Liaison externe et soignants du domicile: Symphonie et fausses notes

Analyser le processus en cours pour mieux le comprendre

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Collaboration et intégration des soins

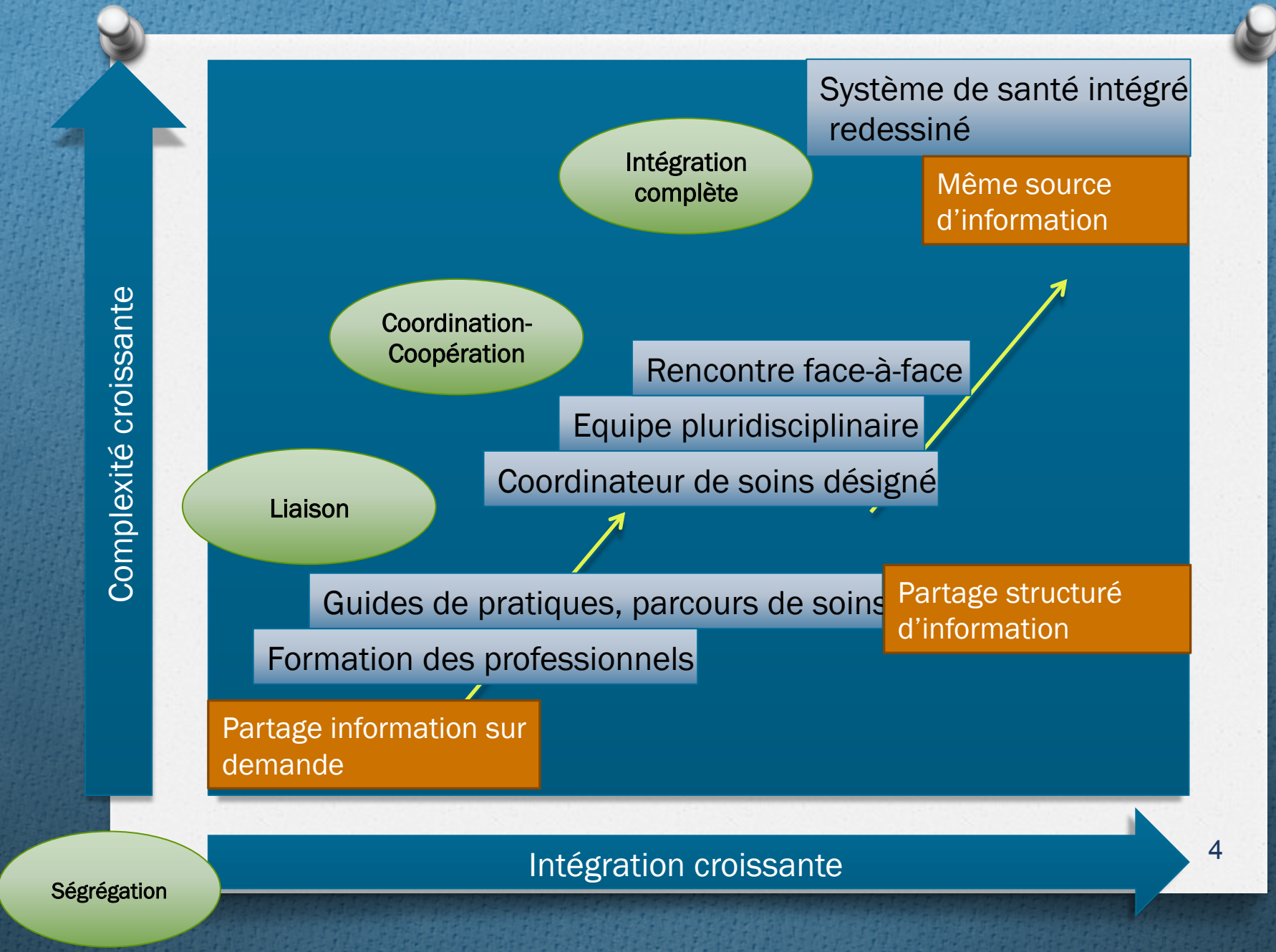
- Il y a différents niveaux d'intégration en fonction de la complexité d'une situation…
- …et différents outils en support aux différents stades d'intégration

