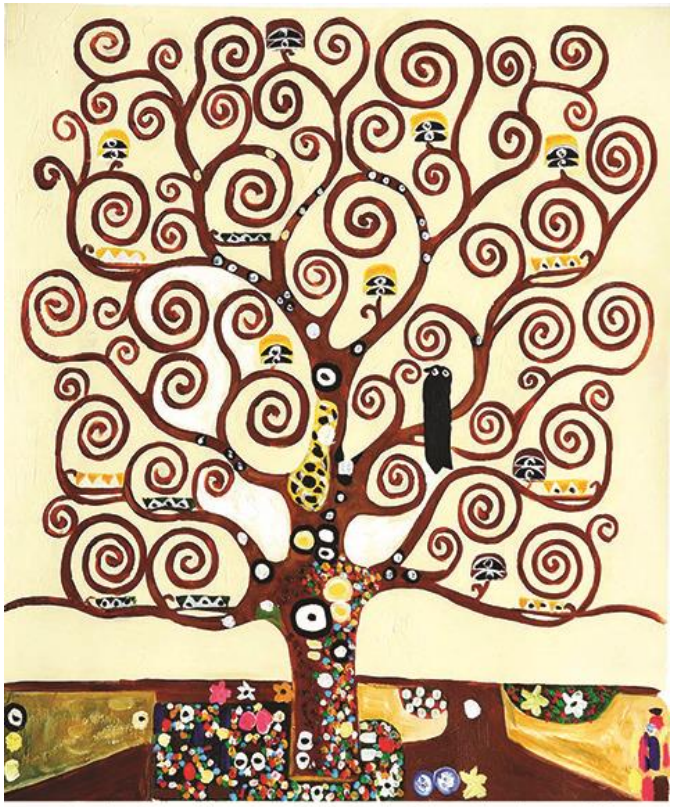
Regional Cooperation for the Care of the Elderly

Interview with Dr. Erik Buskens and Dr. Klaske Wynia



Based on Gustav Klimt, Tree of Life, Stoclet Frieze, Lebensbaum, 1905

Case Study by Sofia Widén and William A. Haseltine
ACCESS Health Sweden

November 2016

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Elder and Long Term Care
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Background

As part of a series of case studies on best practices in elder care, Sofia Widén, Program Manager of ACCESS Health Sweden, visited the University Medical Center at the University of Groningen, the Netherlands in September 2015. Please find more information on the website of Healthy Ageing at the University Medical Center[1]. At the University of Groningen, Sofia interviewed Dr. Erik Buskens and Dr. Klaske Wynia. They discussed the recent National Care for the Elderly Program introduced by the Dutch government.

The National Care for the Elderly Program is designed to improve care for elderly people with complex care needs. Many organizations, including the University Medical Center at the University of Groningen, have joined forces to ensure the success of this program. The objective of the program is to provide integrated care that is better suited to the individual needs of the elderly. For many older people, this improvement in quality results in a greater degree of independence, less reliance on care services, and a reduced risk of care and treatments that are unnecessarily burdensome.

The strength of the program lies in regional cooperation between care providers and researchers. The program funds the creation of regional networks. Everyone involved in healthcare for the elderly is invited to participate in these networks. A large part of the program budget funds projects and experiments that organize care in a new way. Regional networks can submit proposals for project. Dr. Wynia, along with a group of researchers, has successfully conducted a transitional experiment developing and implementing a community based integrated primary care service.

The involvement of individuals in their own care is crucial for the success of the program. Individuals who receive care discuss projects and interventions. Patients design the programs with care professionals. Dr. Erik Buskens and Dr. Klaske Wynia report about their research projects related to the National Care for the Elderly Program and the development of person centered and integrated elderly care in the Netherlands.

[1] https://www.umcg.nl/NL/UMCG/healthy_ageing/Paginas/default.aspx

About Dr. Erik Buskens

Dr. Erik Buskens was the Program Director of Healthy Ageing at the University Medical Center, University of Groningen, the Netherlands. He is now working at the Department of Epidemiology as professor of Health Technology Assessment. His research focuses on epidemiology and Medical Technology Assessment on topics related to Healthy Aging. He is also one of the principal investigators in national and international collaborative projects addressing quality of life, cost effectiveness, and organization of care in diagnosis and treatment of carotid artery stenosis, abdominal aortic aneurysm, and intra-cranial aneurysms. Several groundbreaking results were attained.

