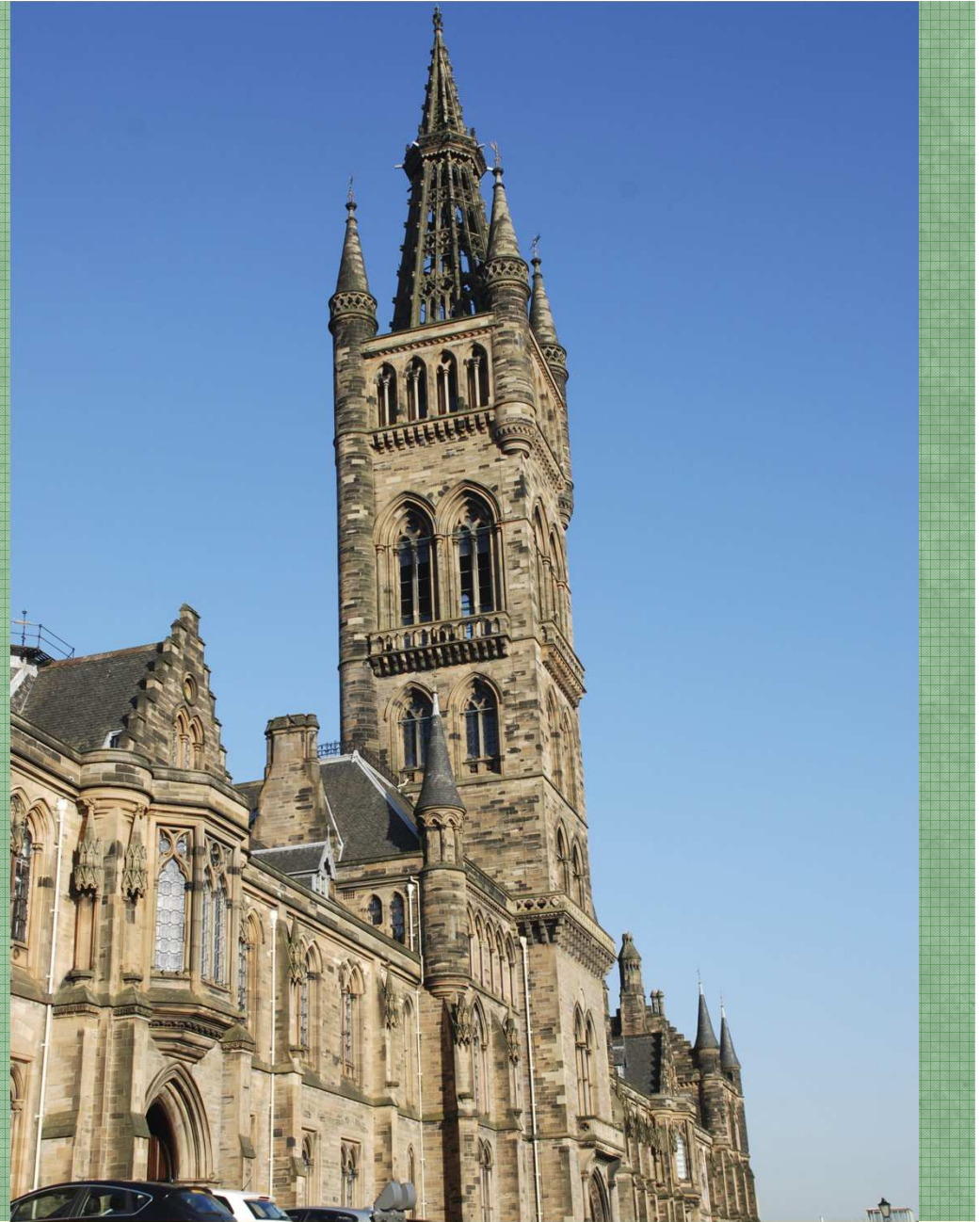


ESTANCIAS FORMATIVAS DE INTERNISTAS EN PLURIPATOLOGIA Y CRONICIDAD

GLASGOW SCOTLAND UK

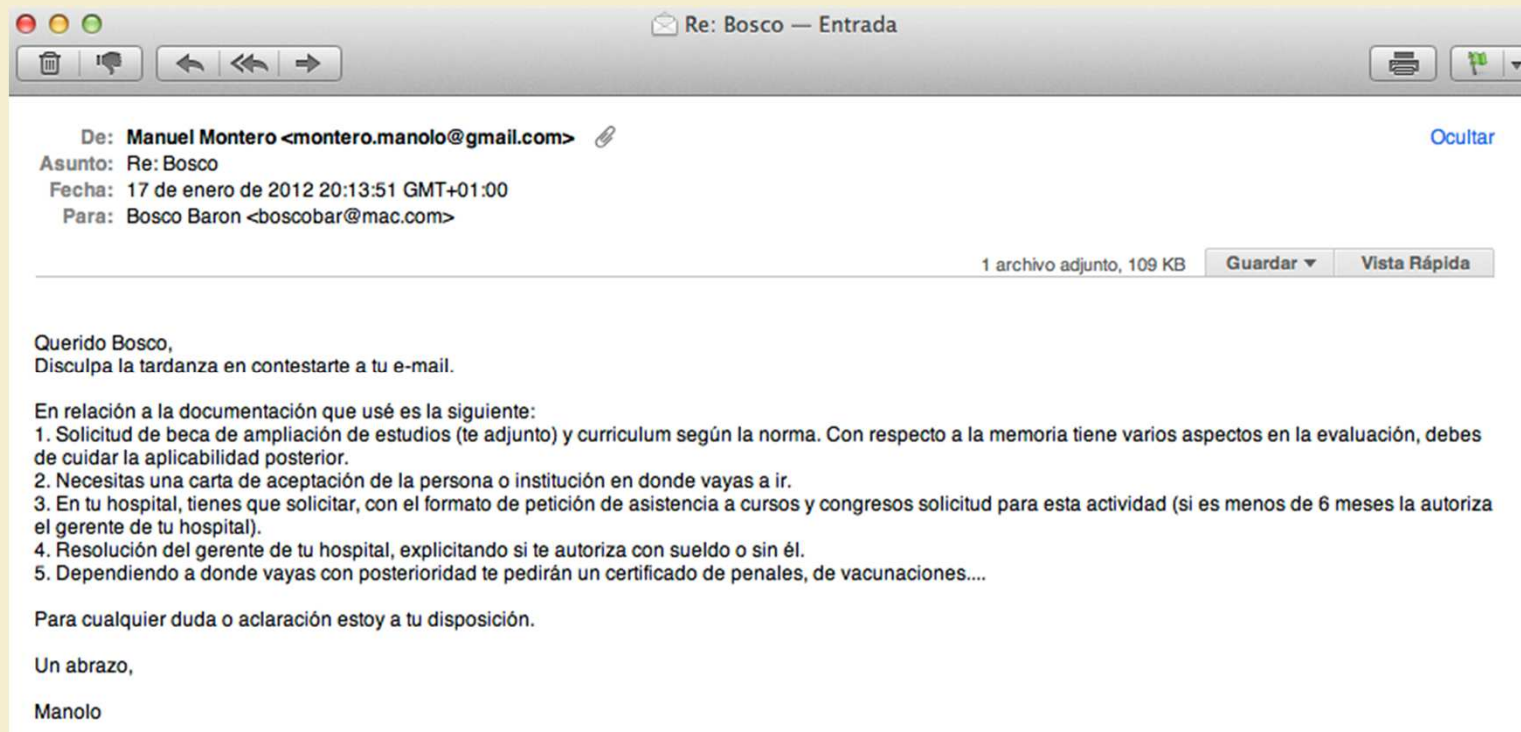
Bosco Barón
Juan Ramón Jiménez
Huelva



ESTANCIAS FORMATIVAS DE INTERNISTAS EN PLURIPATOLOGIA Y CRONICIDAD

- 1. LUGAR**
- 2. FINANCIACIÓN**
- 3. ESTANCIA**
- 4. RESULTADOS**

LUGAR



LUGAR

Dr Seth Rankin

MBChB, Dip Obst, MRCGP

Senior Partner



St George's Healthcare **NHS**
NHS Trust

Wandsworth Community Wards

"...reducing hospital admissions by supporting existing community services in the management of chronic conditions and the provision of acute interventions in the community."

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Research

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Denis O'Mahony

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STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria

PAUL GALLAGHER, DENIS O'MAHONY

Department of Geriatric Medicine, Cork University Hospital, Wilton, Cork, Ireland

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Denis O'Mahony. Email: Denis.omahony@maip.hse.ie

Abstract

Introduction: STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions) is a new, systems-defined medicine review tool. We compared the performance of STOPP to that of established Beers' criteria in detecting potentially inappropriate medicines (PIMs) and related adverse drug events (ADEs) in older patients presenting for hospital admission.

Methods: we prospectively studied 715 consecutive acute admissions to a university teaching hospital. Diagnoses, reason for admission and concurrent medications were recorded. STOPP and Beers' criteria were applied. PIMs with clear causal connection or contribution to the principal reason for admission were determined.

