Project Intermed

a new model of coordination and proactive support for patients with chronic diseases

Haute Ecole Spécialisée de Suisse Occidentale, HES-SO//Haute Ecole Arc Santé, Espace de l'Europe 11, 2000 Neuchâtel

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Our partners

- Project carried out at the Haute Ecole Arc Santé in Neuchâtel, in partnership with the CSS health insurance
- Co-financement : Swiss Agency for the Promotion of Innovation (Innosuisse) and Medi-Centre SA
- At the moment is one single medical office involved in this research which is called Medi-Centre SA and located in La Chaux-De-Fonds

Project presentation

1. Problematic issues
2. Definition of care and case management
3. Intermed Project
4. Intermed support nurses (ISP)
5. Research methodology
6. Project participants
7. First results

1. Problematic issues

FOLLOW-UP AND SUPPORT OF CHRONICALLY ILL PATIENTS IN PRIMARY CARE

1.1 Epidemiology of chronic diseases

2.2 millions

¼ of population

~ 80% of health costs

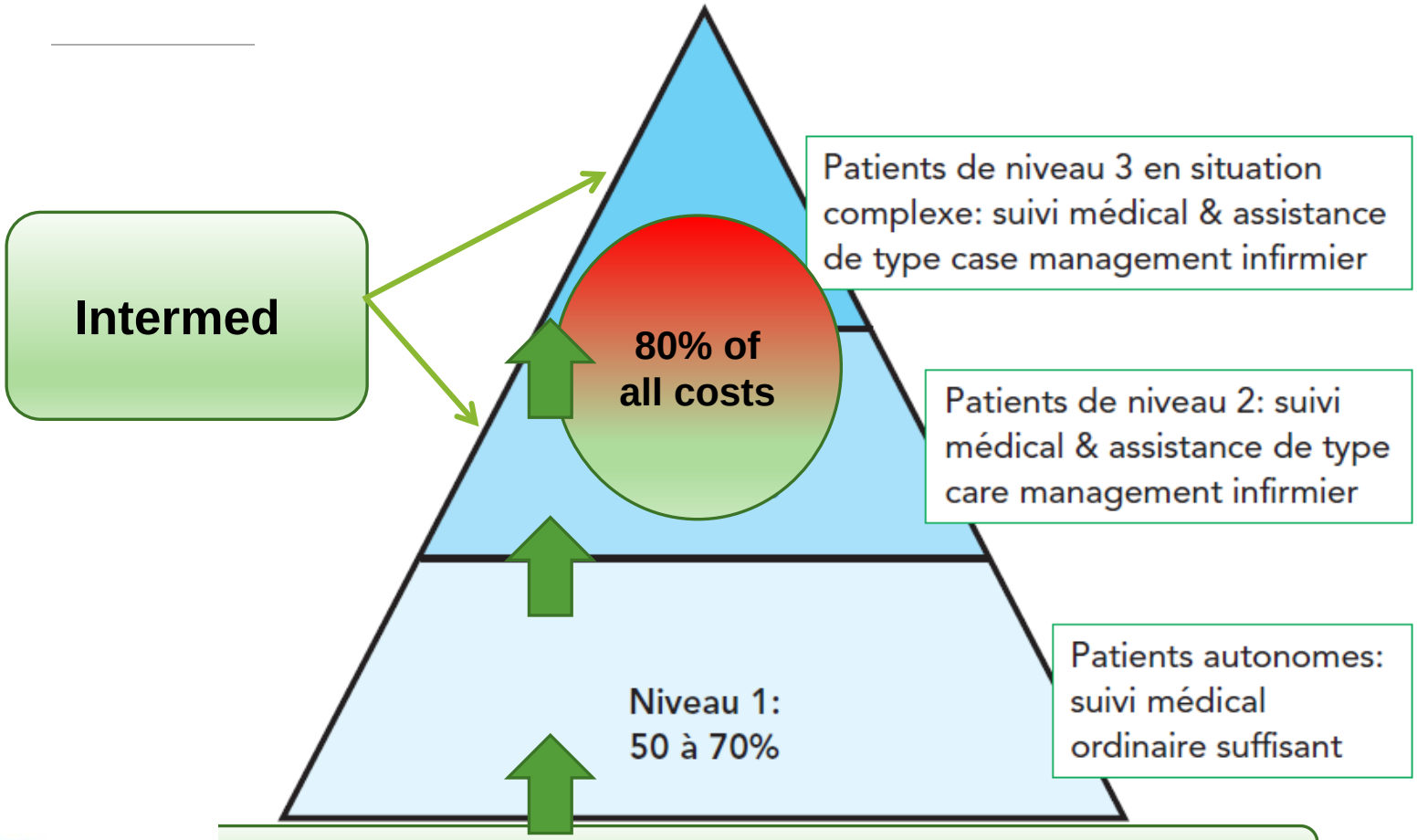
Multimorbidity: 10-30%

(OFSP, 2016)

