Vilans

Integrating Care of Older Persons: Innovations from the EU

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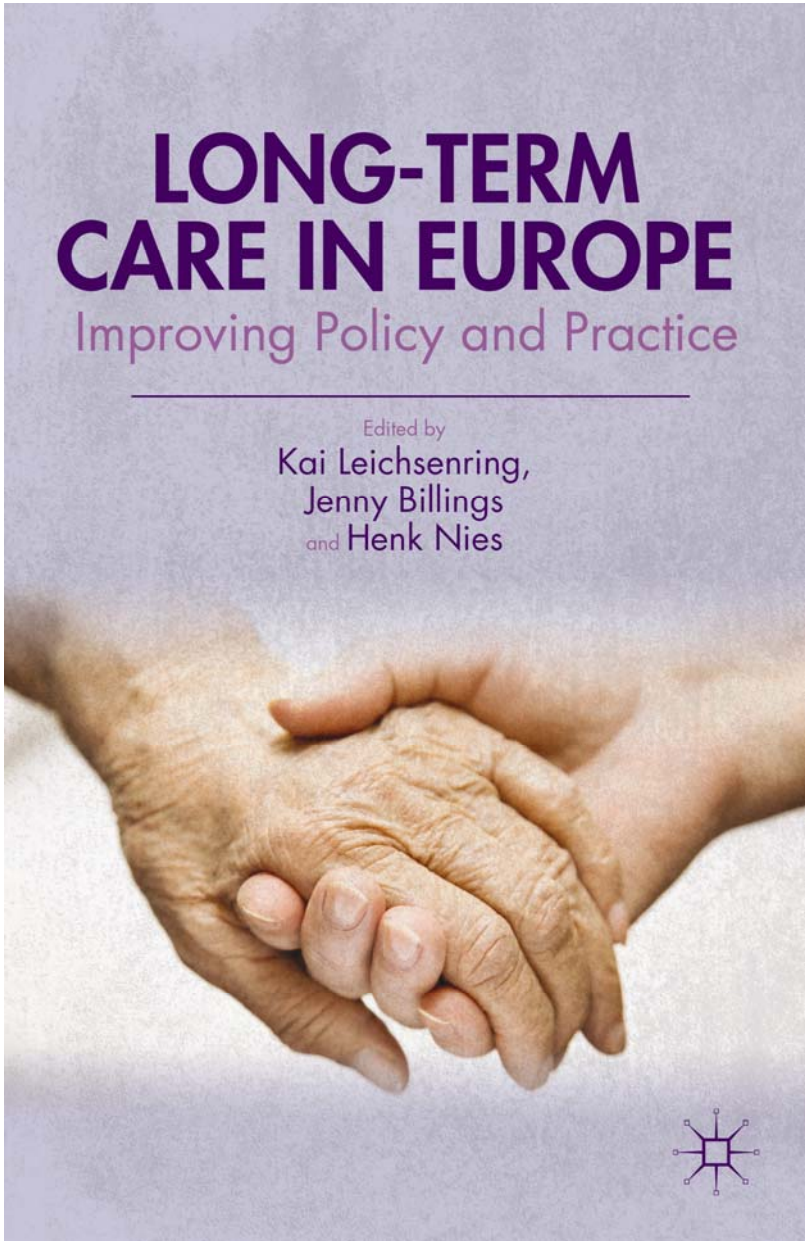
Integrating Care for Older Persons: If It's Such A Great Idea, Why Haven't We Done It Yet?

Presentation

- What is going on in Europe?
- The main barriers….
- Insurmountable obstacles….?
- Spreading success stories
- Spontaneous spread
  - Programs
  - Leadership
- What really matters

What is going on in Europe?



What's going on in Europe?