Results: median patient age (interquartile range) was 77 (72-82) years. Median number of prescription medicines was 6 (range 0-21). STOPP identified 336 PIMs affecting 247 patients (35%), of whom one-third ($n = 82$) presented with an associated ADE. Beers' criteria identified 226 PIMs affecting 177 patients (25%), of whom 43 presented with an associated ADE. STOPP-related PIMs contributed to 11.5% of all admissions. Beers' criteria-related PIMs contributed to significantly fewer admissions (6%).

Conclusion: STOPP criteria identified a significantly higher proportion of patients requiring hospitalisation as a result of PIM-related adverse events than Beers' criteria. This finding has significant implications for hospital geriatric practice.

Keywords: inappropriate prescribing, elderly, STOPP, screening tool

Introduction

Older people often experience multiple co-morbidities and are prescribed multiple medications thereby increasing the risk of adverse drug events (ADEs), drug-drug and drug-disease interactions [1, 2]. This risk is heightened by age-related physiological changes, which influence pharmacokinetics and pharmacodynamics [3]. Particular drugs pose special risks to older people as a result of these changes, e.g. prolonged sedation and increased risk of falls with long-acting benzodiazepines [4] or increased risk of upper gastrointestinal bleeding with non-steroidal anti-inflammatory drugs [5]. Prescription of such drugs is potentially inappropriate, particularly where safer alternatives exist.