Dr. Buskens obtained his medical degree from Rotterdam and subsequently worked as a military doctor and resident of internal medicine. He was then appointed as a research associate at Erasmus University and Sophia Child Hospital Rotterdam where he completed his training in epidemiology, and earned his PhD.

Dr. Buskens was previously the President of the Board of the Dutch Society for Technology Assessment in Healthcare, and member of several national and international committees and bodies on Medical Technology Assessment. He took part in the development of guidelines and policy making. Since 2009, Dr. Buskens is a member of the Advisory Board to the Minister of Health.

About Dr. Klaske Wynia

Dr. Klaske Wynia is a researcher for integrated care, and assistant professor at the University Medical Center, University of Groningen, the Netherlands. Originally trained as a nurse, Dr. Wynia completed her PhD in Medical Science in 2008 from the University of Groningen. Currently, her research focus is on organizing person centered and integrated care for vulnerable people.

Interview

Sofia Widén (SW): Tell us a bit about your background, Professor Buskens.

Dr. Erik Buskens (EB): I am Dr. Erik Buskens. I am the Program Director of Healthy Ageing at the University Medical Center at the University of Groningen in the Netherlands. My research focuses on epidemiology and Medical Technology Assessment. Since I moved to Groningen in 2006 my research also focuses on topics related to Healthy Ageing. As one of the principal investigators in elder care, I have frequently participated in national and international collaborative projects addressing quality of life, cost effectiveness, and organization of care in diagnosis and treatment.

I know that you are studying best practices of elder care in Sweden. There are several programs in place in the Netherlands, one is called Care Without Rules. In Dutch, it is called Zorg Zonder Regels.

There are standard levels of care. However, care professionals are usually left to determine care needs. Sometimes, extra care and attention might be needed. This might differ from the standard level determined by the government. We need to focus on something else rather than just standards of care. The current system is inflexible.

Care Without Rules involves more freedom and allows for a certain level of risk taking in caregiving. It has been shown that this approach has worked well. Both clients and professionals are happier with the outcomes. The sick leave among care professionals has decreased because they are much more involved. The staff feel responsible and more motivated. The new approach has been good for everyone.

SW: Is Care Without Rules just applied in one care home or part of a larger organization?

EB: Care Without Rules is applied in one care home. The home is in a single location but it is one organization. It is situated just twenty or thirty kilometers from here in one of the smaller urban wards.

SW: Apart from flexibility in standards and guidelines, what factors are important in improving quality of care?

EB: Care integration is one of the most important factors in improving quality of care. In healthcare and especially elder care, there are different professionals responsible for different domains of care. There is a social domain, chronic care domain, and a medical domain. Typically, each domain has their own budget, guidelines, and standards. There is a great need for care integration between the domains.

One of my colleagues, Klaske Wynia, who will be joining us for this interview later, has worked with care integration. She came up with this idea that we need to have healthcare professionals involved in providing care. They have to come together. Together, they all recognize various barriers between their own budgets and their own responsibilities. Allowing these people to sit together and develop a new concept of care would allow for better care integration.

SW: How would they begin to develop new concepts for better integration?

EB: To start with, the healthcare professionals need to look at what is necessary. What is at stake here? What are the responsibilities? What can these elderly people still do themselves? Can we help them to achieve their goals rather than just to look at their medical conditions? The majority of elderly people in the community are self sufficient and robust. They have certain chronic conditions due to aging. They may have high blood pressure, high cholesterol, some joint issues. But they are still fit. They can manage to buy their own groceries. They cook. They can still manage their own bank accounts. So the question arises: How do we keep these people safe and assure them appropriate care when it is needed? This means that the elderly only need to be aware of the fact that these institutions are out there. The people need to be aware of their medical needs and conditions. They need to be assured that they can count on help, if and when necessary.

The people also need to be assured that their needs are being identified and then a plan is drawn. When there is no emergency, there is no hassle. But if conditions worsen, there is only a limited amount of time.