Gradation de la complexité

«Dans un système intégré de soins, on s'attend à ce que l'intensité et la nature de la coordination s'ajustent en fonction des besoins de chacune des personnes »

Type de coordination	Degré d'incertitude	Séquence d'intervention des acteurs	Durée de la relation	Degré d'interdépendance des acteurs
Séquentielle	Faible	L'un après l'autre	Courte, non répétée	Faible
Réciproque	Moyenne	En même temps		Moyenne
Collective	Elevée	En même temps	Longue	Elevée

Contandriopoulos A, Denis J, Touati N, Rodriguez R. Intégration des soins: dimensions et mise en oeuvre. Ruptures, revue transdisciplinaire en santé. 2001;8(2):38-52.


Complexité croissante
Système de santé intégré redessiné
Intégration complète
Même source d'information
Coordination-Coopération
Rencontre face-à-face
Equipe pluridisciplinaire
Coordinateur de soins désigné
Liaison
Guides de pratiques, parcours de soins
Partage structuré d'information
Formation des professionnels
Partage information sur demande
Ségrégation
Intégration croissante

Ces concepts adaptés à la situation de la personne âgée

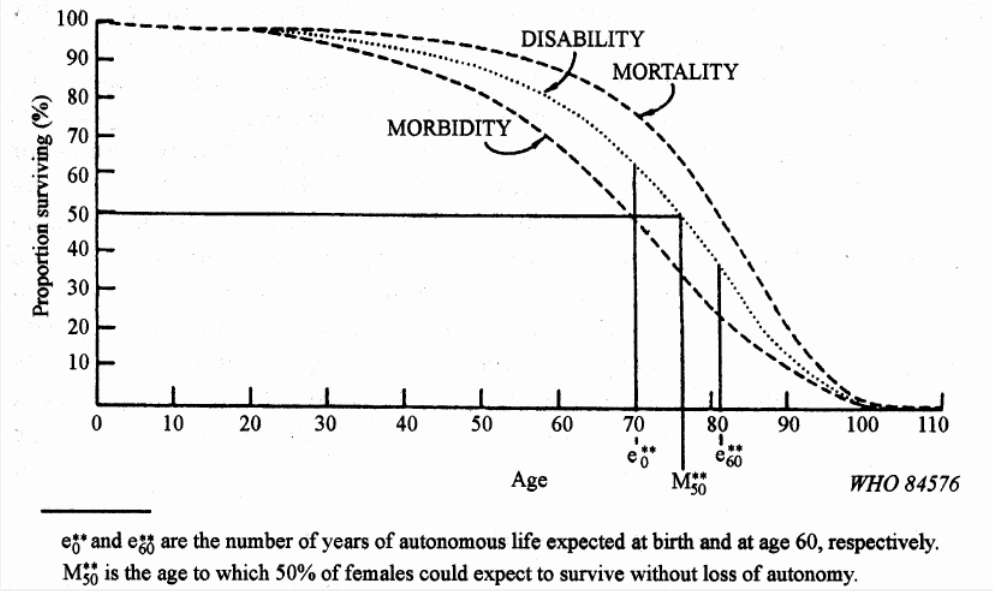
Toute personne âgée n'est pas complexe

Différentes intensité de suivi (aide/soins) en fonction de la situation

Toute personne âgée n'est pas (dans) une situation complexe (I)

On vit plus longtemps en bonne santé.

(bémol: gradient socio-économique)



e_0^{**} and e_{60}^{**} are the number of years of autonomous life expected at birth and at age 60, respectively.
M_{50}^{**} is the age to which 50% of females could expect to survive without loss of autonomy.

OMS 1984

Toute personne âgée n'est pas (dans) une situation complexe (II)

- Notion de fragilité
  - >âge
  - =« la coexistence de plusieurs pathologies chroniques invalidantes à l'origine d'une dépendance physique et/ou psychique et par l'intrication fréquente des pathologies neuro- dégénératives et somatiques »

- Prévalence de la fragilité
  - Au domicile: 20% des 80+, 50% des 90+
  - En MRS: 100% ?