1.2 Context

- Health policy for promoting home care.
- Shortage of general practitioners. (Swiss Confederation, 2011; Gaspoz, 2011)
- Health policy for the development of ambulatory care // high hospital costs. (Obsan, 2015)
- Fragmentation of the healthsystem that undermine collaboration and continuity of care.(Organisation for Economic Cooperation and Development & World Health Organization, 2011)

1.3 Several categories of patients



Bramaud du Boucheron, A., Giovannini, M., & Walger, O. (2017). Le Chronic Care Model appliqué au premier recours. *Soins Infirmiers : Krankenpflege*, (6), 55–57.

Definition

Additional contribution to those of the physician

Care management :proactive and personalised support

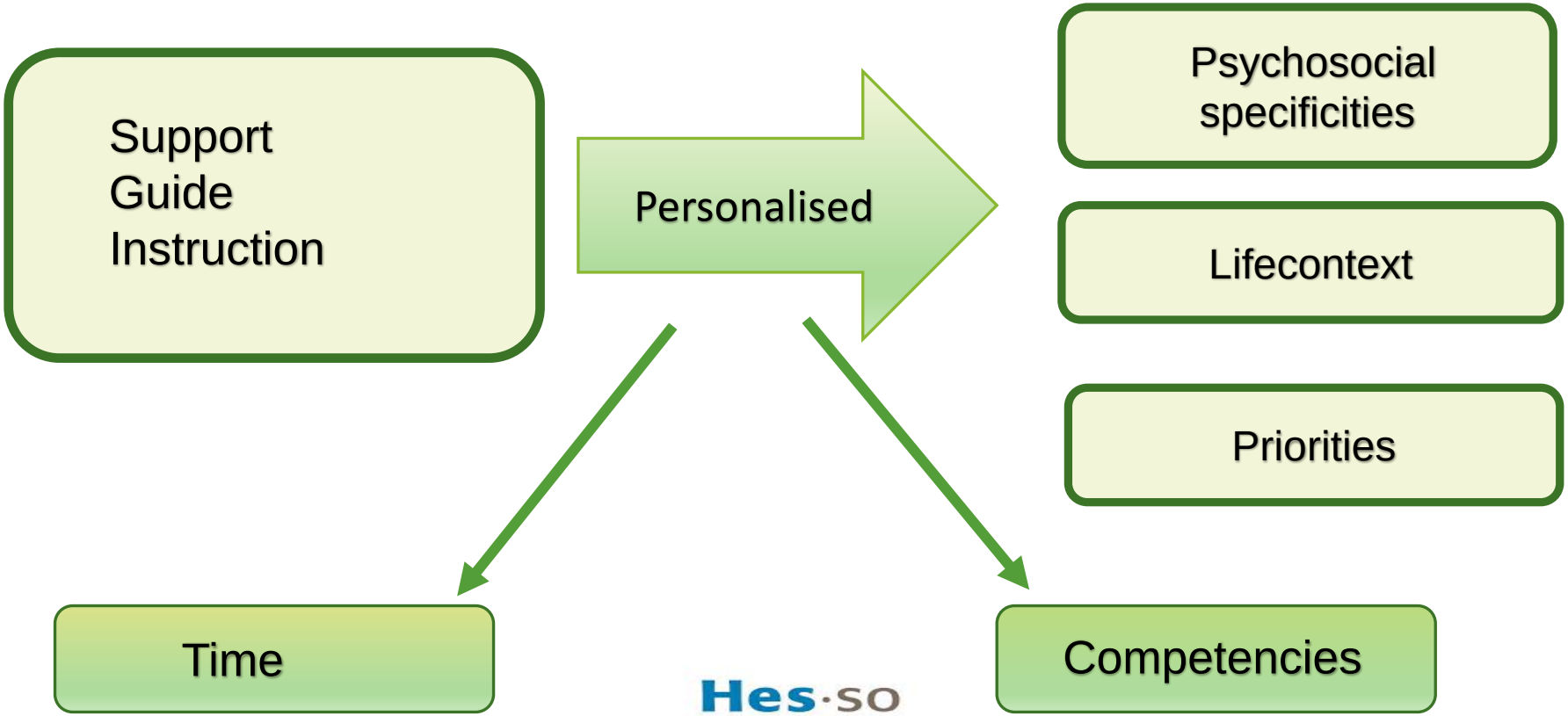
- Support activities for self-management and empowerment, patient education, data sharing