I am sure you have been told that care integration has been part of the National Care for the Elderly Program. There are many other experiments which have been conducted all around the country.

SW: This was the national program from 2008 to 2012?

EB: Yes, the program was specifically focused on elder care. It was a stimulus from the central government. The total amount of money available for the program was eighty million euro. It is a considerable amount of money. It was for a five year period and it was allocated in principle to eight university medical centers. The university medical centers had to set up networks. In these networks, they had to act as coordinators and come up with proposals for transitional and experimental projects. They also had to find implementation projects.

The eight medical centers were in Maastricht University Hospital, Radboud in Nijmegen, Utrecht, Rotterdam, Leiden, two in Amsterdam, and Groningen. Every university medical center has either a geriatrician or an intern specializing in geriatrics. A primary care ward and specialists in elder care were also represented. These used to be the nursing home physicians. Previously, this was not a high status specialization. It is increasingly becoming recognized as an integral part of care. Currently, there is an urge to develop the academic stance, research programs, and educational programs. There is also a need to reach out and connect with general practitioners.

SW: If you look at the program for the elderly, what were the key challenges in the system that the government tried to overcome? What are the greatest weaknesses?

EB: To start with, it appeared that a periof of five years and eighty million euro is insufficient. The government has been informed about this. However, the stakeholders have become much more aware. This has also led to the recognition of the fact that the disease networks are an important virtual center to turn to for advice. This is not a formal way of asking for advice. But it has become a network and patients have been informed about it. Patients have found ways to discuss new ideas and think of new plans. This would not have happened without this money The investment has helped I think.

Another weakness was the availability of expertise. First of all, we need to become aware of the type of expertise required to address the growing size of the elderly population. Both the primary care physicians and specialists in hospitals are aware that they will be tending to an increasing number of elderly in the future. They need to decide what type of care is appropriate and where and how to provide it, given the frailty that these people tend to develop.

When people are frail, their dependence increases. Furthermore, as the severity of the conditions increase, risk of hospitalization increases. Given the limited reserve capacity, there is a greater need to address the possible needs and risks early on. Specialists and also geriatricians are not trained to recognize these needs.

SW: What are the other weaknesses or problems?

EB: The problems center on integration. We have recently had a change in regulation and funding of care. We are the second largest spender in healthcare around the world. The United States spends eighteen percent of their gross domestic product on healthcare. We spend around thirteen. I think Sweden spends around eleven percent. So, the question is why is the expenditure so high? And does this add to quality of life and functioning?

These are some of the worries for the national government. The idea was that we need a new organization. To handle responsibilities and to develop appropriate care has now been delegated to the municipalities rather than the central government. The municipalities have to decide on what is the appropriate care and who has to pay for it. Is it paid through taxation or through regular national health insurance? Or is this part of the municipalities budgets?

SW: So the national insurer allocates money to the municipality?

EB: No, we actually fund healthcare in two ways. One is for the general health insurance. Under the health insurance, part of it is paid by the employer and part of it is paid by the individual. This amounts to thousand or thousand two hundred euro a year. This is called the National Healthcare Law. Then there is a large part which is for chronic care. This part is for the elderly, for the mentally retarded, and psychiatric care. This is under the Specialized Care Needs law.

SW: What are those two called in Dutch?

EB: There is Algemene Wet Bijzondere Ziektekosten which is specifically for healthcare costs not only curative care. It is also for chronic care. And now it is split in three to cover the youth care, youth delinquency, and mental problems. All these care categories, used to be followed through that system. Many of these care categories have now been delegated to the municipalities. And we have got hundreds of them. The municipalities now need to look at the staff that they have got. They need to make budgetary decisions. And also be aware of the new types of care which have been developed.

SW: Have the municipalities been responsible in the past for any part of elder care or long term care?

EB: No.

SW: So there is drive now to build up the competences in the local municipalities?

EB: Yes. But they do not have the expertise yet. The handover is happening now. Many people in the chronic care setting worry about this. During the period of the National Care for the Elderly Program, the reformation of funding schemes was implemented. It used to be a two way funding scheme, it has now become a three way scheme. It is no longer the responsibility of our central care agency to monitor quality standards and expertise. It has all been delegated to the municipalities. This is where you worry in terms of quality of chronic care.