Various criteria have been devised to identify potentially inappropriate medicines (PIMs) in older people [6-10], the most frequently cited being Beers' criteria [6]. Though often used to detect PIMs in large-scale epidemiological

studies, some of Beers' criteria are controversial [11]. There is disagreement over the designation of certain drugs as inappropriate, e.g. amitriptyline [12] and nitrofurantoin [13], and almost half of the PIMs in Beers' criteria are unavailable in European formularies [14]. Furthermore, few studies report a tangible benefit to patients in terms of clinical outcome from using Beers' criteria [15]. Therefore, the general clinical relevance and applicability of these criteria is uncertain. Nonetheless, quality and safety of prescribing in older people remains a global healthcare concern and further endeavours to improve appropriateness in medication selection for older people are warranted.

We have devised a new screening tool of older patients' medicines called STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions). Validation of STOPP is described in detail elsewhere [16]. Briefly, 18 experts in geriatric pharmacotherapy with recognized credentials in their specialist areas were recruited to establish the

LUGAR

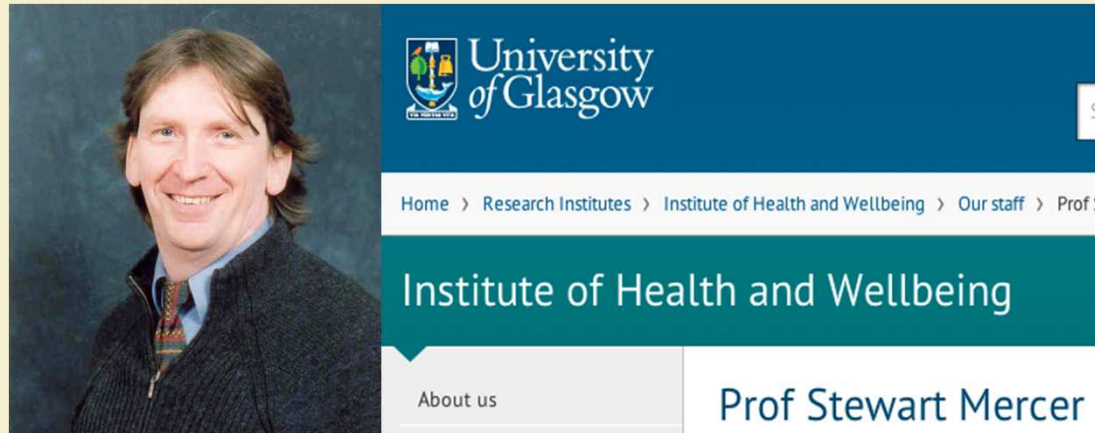


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Prof Stewart Mercer

- Profile
- Publications
- Grants
- **Chair in Primary Care Research** (General Practice and Primary Care)

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MBChB, Dip Obst, MRCGP

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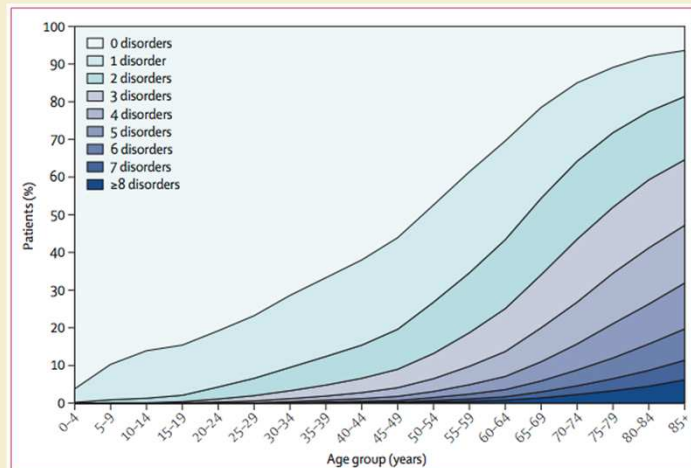


Figure 1: Number of chronic disorders by age-group

Articles

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Narbury, Graham Watt, Sally Wyke, Bruce Guthrie

Summary

Background Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multimorbidity. We examined the distribution of multimorbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation.

Methods In a cross-sectional study we extracted data on 40 morbidities from a database of 1751841 people registered with 314 medical practices in Scotland as of March, 2007. We analysed the data according to the number of morbidities, disorder type (physical or mental), sex, age, and socioeconomic status. We defined multimorbidity as the presence of two or more disorders.

Findings 42.2% (95% CI 42.1–42.3) of all patients had one or more morbidities, and 23.2% (23.0–23.2) were multimorbid. Although the prevalence of multimorbidity increased substantially with age and was present in most people aged 65 years and older, the absolute number of people with multimorbidity was higher in those younger than 65 years (210500 vs 194996). Onset of multimorbidity occurred 10–15 years earlier in people living in the most deprived areas compared with the most affluent, with socioeconomic deprivation particularly associated with multimorbidity that included mental health disorders (prevalence of both physical and mental health disorder 11.0%, 95% CI 10.9–11.2% in most deprived area vs 5.9%, 5.8%–6.0% in least deprived). The presence of a mental health disorder increased as the number of physical morbidities increased [adjusted odds ratio 6.74, 95% CI 6.59–6.90 for five or more disorders vs 1.95, 1.93–1.98 for one disorder], and was much greater in more deprived than in less deprived people (2.28, 2.21–2.32 vs 1.08, 1.05–1.11).