- Ageing of the population
- Changing family structures: less informal care?
- Workforce at stake
- High expectations of society
- Concern about financial sustainability: increasing expenses and economic crisis
- LTC/chronic, prevention and rehabilitation being discovered → need for integration
- Paradigm shift: what frail older people need and want→ from quality of care to quality of life

Barriers

- Structures
  - Complexity of the system
  - Diffuse allocation of responsibilities
- Procedures
  - Unbalanced, non-corresponding systems
  - Timeframes
  - Information systems and protocols, confidentiality
- Finances
  - Funding
  - Counteracting mechanisms (e.g. means-testing, co-payments)
  - Differences in resources

Barriers

- Professions
  - Autonomy and domains
  - Professional cultures: competitive, conflicting views,
  - Professional interest: roles and interests
  - Threats to job security
- Organizations
  - Competition for domains
  - Organizational self interest
  - Interface problems
  - Supply driven
  - Public-private

→ There are enough reasons not to integrate…

But these barriers are not an insurmountable obstacle!

- Good examples exist everywhere
- Dissemination of knowledge exists everywhere


http://interlinks.euro.centre.org/project
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ealth systems and long-term care for older people in Europe. Modelling the interfaces and links between prevention, rehabilitation, quality of services and
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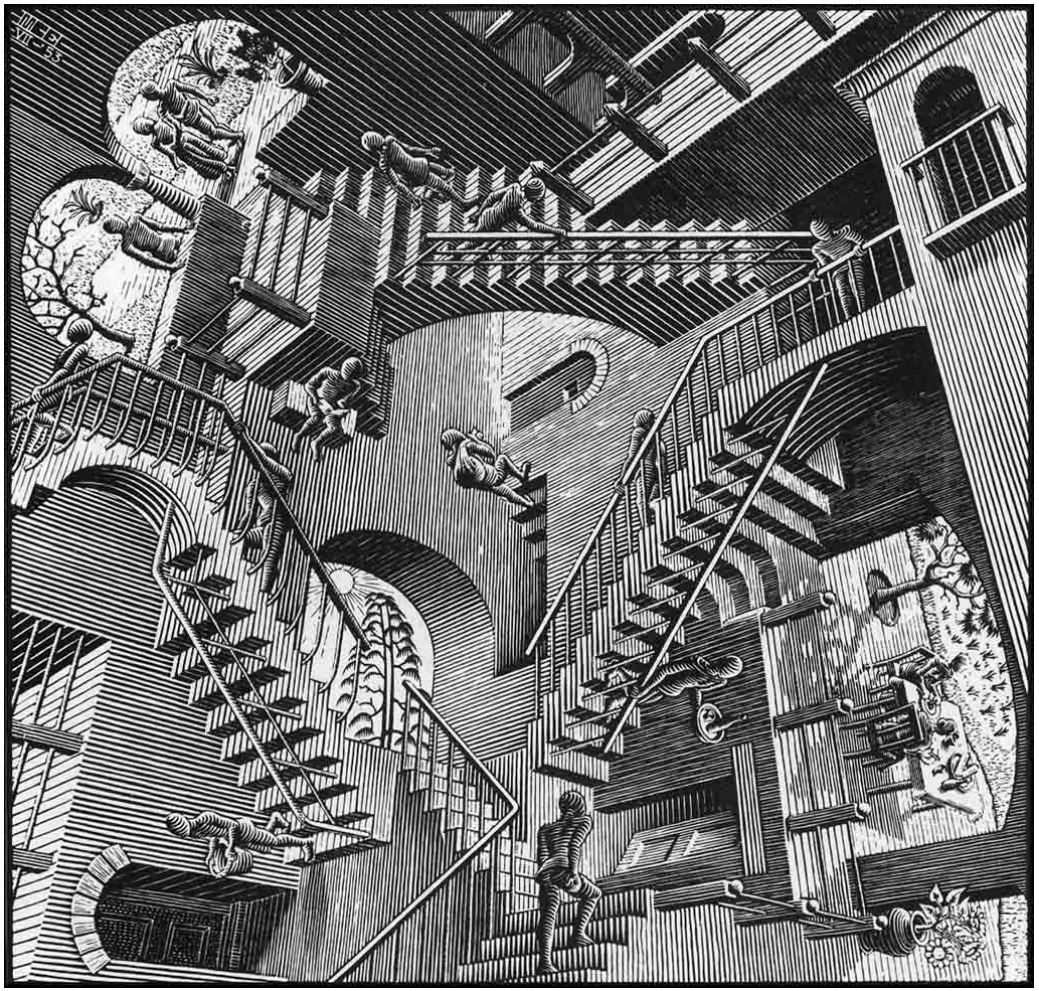
Health systems and long-term care for older people in Europe - Modelling the INTERfaces and LINKS between prevention, rehabilitation, quality of services and informal care
The INTERLINKS project helps people in Europe who work with and represent older people in need of long-term care (LTC). We want to inspire health and social care professionals, policy makers, people from administrative agencies, and people working in non-governmental organisations (NGOs) to:
work towards integrated systems of LTC;
improve planning and delivery of services for frail older people at the interfaces between formal and informal care, and between social and health care;
integrate prevention, rehabilitation, quality management, governance and finance in the toolbox to develop LTC systems.

