The future of geriatric care: core values, outcomes and perspective

The vision of CSO, NFU and ZonMw

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Summary

In this document CSO, NFU and ZonMw present their joint vision on the future of geriatric care. It has been compiled in the context of the National Care for the Elderly Programme (NPO) that will draw to a close in 2012, and it shows what needs to be done to change the structure and culture of geriatric care to bring it more in line with what the elderly want. The initial experiences in the regional networks developed within the NPO demonstrate that new working methods and tailored approaches are definitely possible. That provides a perspective for the future well-being of a very large and growing part of the population, the elderly. The emphasis is on frail elderly people who are in a phase between complete independence and being dependent on care and welfare. The document calls for further action: do not allow the experiences that enable elderly people to remain self-reliant for as long as possible to be lost. And let the expertise built up within NPO with integrated care, welfare and housing be applied more widely. That can prevent unnecessary care. In brief, it calls for all parties involved to further develop a future geriatric care that can support the elderly throughout the course of their lives and which is based on a tried and tested approach.

The document has three parts:
1. A vision of the core values for the future of care for frail elderly people;
2. An outline of the NPO outcomes;
3. A perspective for investments to realise the application of results from the NPO and where necessary to further develop these.

The vision

The vision assumes that elderly people direct and manage their own care. And it also assumes an integrated approach in which medical and long-term care and support, welfare and housing form a single continuum. Tailored help according to the needs of the elderly person is a guiding principle. Realising all of this requires a process of change in the culture and structure of geriatric care that is characterised by four core values. These four core values – *Self-determination, Prevention, Coherency* and *Quality and effectiveness* – are further elaborated.

NPO outcomes

In the four years of the NPO, 75 projects were started in the regional networks that focussed on improving the quality of care for the elderly and researching the outcomes and effectiveness of these approaches. The provisional outcomes reveal how the four core values were operationalised within the NPO. *Self-determination* was expressed in projects that encouraged the elderly to manage their own help as well as through encouraging the participation of the elderly in all networks. For the core value *prevention* attention mainly focussed on screening instruments for the early detection of vulnerability among the elderly. Many projects around the theme chain coherency reflected the widely recognised importance of the core value *coherency*. The emphasis was on coherency in care. Although various projects focussed on welfare and housing already exist, the connection between care, welfare and housing still merits further action. And the fourth core value, *quality and effectiveness* is visible in the building blocks for the system discussion and financing possibilities but also in the deployment of technology and the translation of knowledge in education modules and manuals.

A perspective for investment

With the NPO a new approach has been introduced that is sustainable in the future and worth retaining.[1] The aim of the following priorities is to ensure that innovations are implemented in every facet of care, welfare and housing with a view to maximising the health gain against manageable costs. That means:

[1] Regional collaboration between different parties involved in accommodation, welfare and care in which the needs and wishes of the elderly play a decisive role.

- Safeguarding the results: Training and education are vital aspects of this. But communicating to all interested parties is also vitally important as equally the implementation and dissemination, the testing of outcomes against the core values in the networks, and focussing on any gaps during the follow-up.
- Continuation of the infrastructure: The network structure has proved to be very valuable. The fruitful approach of the networks with a strong and ongoing contribution from the elderly should be continued. An important point here is the need to transfer the role of the UMC to natural networks and to widen the focus from care to welfare and housing. Furthermore, it is vitally important to allow any ongoing projects from the NPO to be completed according to schedule and to continue to manage these independently so as to maximise the benefits from the investments made.
- Additional activities: attention for life-course related prevention activities in the widest sense of the word. These activities should focus on active participation. A limited number of follow-up projects based on this vision and targeted at the well-being of the elderly in a vulnerable position.

Finally the realisation of a permanent change in mentality in all aspects of care, welfare and accommodation, as equally among the elderly themselves, requires more than a single impetus of four years. However the NPO has shown that real change is possible. In the coming years we should use this experience to realise a sustainable renewal in the care, welfare and accommodation of the elderly in the Netherlands.

1. Introduction and aim of this vision on geriatric care

With this vision CSO, NFU and ZonMw jointly present a vision on the future of medical and long-term care and support, welfare and housing of elderly people with complex problems.[2] This vision has been developed in consultation with the elderly, their representatives, and researchers, and it further builds upon the National Care for the Elderly Programme that funded networks, transition experiments, projects and research from 2008 to 2012.

The vision serves a threefold purpose:
1. It formulates several core values with a long shelf-life based on the needs of the elderly.
2. It briefly describes the provisional outcomes of the NPO and in doing this attempts to provide a clear focus for the implementation of the results realised in the NPO networks.
3. It presents the contours of a follow-up programme for sustainable geriatric care with plans for the short and long term.

The core values in this vision jointly form the geriatric care concept that seeks to provide a direction for future developments in geriatric care. In terms of content the core values are based on the – sometimes not previously expressed – values of the NPO and on the outcomes of two think tank sessions with the elderly. This vision focuses on the frail group of elderly people.