Interpretation Our findings challenge the single-disease framework by which most health care, medical research, and medical education is configured. A complementary strategy is needed, supporting generalist clinicians to provide personalised, comprehensive continuity of care, especially in socioeconomically deprived areas.

Funding Scottish Government Chief Scientist Office.

Introduction

Management of the rising prevalence of long-term disorders is the main challenge facing governments and health-care systems worldwide.¹ Although individual diseases dominate health-care delivery, medical research, and medical education, people with multimorbidity—those with two or more chronic morbidities—need a broader approach. Use of many services to manage individual diseases can become duplicative and inefficient, and is burdensome and unsafe for patients because of poor coordination and integration.^{2,3} Multimorbidity becomes progressively more common with age⁴ and is associated with high mortality,⁵ reduced functional status,⁶ and increased use of both inpatient and ambulatory health care.⁷ Estimates of the prevalence of multimorbidity vary widely: most studies have counted small numbers of morbidities, frequently based on self-reports, and focused on either older people or hospital populations.⁸

Although the association between socioeconomic status and prevalence of individual chronic diseases is well established,^{9,10} few studies have examined the association between multimorbidity and socioeconomic status.^{11–13} In the most deprived 10% of the Scottish population, men

have life expectancies 13 years shorter, and women 9 years shorter, than do those in the most affluent 10%. The most deprived people spend twice as many years in poor health before they die than do the most affluent (10.3 years vs 5.5 years for men; 14.4 years vs 6.0 years for women).¹⁴

Better understanding of the epidemiology of multimorbidity is necessary to develop interventions to prevent it, reduce its burden, and align health-care services more closely with patients' needs. We aimed to use a large, representative primary medical care electronic database to examine the distribution of multimorbidity in relation to age and socioeconomic deprivation, and the relation between comorbidity of physical and mental health disorders and deprivation.

Methods

Study design and participants

Our study is a cross-sectional analysis of a national dataset held by the Primary Care Clinical Informatics Unit at the University of Aberdeen, UK. The dataset consisted of complete copies of clinical data for all registered patients from 314 medical practices caring for about a third of the Scottish population. The UK National Health Service (NHS) requires registration with a medical practice to



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See Comment page 7

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Prof B Guthrie PhD, Institute of

Health and Wellbeing, General

Practice and Primary Care

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Prof G Watt MD, and Institute of

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LUGAR



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ANALYSIS

We need minimally disruptive medicine

The burden of treatment for many people with complex, chronic, comorbidities reduces their capacity to collaborate in their care. **Carl May, Victor Montori, and Frances Mair** argue that to be effective, care must be less disruptive

Chronic disease is the great epidemic of our times, but the strategies we have developed to manage it have created a growing burden for patients. This treatment burden induces poor adherence, wasted resources, and poor outcomes. Against this background, we call for minimally disruptive medicine that seeks to tailor treatment regimens to the realities of the daily lives of patients. Such an approach could greatly improve the care and quality of life for patients.

Non-adherence, culpability, and susceptibility

Poor adherence to medical advice and drug regimens is a global problem with a long history. Non-adherence is important because many therapeutic interventions are effective only if used correctly, which requires continuous personal investment of time and effort from patients. The epidemiological transition from acute diseases, where the emphasis was on cure, to chronic illnesses that instead require management also means that patients take on a lifetime burden. Poor adherence can lead to complications in professional-patient relationships, additional ill health and expenditure for patients and their families, and the waste or misallocation of healthcare resources.^{1,2}

The aetiology of non-adherence is complex, but individual culpability has been assumed to play an important part.^{1,2} People with chronic (and other) illnesses who do not adhere to treatment generally say that they recognise that they ought to do otherwise but that they lack the capacity, skills, and understanding to do so. In one study, 45% of patients gave such reasons for intentionally not adhering to treatment for chronic illnesses.³ Recent research on adherence has focused, therefore, on interventions. The aim of these interventions is twofold: to improve patient uptake of treatments by giving them tools to share in understanding the relevance and importance of certain behaviours and treatments; and to encourage them to "buy in" to those behaviours and enhance their ownership of therapeutic regimens. Much of the research has been done in the context of randomised controlled trials of treatments

for quite narrowly defined patient groups. Thus our understanding of adherence is of limited applicability to usual care.^{3,7,9}

Chronic illness and chronic workload

Studies that examine adherence often exclude two large groups of patients that health professionals encounter in real life: people who have diminished capacity to cope with therapeutic regimens because of cognitive impairment and people with multiple chronic comorbidities. Both groups often present complex social problems that are related to their illness and confound treatment.¹⁰ Perhaps more than 60% of older people have multiple chronic conditions, representing an increasing proportion of people who need health care.^{11,12}

The burden of chronic illness falls not only on health services but also on patients and carers, as the work of managing chronic disease increasingly shifts from the clinic to the home. They must cope with increasingly complex treatment regimens and work to normalise these in their daily lives (see example 1 in box).¹³

Other factors exacerbate this situation. Treatment burdens are often imposed on patients with little coordination between, or even within, clinics dealing with different conditions and little explicit recognition that treatment regimens are demanding in time and effort. In addition, evidence based guidelines provide disease specific guidance for doctors but often fail to acknowledge multiple morbidities as management



