Geriatric rehabilitation

VALORISATION

In this thesis, the process of developing and implementing an integrated care pathway in geriatric rehabilitation for patients with complex health problems is described, together with its acceptability, feasibility and its (cost-) effectiveness. This chapter elaborates on the societal relevance of this study and its value for different stakeholders. Furthermore, activities to be undertaken to disseminate the study results are discussed.

Societal relevance

The number of community-dwelling older adults in the Netherlands who are admitted to a geriatric rehabilitation facility after hospital discharge is increasing. Whereas this number was approximately 27,000 in 2008, this number exceeded 47,000 in 2014.[1] This increase is probably a consequence of the Dutch 'ageing in place' policy objective, reflected by both housing policies aiming to keep older adults to live in their own homes as long as possible, as well as the welfare state reform towards the participation society. In such a society, involvement of all different societal groups in essential, as well as taking responsibility to be an active member of this society.

Due to the 'ageing in place' policy objective, a larger proportion of older adults remain community-dwelling instead of being admitted to a long-term care facility. Therefore, a larger number of patients are in need geriatric rehabilitation after hospital admission. This should enable them to safely return to their original home situation. Because patients who need geriatric rehabilitation transfer between hospital, geriatric rehabilitation facility and primary care, they are vulnerable for gaps in coordination and continuity of care during these transitions. These gaps relate to a lack of timely and safe transfers, which can result in adverse events, dissatisfaction with the care received, readmission or permanent placement in long-term care facilities.[2, 3] Therefore, it is essential to improve continuity and coordination of care in this trajectory.[4] In the project described in this thesis, we tried to improve continuity and coordination of care by developing and implementing an integrated care pathway in geriatric rehabilitation for older adults transferring between the hospital, the geriatric rehabilitation facility and community care. The results of the effect evaluation and the cost-effectiveness analysis showed an reduced length of stay in the hospital and a reduced length of stay in the geriatric rehabilitation facility, an increase in the proportion of patients discharged home (instead of being permanently admitted to a long-term care facility), an increase in the frequency of performing extended daily activities among patients and a decrease in self-rated burden among informal caregivers. The shorter length of stay in the hospital and the geriatric rehabilitation facility also resulted in substantial cost savings. Taking all these results together, this pathway is considered important to promote ageing in place. Therefore, it is recommended to implement the integrated care pathway in regular care.

Stakeholders

The first target group benefiting from wider implementation of the integrated care pathway are the older patients and their informal caregivers. Yearly, over 47,000 patients transfer between the hospital and the geriatric rehabilitation facility. The majority of these patients are also discharged home where they receive primary care. Wider implementation of the pathway might lead to more patients being discharged home where they are more successful in performing extended daily activities. Also, the informal caregivers of these patients might experience a lower burden.

The integrated care pathway for geriatric rehabilitation was developed for patients with complex health problems, which is one out of the four classified patient groups in geriatric rehabilitation in The Netherlands. The other three groups are patients with a stroke, trauma orthopeadics and elective orthopeadics. Because the integrated care pathway is primarily focused on improving the logistical and organizational processes of care, it can probably be helpful for improving the care pathways of the other diagnosis groups in geriatric rehabilitation as well. Implementation here could also lead to a larger group of patients and informal caregivers taking advantage of the aforementioned effects.

Another target group benefiting of dissemination of the integrated care pathway on a wider scale are health care professionals working in hospitals, geriatric rehabilitation facilities and in primary care. These healthcare professionals often experience a high workload. When patient transfers between the organisations are not adequately organised, this might lead to extra work (e.g. when patient information is lacking or when patients are not adequately informed), incomprehension and disturbed relationships between the different healthcare providers. This not only can lead to decreased job satisfaction but it might also lead to stress among patients and informal caregivers and to inadequate quality of patient care. Professionals indicated that after implementation of the integrated care pathway, there was more and better communication between the different organisations, possible barriers were structurally dealt with and mutual understanding improved.

The last group of stakeholders who probably will benefit of wider implementation of the pathway are healthcare financers, such as health insurance companies and local municipalities. As shown in the economic evaluation, implementation of the integrated care pathway resulted in cost savings. These cost savings are mainly the result of a shorter length of stay in both the hospital and the geriatric rehabilitation facility. Furthermore, more patients are discharged back to the home situation instead of being institutionalized. As living at home is a cheaper alternative compared to living in a nursing home, this may be of interest for those who are in charge of financing this type of care. Therefore, implementation of the integrated care pathway in regular care might result in cost savings on a wider scale.