1.1 Report structure

In Section 2 the term frail is further defined and linked to empowerment. In Section 3 the essence of an integrated approach – care, welfare and housing – is presented. This is based on four core values that are elaborated on in Section 4. Section 5 gives a summary of the NPO outcomes and Section 6 outlines the perspective for a follow-up.

2. Frail elderly people: care for empowerment

Life at an advanced age can be highly pleasurable and for many elderly people it is. Yet on the other hand many elderly people are also confronted with long-term disabilities, chronic illnesses and other health problems that make everyday life difficult. The ability of elderly people to adapt and to manage their own lives gradually deteriorates with respect to social, physical and emotional challenges. Elderly people can then become frail for disruptions that imbalance their lives (due to illness or social factors). Elderly people need to be aware of their limited ability to adapt and to take the necessary precautionary measures (self-management). Geriatric care should connect with and support these measures.

Elderly people have a strong wish to be autonomous and strongly hold on to the right to self-management. Numerous factors such as the physical and mental state, the social network, the living situation, the local infrastructure, the organisation of formal and informal care, and public facilities determine how long elderly people remain capable of managing their own lives and home. To maximise the opportunities of the elderly to live life to the full, take part in social activities and live independently, geriatric care should focus on preventing and detecting the consequences of a reduced ability to adapt and self manage. Where necessary it should compensate for these consequences or assume partial or full responsibility on the elderly person's behalf.

Maximising elderly peoples' ability to continue to adapt and manage their own lives is something that elderly people themselves can influence if they are supported in dealing with illness or disability.

[2] CSO= Centrale Samenwerkende Ouderenorganisaties, NFU = Netherlands Federation of University Medical Centres. ánd ZonMw= The Netherlands Organisation for Health Research and Development

From a broader perspective, efforts can also be made to postpone the loss of self-management and own choices for as long as possible. Put briefly there is a need to empower where vulnerability is present. The well-being of these empowered elderly people is further facilitated by a trying to exercise restraint in medical interventions. And where treatment is necessary, the emphasis should be on the quality of the intervention provided in terms of the medical care and long-term care (such as in nursing homes) as equally the support provided for welfare and housing. In brief, less superlative care but an emphasis on good quality that contributes to the well-being of elderly people.

3. Care, welfare and housing for the elderly 2.0

What are the core values for good care for the elderly and for which society as a whole is willing to assume collective responsibility? Due to an ageing population the Netherlands is being confronted with an increasing number of frail elderly people. That also means an increase in demand for complex integral care, welfare and housing. Care, welfare and housing for the elderly merit an integrated approach in the future.

An integrated approach encompasses different levels: at the level of the individual elderly person and his direct relations in welfare, housing and care it is about making choices and harmonising these with what the elderly person considers useful and necessary in welfare, housing and care. Not everything that could be done needs to be done. At the level of organisations the issues are coherency and harmonisation of care (primary care, hospital, nursing, and caring), welfare (neighbourhood and social support) and housing (home support, types of sheltered accommodation, home care and care institutions and nursing homes). Such an integrated care is also referred to as chain care and care management but in fact it is about care professionals looking beyond their own discipline and seeing things from the perspective of an elderly person's well-being and that is not always synonymous with medical care. Informal care is also an essential factor in a good geriatric care policy. At the policy level this is about the integration of different sources of funding from the Health Insurance Act (Zvw), General Exceptional Medical Expenses Act (AWBZ), and the Social Support Act (Wmo). The current financial partitions hinder the funding of innovations; the funding of key functions is far from simple and the efficacy of a new approach is difficult to demonstrate.

In the future, the need of elderly people in a vulnerable position ('the question') will be the guiding principle. And that means tailored approaches instead of standard packages, and coherency instead of fragmentation. Such a shift in direction requires a change in mentality and action that is coupled with serious changes in the management and organisation of care, such as work practices, rules, the role of the elderly, the role of formal and informal supporters and funding. It therefore concerns a process of change in the culture and structure of care, welfare and housing at each of the three levels, including the removal of financial partitions and an integration of the Zvw, AWBZ and Wmo. An integrated approach in which knowledge and practice are linked and based on the conviction of the elderly themselves, as well as the professionals and volunteers who support them in the networks, on the four core values.

4. Core values

4.1 Core value Self-determination

Self-determination of the elderly is a guiding principle and is about honouring the subjective wishes of the elderly as much as possible with respect to their well-being. In the broadest sense this concerns giving the elderly the opportunity to make their own choices irrespective of age, illness, disability or socioeconomic status. This freedom of choice is based upon sufficient information about the choices available. Self-determination is – if the elderly person is no longer capable of this – supported by next of kin who are enabled to help the elderly person make choices that are in his/her own interest. From a more operational perspective self-determination is also about contributing to discussions, ideas and decisions. The collaboration of institutions and care providers with the target group – the elderly – is

necessary to ensure that the demands of elderly people in a vulnerable position are actually heard. The core value is divided into the following aspects:

- Self-management
  With self-management the elderly person assumes responsibility for what he/she can and wants and takes the necessary steps to realise what is possible. The elderly person continues to take as many decisions as possible within the entire spectrum of care, housing and welfare. In the light of the approaching end of life the freedom of choice includes the individual being able to indicate the boundary of treatment, and that support appropriate to such a choice (detachment and withdrawal) is available. Treatment directives are important in this respect. For elderly people who lose the ability to give informed consent proper representation needs to be arranged.