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para la I+D+i EN SALUD

Guía de Bolsillo 2012



Última actualización del documento:
2 de febrero de 2012



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ID	CONVOCATORIA	ENTIDAD	DURACIÓN	DOTACIÓN ECONÓMICA (cantidades aprox.)	REQUISITOS BÁSICOS CANDIDATO	TIPOLOGÍA	SENTIDO	IMPORTANTE	PLANIFICACIÓN 2012											
									Ene	Feb	Mar	Abr	May	Jun	Jul	Ago	Sep	Oct	Nov	Dic
RP94H 33	Bolsas de Ampliación de estudios (BAE)	ISCIII	Min. 2 m. - Máx. 2 a.	Min. 24.000 € brutos/año	Tener una antigüedad superior a 6 meses en un centro del ámbito del SNS (excepto CIBER)	Nacional / Internacional	Salida	Estancia iniciada en el año de la convocatoria												
RP94H 34	7PM Becas Marie Curie Intra-europeas para el desarrollo de la carrera profesional (Intra-european fellowship. IEF)	CE	Min. 12 m. - Máx. 2 a.	Min. 58.500 € y Máx. 87.500 €	Titulación (doctorado) o más de 4 años de experiencia investigadora Nacionalidad UE 27 o AC o residente en UE 27	Internacional	Incorporación	Origen: UE 27 / AC Destino: Otro UE 27 / AC												
RP94H 35	7PM Becas Marie Curie para investigadores de terceros países (International incoming fellowship. IIF)		Min. 12 m. - Máx. 3 a.	Min. 58.500 € y Máx. 87.500 €	Titulación (doctorado) o más de 4 años de experiencia investigadora Cualquier nacionalidad	Internacional	Incorporación / Retorno	Origen: Tercer país Destino: UE 27 / AC + retorno en caso de ICPC												
RP94H 36	7PM Becas Marie Curie internacionales de salida a terceros países para el desarrollo de la carrera profesional (International outgoing fellowship. IOF)		Min. 12 m. - Máx. 3 a.	Min. 58.500 € y Máx. 87.500 €	Titulación (doctorado) o más de 4 años de experiencia investigadora Nacionales, UE 27 y AC o residentes	Internacional	Salida / Retorno	Origen: UE 27 / AC Destino: Tercer país + retorno UE 27 / AC												
RP94H 37	7PM Ayudas Marie Curie para la integración de investigadores (Career integration grants. CIG)		Min. 2 a. - Máx. 4 a.	Min. 25.000 €/año	Titulación (doctorado) o más de 4 años de experiencia investigadora Cualquier nacionalidad	Internacional	Incorporación	Origen: Cualquiera Destino: UE 27 / AC												
RP94H 38	Becas de larga duración	HFSP	Máx. 3 a.	Min. 37.320 €/año	Titulación (doctorado) obtenida en los últimos de 3 años	Internacional	Salida / Retorno	Investigación básica (biología), en ciencias de la vida												
RP94H 39	Becas multidisciplinares		Máx. 3 a.	Min. 37.300 €/año	Titulación (doctorado) obtenida en los últimos de 3 años	Internacional	Salida	Investigación básica de físicos, químicos, ingenieros e informáticos en áreas afines a la biología												
RP94H 40	Beca de Doctorado	BIF	3 a.	Min. 18.000 €/año	Titulación (licenciatura) Menor de 27 años	Internacional	Salida	Contar con un proyecto a realizar Doctorado internacional												
RP94H 41	Convocatoria de becas para ampliación de estudios en el extranjero en ciencias de la naturaleza	FRA	Min. 12 m. Máx. 2 a.	Min. 26.400 €/año	Titulación (doctorado) obtenido en los últimos 4 años. Nacionalidad española	Internacional	Salida													
RP94H 42	Becas de investigación en universidades o centros extranjeros	FAME	Min. 12 m. Máx. 2 a.	Min. 22.800 €/año	Titulación (doctorado) o formación sanitaria especializada Nacionalidad española	Internacional	Salida													

FINANCIACIÓN



BOLSAS DE AMPLIACIÓN DE ESTUDIOS CURRÍCULUM NORMALIZADO CANDIDATO

Subdirección General de Evaluación y
Fomento de la Investigación

Expediente N°

B	A	1	2	/					
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APELLIDOS: BARÓN FRANCO

NOMBRE: BOSCO

Bolsas de ampliación de estudios (BAE)

Qué se puede solicitar

Ayudas para realizar estancias en instituciones nacionales o extranjeras de prestigio, con una duración de 2 a 24 meses, para el aprendizaje o perfeccionamiento de técnicas, tecnologías o procedimientos en investigación desarrollo e innovación tecnológica del campo de la biomedicina, que sean de interés para el Sistema Nacional de Salud.