Case management : management of situations with high level of complexity

- Activities of orientation, coordination, optimization of services thanks to an overall vision, resources mobilisation, support in psychosocial dimension

1.4 Implications

Taking into account :



(Gaspoz, 2011)

1.4 Implications (2)

Increase in the prevalence and complexity of chronic diseases

Shortage of general practitioners

Reduction of the time available per Patient

1.5 Consequencies

Breakdown in the continuity of care

Complications

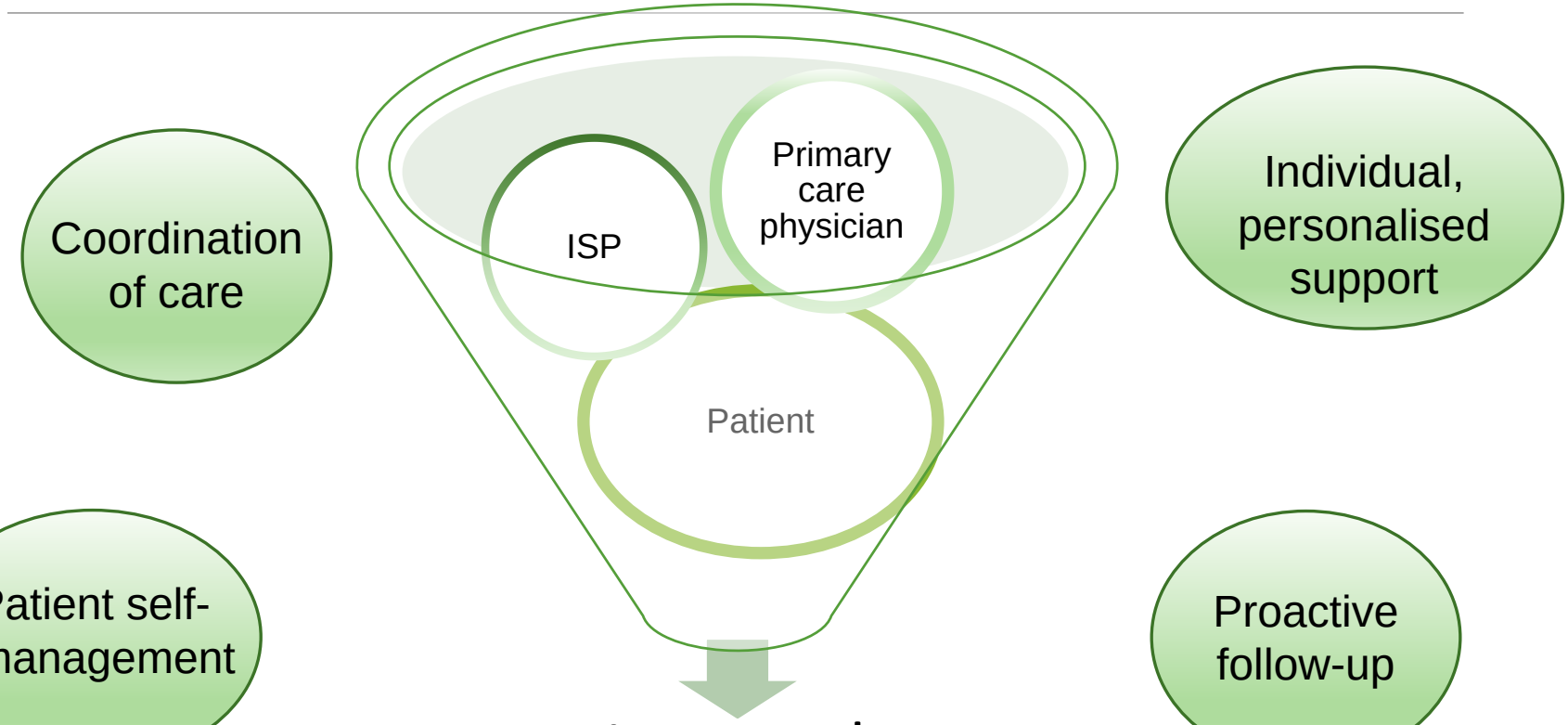
Decompensations

Rehospitalization

2. Project Intermed

Through the modelling and evaluation of an innovative nursing system of Care and Case Management in primary care in Switzerland.