- Participation
  In general participation means elderly people being able to participate in social activities. In the context of research and development (as in the NPO) participation also means that the elderly are included in the networks and involved in projects and research. They participate in target group panels and advisory boards about programming, selection, realisation, evaluation and implementation of research, projects and results. The participating elderly people are the antennae of the target group so to speak. And the elderly have a say in determining policy at the national, local and institutional levels. Local policy is increasingly important in this respect.

- Respect
  Forms of support in the area of care, welfare and housing are provided in a manner which demonstrates that carers and supporters are aware of the successive processes associated with ageing. And a more specific provision of support or care is set up in such a way that the elderly suffer as little inconvenience as possible (for example successive appointments in a single day). The elderly are treated with respect so that they feel understood, valued and heard and can continue to manage their own lives.

- Empowerment
  The elderly are supported in their ability to remain self-reliant. Family members, volunteers and care professionals provide opportunities for other forms of care such as social, emotional, physical and financial support. Support is focussed on facilitating the self-management ability of the elderly instead of relying on care for the elderly. For immigrants the family plays a more important role as the first ring of care and therefore needs to be involved in all forms of support related to care, welfare and housing.

4.2 Core value Prevention

Prevention mainly concerns forms of support in care, welfare and housing that prevent the situation of an elderly person or group of elderly people from deteriorating. It is important to know which risk factors are suitable for identifying vulnerability at an early stage. A timely detection makes positive intervention possible in some cases. Action can then be taken from a broader perspective at an early stage with respect to integrated care, housing and welfare needs of the elderly person concerned. The aim of such intervention is to enable the elderly person to manage his/her own life and to live independently for as long as possible. Elderly people with problems need to be detected as soon as possible to ensure that the problems can still be managed, thereby preventing the need for more serious and extensive support. In other words to anticipate the need to strengthen the well-being and health and to prevent complications in the broadest possible sense. The core value is divided into the following aspects:

- Early detection
  Early detection means detecting in good time those risk factors that can be influenced and which are characteristic for an early stage of vulnerability. The detection of these risk factors is fully integrated in the existing diagnostics. These factors provide an impression of an elderly person's

well-being and health, the physical, psychological and social functioning and any possible limitations in everyday life. The need for this is considerable now that the Netherlands Institute for Social Research has established that the group of frail elderly will grow to 1 million people by 2030. A timely insight in and a good overview of the group of frail elderly people is necessary but at present is only available to a limited extent.

- Strengthening social network
  Strengthening the social network means strengthening the support system around the elderly person including informal care, family and friends. A stable social network not only provides support in the event of difficulties, but it also helps to signal problems related to well-being and health, independence, unsafe living situation etcetera in good time. Combating loneliness among the elderly is also an action point. Neighbourhood-specific support is a good way of strengthening the network around an elderly person as this makes the connection between the elderly person's informal network and the formal network of neighbourhood-related care and welfare facilities. Aspects of this are mobilising local residents for example by deploying healthy old people and encouraging and facilitating social activities in the neighbourhood that contribute to participation and support for frail elderly people. In the neighbourhoods, primary care also plays a key role in preventative care, especially in view of the 24-hour availability.

- Healthy and active ageing
  For healthy ageing the emphasis is on ageing as healthily and fit as possible. Disposition, upbringing and socioeconomic status are important in this respect. How well we age is partly determined by our lifestyle. Chronic diseases and impairments can be prevented and managed by influencing lifestyle factors such as exercise, diet, overweight, smoking but also by housing and work, in short by the choice to lead an active life.

4.3 Core value Coherency

Coherency is about harmonising care, welfare and housing, between formal and informal care, between primary and secondary care, between disciplines, between home and the institution, between professionals, authorities and the elderly in all types and sizes and at the right moment in time. Efforts must be made to ensure that care providers do not deploy treatments and interventions that conflict with each other or are superfluous or undesirable. That is no easy matter. Therefore an important starting point is that all elderly people have access to accommodation that sees them through the course of life. Coherency also concerns harmonisation between relevant domains of knowledge as well as learning from each other's knowledge and expertise. The core value is divided into the following aspects:

- Information and communication
  To navigate their way in the care system, elderly people must be able to easily find, access and understand information that is relevant to them. Knowledge must be translated into information that is comprehensible in both an ICT-supported and conventional manner. Manuals are available for the entire support process that are matched to the needs of the elderly and specific target groups in terms of the language used and the form of publication (not just digital!). Organisations for the elderly provide information campaigns run by the elderly for the elderly. Care providers also share knowledge with others and provide adequate information to the elderly. If elderly people can find their way in the complex world of care, welfare and housing then maximum use can be made of prevention.