J.Petermans; Rev Med Liège 2014; 69 : 5-6 : 233-238

Toute personne âgée n'est pas (dans) une situation complexe (III)




Fragilité

Gradient de réponse d'aide et soins

Médecin généraliste

Spécialistes organes

Professionnel aide/ soins à domicile

Institution

Gériatrie

Médecin généraliste

Spécialistes organes

<u>Intégration séquentielle</u>
MG: coordination-globalité-synthèse
Transfert d'information limité
Capacité de coordination du patient

Médecin généraliste

Spécialistes organes

Professionnel aide/ soins à domicile

Coordination-coopération

Fonction de coordination reste à assumer[1]

Réseau informel et spécifique à chaque patient[1]

Mise en commun partielle

Faible participation du MG aux concertations pluridisciplinaires[2]

1. Belche JL, Buret L, Duchesnes C, Giet D. La coordination de soins en 1ère ligne: et Mme Dupont? Santé Conjuguée. 2016;74:45-50.
2. Buret L. La concertation multidisciplinaire GLS 2016

Médecin généraliste

Gériatrie

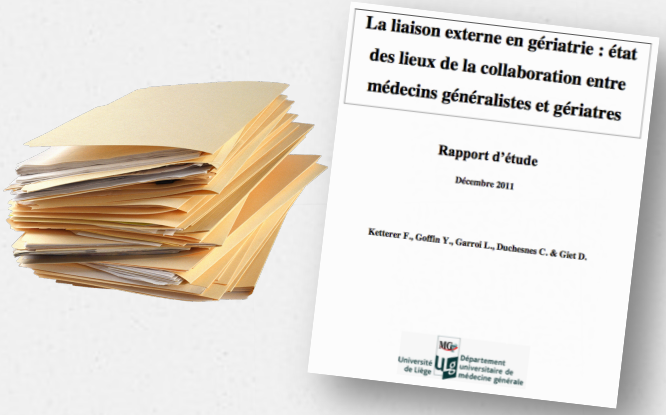
Intégration séquentielle
Coordination-coopération

Equipe pluridisciplinaire intégrée
Le plus souvent en institution (même HdJ)
Dossier partagé
Tâches définies
Procédures et Soins Structurés

La liaison externe en gériatrie : état des lieux de la collaboration entre médecins généralistes et gériatres

Rapport d'Etudes 2011

Ketterer et al. DUMG-ULiège



- Méconnaissance de la gériatrie par les MG
- Habitude de collaboration avec réseau habituel viennent en compétition
- Clarification demandée
- Liaison gériatrique externe: pas à l'ordre du jour

PLACE DU GÉRIATRE DANS LA FILIÈRE DE SOINS

J. PETERMANS (1)

RÉSUMÉ : Cet article a pour objectif de définir la place du gériatre dans la filière de soins pour le patient âgé. Le programme de soins pour le patient gériatrique définit les différentes fonctions; actuellement, l'hospitalisation gériatrique, l'hospitalisation de jour gériatrique (HJG) et la liaison interne sont bien développées au sein de l'hôpital autour du gériatre. Si l'évaluation gériatrique standardisée a fait ses preuves quant à la prévention du déclin fonctionnel, le niveau d'efficience doit encore être précisé pour la fonction de liaison et le travail en HJG. Des initiatives dans le cadre de certaines pathologies médicales et chirurgicales commencent à se développer où le gériatre participe activement à la prise de décision de soins. En première ligne, la place du médecin généraliste est fondamentale pour traiter les patients gériatriques au domicile, mais aussi dans les maisons de repos et de soins. Au vu de l'évolution démographique et de la fragilité de la population soignée, un échange et une coordination entre ces différentes fonctions complémentaires doivent être développés. Un modèle de filière est proposé à partir des composantes existant actuellement, mais il doit encore être testé et validé.