2.1 Project Intermed: An imaginative option



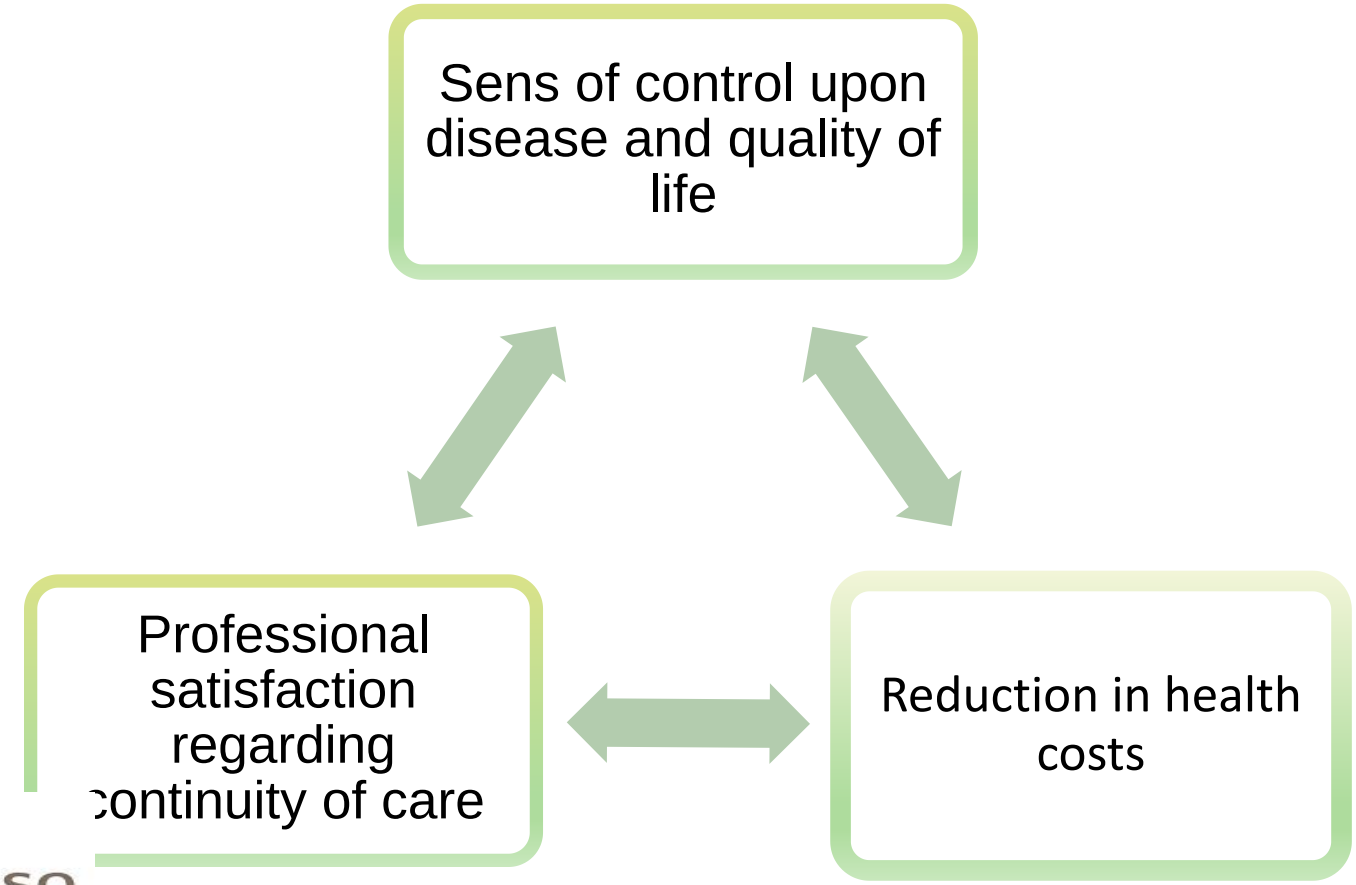
56 files

2.2 Project Intermed: Goals

Improve the coordination of care between the different health professionals that are mandated by the general practitioner .

