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

Annette Boenink, C-L Psychiatry
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<tr>
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<th>VG</th>
<th>Huidige situatie</th>
<th>Prognose</th>
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**Problem:** Swollen abdomen  
**Sex:** F  
**Age:** 56

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**Problem:** Iron depletion anemia  
**Sex:** F  
**Age:** 83

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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
Psychosomatic Medicine: May 2017 - Volume 79 - Issue 4 - p 485–492
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
<table>
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<tr>
<th>Research</th>
<th>Patient Care</th>
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| 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 |
Conclusions / recommendations

1. “leadership” and enthusiasm
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 knowledge, good and patient-oriented care requires other sources of knowledge that EBP underutilises: clinical expertise, local knowledge, knowledge from the patients themselves, knowledge 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 specific context, healthcare decision-making can be seen as an experiment in putting together the various sources of knowledge. The uncertainty that is inherent in this must not be denied – it should indeed be embraced. Every decision can be and should be a learning moment.