But implementation is complex and poor!



What works? National programs

Context

- Awareness of underperformance of the system leading to unnecessary suffering and expenses
- Improving the chain of services leads to process optimalization

What works? National programs initiated by government

Collaborative structures: networks and chains of care

- Stroke services (± 1995) Stepping into stroke care, experiments (around hospitals), evaluation
- Geriatric networks (± 1996) Experiments (regions and geriatric departments), evaluation
- National dementia programme (± 2003) User needs explored, developing (regional) structures, followed by funding mechanisms and care standard; 95% coverage
- Palliative care (± 2000) Regional, stepwise built up, consultation and co-ordination, including networks of volunteers, 100% coverage

What works? National programs

- Up to care!
- 300 organizations + 27 networks (dementia, autism, mental health, palliative care, community care, others)
- Campaigning
- Intensive coaching
- Rather more than less!
- Push across the point of no return
- Knowledge database
- Government as co-producer
- Budget: 20-25 CND per year
- Budget: < 0.075% of annual turnover of national budget

What works? National programs

- Design of model by national experts and stakeholders
- Experiments and research
- Implementation program
- Structural funding
- 10 – 15 years

Where are we now?

More recent in primary care:

- Development of health centres (11% of GPs)
- Care groups (GPs and other professionals around specific groups of patients: 80% of GPs)
- Small scale organization of home care (Buurtzorg) → rediscovery of district nurse as integrating profession

Evidence

- Some evidence of improved clinical processes and performance
- No sound evidence (yet) of better outcomes for patients
- It takes five to ten years to demonstrate outcomes at population level
- Total costs have risen: hospitals seek additional income to compensate gains/losses
- Structures and quality measures have - to some degree - been implemented
- Things get complicated when it is about money and income

