Long-term (institutional) care in the Netherlands and the role of Elderly Care Physicians; the Story So Far

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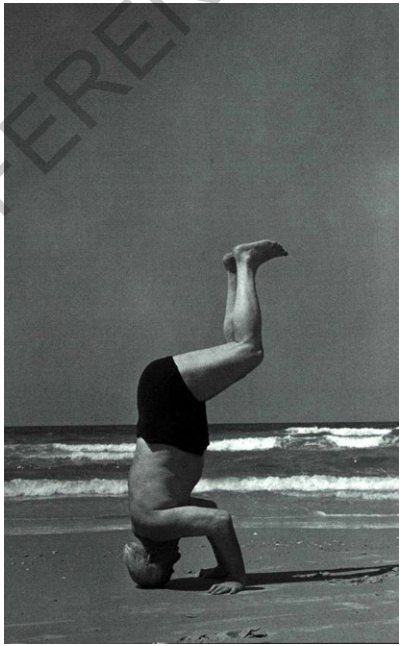
Outline of presentation

1. Introduction
2. Health care services for older people – NL
3. Long-term institutional care – NL
4. NH-resident's profile and relevant care problems
5. NH-care functions – NL
6. NH team – NL
7. Current transformation of chronic care - NL

1. Introduction

People age differently…

ACTIVE AGEING



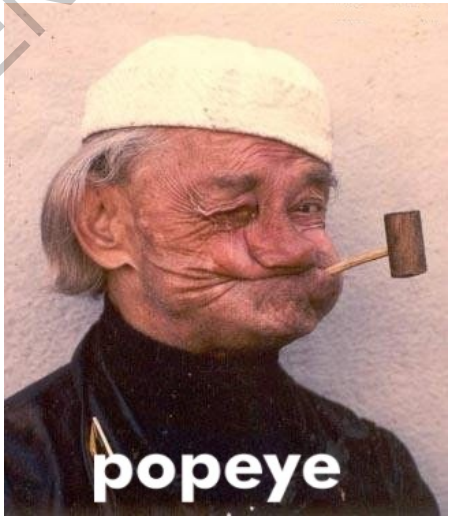
People age differently…

FRAILTY OCCURS…

People age differently…

THE PHASE OF DISABILITY AND (COMPLETE) CARE DEPENDENCY…

Becoming old vitally, in fact is the most realistic wish for all of us.



This wish is antagonistic towards the ultimate fear to be admitted to a nursing home…!

The Netherlands; now…

- How many elderly?

55+	4.0 million
65+	2.2 million
75+	1.0 million
85+	0.25 million

- Long lasting physical disabilities:
  - 55-64: > 30%
  - 75-84: ~ 75%
  - 85 + : ~ 95%
- Main physical diseases: CHD (HF), Stroke, COPD, Arthrosis and Diabetes.
- Depression: 55-84 years of age: 15%
- Dementia: 55-84 years of age: 11% and 85+ : 30%

Data derived from RIVM en SCP

2. Health care services for older people - NL

DOMICILIARY SERVICES

Health care

General Practitioner
Physical therapist
Occupational therapist
Speech therapist
Dentist

Home care services (nursing)

Community mental care services

Social services

Social work
Welfare services
Meals on wheels
Alarm systems
Sitting services
Keep-fit exercises

Housing

Regular housing
Adapted housing
Service flats

INSTITUTIONAL SERVICES

University hospitals
General hospitals

Psychiatric hospitals

Rehabilitation clinics

} ***acute care***

chronic care ***(until 2015….!)***

Residential homes (100.000 beds): primary sheltered living + some additional care

Nursing homes (63.000 beds): ***primary long-term care***

Elderly;…. use of chronic care (NL):

Domiciliary care

- home care: 65+: 10% (220.000)

Institutional care: *(until 2015….)*

- *residential homes: 65+: 5,0% (100.000)!!*

- **nursing homes: 65+: ~2,5% (63.000)**

Relatively high institutionalization rate!!

Data from RIVM en SCP

3. Long-term institutional care – NL

Institutional care started with the former (religious) care asylum..

The time in which the habits still rustled.. and the physician still was an ‘emperor’..

Since 1968, the current nursing home as an institute has developed

Summary of historical developments

- < 1968 : primary a last resort-function; a sanctuary or asylum for patients treated in and put out of hospital

- **1968 : AWBZ (Exceptional Medical Expenses Act)**

- **> 1968 : official status for nursing homes**

Up until now, the Netherlands have always been proud of their large number of professional institutes for chronic care

Strong development of nursing home care

before 1968:
only a substitute for hospital nursing!
(mainly nursing care with scarce (para)medical support from outside)

after 1968:
strong intrinsic development of nursing home care itself;
development of CLSM-care

Some data..