- Informal care (informal carers, family, volunteers)
  Informal care is gaining recognition and plays a valuable role in the care system. The elderly, their informal carers and the professionals share a responsibility in agreeing upon the informal care provided so that informal carers are not overburdened, for example. People who provide informal care can receive training and coaching from professionals. The communication between an elderly

person, informal care and formal care needs to be organised around the elderly person. Health insurers and municipalities reimburse the support of informal care.

- Transitions in the care chain
  Transitions in the care chain and, in particular, transitions between secondary care and primary care and vice versa require attention. Systematic transitions are important for the care of elderly people who have undergone a medical intervention. The subsequent recuperative care is aimed at the retention of independent functioning such as personal care, household tasks, mobility and self-management. This requires a broad primary care with a strong role for nurses in the supervision of the chronically ill. And a shift away from a monodisciplinary and disease-specific approach to a multidisciplinary and problem-orientated approach. In primary care the capacity and expertise in geriatric care must be sufficiently safeguarded. In this context the formation of multidisciplinary teams of GPs, practice nurses and home nursing could be helpful.

- Chain coherency and coordination
  Many elderly people have several health problems that can be associated with severe limitations in everyday life. Chain coherency is necessary to prevent elderly people being confronted with unnecessary care, conflicting strategies and gaps between the provision of cure, care and welfare. Coherency also safeguards that health and self-reliance risks are better recognised. An overarching problem for frail elderly people is the lack of a central care provider who is the first point of contact in the care system for those involved with respect to the coordination and harmonisation of the provision of care, welfare facilities and housing. There are too few connections and there is a predominately medical perspective that possibly leads to an overconsumption of care. A more integrated approach is needed with the active involvement of the elderly person, the cooperating care providers and professionals. From this perspective of an integrated approach, a client-focussed care plan can be drawn up in which the connection with housing and welfare facilities is also included. Elderly people want a central coordination point and as much uniformity as possible in administrative processes.

4.4 Core value Quality and effectiveness

Qualitatively good care brings together self-determination, prevention and coherency on a level playing field. This requires knowledge from different domains and the initiation of a process of change in the culture and structure of care, welfare and housing for the elderly. Such a process of change is urgently needed: The number of elderly people is growing and although the care and welfare sector needs extra personnel the size of the working population is falling. The available budget for care, welfare and housing must therefore be spent as efficiently as possible. This means minimising the wastage of collective resources on conflicting, unnecessary or undesired support. Care providers are competent and proficient, and able to deliver tailored services, in other words services matched to the individual's needs. A qualitatively good and effective geriatric care that has broad public support should contain at least the following elements:

- Accessibility
  The government guarantees the accessibility of care, welfare and housing for all elderly people irrespective of socioeconomic status. The care and welfare provision meets the needs of the diversity in elderly people such as differences in ethnicity, personal preferences, capacity, and underlying medical and psychosocial problems. The provision is also matched to the culture-specific wishes and needs of elderly migrants. Accessible care also concerns public spaces, transport possibilities and accommodation that meet the needs of the elderly. Basic care and welfare and referral to specialised care are supplied as close to home as possible at locations that are physically well accessible. Accessibility also entails diversity at a local level: there is not a single blueprint but elderly people should know where they need to be. A central information point should therefore be available (‘front office’). In short, accessibility is defined as straightforward access to complex care.

- Effective care
  There is sufficient evidence that the care provided effectively realises the objectives for which it was deployed. Care is aimed at the individual needs and capacity of the elderly person. Care providers and professionals agree upon the care for the elderly with each other to safeguard the continuity and to prevent complications. Professionals are competent and proficient. This expertise goes beyond the medical expertise in the narrowest sense. Care is timely, at hand (close by), efficient, organised and available. And care is not only medical: attention for not treating and other forms of support are just as important. That is why meticulous initial consultations are so crucial (for all types of care, welfare and housing).

- Development of technology
  The development of technology can be used to keep care accessible where manpower is limited. Examples are the development of domotics and robotics. Evaluations by the elderly are an integral part of technology development. Technology is also used to give the elderly direct access to information and to offer them a listening ear (e.g. the concept 'Remote care'). The technology for this must be attuned to the mental and physical state of the elderly and may also not replace the human element. Technology must be low-threshold, useful, feasible, applicable and affordable. Finally, technology must not lead to isolation but should instead facilitate human contact.

- Budgeting
  Budgeting facilitates the realisation of the core values stated. There is a publicly supported balance between the spending of public funds on the one hand and the accessibility and quality of geriatric care on the other. The budgeting is based on new geriatric (= taking multimorbidity into account) standards that are based on clear quality criteria in which the client perspective has been incorporated. Non-effective geriatric care is withdrawn.

5. Expected NPO outcomes

Whereas the previous chapters defined the core values, this chapter focuses on the outcomes of the National Care for the Elderly Programme (NPO).