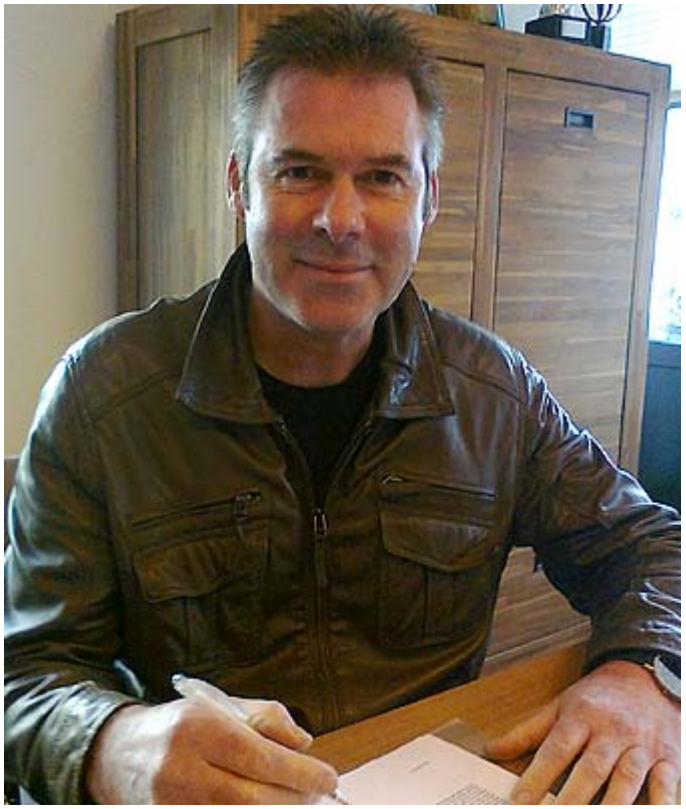
What works? Leadership

Context

- Too much bureaucracy
- Budget cuts → task differentiation → brain drain and alienation
- Mergers and large organisations
- New public management
- Too expensive management
- CEO's over the top
- Postalgia combined with nostalgia


BUURTZORG

Leadership: Jos de Blok



BUURTZORG

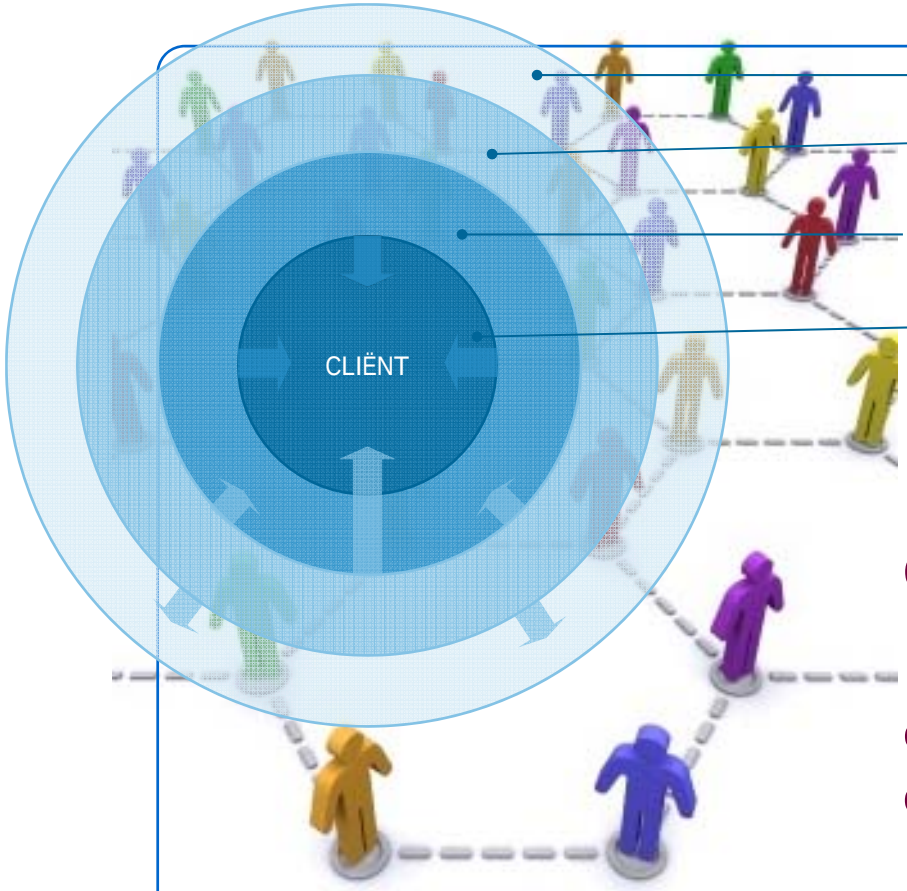
His motivation for change

- Dissatisfaction at work because of lack of autonomy and professionalism
- Excess of bureaucracy, being busy with rules and legislation instead of caring for clients
- Focusing on both individuals and the community
- Better care at lower cost

His vision on what clients want

- People want to be able to control their own lives for as long as possible
- People want to improve the quality of their lives continuously
- People want social participation in their own town
- People want warm relationships

Chain of care



4. Formal networks

3. Buurtzorgteam

2. Informal networks

1. Selfmanagement client

Onionmodel Buurtzorg

Buurtzorg works inside-out: empowering and adaptive, creating networks, supporting.