- The Netherlands: ~ 345 nursing homes
- 63.000 beds: 27.000 for somatic patients
  36.000 for psychogeriatric patients
- 60.000 new, mostly very frail, patients per year admitted
- man : woman = 1:2 (mean age > 80)
- where do patients come from:

somatic patients:	(40.000)	65% from hospital
		25% from home
psychogeriatric patients:	(20.000)	53% from home
		23% from old people's home

4. NH-resident's profile and relevant care problems

The profile of a nursing home resident = the profile of a geriatric patient

- Multimorbidity;
- Many disabilities and handicaps affecting autonomous personal care, mobility, social and mental functioning;
- A high prevalence and/or incidence of relevant care problems…. and of issues that have to do with the remaining life….!

Morbidity

- **Main diagnoses in somatic residents:**

Cerebrovascular accident	(26%)
Fractures and other locomotor disorders	(30%)
Diseases of Central Nervous System	(7%)
Cancer	(8%)
Other	(29%)

- **Main diagnoses in psychogeriatric residents:**

Dementia (all types)	(85%)

Often relevant care problems

- **Polypharmacy: 40%**
  (≥ 5 medicines/day)

"a pill for every ill"

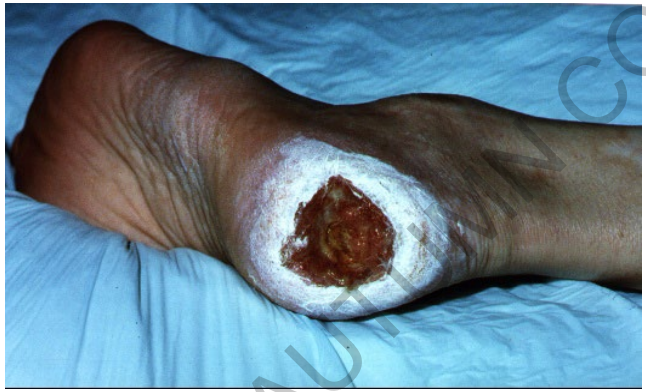
Care home residents are prescribed many medicines, with an average of eight medicines being common. International research has shown that these medicines are often not well managed, with many residents prescribed medicines inappropriately….

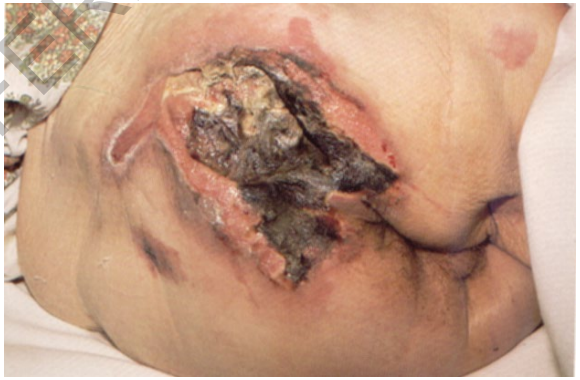
http://www.cochranelibrary.com/

"You don ´t leave here without a prescription"

Often relevant care problems

- **Pressure ulcers: 15-25%**

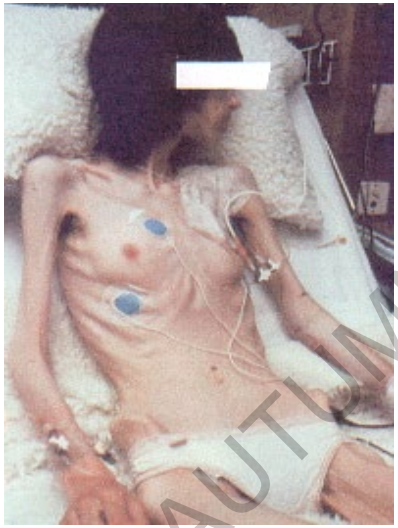


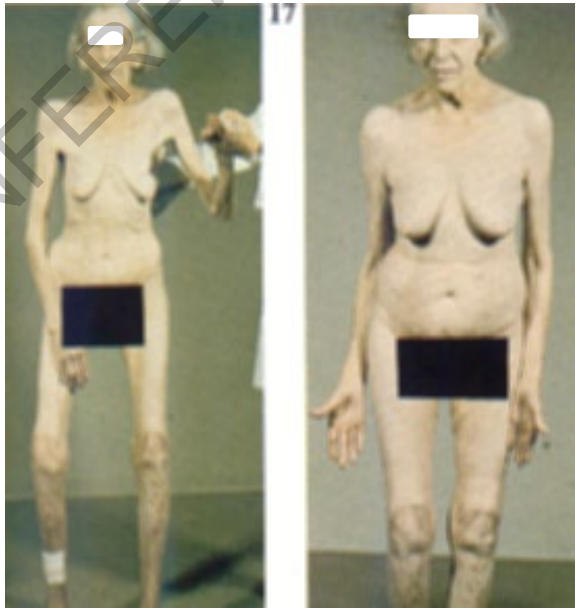


LPZ-i database

Often relevant care problems

- **Malnutrition: 20-25%**





LPZ-i database

Often relevant care problems

- **Urinary incontinence: 75%**
- **Faecal incontinence: 55%**
- **Double incontinence: 53%**

LPZ-i database

Often relevant care problems

- **Fall-incidents:**

  10% of residents have a fall incident in the last 30 days and 40% of these fallers actually have fallen more than once!