MOTS-CLÉS : *Personne âgée - Filière de soins - Fragilité - Evaluation gériatrique standardisée*

THE ROLE OF THE GERIATRICIAN IN THE ORGANIZATION OF THE HEALTH CARE SYSTEM

SUMMARY : The purpose of this paper is to define the role of the geriatrician in the organization of the health care for the elderly. In Belgium, the healthcare program for the geriatric patient defines the various functions; at present, the classical geriatric hospitalization, the hospital day care, and the internal links within the hospital are well developed around the geriatrician. The standardized, comprehensive geriatric assessment of hospitalized patients has demonstrated its value for the prevention of functional decline. The efficiency of the day care services and of the link teams remains to be further appraised. Outside the hospital, the general practionner plays the major role in the treatment of the elderly living at home, or in nursing homes. The demographic evolution and the frailty of the elderly require a good coordination of all those involved in the care of the aged. A model of healthcare organization is proposed to better coordinate the in- and out of hospital activities.

KEYWORDS : *Elderly - Oragnaization of care - Frailty - Geriatric assessment*

J.Petermans; Rev Med Liège 2014; 69 : 5-6 : 233-238

Vanden Bussche *et al. BMC Health Services Research* 2010, **10**:202
http://www.biomedcentral.com/1472-6963/10/202

BMC
Health Services Research

RESEARCH ARTICLE **Open Access**

Geriatric day hospital: opportunity or threat? A qualitative exploratory study of the referral behaviour of Belgian general practitioners

Piet Vanden Bussche[1], Fien Desmyter[1], Christiane Duchesnes[4], Valérie Massart[4], Didier Giet[4], Jean Petermans[3], Veerle Vyncke[1], Nele Ven Den Noortgate[2] and Sara Willems*[1]

Abstract

Background: In order to address the challenges of an ageing population the Belgian government decided to allocate resources to the creation of geriatric day hospitals (GDHs). Although GDHs are meant to be a strategy to support general practitioners (GPs) caring for the frail elderly, few Belgian GPs seem to refer to a GDH. This study aims to explore the barriers and facilitating factors of GPs' referral to GDHs.

Methods: A qualitative study using focus group discussions (FGDs) was conducted. Fifteen FGDs were organized in the different Belgian regions (Flanders, Wallonia, Brussels).

Results: Contextual factors such as the unsatisfactory cooperation between hospital and GPs and organizational barriers such as the lack of communication on referral procedures between hospital and primary health care (PHC) were identified. Lack of basic knowledge about the concept or the local organization of GDH seemed to be a problem. Unclear task descriptions, responsibilities and activities of a GDH formed prominent points of discussion in all FGDs. Nevertheless a lot of possible advantages and disadvantages of GDHs for the patient and for the GP were mentioned.

Conclusions: In the case of poor referral to GDHs, focusing on improving overall collaboration between primary and secondary health care is essential. This can be achieved by actively delivering adequate information, permanent communication and more involvement of PHC in the organization and functioning of GDHs. The absence of a transparent health care system with delineated role definitions, seems to hinder the integration of new initiatives like GDHs in the care process. Strategies to enhance referral to GDHs should use a comprehensive approach.

Elderly patients admitted to the Emergency Department: A 5-year epidemiology study in Liege University Hospital Centre.

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Introduction

With the increase in life expectancy, aging of the population is a well known phenomenon in western countries. These elderly patients often present acute exacerbation of chronic poly-pathological conditions, representing a specific challenge for the emergency physician. The knowledge of the epidemiologic particularities of these patients could offer interesting perspective in a better understanding of the specific issues of these patients.

Material and methods

This was a 6-year retrospective study including every patients > 75-year-old admitted in the emergency department (ED) of the Liege University Hospital Centre, from January 2009 to December 2014. The epidemiologic data were extracted from electronic medical data files and further analysed.

Results

During the study period, 24564 patients > 75-year-old were admitted to our department (representing 9.8% of overall admissions). Most of these patients (82.9%) came directly from their home and 44.1% on their own initiative. Only 27.6% of these patients were referred by their general practitioner. The annual increase in the admission rate was 3.01%, while it was 2.19% for

Conclusion

We demonstrate that the increase in elderly patients' admissions in the ED is greater that the global population. Surprisingly, these patients are mainly self-referring patients, consulting at daytime during working days.