SW: So the social care aspects in elder care would be the responsibility of the local municipality?

EB: Yes.

SW: But other healthcare will be central?

EB: Yes. The national policy determines what is covered by the healthcare budget. The law also determines how much of additional care is covered. Most of the chronic care needs are paid out of pocket unless clients cannot afford it. Now the budget has been cut and the care responsibility has been delegated to the municipalities. This is because the government maintains that the municipalities know best the needs of its population. But most people who are aware of what has been ongoing are worried about this elderly care program.

SW: What is the worry about exactly?

EB: The budget has been cut and the municipalities now need to contract elder care organizations and other chronic care individually. It used to be contracted through larger healthcare insurers. But now they have their individual budget. So now, there are eight national healthcare insurers and two or three large ones. Before, all the healthcare institutes knew who to turn to and sell their products. Now they have to liaise with individual municipalities. They now need to have different contracts with every municipality. We have over a hundred municipalities in the Netherlands and several tens in the regions.

SW: In 1992, in Sweden, we implemented Ädelreformen, the elder care reform. We moved elder care and the budget from the counties to the local municipalities. The idea was that we should demolish the long term care wards that just looked like a hospital where we kept people for three years and let us move it to the local community. The goal was to reform care and bring it closer to home. I think over the years the municipalities have built up a lot of competences in terms of assessing needs. But the issue is care coordination. The social care team does one thing. And the hospital does another. The general practitioner has no idea. Is that the same problem here?

EB: This was one of the issues brought up before the national program on elderly care was introduced. This program identified all these issues and came up with a number of ideas like the one you will come to hear about a little later. There have also been some outreach programs. One is the hospital at home concept. After hospitalization, people need to go back home. However, they cannot entirely manage their own lives for some time. There is no longer a medical need to be admitted to hospital but they cannot manage on their own. What do we do in between? What sort of outreach service do we need that will be cheaper than being hospitalized? We have to look for opportunities. These issues and opportunities have been recognized. I think we have had wonderful experiments showing what can be done.

SW: And were these experiments a success?

EB: I think there is an English version for the website on the National Care for the Elderly Program where all these experiments have been described. There have been around seventy five or eighty experiments in various domains.

I hope they have made the effort to translate all the programs. Most of this work has already been published. Or it is on the way to be published in theses and publications. But the information is scattered.

SW: We have had a very similar program in Sweden. For four years, from 2010 to 2014, we had the program called The Most Ill Elderly. I think, the budget was around four billion Swedish kronor. Looking at the total overall healthcare budget, this was not a lot. But it involved all the municipalities and all the counties. And it was trying to reduce readmissions to hospital and avoidable inpatient care. And we used a lot of quality registries. The program was based on what are your outcomes in a number of areas, such as integrated elder care, prevention measures, whether that was for bed sores or falls. We saw a lot of innovation in forming these kinds of integrated islands. It would be very interesting for us to study the Dutch innovations as well.

EB: I think there is a huge similarity to the problems that we have identified and these are universal. We have had quite some uproar in the Netherlands and the Secretary of State is being held responsible for the quality of nursing home care. That is his responsibility.

SW: What is the secretary's name?

EB: Van Rijn. The Minister of Health is Edith Schippers. She is responsible for the hospital care. The Secretary of State is responsible for chronic care and delegation of care to the municipalities. All the care services and the funding schemes thereof are his responsibility as well.

The quality of care in nursing homes has always been an issue. The people employed in nursing homes typically have middle level education. They are not academics. They are not used to looking for evidence with regard to the outcomes. They are not trained to do experiments and come up with ideas to improve services. They do try interesting things but it stays local because they are not used to share these ideas. And if a certain school of nursing says this is what we do in your region, then all the nurses trained there will do the same for the next decade at least.

We have got eight university hospitals where all our doctors are trained. The standards they follow mostly refer to the national care standards and guidelines. These standards are mostly similar throughout the world, at least the western world. These standards and guidelines are evidence based. This is not the case in nursing and in chronic care. And this has been signaled also nationally.