5.1 The set-up of the National Care for the Elderly Programme

In 2008 a broad group of researchers, elderly people and care and welfare organisations started the necessary reform of geriatric care, especially for the frail elderly, in the framework of the NPO. Nearly 600 parties in the area of care, welfare and housing joined forces in eight regional networks. They jointly carry out research, experiments and projects so that frail elderly people can receive the best and most efficient care and support. The aim of the programme is to realise added value for the elderly person with a complex problem. To achieve this the programme must result in a coherent provision of care that better meets the individual needs of elderly people.

For elderly people this should lead to more quality of life through:

- More self-determination, self-reliance and retained functioning;
- Less need for support from care and welfare;
- Less chance of care and treatments that are unnecessarily burdensome.

NPO tries to achieve this by:

- Improving the quality of the geriatric care;
- Reducing fragmentation by integrated provision of care and support;
- Improved care for the same or lower costs.

All NPO projects have three elements:

- The demand: The needs of the elderly took and take centre stage.
- The organisation: Setting up an organisational infrastructure around the elderly person in which supportive types of care, welfare and housing and the funding are seamlessly connected. Representatives from the different parties are always involved in the networks to facilitate coherency in the entire chain.
- Measurement and efficacy: Each project is accompanied by a study to measure the outcomes and to establish the efficacy of a new approach to intervention/care and whether this also leads to effective and qualitatively good care.

In the networks about 40,000 elderly people are participating in 75 experiments and projects. And more than 1000 general practitioners are working on the provision of integrated geriatric care together with many others. The UMCs have been given a special role in the networks and projects. They have initiated the regional networks and are responsible for ensuring the validity of the scientific methods. In the networks 550 organisations (general practices, general hospitals, old peoples' homes, nursing homes, home care organisations, pharmacies, municipal mental health services, regional elderly or patient organisations, welfare and informal carers organisations, health insurers and municipalities), care professionals (physicians, nurses, paramedics, pharmacists, carers, welfare workers), elderly people, informal carers and family have enthusiastically become involved. They contribute from the perspective of their own involvement and that provides many insights based on practical experience. Now consensus needs to be obtained about how knowledge and practice can be systematically linked to increase the overall quality. That requires a process of change in which everyone involved must be willing to become familiar with each other's frames of reference, to learn from each other, and to allow changes to take place in synergy with each other.

In the NPO the outcomes of the projects are described and evaluated. Then after the completion of the projects and experiments it is clear what is effective and how the geriatric care can be improved without the wheel having to be repeatedly invented. However this requires that interventions with

demonstrated effectiveness (evidence-based) are implemented, learning experiences from the collaboration in the networks and projects are disseminated, and elderly people continue to be involved. These outcomes can be further built upon in the future. However, things have not got that far yet. Therefore in the following sections the provisional outcomes from the NPO are organised and tested against the core values.

5.2 The outcomes

In the NPO the core values are materialised in new approaches to care, welfare and housing focussed on the quality and suitability of complex care and support processes for frail elderly people. The projects in the NPO have not been completed yet but the first results and provisional outcomes already provide an idea of the future implications for care, welfare and housing that the NPO can and must have. Examples are given for illustrative purposes but are not exhaustive.[3]

5.2.1 Self-determination

Participation in the programme

Right from the start the NPO has tried to give the elderly a say. Therefore in all eight NPO networks a formally established form of representation for the elderly has been developed. Participation of the elderly is supported by the umbrella group of organisations for the elderly (CSO) that provides elderly people with the tools they need (through training courses, exchange programmes and a manual) to let their voice be heard. The aim is to embed the structural participation of the elderly. Within the NPO a dialogue model is being developed that focuses on strengthening the collaboration between the elderly and professional practitioners. Everyday practice has revealed that enabling the elderly to participate leads to improvements in innovation projects, a strengthened autonomy and a valuable self-determination of the elderly.

Self-management and strengthening independence.

Frail elderly people can also do more than care providers sometimes think. In the NPO self-management and self-reliance are encouraged in various ways:

- By supporting specific groups of elderly people to acquire knowledge through courses that are, for example, aimed at the determinants of self-management and well-being.
- By making care providers aware during their training of their own role, attitude and approach towards elderly people and to focus this more on the elderly person's self-reliance.
- By arranging the care in such a manner that it is modified on the basis of regular observations: it is already clear that the elderly lose their self-reliance less quickly with such an approach.
- Through targeted interventions to keep them active, as part of a care action plan, e.g., a training programme for the elderly aged 75 years and over who live independently. The training programme is included in the training of physiotherapists.
- By formulating recommendations for modifications to and the renovation of the existing living environment and by the construction of new living environments. Because in addition to individual characteristics, the physical and social environment of the elderly also affects their self-reliance.