Therefore, we believe that collaboration between EDs and geriatric departments should be reinforced during this period in order to identify patients meeting weakening criteria.




Médecin généraliste

Gériatrie

Evolution de la fonction/rôle du MG au cours du temps

- Méconnaissance réciproque, méfiance, perception de concurrence
- Transfert d'information: effet d'interface, faible partage ou mise en commun
- Tâches respectives et complémentarité peu définies
- Itinéraires cliniques n'incluent pas systématiquement le MG
- Moyens de rencontre peu structurés




Gériatrie

M

Evol

Méconna
concurre
Transfe
en commun
Tâches respectives et compleme
Itinéraires cliniques n'incluent pas systématiq
Moyens de rencontre peu structurés

Tendance générale des relations 1ère-2ème ligne

Quand
Hospitalocentrisme
1ère ligne faiblement structurée
Recouvrement avec les fonctions de la 1ère ligne
(accessibilité-globalité-longitudinalité-coordination)

Pistes de solution (I)

- Construire la complémentarité
  - Reconnaître leur apport spécifique
  - Définition de tâches à co-construire
  - Formation initiale et continue commune
  - Comprendre la profession de l'autre (cadre-contraintes,etc.)
  - Connaissance interprofessionnelle

Journal of Multidisciplinary Healthcare

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ORIGINAL RESEARCH

Care of elderly people by the general practitioner and the geriatrician in Belgium: a qualitative s of their relationship

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Jan De Lepeleire[3]

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Objectives: The care of elderly people is a large part of a general practition growing elderly population means that the medical community must give management of their care. Within this large field, we focused on the relationship b practitioners and hospital geriatricians.

Methods: Focus group discussions were performed to describe the collabo general practitioners and hospital geriatricians: four of these focus groups contain practitioners, two groups contained only hospital geriatricians, and one group w general practitioners and hospital specialists. Participants were invited to speak ab experiences of intercollaboration. The discussions were recorded, transcribed, a

Results: An important regional disparity was observed: better relationships and e tion were reported in those regions that benefit from a wider range of geriatric se with few geriatric services, doctors knew little of other professionals and reported even conflicts. Positive experiences and communication favor good relationship

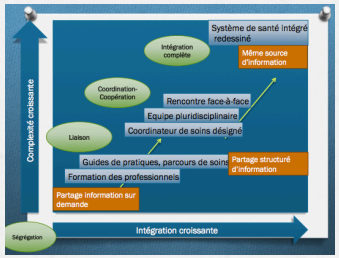
Conclusions: The collaboration between general practitioners and hospital geria be enhanced: information, exchanges, and reflection on roles and competencies

Keywords: geriatrics, general practitioner, collaboration, qualitative research,

to the attending doctor. And I think that these are two very different lights." (FGD1-HG)

The last FGD (FGD7) was very different from the others: it was obvious that GPs and hospital specialists were accustomed to speaking to each other, and the discussion showed mutual respect and tact. A part of this group used to meet for several years to address collaboration and shared health care approaches at a local level (SYLOS project).[36] They don't agree with the perception that there is a conflict in their roles:

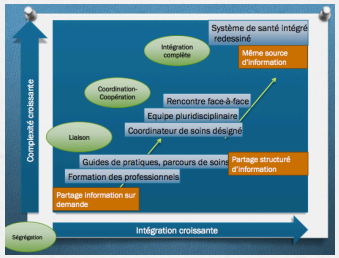
"There is not this conflict of skills, here. It is necessary to make the things that each can make with the possibilities that he has to make it. And the hospital is made to make things which the general practitioners cannot make. If they can make it, well, they made it at home, that it is completely true. (…) if the general practitioner refers a patient, it is to facilitate the matter, so that we, the specialists, serve as intermediary to make this or that. (…) The general practitioners are going to take advantage of that, as they will have a second opinion which is different from theirs (…) If it is not to make that, it makes no sense." (FGD7-specialist)



Pistes de solution (II)