Buurtzorg

- New organization and care delivery model
- Started in 2007 with 1 team/4 nurses
- Delivering Community Care/working with GPs
- 2012: 4700 nurses in 440 independent teams
- 25 people in (one) back office; 10 coaches, 0 (zero) managers, 8% overhead costs (average: 25%), 8% profit
- Organization cares for (inevitable) bureaucracy, so the nurses won't be bothered with it:
  - Care delivery is charged
  - Employees are paid
  - Financial statements are made
- 60,000 patients annually

Buurtzorg snowballing

Year	Million Euros	Clients	employees
2007	1	300	100
2008	12	5000	1000
2009	40	15000	2200
2010	80	25000	3000
2011	130	50000	4500

Also starting in Sweden and ….

Buurtzorg spreads across the country

The formula

- Independent teams of max 12 nurses, 40 to 50 clients, with optimum autonomy:
  - Who organize and are responsible for the complete process:
    - Clients, nurses, planning, education and finance;
    - And all kind off coordination activities
    - Quality and education
- Complexity reduction (also by ICT)
- Assessment and caring all categories of clients: generalists
- 50% bachelor educated nurses
- Informal networks are much more important than formal organizational structures!

Employees

- Appreciate small teams, working autonomously, strong teamspirit, user-friendly ICT
- Share values all over the country but feel like ‘one’
- High professionalism: nurses exchange good examples with colleagues across the country
- Easy exchange of ideas in digital community
- Easy way of communication with all the nurses by back office
- Contact between nurses and informal carers and other carers in the neighbourhood
- Award for best employer of the year 2011 and 2012
- Absenteeism figures: 3% (national: 7%)