Implement personalized nursing support for patients who are in too complex psychosocial situations to be able to manage treatments by themselves.

2.3 Project Intermed: Goals



2.4 Project Intermed: theoretical framework

Chronic Care Model : collaborative and proactive model focused on maintaining health . (Wagner, 1998)

- Health systems
- Efficient clinical information system
- Decision support (evidence-based choice of treatment and care)
- Patient self-management support
- Community resources
- Delivery system design

3. Intermed support nurse (ISP)

3.1 Roles of ISP (1)

- Assessment of the patient's situation at home
- Creation of an evidence-based care guide (care plan)
- Proactive patient monitoring (follow-up of the patient's through a computer file)
- Fostering of patient self-management (empowerment)

(Boult, C., Giddens, J., Frey, K., Reider, L., & Novak, T., 2009)

3.1 Roles of ISP(2)

- Coordination of care providers (communication, consultation, training)
- Facilitating the patient's transition from home to hospital or other care institutions and back home after hospitalization
- Education and support for caregivers
- Facilitating access to community resources

(Boult, C., Giddens, J., Frey, K., Reider, L., & Novak, T., 2009)

3.2 Project Intermed: Law context

Article 7 de l'Ordonnance sur les prestations de l'assurance des soins OPAS. (Département Fédéral de l'Intérieur, 2012)

Part of :

Benefits in accordance with al. 1 include:

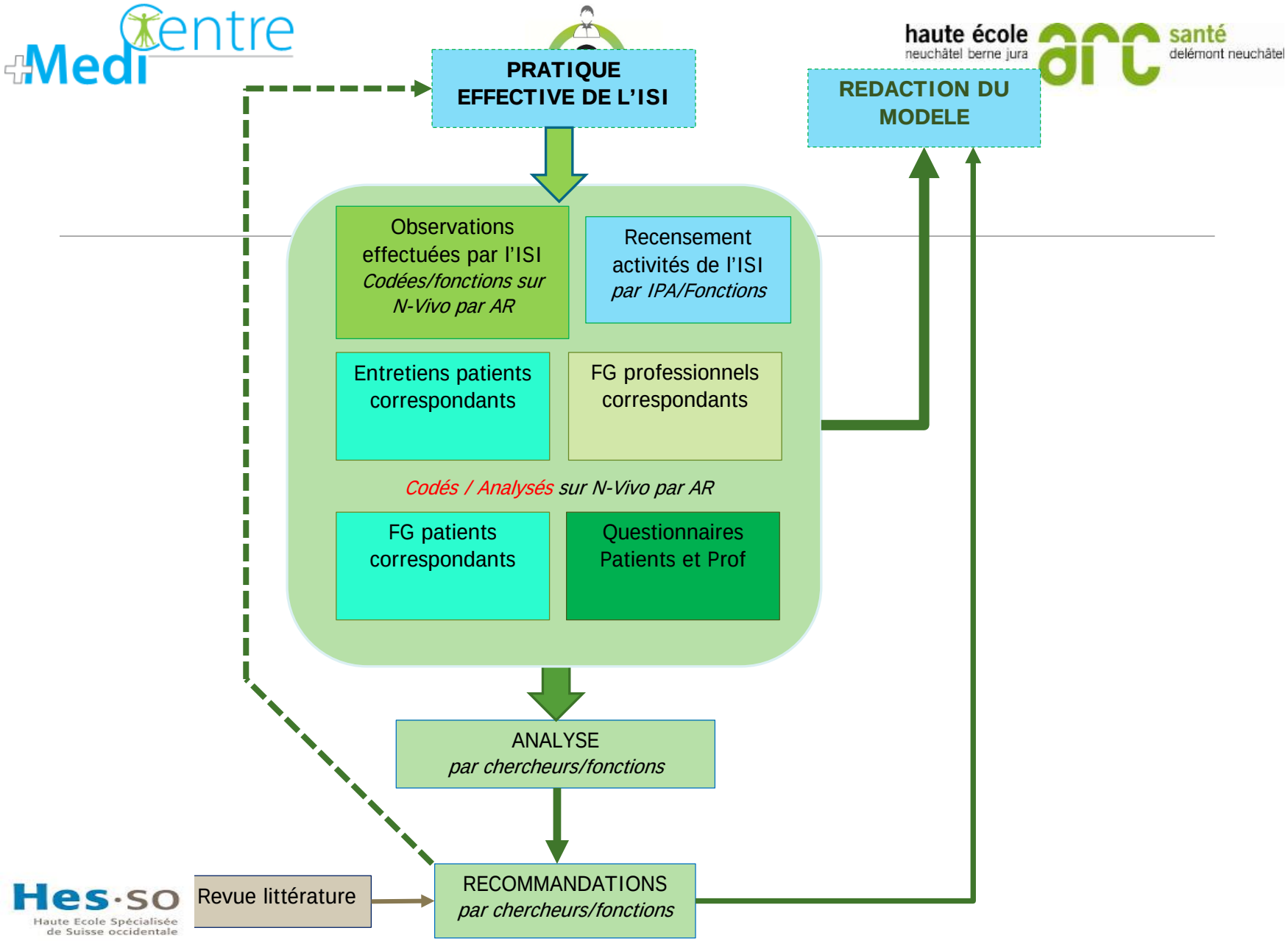
1. **Evaluation, advices, coordination:**
    1. Assessment of the patient needs and needs of his environment; plan of specific measures in collaboration with the physician and the patient…
    2. Advice to patients…
    3. …
4. **Medical examination and treatments:**
    5. Checking of vital signs (blood pressure, pulse,...)
    6. Glucose test in blood or urine
    7. …