Définir les outils d'intégration/ collaboration

- Modalités du transfert/partage d'information
  - RSW, rapport d'Hospitalisation, téléphone
- Définir la fonction de coordination
  - Qui, où
- Co-construire les itinéraires cliniques transmuraux
- Définir des modalités de concertation (rencontre) adaptés
  - Réunion pluri domicile/hôpital
  - Téléphone, …



Pistes de solution (II)

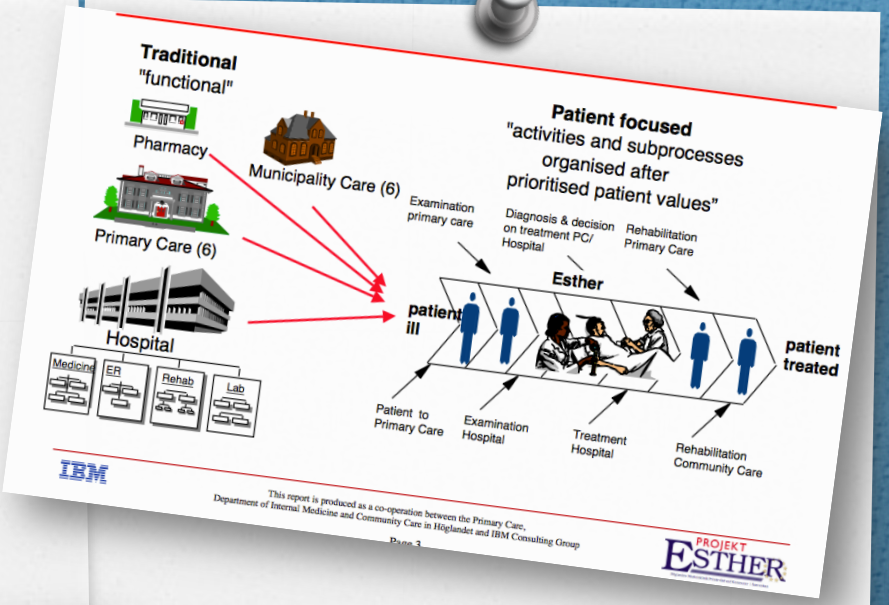
Définir les outils d'intégration/ collaboration

Exemple concret Via SYLOS CHR

- Groupe de travail mixte MG-Gériatre
- Numéro GSM de MG >>Gériatre
- Numéro d'appel direct d'un gériatre pour tri
- Rapport d'entrée structuré, défini conjointement
- Invitation à la CM du service hospitalier
- Visite de service hospitalier et HdJ
- Page internet avec partage documents d'évaluation

Esther Projekt-Sweden

Collaboration Communauté-1ère Ligne ambulatoire-2ème Ligne hospitalière



***ESTHER LIVED ALONE** and one morning developed breathing difficulties. After contacting her daughter, who did not know what to do, Esther sought medical advice. She was seen by a district nurse and told to visit her general practitioner (GP). The GP said she needed to go to hospital and called an ambulance. After being admitted to emergency care she retold her story to a variety of clinicians at the hospital during a five-and-a-half-hour wait. Esther saw a total of 36 different people and had to retell her story at every point, while having problems breathing. This process caused Esther to become confused. (In a worst-case scenario, she could have been misdiagnosed with dementia). After her long wait, a doctor finally admitted her to a hospital ward and treatment began.*[3]

With Esther's experience in mind, Bojestig initiated an extensive series of interviews and workshops between 1997 and 1999 to identify redundancies and gaps in the medical and community care systems and develop an action plan for improvement. "Esther" came to represent elderly persons who have complex care needs that involve a variety of providers. Creating a persona for the patient

Esther proved inspirational for the team. During the three-year project, they were able to achieve the following improvements:

- Hospital admissions fell from approximately 9,300 in 1998 to prognostic 7,300 in 2003.
- Hospital days for heart failure patients decreased from approximately 3,500 in 1998 to 2,500 in 2000.
- Waiting times for referral appointments with neurologists decreased from 85 days in 2000 to 14 days in 2003.
- Waiting times for referral appointments with gastroenterologists fell from 48 days in 2000 to 14 days in 2003.

Je vous remercie pour votre attention!

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