- If a subsequent hip fracture is diagnosed…:
  then 30% chance to die within 1 year!

LPZ-i database

Often relevant care problems

- **BPSD:**

> 80% of <u>demented</u> nursing home residents suffer from at least 1 neuropsychiatric symptom:

The most relevant symptoms are:

-agitation / aggression / irritability and general restlessness

versus

-apathy

e.g. Zuidema et al, 2007

Often relevant care problems

- **Delirium: 30-60%**

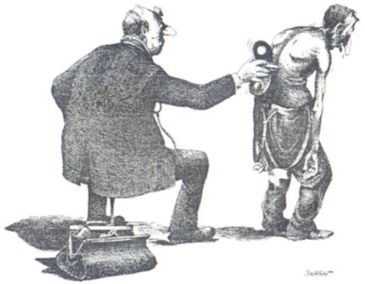
…"Delirium is an acute disorder of attention and cognition in elderly people that is common, serious, costly, under-recognised, and often fatal. A broad formal cognitive and physical assessment incl. the history of acute onset of symptoms are necessary for diagnosis.
In view of the complex multifactorial causes of delirium, multicomponent non-pharmacological risk factor approaches are the most effective strategy for prevention.."

Inouye, 2013

Issues of remaining life

- How can I stay myself and lead a meaning ful life in the nursing home?

- Spirituality and End of life issues..



Balancing between cure and care

Message for high tech health care nerds, who do not like long-term care….

Nursing home care is challenging and not boring!!

5. Nursing home care functions

Nursing home care functions

- Rehabilitation (mostly long-term rehabilitation)
- Chronic care (long-term care or continuing care)
- Palliative care
- Respite care
- Crisis-intervention

6. Nursing home team - NL

Execution of Dutch nursing home care (1)

- **Nursing home care in the Netherlands is executed by multidisciplinary care teams employed by the nursing homes themselves!**

- The nursing home team consists, next to physicians and nurses, of physiotherapists, occupational therapists, speech therapists, dietitians, psychologists, social workers, pastoral workers, and recreational therapists.
- The nursing home team can be supported complementary by medical specialists; e.g. hospital geriatrician, neurologist, psychiatrist etc.; e.g. to avoid unnecessary hospital admissions.

Execution of Dutch nursing home care (2)

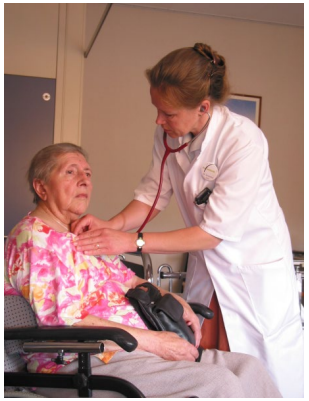
- Nursing and treatment are based on each resident's personal needs and wishes and on an integration of relevant cure and care.
  In agreement with the resident and his or her relatives, a resident tailored, integrated care plan is defined after admission and of course after a thorough multidisciplinary assessment of the resident's problems.

- In addition to medical care, the nursing home physician is responsible for providing substantial directions for the total care, while the first responsible nurse on the ward is responsible for the daily coordination of the execution of the multidisciplinary care plan.

- The effectiveness of the care is evaluated regularly within the team and with the resident and/or the family relatives; and, if necessary, the care plan is revised.

This multidisciplinary, cyclically evaluated systematic approach characterizes the delivery of care in Dutch nursing homes

Hertogh et al 1996; Schols et al. 2010



Why has the Dutch nursing home sector chosen for a model in which all professionals of the multidisciplinary team are employed by the nursing home itself and not for a situation in which the nursing home is visited by many different consulting professionals?

Reasons to employ the total MDT (1)

- Nursing home residents need more and longer medical, psychological and paramedical consultations;

- The complex problems of these residents require more continuity of care and also more proactive and preventive interventions;

- General practitioners, other consulting medical specialists and paramedical professionals from community health care services often have inadequate time, affinity or experience to give these residents the continuous attention they need;

- Medical, paramedical and psychological care in nursing homes is not a job that can be done fast and simply on the side of main general practice medicine, hospital medicine or community care;

Reasons to employ the total MDT (2)

- By using their own physicians, psychologists and paramedical personnel, nursing homes can achieve logistic and organizational advantages contrary to the situation in which a nursing home is visited by many different consulting professionals;
- Professionals employed by the nursing home itself or working within a closed staff model seem to be more committed and knowledgeable about long-term care practice and are more continuously available;
- The nursing staff will get more uniform and testable instructions and the implementation of a well-considered quality system of care will be facilitated.