We used to have the Board of National Health Insurance, College for National Health Insurance. And now they have been renamed and are called the National Care Institute, Dutch Care Institute Netherlands. They have got a committee on quality and I am a member of this committee. I now chair the committee on long term care and also the committee on nursing home care and quality. So I have been involved in the National Care for the Elderly Program and I am aware of the various issues. This helicopter view which I have developed, puts me in a position to question the nursing specialists and the boards of nursing homes. Why are you doing these things? Do we need to come up with an integrated plan? They do not all recognize this, yet.

The Care Institute Netherlands was asked to help the Secretary of State develop a standard of nursing care. How should we define the quality of care in the nursing home? This is something we need to finish by spring next year. I am now looking for organizations which run nursing schools. They have got this society. Can they help come up with an answer? How do we move forward? How do we make sure that everybody

abides by the same standards or recognize the same standards? This is something which is not well developed here.

SW: And what would be the greatest obstacles in developing a national standard and also implementing it?

EB: To start with, we need to have consensus about what is adequate care, what is best care, and what are good examples. If you cannot meet your standard what is wrong? The nursing homes should not come up with silly excuses. We need to have quality policing to look at the quality of health provided in nursing homes too. Interestingly, currently, they do not have jurisdiction in municipality settings. The social care provider is not in that jurisdiction. So everybody is looking at what is happening here. Who will be taking responsibility for the quality of care delivered?

SW: Who can fill that vacuum?

EB: The society of municipality says they can. They are a community. They are an organization. They are now responsible for it.

SW: In Sweden, the inspectorate for healthcare has jurisdiction over the counties and the municipalities. The standards are very clear. It might be interesting for you to read two of my case studies on the program The Most Ill Elderly. I have described how they developed the standards for this program. They incentivized all the municipalities to start using quality registries. So when someone is diagnosed with dementia, they register how the diagnosis was performed. What kind of diagnosis? How long did it take? So that everyone in the entire country diagnoses and compares that in the same way. The nursing homes then use another registry which says if someone suffers from dementia, and what kind of symptoms the person shows on a scale from one to twelve. And then they have a set of interventions. They try these interventions. The nurses obtain training on how to use the quality registry. And they impute the data. Same for palliative care, for care coordination, and prevention.

EB: They are national standards?

SW: Yes. The national standards are available online for every single nursing home.

EB: Where do you get all of these?

SW: The National Board of Health and Welfare in Sweden, the Inspectorate for Healthcare. Individual non profit organizations like Swedish Dementia Care also have a quality registry. In about a year over two hundred municipalities introduced this. And then in the last year, they also started including avoidable inpatient as a rather

contested indicator. It tied funding straight to that indicator for every county and also readmissions in thirty days. And then finally last year they introduced the number of days after discharge the patients stay in the hospital as a measure of care coordination.

EB: So being fit for discharge is noted and then you still count the number of days that people still stay in hospital?

SW: This was a very contentious process. Nationally they could not agree on the definition of when is a patient ready for discharge. Then the Inspectorate and the Association of Local Municipalities and Counties, closed the door and said that they would not leave the room until this definition was agreed upon. So they came up with a definition. When the doctor declares that the patient can go home he or she is ready for discharge. From that day the hospital needs to pay for about four to five days. They are changing it now to three days.

EB: The incentives for the doctors to use this discharge assessment would be lax.

SW: In a way. So you can create incentives. Some regions have eight days on average where patients stay in the hospital instead of receiving home care or a place in a nursing home. It is just that coordination part. It is so difficult to measure integrated elder care. Now every municipality can show these numbers. I can go online and say, oops our municipality has eight days. And the municipality next door has two days. What are they doing differently in terms of coordinating these elder care services? The process of gathering the data on a national scope using the quality registries has been successful in Sweden. So I would love to share and connect that.

