting togeth er the various sources of knowledge. The uncertainty that is inherent in this must not be d enied –
it should indeed be embraced. Every decision can be and should be a learning moment.