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SUBVENCIONES PARA LA FINANCIACIÓN DE LA INVESTIGACIÓN BIOMÉDICA Y EN CIENCIAS
DE LA SALUD EN ANDALUCÍA

LÍNEA DE RECURSOS HUMANOS PARA LA INVESTIGACIÓN: ESTANCIAS FORMATIVAS DE
INVESTIGACIÓN

Orden de **22 de Mayo de 2012** (BOJA nº **116** de fecha **14 de Junio de 2012**)

MEMORIA CIENTÍFICO-TÉCNICA Y ECONÓMICA

DATOS DEL/LA INVESTIGADOR/A QUE SOLICITA FINANCIACIÓN PARA LA ACTIVIDAD

NOMBRE Y APELLIDOS **JUAN BOSCO BARÓN FRANCO**

CARGO ASISTENCIAL **FACULTATIVO ESPECIALISTA DE ÁREA**

TÍTULO **DOCTOR EN MEDICINA Y CIRUGÍA, ESPECIALISTA EN MEDICINA INTERNA**

FINANCIACIÓN

Convocatoria de subvenciones para la financiación de la Investigación, Desarrollo e Innovación Biomédica y en Ciencias de la Salud en Andalucía para el año 2012

Lista Provisional de **ADMITIDOS**

Escuela Andaluza de Salud Pública (EASP)			
SOLICITUD	EXPEDIENTE	INVESTIGADOR	CENTRO
S0175	EF-1077-2012	Antonio Daponte Codina	EASP-Escuela Andaluza de Salud Pública
S0881	EF-0995-2012	Amelia Inmaculada Martín Barato	EASP-Escuela Andaluza de Salud Pública
S0947	EF-0999-2012	Mª Isabel Tamayo Velazquez	EASP-Escuela Andaluza de Salud Pública
S0949	EF-1000-2012	Clara Bermudez Tamayo	EASP-Escuela Andaluza de Salud Pública
S0957	EF-1002-2012	Jaime Espin Balbino	EASP-Escuela Andaluza de Salud Pública
S0959	EF-1001-2012	Alina Danet Danet	EASP-Escuela Andaluza de Salud Pública
S0981	EF-1071-2012	Inmaculada Mateo Rodríguez	EASP-Escuela Andaluza de Salud Pública
S0982	EF-1023-2012	Mª Araceli Caro Martínez	EASP-Escuela Andaluza de Salud Pública
S0984	EF-1022-2012	José Luis Bimbela Pedrola	EASP-Escuela Andaluza de Salud Pública

Fundación Andaluza Beturia para la Investigación en Salud (FABIS)			
SOLICITUD	EXPEDIENTE	INVESTIGADOR	CENTRO
S0928	EF-1045-2012	Esperanza Begoña García Navarro	H. Juan Ramón Jiménez
S0987	EF-1044-2012	Bosco Barón Franco	H. Juan Ramón Jiménez

FINANCIACIÓN

PARTIDA	IMPORTE MÁXIMO APROXIMADO
Desplazamiento	○ Para desplazamientos en España: hasta un máximo de 600€ dependiendo del medio de transporte utilizado. ○ Para desplazamientos en el extranjero: Hasta un máximo de 1.200€ dependiendo del lugar de destino.
Matrícula	○ En función del curso de formación
Estancia (alojamiento y manutención)	○ El importe de la manutención, será de hasta 30€ por día, en función del país de destino. ○ El importe del alojamiento, será de aproximadamente 500-600€ por mes en función del país de destino.
Otros gastos (si procede)	○ Costes de seguro de asistencia sanitaria, y de accidentabilidad. ○ Otros gastos.

FINANCIACIÓN

3. DATOS DEL PRESUPUESTO SOLICITADO

3.1 PRESUPUESTO SOLICITADO (VER ANEXO)

Se valorará el ajuste del presupuesto a las características, objetivos y alcance de la actividad.

CONCEPTO	IMPORTE (€)
Gastos de desplazamiento	1.200 €
Matrícula	
Estancia (alojamiento y manutención)	3.000 €
Otros (especificar)	
TOTAL	

5 DATOS SOBRE LA ACTIVIDAD, PROYECTO, COMPORTAMIENTO O SITUACIÓN PARA LA QUE SE SOLICITA LA SUBVENCIÓN

Nombre y apellidos de/de la investigador/a principal que va a realizar la actividad: **Bosco Barón Franco**
 Centro/Unidad de Gestión Clínica de/de la investigador/a principal que va a realizar la actividad:

Título: **Estancia Formativa Sobre Investigación de la Mejora de la Atención A Pacientes Crónicas Con Multimorbilidad**

Duración: **61 días**

Presupuesto: **14.227,40€**

Datos completos sobre la actividad, proyecto, comportamiento o situación para que se solicita la subvención detallados en la convocatoria.

- | | |
|---|---------------------------------|
| 1: Memoria científica | 18_EF_1044-2012_Memoria.pdf |
| 2: Curriculum vitae del equipo investigador | 28897427_18_0_1208172225_CV.pdf |
| 3: Otros | 18_EF-1032-2012_Otros.pdf |

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1. LUGAR
2. FINANCIACIÓN
3. **ESTANCIA**
4. RESULTADOS