EB: That would be great. What has been popping up here is that we do not need to look for this type of registration and assessment. But instead have an entirely different incentive system. For example, we are not paying for hospitalization, but we are paying for individuals who need care. With whoever should be involved, we decide on a budget. If you think you can provide all care services in the hospital in this budget, that is fine. If you think that is going to be way too costly, then we need to get you out of hospital as soon as possible. Then it is the responsibility of the entire chain of providers to come up with the answer. This has also been experimented. Can we come up with a scheme that would allow you to just make people less insensitive as to what is good for patients? They need to do this in their entire system of care as well as decide where to spend the budgets.

SW: Where have you experimented with this?

EB: We have actually experimented in this region. I am sure there have been other experiments as well. There are actually experiments like testbeds in some regions. One of the healthcare insurers, Achmea has done this. I think, Klaske Wynia has also filed for funding for a similar experiment. We are looking for other testbeds to do the same thing, which will more or less force people to sit together because they are being paid just once. It is not feasible to hospitalize a patient for thirty days. Then the hospital will start to complain. And then they need to think and sit down with those that provide cheaper care. What can we do?

SW: When do you have to present the idea for the national guidelines? In March or April right?

EB: Yes. We need to define the quality of nursing home care.

SW: For us, if I could follow up with you about this work and document the process, the information would be very valuable for us.

EB: Yes. I think this would be of interest for us as well if you document this in English.

SW: You are also the Program Director at Healthy Ageing, correct? Can you tell us a bit more about that?

EB: I got this popular publication in English which describes what we are doing currently, what our ambitions are, what our goals are, what our objectives are. We have a three pillar approach.

The first is the fundamental biomedical research. We must understand the mechanisms of aging at subcellular and cellular level and determine why we get wrinkles and whatever shows on the outside, gray hairs, moles. Clearly a similar process occurs on the inside so we also study how and why our internal organs start to fail. Are the common underlying pathways which we could alter with new drugs or stem cell research? This is a very high risk, long term perspective on understanding the mechanisms of aging.

Then there is a large scale population based study. We study around ten percent of the population in the three northern provinces, more than one hundred sixty five thousand people. Three generations of people are to be followed for thirty years. So that will be a lot of information on who develops which kind of diseases depending on all sorts of determinants from medical history to education to exercise.

Then there is of course, what we have been discussing the last hour, how to organize care. What care is appropriate for who in which phase of life. We need to critically look at the healthcare we provide now.

We also try to turn new concepts into business opportunities. We think these ideas might be worth upscaling and inspiring. In the future, we could possibly provide healthcare consultancy as well.

SW: It would be very interesting for us to also study the various ideas that your team develops. Thank you very much Erik.

EB: Thank you Sofia.

Dr. Klaske Wynia joins Sofia

SW: Hello Dr. Klaske Wynia. Before we start with your research on integrated care, could you tell us a bit about your background?

Dr. Klaske Wynia (KW): I am Klaske Wynia. I am a researcher for integrated care and an assistant professor at the University of Groningen at the moment. I was originally a nurse. At the moment my focus is on organizing integrated care for vulnerable people and older people. We recently published the results from an experiment on integrated care. I am very happy that this is successful. I think part of the success is that clinical practice is very simple. It is based on evidence based models and focusing on older adults.

SW: What is the paper called?

KW: The paper reports the results of a qualitative study and is published in PlosOne entitled “Experiences of Community-Living Older Adults Receiving Integrated Care Based on the Chronic Care Model”. Actually, we are in the middle of publishing. We had a study protocol for the trial we performed that was published before.

SW: Could you tell us a bit more about your paper?

KW: Sure. We basically wanted to examine the impact of Embrace, a community based integrated primary care service, on perceived quality of care. In Dutch, we call it SamenOud. The English translation is not so good, so we call it Embrace. Embrace provides integrated, person centered primary care and support to all older adults living in the community, with intensity of care dependent on risk profile. It refers to the Chronic Care Model and the Kaiser Permanente Triangle, a Population Health Management Model that we combined and translated to the Dutch situation and specified it for the older adults. These models can also be specified for other vulnerable populations like the chronically ill or the youth or mental health groups.

SW: Can you explain the model?

KW: Embrace, combines the Chronic Care Model and the Population Health Management Model. We have been recognized in Europe as a good practice. There are three reference sites in Europe and we are one of them.

SW: What are the other ones?