Innovative geriatric care must also benefit older migrants. Therefore an intervention programme is being developed within the NPO in cooperation with the Network of Organisations for Older Migrants (NOOM), focussed on a better harmonisation of the facilities to the needs of older migrants. This includes training the people who make home visits and the deployment of young allochtonous informal carers who will be approached via new media such as Internet. The scope of this approach

[3] See also: Landelijk werken aan betere zorg voor ouderen; Overzicht van projecten van het Nationaal Programma Ouderenzorg, (Working nationally on an improved care for the elderly; Overview of projects from the National Care for the Elderly Programme) ZonMw, 2011

has proven to be considerable. A widespread respectful treatment of the elderly requires more than a single project in the NPO.

5.2.2 Prevention

Early detection and integral diagnostics
The NPO has strongly focussed on the early detection of the risk factors to determine how frail elderly people can be identified at an early stage. For example, there are various pro-active screening instruments under development for the measurement of vulnerability, well-being, complexity of the care situation or indication assessments (for example, ISAR-PC, the Groninger Frailty Indicator (GFI), the INTERMED client version, the AMC Linear Disability Score (ALDS)). These instruments are used in combination with other activities, such as the care action plan or care dossier, training of general practitioners and practice support staff, and preventative intervention by practice nurses.

The NPO research must clearly demonstrate whether the screening instruments are valid and reliable so that these can be used as triage instruments. The instruments provide insights into the current situation of elderly people and contribute to them retaining functions. After that, such integral diagnostics must also be made available to other parties (regions, networks). Efforts are also being made to gain a better understanding of elderly people with a learning disabilities, psychiatric complaints, heart failure, joint problems, falling problems, nutritional problems and exercise/exertion problems. It is also being investigated whether the use of the early detection instruments is cost effective.

Neighbourhood-centred support and strengthening the social network
The NPO also focuses on welfare and housing, especially at the neighbourhood level so as to strengthen the social network. This happens at a range of levels:

- At an individual level, such as the proactive support of work in and around the house, or assistance with shopping and transport or by the involvement of neighbours, volunteers and others in the network of support;
- At the neighbourhood level, where investments are mad in connecting the provision of care and welfare, and in the training and education of neighbourhood residents and professionals, in which frail elderly people are actively involved;
- At the level of education in which modules are developed for non-university-trained professionals so that they learn to look at a person in his or her social environment;
- At a technical level by making use of ICT facilities (e.g. a video camera in a village hall) with which people in rural areas can still be supported so that they can continue to live independently;
- At a policy level by evaluating how the *Proeftuinen Woonservicegebieden* (ordinary neighbourhoods or villages with a coordinated provision of services in the areas of care, welfare and housing) have worked out for the preservation of well-being and health of frail elderly people.
- At an effectiveness level. The results are translated into an advisory report for the responsible government ministers. The projects are also evaluated in economic terms to determine the extra costs involved in an integral neighbourhood approach and whether these costs are proportionate to the expected improvement.

5.2.3 Coherency

Harmonising formal and informal care
The harmonisation between formal care, the client and informal care requires a lot of insight, tact and attention. In the NPO this is realised though the development of an instrument to embed family-friendly work in daily practice. The instrument includes, for example, a training module for all care providers, an e-learning platform and a lecturer's manual.

The NPO also provides support for obtaining more knowledge about the functioning of care networks around frail elderly people with complex health problems. In addition to this all projects in the NPO examine the burden for informal carers and the influence of the new manner of working on this. This is done by using a Minimum Dataset for informal care.

Strengthening primary care

Many NPO projects focus on the functioning of primary care. This primary care, whether or not it is managed by a general practitioner, is the first point of contact for elderly people in a vulnerable position. Projects focus on support through:

- General practitioners who actively provide a preventative consultation in the form of a home visit in which apparently healthy old people are screened for vulnerability. The effect of this is currently being investigated with respect to physical health, well-being, lifestyle and social, emotional, psychological and cognitive functioning.
- General practitioners who deploy an intervention according to need, for example, through actively identifying frail elderly people and drawing up a tailored care action plan in consultation with them. The effects of this are also compared with the standard provision of care. Effects are, for example, less limitations in activities, fewer symptoms of depression, less loneliness, more quality of life, less falling, less worry, more social participation, and fewer cognitive problems. But also the postponement of mortality, a better last phase of life, an adequate use of care and other supportive resources and specific modifications to the home that meet the elderly person's needs.
- General practitioners who have a central role in the partnership between general practitioners and nursing homes and care institutions, in which the general practitioner calls upon the services of professionals such as geriatricians, geriatric medicine specialists, healthcare psychologists, physiotherapists, dieticians, nurses and home care so that elderly people can live at home for as long as possible. That provides a low threshold consultation opportunity for the general practitioner who retains the 24-hour management of the care for the frail elderly patient.
- A wide range of resources in an era in which the number of demands for care and the complexity of these is increasing and the affordability of care is under increasing pressure. This concerns, for example:
  - Manuals for collaboration that provide a complete overview of the different types of collaboration with other domains, communication and coordination and funding.
  - On-line information via a new website (www.effectieveouderenzorg.nl). Here care professionals in geriatric care can find information about the systematic approach to many frequently occurring problems. These are care models and strategies to improve the care for the elderly who still live at home or who have been admitted to hospital.
  - A practical toolkit (a step-by-step plan and effective interventions) with which professionals can detect, diagnose and treat problems. The toolkit contains information from practice guidelines, scientific research, best practices and parts of the NPO studies such as screening instruments and questionnaires.