User experiences

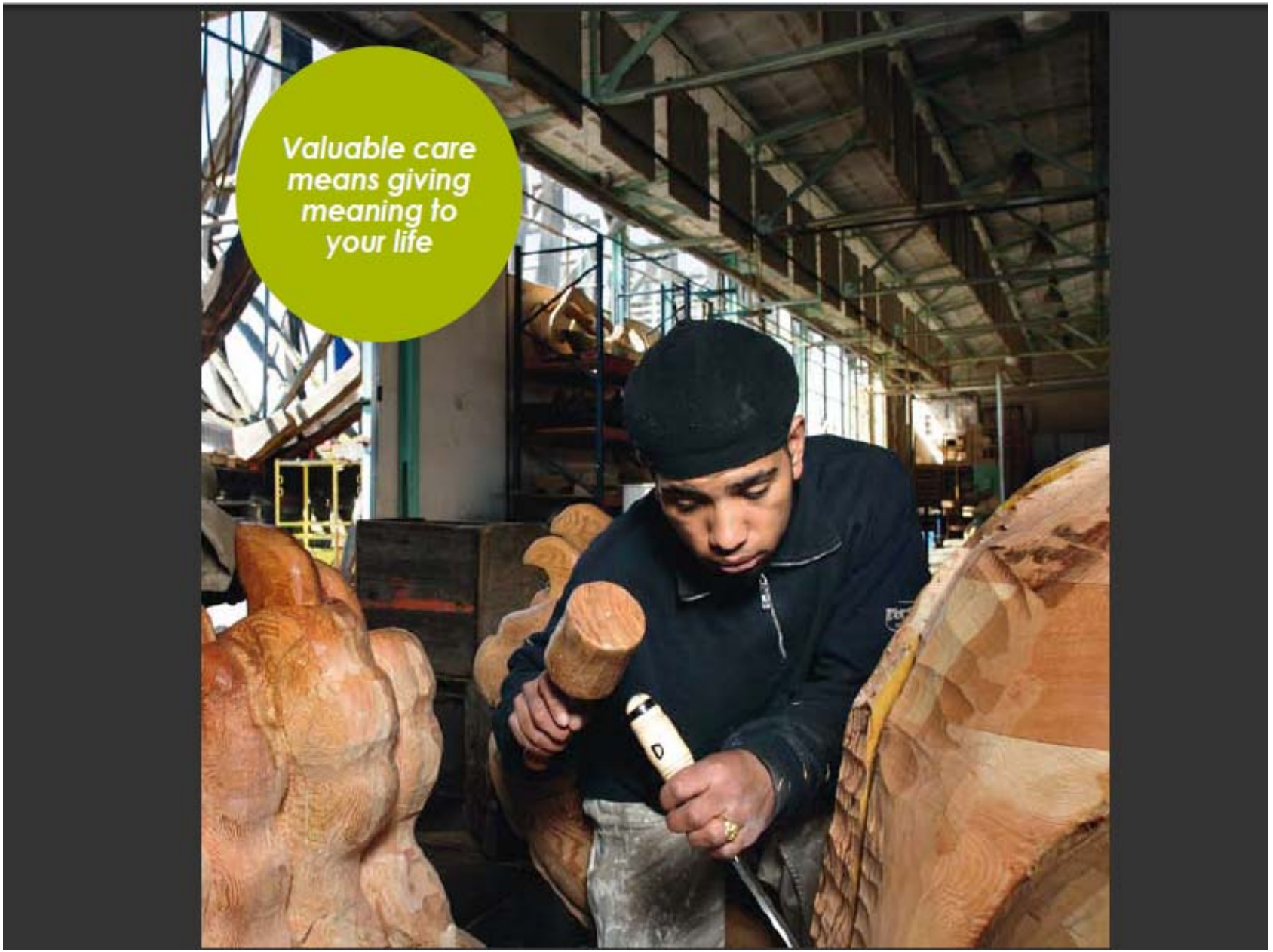
- Good quality of care
- In 2010 and 2011: highest client satisfaction rates: 9,0 and 9,1 (out of 10)
- Supported by patient- and older people's organizations

What works? Leadership

- Mission clear and easy to communicate
- Appeal on professionalism and responsibility
- Lean organization principle
- Not-for-profit and social entrepreneurship profile
- Theoretical basis: Eckart Wintzen (BSO/Origin)

Community care at Buurtzorg

What works? Spontaneous spread: Care farms


Valuable care means giving meaning to your life

What works? Spontaneous spread: Care farms

- Normalisation and social inclusion, meaningful activities
- Crisis in agriculture
- Personal budgets and LTC funding
- Farming products, shops, crafts

Care farms

1999	75	**2005**	591
2000	214	**2006**	720
2001	323	**2007**	839
2003	372	**2008**	944
2004	432	**2009**	1088

What is being offered?

In 2009:

- Day activities (N=759)
- Social activation/ rehabilitation to work (N=238)
- Work and lodging (N=93)
- Lodging (N=206)

For whom? People with:

- Learning disabilities
- Psychic or social problems
- Physical impairments
- (Former) addiction
- (Former) imprisonment
- Dementia
- Older people requiring meaningful activities
- At large distance from labour market
- Autism
- Acquired brain damage
- Problems at school or in education
- Burn out
- And combinations

Organization

Providers

- Farmers and their families
- Care organisations
- Day facilities
- Small scale operation

What works? Spontaneous spread Care farms

- Vision and ideology
- Urgency
- Funding
- Small scale operation

But:

- Quality and financial mismanagement is sometimes an issue
- Funding is currently threatened

What really matters?

- Quality as primary driver
- Mission and vision reflecting time spirit
- Small additional money: € 13 CND → all LTC offices include integrated dementia care in their contracts; primary care
- Self steering teams: cells
- Basis in community
- User involvement
- Collaboratives
- Leadership
- Timing

It may be Dutch….

But it can be sustainable!