KW: There is one in Catalonia and another one in Scotland. These are the reference sites with three stars. There are reference sites with one star or two stars, but there are only three with three stars.

SW: So this is a reference site in this Healthy Aging Network?

KW: Yes. The Healthy Aging Network is the reference site in Europe.

SW: Who has picked you as the reference site?

KW: A European committee. This one is a large program, Horizon 20/20. The goal is to stimulate the collaboration and good practices and research.

SW: How was the study conducted?

KW: The study is a randomized controlled trial on the effectiveness regarding patient outcomes, service use, costs, and quality of care. We effectively redesigned the healthcare system. That was also our call for the National Care for the Elderly Program.

SW: Where did the funding come from?

KW: From the National Care for the Elderly Program, a funding program organized by the Ministry of Health. This program received about eighty million to redesign the healthcare system. All regional networks in the country could apply to it. We are one of the largest programs that was funded.

SW: So the National Care for the Elderly Program asked you to think about a completely new healthcare system.

KW: Yes. It was stimulated. We had the freedom to make any changes we felt necessary. Do not look at the rules. Redesign the system.

SW: Exciting!

KW: It is very exciting. I had some ideas. I had been to Kaiser Permanente. They are a healthcare insurance company and a care provider at the same time. Their focus is on

health. Our Dutch system focuses on disease. It is good for the business of care providers when more people are ill. So, the incentives in our system are basically wrong. I learned more about the vision of Kaiser Permanente and saw how they organized their care services. I built this new model in the Netherlands. Because of this program we had the opportunity to try it in clinical practice.

SW: Where did you try your experiments?

KW: Up here in Northern Netherlands. We started this program with fifteen general practitioner practices and fifteen hundred older adults living at home. We examined the outcomes. We found increased quality of care after one year at the same costs. So it was a good start that our business model indicated savings. However, a one year period was too short. So, we received money for some more years for clinical practice.

We also have a policy rule now to continue Embrace in clinical practice for two more years and to examine the long term effects of the model. Until now, healthcare organizations are paid based on medical diagnosis. Now during the policy rule, they temporarily adapted the payment rules for Embrace. We have now payments not based on medical diagnosis, but based rather on risk profiles.

SW: So what does that mean in terms of quality of care?

KW: In clinical practice, this is what we do. We organize person centered individualized care. Each general practitioner has its own elderly care team who supports older adults living at home. The team also supports the elderly in making their choices. Now, team members are supporting the older adults and not representing the organizations. So, this is a fundamental change in the healthcare system.

SW: Who is included in the elder care team?

KW: In this elderly care team there are four professionals. A general practitioner, an elder care physician, a district nurse and a social worker. The general practitioner and elderly care physician develop the medical care plan so that the older adults do not need to visit every medical specialist in the hospital. There is a district nurse and a social worker who are responsible for case management. They support the frail older adults and older adults with complex care needs at home. They make an integrated care and support plan together with the older adults. The older adults decide. So they are in the lead. The case managers encourage the elderly to do things and decide on their plans.

SW: Do you use a specific methodology during the care planning to bring out the wishes of the patient and the priorities?

KW: We use motivational interviewing. We made an assessment tool to identify the wishes of the patients based on the International Classification of Functioning, Disability, and Health. Then we worked together with several disciplines. They all have their own assessment tool which does not work in a multidisciplinary person centered team. We therefore designed a tool from the perspective of the older adults. Older people have problems with health, living situations, social context. This is a broad spectrum. The International Classification of Functioning, Disability and Health describes all these aspects in neutral terms. There are around fifteen hundred categories. Together with the older adults and professionals, we selected the most relevant ones and reached consensus on thirty categories. We used these thirty categories as an assessment tool.

SW: So it is not just looking at the medical care. It is also understanding what is important for older people. That is the motivational part of it.

KW: Yes. We use a technique for interviewing them, the motivational interviewing technique.

SW: What are the results here?

KW: We found improved quality of care. Our model was built on the Chronic Care Model. Do you know the Chronic Care Model?

SW: No.