ESTANCIA



ESTANCIA



ESTANCIA



ESTANCIA



ESTANCIA

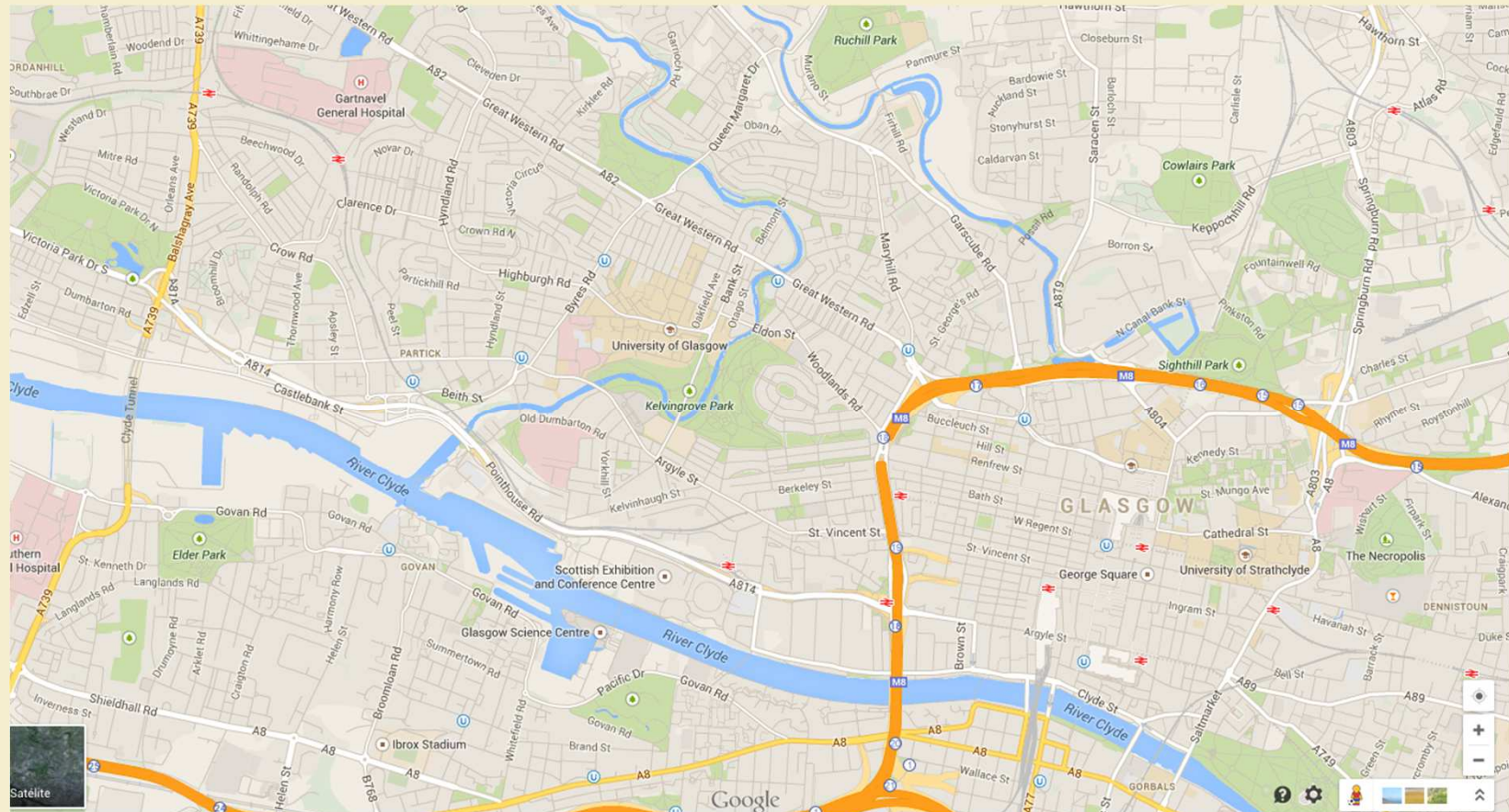


This is a detailed map of Glasgow, Scotland, showing the city's layout, major roads, and surrounding areas. The map is centered on Glasgow, with the River Clyde flowing through it. Major roads are highlighted in orange, and the city's boundaries are marked. Surrounding areas like Paisley, Renfrew, and Coatbridge are also visible. The map includes a scale bar and a compass rose.

ESTANCIA

FORMATIVA

ESTANCIA





ISA BAKR	OUT	OUT	PAT SMITH
MICHÈRE BEAUMONT	IN	OUT	ELAINE TAYLOR
ALAN BENNIE	OUT	OUT	GRAHAM WATT
CHRISTINE BLYTH	OUT	IN	ANDREA WILLIAMSON
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YVONNE MCILVENNA	IN	OUT	
CATRIONA MCPHAIL	OUT	OUT	
JILL MORRISON	OUT	OUT	
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Dr Baron Juan Bosco

[Contact](#)

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Glasgow G12 9LX

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3. ESTANCIA
4. **RESULTADOS**

RESULTADOS

DINÁMICA DE TRABAJO:

- Despacho propio
- Reuniones semanales con S. Mercer
- Asistencia a sesiones del departamento
- Contactos periódicos con otros profesores

RESULTADOS

INVESTIGACIÓN:

Explotación de una base de datos:

Más de 1.700.000 pacientes de toda Escocia
312 Centro de Atención Primaria,
Recogido 40 enfermedades crónicas.

Aquellos con Insuficiencia cardíaca: más de 18.000 pacientes

La patología crónica grave más prevalente

Evaluando: Prevalencia, presencia de multimorbilidad y relación
con el nivel socioeconómico.