Chain coherency

Many of the NPO projects and experiments focus on coherency across domains and disciplines and on the transfer moments between different types of care and support. This entails various types of care programmes which try to realise a provision of care and welfare that satisfy the long-term complex care needs of the elderly. Several outcomes are described below:

- Directive role and coordination. The NPO strongly focuses on primary care being the important directive party with responsibility for the entire chain. Here continuity and coordination are organised with coherency in the provision of care, welfare and housing.
- Multidisciplinary consultation. The NPO is about going from detection to treatment from a single accessible location, according to an integral care model that includes informal care based on multidisciplinary consultation. There are clear agreements about who needs to initiate what care and welfare activities and the results of this are measured. In nursing and care homes the medical and other care is also harmonised in Local Workgroups, through consultation between institutions,

general practitioners, pharmacists and geriatricians to shape the medical policy with agreements about cooperation, personnel, infrastructure and funding.

- Recuperative care (the care provided when an elderly person returns home following a hospital admission). Here multidisciplinary consultation and a proper transfer are vital to prevent a loss of function (deterioration in the Activities of Daily Living (ADL)). The NPO is investigating if such a multidisciplinary intervention with a transition coach based on a care treatment plan has effect.
- Dementia. A growing group of dementing elderly people needs integral care that places a considerable demand on informal care. The NPO supports, for example, a digital care chain dossier dementia and case management with the aim of providing less incoherent support at an early stage. In this approach particular attention is paid to the support of informal carers and to optimising the transfer associated with nursing home admission. The NPO activities tie in with the national Delta Plan Dementia currently under development.
- Practice guidelines and models. The NPO projects must result in practice guidelines and models for a coherent, demand-driven, proactive and preventive care and welfare for chronically ill elderly people. The Extended Chronic Care Model has been further built upon with the development of care trajectories, the information pass and the Care and Welfare Standard (ZWS). The models contribute to a content-based standardisation, quality indicators, and the support of consultations between health insurers and municipalities.

5.2.4 Quality and effectiveness

Outcomes from the NPO contribute to the improvement of the quality and effectiveness of care, welfare and housing. To evaluate, safeguard and disseminate these outcomes the NPO also supports:

Education

In collaboration with the ZonMw programme *Zorg voor Beter* (Care for Better) the NPO encourages education projects aimed at realising a better match between knowledge, care education and care practice. It mainly concerns education for nurses and carers, home care employees at non-university-training level and paramedics. The outcomes of these projects are teaching material in many forms that helps care education to advance such as e-learning and printed forms of modules, manuals, handouts, and teacher manuals for a wide range of target groups (family friendly working, oral hygiene of the elderly, medicine safety, domotics, expertise for dementia, dignified care, etc.).

Budgeting

The NPO aims to improve the care, welfare and housing for the elderly with specific attention for the needs of the elderly, the content and its realisation. However, paying for and safeguarding that same content is more difficult. Consequently fantastic results are often not implemented. The NPO therefore also deliberately focuses on the financial safeguarding of its projects. Collaboration across domains and disciplines places demands on many different financial sources. The NPO itemises limitations and ideas and provides an overview and advice in a booklet that contains building blocks for dealing with different interests and sources of funding. Such a system discussion contributes to a financial safeguarding and that in turn ensures that collaboration can be maintained.

Measuring and knowing

All projects in the NPO are monitored: All outcomes are registered and for this use is made of a uniform set of outcomes measures: the Minimum Dataset (MDS). This contains background variables and outcomes measures The MDS is used to measure the added value of projects an experiments. The MDS registers, for example: the quality of life experienced, the psychological and social well-being experienced, multimorbidity, functioning in ADL, and use of care and welfare. The data are eventually included in a national database of MDS data, The MDS evaluation instruments are also translated into the native language of older migrants.

Technology & ICT

The NPO supports the use of technology and ICT, for example through the broad concept of Remote Care that is being used increasingly more often in the form of telemonitoring and teleconsultation. The

effects of this are maximised when feedback can be given based on the measurements/findings. Using specific instruments (such as a balance-weighing scale and grip ball) the physical vulnerability of elderly people can be measured and registered after which a specific advice can be returned to the clients and the carers. The digital care dossier and learning pathways make use of specific ICT applications.

6. The future of geriatric care – a perspective

With a vision of the essence of geriatric care 2.0 and the provisional outcomes in terms of knowledge, expertise and results from the NPO, what still needs to be done to realise the full scope of care and support for a good geriatric care based on proven quality impulses can now be determined.