Dissemination of study results

The results of this study are currently being disseminated in a follow-up study entitled 'Sustainable implementation of the integrated care pathway in geriatric rehabilitation'. In this project, researchers work together with various stakeholders (i.e. patients, informal caregivers, professionals, healthcare insurers and local municipalities) to optimize the integrated care pathway on elements which were not fully implemented yet, and on improving elements of the pathway which were recommended by patients and informal caregivers during the process evaluation. Furthermore, this study focuses on the dissemination of the pathway and on reaching sustainable implementation of the pathway in regular care. This project aims to achieve the following objectives:

1. Optimization and (practical and financial) sustainability of the integrated care pathway;
2. Dissemination of the integrated care pathway in the south of the province of Limburg;
3. Country-wide availability of the integrated care pathway and its corresponding implementation materials.

Objective 1: Optimization and sustainability of the integrated care pathway

This objective constitutes of two parts: reaching optimization and practical sustainability of the pathway on the one hand, and reaching financial sustainability of the pathway on the other.

The optimization and practical sustainability of the pathway focuses on implementation of elements of the integrated care pathway which were not fully implemented yet, and on improving elements of the pathway which were recommended by patients and informal caregivers during the initial study. Also, we will make use of interviews with patients, a focus group with informal caregivers and group interviews with healthcare professionals to determine additional proposals for improvement. The results of these interviews will be discussed in a workgroup consisting of health care professionals directly involved in the care provision along the pathway and representatives of patients and informal caregivers. Based on these results, new elements will be added to the integrated care pathway and existing elements might be changed. Besides developing and/or changing elements of the integrated care pathway, local implementation strategies will be developed in order to reach successful implementation and sustainability of the optimised pathway.

As structural financing is often regarded as a requisite for sustainability of an innovation, reaching structural financing of the integrated care pathway within the Dutch healthcare system is an important part of the first objective of the project 'Sustainable

implementation of the integrated care pathway in geriatric rehabilitation'. We aim to reach structural financing by involving the possible financers of the pathway (i.e. the largest healthcare insurers in the region and local municipalities) in a workgroup. In this workgroup, all costs, benefits and effects of the integrated care pathway will be presented and discussed. Furthermore, a business case will be developed including all essential information for financers to make a decision about structural financing. This business case will be developed in collaboration with the possible financers and with representatives of patients and informal caregivers and will be disseminated to all healthcare insurers and other relevant stakeholders.

Objective 2: Dissemination of the integrated care pathway in the south of Limburg

This objective focuses on dissemination of the integrated care pathway among four organisations providing geriatric rehabilitation in the south of Limburg (MeanderGroep, Cicero Zorggroep, Zuyderland and Sevagram). These four organisations are chosen based on their partnership with the Academic Collaborative Centre on Care for Older People (AAC-OP). This academic collaborative centre is a formal multidisciplinary network consisting of Maastricht University, seven large long-term care organisations and Zuyd University of Applied Sciences.
As a first step, the four previously mentioned organisations will be visited by the researcher of this project to provide information about the integrated care pathway. After these visits, one or more meetings will be organized where the different organisations come together (both the organization who implemented the integrated care pathway and the four organisations previously mentioned). During these meetings, information will be provided about the content of the pathway and about the steps needed to implement (elements of) the pathway. Also, information will be exchanged about best practices in the different organizations. It is expected that this will lead to dissemination of the pathway. The organisations will also be offered help if they want to take further steps in the implementation of the pathway.

Objective 3: Country-wide availability of the integrated care pathway and its corresponding implementation materials

In order to disseminate the integrated care pathway on a wider scale (i.e. in the whole of the Netherlands), it is important to keep the integrated care pathway and its corresponding implementation materials available for care networks in the whole country. These materials should also be kept available on a structural base (also after termination of the current project). Therefore, we will invite several national interest groups which are involved as project partners (i.e. Actiz as representative of residential and

home care organisations, Patient Federation Netherlands as representative of patients, Verenso as the representative of elderly care physicians and 'BeterOud', the website of the National Care for the Elderly Program) if they are willing to take ownership of the materials. This includes keeping the materials available on their websites, as well as regularly updating the materials. If they are not willing or capable to take ownership of the materials, alternatives will be explored.

We hope that the outcomes of this study on the 'Sustainable implementation of the integrated care pathway in geriatric rehabilitation' will contribute to the structural integration of the care pathway in regular health care for older people in The Netherlands.

References

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