The Dutch National Care for the Elderly Programme

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Chair of the programme
Overview

Å Introduction of the programme
Å Outline of the programme
  ï Networks
  ï Experiments and projects
  ï Dissemination and implementation
Å Discussion
Å Future
The National Care for the Elderly Programme

Start: April 1\textsuperscript{st} 2008 – 4 year programme

ZonMw

\begin{itemize}
  \item Director of the programme
  \item On behalf of the Ministry of Health, Welfare and Sport
\end{itemize}

Budget: 80 million euro

Aimed at frail elderly persons
Frail elderly persons?

- Combination of different diseases and physical, psychological and social problems
- Increased vulnerability
- Loss of vitality
- Loss of self-reliance
Aim of the programme

Better quality of life for frail elderly persons through better quality of care which is tailored to the needs of the elderly persons.
Outcomes

Â Added value for frail elderly
   â• improved self-reliance
   â• improved daily functioning
   â• reduced burden of care/treatment
   â• reduced consumption of care

Â Added value for professionals

Â Added value for the society
   â• cost-effective interventions
Outline of the programme in three steps

1. Formation of regional networks with executive commitment
2. Innovative experiments and projects
3. Nationwide dissemination and implementation
Step 1: networks
Dynamics in network

- Regional parties get to know each other
- Networks continue to grow
- Needs and wishes of elderly are focal point
- Contribution of elderly is formally arranged
- Each network runs multiple experiments and projects
Step 2: Experiments en projects

- 17 Transition-experiments
- 32 Research projects
- 11 Implementation projects
- 15 Education projects
Transition-experiments

Å Reorganisation of care and support
Å Restructuring of regulations and finances (AWBZ/ WMO/ Zvw)
Å Needs of elderly are guiding principle
Å Innovative en ambitious
Å Multiple areas (cure, care, welfare, prevention→ interaction)
Å Evaluation Minimal Data Set
Minimal Data Set

Å Multimorbidity

Eg. What illnesses and conditions do you have at the moment or did you have in the past 12 months

Å Subjective health

Eg. How is your health in general, in comparison to one year ago (much better, slightly better, about the same, slightly worse, much worse)?

Å ADL functioning

Eg. Do you need help to get up out of a chair (yes, no)?

Å Social functioning

Eg. How often in the past 4 weeks have your physical health or emotional problems hampered your social activities (such as visits to friends or close family members) (continuously, mostly, sometimes, rarely, never)
Minimal Data Set

- Psychological wellbeing
  Eg. How often in the past month have you been very nervous (always, very often, quite often, sometimes, almost never, never)?

- Quality of life
  Eg. How is your quality of life in general (excellent, very good, good, reasonable, poor)?

- Healthcare use
  Eg. Do you receive home care? For example a community nurse, family care or home help (no, yes, namely… hours per week).
Content experiments

• Identification frail elderly by screening + diagnosis
• Improvement of primary care
• Reactivation after hospitalisation
• Integrated care
• Community support and social network
General elements in experiments

- Screening: early detection of frailty and extensive assessment
- Integrated health care plan: draft and implementation
- Coordination: monitoring, consultation and support with transfers

Different starting points: primary care, hospital, community
Screening

Å Level of frailty
   (Eg. with GFI, TFI, Easycare, ISAR, TRAZAG)

Å Instruments are tested and validated in our programme

Å Often in combination with other measures
   (Eg. Intermed, opinion of physician, wellbeing list)

Å Instruments are applied by different professionals (most often a practice nurse)
Integrated health care plan

Å Drafted by different professionals (GP, practice nurse, specialised nurse, physician assistant)

Å Needs and wishes of elderly are guiding principle

Å Multidisciplinary approach; beyond boundaries of cure, care and wellbeing

Å Cooperation between various parties
Coordination

Different professionals
Å Eg. Visiting nurse, practice nurse, geriatric nurse

Different titles
Å Eg. Case manager, healthcare coordinator, mentor, multidisciplinary team
Examples in primary care

Cooperation and cohesion in geriatric care

Maintaining functional integrity in primary care

ISCOPE

Multidisciplinary care for frail elderly

Programme of integrated care for frail elderly

Practice nurses taking care of vulnerable elderly

Guidelines for care and welfare

The chronic care model for frail elderly
Examples in hospital

Transitional care bridge between hospital and primary care

The re-activation programme

Care programme for recovery and prevention

Guidelines for care and welfare
Examples in the community

- Improving care for older ethnic minorities
- Integral community based approach to reach frail elderly
- ICT applications in community centers for frail elderly persons
- Interventions to improve wellbeing in districts with low social economic status
Step 3: Nationwide dissemination and implementation

- Extending and sustaining networks
- Activities for nationwide implementation of evidence based knowledge and best practices
- Elderly, science and practice working together towards:
  - Guideline for care and welfare
  - Plan-do-act cycle for quality improvement, innovation and financing
Guidelines and cycle

• Common, shared vision on good care for frail elderly → based on views of elderly and professionals
• Grounding this vision with scientific evidence on effectiveness and cost-effectiveness
• Dynamic process
Cycle

Needs and demands of
- Elderly
- Government
- Professionals
- Financers
- Etc.

1. Hypothesis

2. Experiments and scientific results \(\rightarrow\) evidence

3. Implementation through practice guidelines

4. Evaluation

Input of elderly in every step of the cycle!
Discussion

- Duration of programme is 4 years
- Evidence based results take more time
- Innovation: a change takes a generation
- Preparing for nationwide implementation without known scientific results
Future

• Harvesting and implementing scientific results
• Development of guideline and cycle
• Secure the position of elderly
• Financing of new care and wellbeing initiatives
Care and support for frail elderly should fit like a warm and cozy jacket.
More information?

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