RESULTADOS

INVESTIGACIÓN:

Artículo:

Patterns of Multimorbidity in Heart Failure

INTRODUCTION

Heart failure (HF) constitutes a major public health problem internationally, in terms of mortality, morbidity, negative impact on quality of life (REF), and resource utilisation.^{1,2} While the incidence of heart failure may not have increased over time³, apart from within older age groups⁴, the overall prevalence has increased because of increasing life expectancy and improved survival due to improved pharmacological and non-pharmacological interventions and therapies.^{5,6} There has also been a significant decrease in mortality in recent years,⁷ although mortality still remains high with approximately 50% of those diagnosed with heart failure dying within five years³ and survival rates described as similar to those with colon cancer.⁸ Heart failure is also known to have major negative impacts on quality of life⁹.

RESULTADOS

CONTACTOS:

- Prof. Stewart Mercer
- Prof. Frances Mair
- Prof. David Stott

Institute of Cardiovascular & Medical Sciences. University of Glasgow

RESULTADOS MARKETING:



MULTIMORBIDITY IN SPAIN

THE ROLE OF THE INTERNAL MEDICINE

RESULTADOS PROYECCIÓN:



ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW



University
of Glasgow **j**it joint improvement team
creativity, collaboration and continuous improvement

MEETING THE CHALLENGE OF MULTIMORBIDITY

Lessons from home and abroad

Tuesday 27 May 2014

RESULTADOS PROYECCIÓN:



MEETING THE CHALLENGE OF MULTIMORBIDITY Lessons from home and abroad Tuesday 27 May 2014

The Royal College of Physicians and Surgeons of Glasgow and the University of Glasgow in partnership with the Scottish Government Health and Social Care Directorates and the Joint Improvement Team, is hosting the first event in Scotland on the impact of Multimorbidity on individuals, professionals and care services.

PROGRAMME

08.30 – 09.30	Registration, Tea & Coffee	
09.30 – 09.40	Welcomes and Introduction	Dr. Frank Dunn, President, Royal College of Physicians and Surgeons of Glasgow
SESSION 1: The nature, extent and implications of multimorbidity Chair: Professor Bruce Guthrie, Professor of Primary Care, University of Dundee		
09.40 – 10.05	Integration of care for patients with multiple complex problems; insights from the Bridgepoint Collaboratory for Research and Innovation, Canada	Dr Renee Lyons, Bridgepoint Chair in Complex Chronic Disease and Professor, Dalla Lana School of Public Health and Faculty of Medicine, University of Toronto, Canada
10.05 – 10.20	Multimorbidity in Scotland	Professor Stewart Mercer Professor of Primary Care Research, University of Glasgow
10.20 – 10.35	Challenges : the inverse care law, service fragmentation , co-production, patient experience	Professor Graham Watt, Professor of General Practice, University of Glasgow
10.35 – 10.50	Treatment burden – the work that patients have to do	Professor Frances Mair, Professor of Primary Care Research, University of Glasgow
10.50 – 11.10	General discussion	
11.10 – 11.35	Refreshment break	
SESSION 2: Experiences of multimorbidity Chair: Ian Welsh, Health and Care Alliance		
11.35 – 11.50	Perspective from general practice	Dr Peter Cawston, General Practitioner, Drumchapel Health Centre
11.50 – 12.10	Perspective from hospital	Dr Simon Eaton, Northumbria Health Care Trust
12.10 – 12.25	Whole person care- a personal story	Graham Bell, RCGP P3 Group
12.25 – 13.00	Panel and audience discussion.	Panel members : Janette Barrie, Consultant Nurse, LTC NHS Lanarkshire Dr Moira Connolly, Senior Medical Officer, Scottish Government Mental Health Division



		<i>Alpana Mair, Deputy Chief Pharmaceutical Office, Directorate for Health and Healthcare Improvement, Scottish Government</i> <i>Ms Shiona Strachan, Renfrewshire Social Work</i> <i>Professor Miles Fisher, Consultant Diabetologist, Glasgow Royal Infirmary and Honorary Professor, University of Glasgow</i> <i>Dr John Gillies, Chair of Council, RCGP Scotland</i>
13.00 – 14.00	Lunch	
SESSION 3: Planning services for people with multimorbidity Chair: <i>Dr Anne Hendry, National Clinical Lead for Integrated Care, Scottish Government Health and Social Care Directorates</i>		
14.00 – 14.25	Integrated in-patient care for patients with multimorbidity in Southern Spain'	<i>Bosco Baron Franco Internal medicine specialist Hospital Juan Ramon Jimenez Huelva, Spain</i>
14.25 – 15.20	Plenary session: "What needs to be different"	<i>Facilitated by Andrew Jones, International Futures Forum</i>
15.20 – 15.45	Refreshment break	
SESSION 4 Responding to the challenges Chair: <i>Dr Frances Elliot, Deputy Chief Medical Officer, Scottish Government Health and Social Care Directorates</i>		
15.45 – 16.00	Challenges for education and training	<i>Dr Stuart Irvine, NES</i>
16.00 – 16.15	Challenges for research and development	<i>To be confirmed</i>
16.15 – 16.30	Challenges for clinical guidelines	<i>Dr Jenny Bennison, Vice Chair of SIGN</i>
16.30 – 16.45	Closing comments	<i>Dr John Gillies, Chair of Council, RCGP Scotland</i>
16.45	Close	

RESULTADOS

PUNTOS DÉBILES:

- No contacto con la clínica
- Ámbito 100% Primaria (EIR)

**ESTANCIAS
FORMATIVAS DE
INTERNISTAS EN
PLURIPATOLOGIA
Y CRONICIDAD**

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