A new, future-proof, working method has been implemented by the NPO: Collaboration across domains, network formation and working in consultation with the elderly. This approach is worth safeguarding. It is good to note that regional experience has been gained with other approaches that have proven to be effective. However a temporary national programme of four years cannot lead to national changes in mentality or practice. For that to happen, success need to be safeguarded and disseminated, non-effective solutions need to be scrapped and outstanding questions need to be answered. Even more important still is that the innovations are implemented in every facet of care, welfare and housing. Only then can maximum health benefits be realised against manageable costs. Such an ambition requires continued attention for the realisation of integral innovations cycles (plan-do-check-act).

As choices need to be made in economically less favourable times, a number of subjects have been prioritised that on the one hand focus on the broad application of results from the NPO and on the other on filling in gaps.

The priorities focus on:

- Safeguarding the results of the NPO by further disseminating the core values and implementing the outcomes.
- Continuation of the infrastructure.
- Additional activities in the framework of prevention and unanswered questions from the NPO.

6.1 Safeguarding the NPO results

Communication and information

1. The outcomes of the NPO projects must become available in an open and systematic manner for different target groups (the elderly, informal carers, professionals in care, welfare and housing, health insurers, municipalities and government bodies, network partners and non-network partners). A translational step should be made for each specific target group and this needs to be communicated and made available (for example, a series of booklets and ICT applications about relevant themes). The practical applicability is the main priority in such efforts and the support for this (evidence base) is also made visible. In the projects a start has already been made on communication and information but this also needs to be continued.

Implementation

A strategy is being developed for the implementation of concrete, proven and effective results from the projects into everyday practice. The results implemented tie in with and make use of existing organisations and initiatives. The systematic implementation of these results will require considerable effort at all levels and in all of the organisations involved. One aspect of this is the training and education described later.

2. At the level of networks. Mapping the regions in which peripheral networks and building blocks for core values still need to be strengthened. The NPO will make the building blocks available and will transfer these to the natural partners within their own network and to other natural care networks, who will integrate these into care, welfare and housing practice.

3. National. The outcomes are made available and are further developed by organisations that work on guidelines and standards, building blocks, policy and legislation, including ongoing support for participation of the elderly in existing and new networks.[4] The experience with integrated funding sources will also be incorporated into this. Collaboration will result in more synergy.

Training and education

Competent and proficient professional practitioners are vitally important for good care. Investments in education and training are therefore essential.

4. Greater attention for geriatric care in the education programmes for care and welfare: in the basic training, specialised training and continuous professional development of current professionals (physicians and specialists, nurses, paramedics, carers and ancillary staff in care, housekeeping, etc.). This includes the continued professional development for the additional nurses and carers that have been promised by this Cabinet. Training includes awareness of a process of change in the culture and structure of care, welfare and housing for frail elderly people.

5. The provision of information to elderly people, family and other informal carers about the range of options available in a language that is comprehensible to both the elderly and their informal carers.

6. Training in the area of e-Health: Encouraging the use of ICT and ICT applications for and by the elderly and the integration of e-health applications in standard care practice.[5]

6.2 Continuity of the infrastructure

7. A follow-up programme is needed to safeguard the results from the NPO projects. First of all it is vital that current projects can be adequately evaluated and completed. Then it is important to consolidate results, implement successful projects and scrap non-effective solutions. This requires an independent management. Without a good completion of these projects the possible outcomes of the NPO cannot be fully utilised and previously made investments will be lost

8. Networks should be maintained to create ongoing continuity. Peripheral networks should be strengthened to acquire national coverage (for example in the provinces of Overijssel and Brabant). The central role of the UMCs will shift to the partners in practice and with this attention will be paid to a careful transfer of the directive role that is appropriate to the development stage of the regional network. The UMCs will continue to play a central role in the application of project-overarching scientific methods and implementation research. The specific focus of the networks will be expanded from just care to include welfare and housing as well.

9. Continued strengthening of the demand side. A powerful use of the demand side (the elderly) is necessary to ensure that the vision is actually realised within the regional networks. The elderly must ensure that the change described in Section 3 is actually made. Such a change in structure and culture cannot be completed in a period of 4 years. A strong and ongoing participation of the elderly requires support (from organisations for the elderly).

[4] At a national level this ties in with the developments of the Quality Institute, quality criteria for geriatric care from The Health Care Inspectorate (including the client perspective), the Covenant Long-term Care, Action Programme Care Innovation, Quality of Care programme, and the activities of the national professional organisations.

[5] This ties in with a priority in European Innovation Partnership on Active and Healthy Ageing (EIP AHA), as equally in the European Knowledge and Innovation Communities (KIC) where Innovation for Healthy Living has a central role.

6.3 Additional activities

10. Development of life-cycle-related prevention activities that encourage 'younger elderly people' in their employment and social participation, voluntary work, new social contacts, activities, leisure, expression, development and education as equally a healthy life.[6]

11. The outcomes from the NPO will only become fully and clearly visible in the coming period. Then it will be known if the intended results have been fully realised or if there are still gaps in the knowledge and concrete new approaches that have been built up and that need to be implemented. Therefore opportunities need to be created for additional experiments and research to specifically fill any gaps.

[6] This ties in with the Joint Programming Activities concerning 'More Years Better Lives' and the EIP AHA.