4. Research methodology

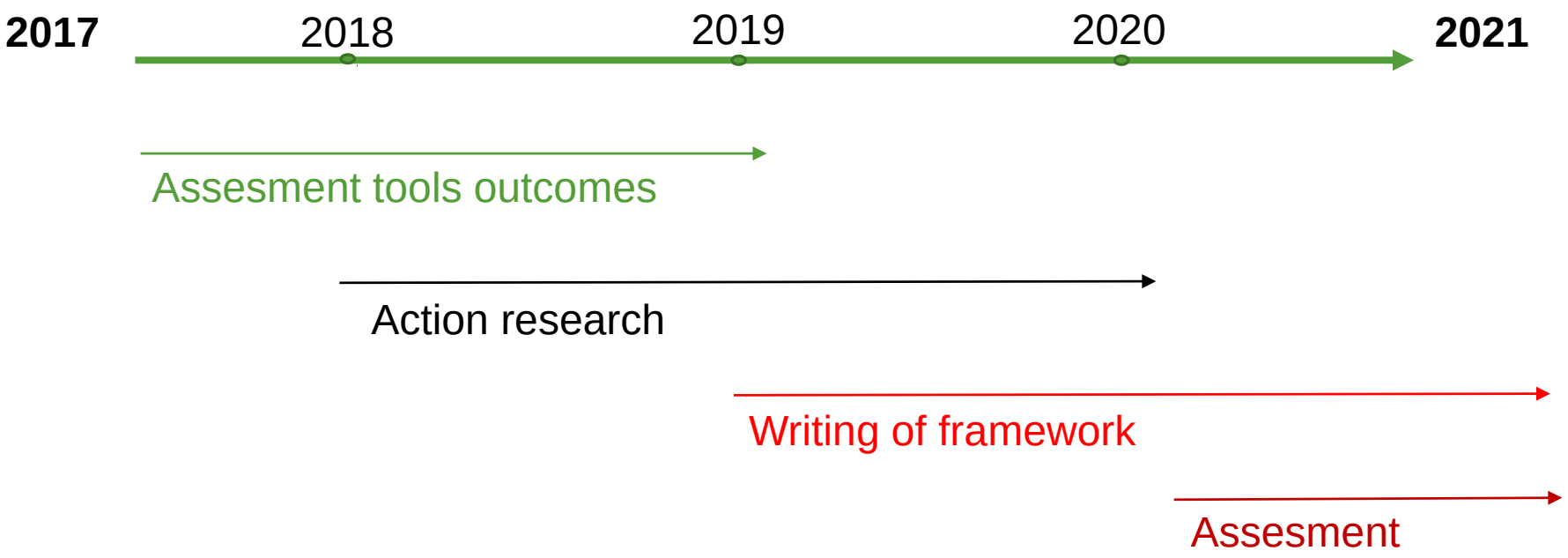
4.1 Research goals

Describe, enhance and **design** the activity of the ISP in the form of a framework that can be disseminated to other physician's offices.