- **Finally, it is expected that such an employment model may facilitate the concrete multidisciplinary care approach in a much easier and controllable way.**

Schols & Kardol 2017

In addition……

- In the Netherlands **nursing home medicine (nowadays called elderly care medicine)** has been recognized as a distinguished specialty….!

- Actually, this means acknowledgement of the fact that nursing home residents need specific and continuous medical care and that the competency in nursing home medicine requires specific training and experience in handling complex medical care in a highly regulated, multidisciplinary care context, that accommodates both post-acute and long-term care.
- The acknowledgment of nursing home medicine as a specific discipline has provided the nursing home physician an own identity and a position between the family physician and the hospital (clinical) geriatrician.

Dutch nursing home care:….. outcome?

- The multidisciplinary care approach is felt to be helpful in tackling the complex problems of nursing home residents, to ultimately offer them the right and tailored living, welfare and care services.

- Although there is still little scientific evidence, some literature supports that this care approach may lead to a lower prevalence and incidence of relevant care problems such as pressure ulcers, malnutrition, falls and unnecessary use of physical and/or chemical restraints and that it also prevents unnecessary hospital admissions…

Halfens, Schols et al.

2013; Gulpers et al. 2011

7. Current transformation of chronic care - NL

Nowadays, it is all about….

Postponing institutionalization of frail and disabled elderly…

WHY?

1. NL had/has already a too high institutionalization rate.
2. Cost aspect.
3. Aging in place is EU policy.
4. Aging in place fits in preferences of most (frail) older persons.

Dutch government has decreased institutional LTC-services, since 2015:

Institutional elderly care….; what is happening, since 2015?

- **163.000 – 100.000 + 33.000 = 96.000 NH beds**

  RH/NH beds - RH beds + ‘extra NH beds’

FUTURE

- **In the future, most (chronic) elderly care (informal and formal!) will take place at home, in the community!**

- The overall care burden at home and in the community will increase…
- This will require strengthening of and support for community care to successfully go through a trajectory towards a more proactive elderly care in the community …

Challenges for nursing homes and nursing home physicians

- The trend towards aging in place of older people challenges Dutch nursing homes today more and more to complementary support the community-based care for home dwelling older persons.

- By doing so, also relevant aspects and benefits of the intramural multidisciplinary approach can be extended towards the community health care services.

- NHPs started already to act ambulatory (so outside their institutions) in the middle of the eighties of the last century…; most often in an advisory, consultative function for GPs…

Outreaching support by nursing home physicians, in the meantime….

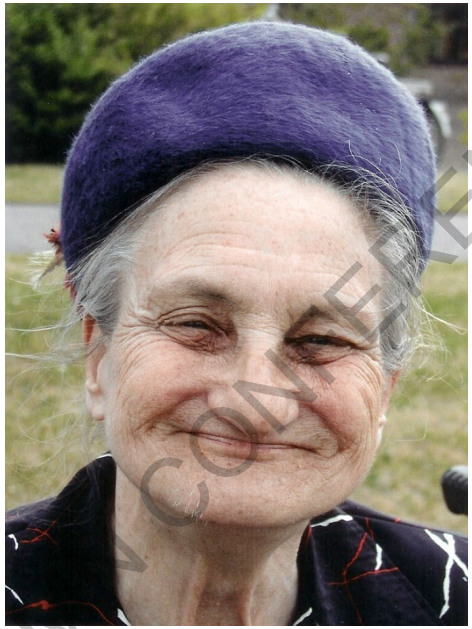
- The conviction of the fact that profiling in the community would be necessary also led to a change in the name of the Nursing Home Physician into Elderly Care Physician, which made it clear that the ECP can and will also play a role across the borders of the nursing home…

- Next to the regular 3 year postgraduate education program to become ECP, an additional course has been developed for ECPs who work a substantial part of their time in the community….

- In the near future, regular funding for nursing home physicians will be available to offer medical services to community care!

Collaborative models to support community care for frail older persons; to enable aging inplace and prevent unnecessary hospital admissions…

- Regular consultation services of ECPs at home or in GP practices.
- ECPs regularly working in GP practice during 1 or more days/month.
- ECPs active in ambulatory geriatric teams, in which they work together with hospital geriatricians and/or old age psychiatrists to support community care.
- ……?



Thank you for your attention!