KW: This model is especially for populations with chronic diseases or long term health needs. The model was developed by the McCall institute based on literature studies. The key elements of the model are self-management support to strengthen the patients, and redesign of the delivery system. This redesign would result in a prepared and proactive practice team. This is used to provide support and information on older adults in this study. This is not the system belonging to the healthcare organizations. This belongs to the older adults.

SW: So this Chronic Care model is a tool for older adults.

KW: It is a tool for organizing chronic care for vulnerable populations. We have now translated it to the Dutch situation and applied it for older adults. But you can also apply it to other groups of people who are chronically ill or have mental health issues. This is a generic model. Our goal is that older adults can stay at home as long as possible. Most of the other integrated care models focus on the most complex older adults.

SW: Such as the Population Health Management Model?

KW: Yes. Did you hear about these kinds of models?

SW: Not in depth.

KW: The essence of this is that you can split up your population in several risk groups. Healthy people have a low risk and people with multiple chronic illnesses have very high risk. When you know what kind of people you have in your population you can assign a care intensity level to it. That is the basis of the model. Most models focus on people with complex healthcare problems because they have the highest costs. But when we want to be proactive and preventive we also have to include healthy older adults because they are seventy five years or older. In a few years' time they can also become vulnerable or having complex care needs. We focus also on this healthy group and this is new. What very specific for Embrace is, is that we combine the two models. We are the only one in the world who does this.

SW: Combining Chronic Care Model with Population Health Management Model?

KW: Yes. We brought it into practice for all aspects of both models.

SW: How do these two models complement each other?

KW: One of it describes the care. And the other one describes the population to which it is assigned. Robust older adults are also included. They receive group activities as all older adults do. Frail older adults also receive individual support from the social worker in the role of case manager. About twenty percent of all older adults have complex care needs. They receive individual care and support by the district nurse in the role of a casemanager. They also receive group activities.

SW: This is all arranged under the general practitioners in the region?

KW: Yes, each general practitioner has its own elderly care team.

SW: Is that common? Did you find fifteen general practitioners who already had a team?

KW: No one had a team. This is new. General practitioners are very happy with it because now their people are well looked after. Older adults in the qualitative study told us that they feel safe and secure. When you become older, you become more dependent because people around you are also old and dying. Older adults ask themselves: what would happen to me? They worry about it. Now they have the elderly care team and they know that they are well taken care of.

SW: So far you have had this program for one year?

KW: We are now in our fourth year of this program. We have also started this in other parts of the Netherlands.

SW: So what are the indicators of success that you look at?

KW: Improved quality of care and savings.

SW: How do you measure the quality of care?

KW: This Chronic Care Model is representing good quality of care. So we have a questionnaire based on this model. We asked all the adults: do you receive care and support from the elderly care team in an integrated and person centered way? For example: Did they ask what you want? This questionnaire is based on the key elements of the model.

SW: So this is the voice of patients.

KW: Yes.

SW: I feel a lot of times that is lacking.

KW: Yes, but we are focusing on that.

SW: It would be very interesting to read your next publication. When is it going to come out?

KW: It is in press now. It is about the results for quality of care. Also our paper on the patient outcomes will be submitted in a few weeks I think.

SW: Is this in English?

KW: Yes. Of course.

SW: What has been the hardest part in this job? What were the challenges in implementing the new model?

KW: Well we are now implementing it and the discussion is about who should pay the costs. We now have the new integrated care model. The next step is to find solutions for sustainable integrated funding. This is not easy.

SW: Is this because the municipality should pay for the elder care?

KW: Yes, that is a part of it. Because of this model, we have combined the community in the healthcare system. So the communities and the municipalities should also pay for the care provided.

SW: During your study, who has been paying for this?

KW: The government.

SW: Would they be interested in understanding these results?

KW: Yes, they are very interested. They are also interested in the problems we now have. They are visiting us and talking with us. We are looking for solutions together.

SW: Even though it does not save costs, I mean you can deliver a better quality care for the same costs, would they be interested in this?

KW: The government is. The healthcare insurance companies are also interested. They are all interested. Full information on the model, the project, and research publications is available on the website. Just search for SamenOud, the Netherlands.

SW: Great. I will look into it. Thank you very much for sharing all this information.

KW: You're welcome, Sofia.