Have an assessment of the effects of this framework on patients, on professionals that are involved in patient supervision and support, as well as on health costs.


PRATIQUE EFFECTIVE DE L'ISI
REDACTION DU MODELE
Observations effectuées par l'ISI *Codées/fonctions sur N-Vivo par AR*
Recensement activités de l'ISI *par IPA/Fonctions*
Entretiens patients correspondants
FG professionnels correspondants
Codés / Analysés sur N-Vivo par AR
FG patients correspondants
Questionnaires Patients et Prof
ANALYSE *par chercheurs/fonctions*
Revue littérature
RECOMMANDATIONS *par chercheurs/fonctions*

4.3 Project Intermed: Timeline



4.4 Research : combined evaluation

- **Qualitative :**
  - Interviews with patients
  - Focus-groups with professionals and partners

- **Quantitative :**
  - Multicentric (in an ideal)
  - Longitudinal
  - Controlled trial with other similar patients not undergoing follow up

4.5 Inclusion criteria for patients

Patients in complex situations according to the following criteria :

- Polymorbidity
- Difficult psychosocial contexts
- Type of prevention (secondary and tertiary)
- Care/case management

The more precise definition of inclusion criteria is one of the research issues.

4.6 Research : Variables assessed (1)

Primary outcomes :

- Death due to an unexpected complication
- Frequency and duration of hospitalization / recovery in an medical institution
- Number of medical visits (physicians / specialists…)
- Economic cost of prescribed treatments
- Evolution of multiple drug therapy and its cost

4.6 Research : Variables assessed (Suite)

Secondary outcomes for patients:

- Quality of life
- Satisfaction // care
- Empowerment: Sense of self-efficacy / Self-determination
- Coping strategies with the disease

Secondary outcomes for professionals:

- Satisfaction // patient caring
- Satisfaction // Interprofessional collaboration

4.7 Data collection instrument

Embeded in the development process

Related to existing instruments:

- QoL MOS-SF12: quality of life assessment
- PACIC: evaluation of patient satisfaction with care and empowerment
- QSSP-MK: evaluation of perceived social support
- WFP: evaluation of the patient's involvement in health management
- Coping-CHIP: evaluation of the patient's coping strategies to adapt to his disease

Intermed model

Part I : context and presentation of the model

Objectives - Care and case management - CCM - model purposes - model structure - ISP profile – ISP activities - concept of complexity - inclusion criteria - patient recruitment procedure

Part II : ISP's activities

Patient assessment - global, clinical, consistency of care - support for self-management - therapeutic education - motivational interview - clinical decision support - patient advocacy . Evidence-based care plan - Delivery system: implementation of procedures. Interprofessional coordination - facilitating the transition from one place of care to another. Information sharing - Use of community resources - Coaching of professionals - Training of professionals on the model

Part III : Funding of intermed services: invoicing - financing of the evaluation - financing of coordination services

Perspectives : Possible developments

5. Project participants

DIFFERENT PARTICIPANTS AND PARTNERS

5.1 The HE-Arc Santé team, research institut

Project manager

- Monsieur Olivier Walger, MSc, Professor HES

Scientific staff :

- Madame Véronique Haberey Knuessi, Ph.D, Professor HES, researcher
- Madame Olivia Messerli, MSc, scientific assistant
- Monsieur Marco Pedrotti, Ph.D, Manager of the research institut, He-Arc santé

5.2 Medi-Centre staff

- Ms. Anne Bramaud Du Boucheron, independent advanced practice nurse, principal nurse «ISP», Medi-Centre SA
- Dr. Marc Giovannini, primary care physician, Medi-Centre SA, principal physician associated to the research
- Ms. Sophie Brisebard, independent nurse, ISP, Medi-Centre
- Dr. Stéphane Coppi, primary care physician, Medi-Centre SA
- Mr Claude Fischer, Director of Medi-Centre SA

5.3 Extended team : other partners

CSS, health insurance :

- Participate in the development of inclusion and evaluation criteria, especially the socio-economic ones.
- Will be responsible for promoting the model by primary care physicians in the french-speaking part of Switzerland

A supplier is approached to develop an electronic shared care plan

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Thank you for your attention…

QUESTIONS?… DISCUSSION…