Portavita's Integrated Care System (ICS) helps to improve the care of fragile elderly

To ensure that fragile elderly are able to live at home longer, healthcare providers from different disciplines must work together. Crucial is sharing of information. GP's and geriatric specialist experiment in Northwest Utrecht with multidisciplinary cooperation in primary care under the supervision of knowledge centre Vilans. The Elderly Care module of Portavita supports this.

Two years ago Northwest Utrecht decided to start with a structural approach for the issue related to elderly care. Care Group 'Cooperatie Zorg NU' and three doctors initiated a working group of elderly care. The goal of this working group is to implement an integrated care program. This care programme contains the mapping of fragile elderly, to treat them subsequently in a multidisciplinary setting. Hereby general practitioners (GP's), general practice-based nurse specialists, district nurses, dementia advisers and geriatric specialists (GS's) cooperate closely. Crucial are communication and sharing information easily. The pivot in this multidisciplinary approach is the Elderly Care Module that Portavita's integrated care system offers. This ICS has already been implemented for integrated diabetes, Cardio Vascular Management and COPD treatment. A first experiment with geriatric specialists in the primary care is successfully completed. In April, the pilot will be expanded. The patient and caregiver therefore gain access to Portavita.

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Individual Care Plan

GP Eugenie Hodes is one of the initiators of this working group. 'The aim of the corporation is to be able to have a better picture of fragile elderly, so they can live at home independently for longer', she explains. To map this group a general practice-based nurse specialist or a district nurse visits the elderly. We use the Tra-Zag instrument (certified questionnaires). It took them around one and a half hour to get an insight. It's quite an investment. The added value is difficult to substantiate, but the results are promising. This makes it easier to customize the care plans. And now the care plans are in Portavita, we can communicate more easily during multidisciplinary consultation and if there are problems, we can switch faster. 'For each patient there is an Individual Care Plan (ICP) within the integrates care system.' On the basis of the authorization associated with the specific role it is possible for any discipline to work with it. In the ICP you can define problems, objectives, actions and evaluations' says Aloys Langemeyer, Director Sales & Services at Portavita. 'The patient / client record is an important part of the multidisciplinary consultation', says geriatric specialist Jos van de Water, who is also involved in this working group from the beginning. 'So it is essential that dementia advisers, district nurses and general practice-based nurse specialists have access.' The Elderly Care module contains a set of forms in which can be defined to what extent the elderly is self-reliant, for example regarding medication, but also their mood, memory loss and dietary habits, explains Langemeyer.

Consulting

The pilot started in 2014 based on this intensive multidisciplinary collaboration, supported by knowledge centre Vilans. Five general practices and three geriatric specialists are working together in this project. The GS's are requested in consultation with complicated casuistry with somatic problems or multi-morbidity, difficulty in movement and falling, diagnostics and behavioural symptoms of dementia. The GS went to visit the elderly and did a geriatric consultation. 'A GS works in a nursing home. They are used to look at all domains', according to Eugenie Hodes. The outcomes were given back to the GP. This process requires a significant time investment. Hodes: 'A consultation including a home visit takes a GS almost three hours per elderly. However, it is possible that a physiotherapist or a dietician pays a visit instead of a GS. 'Or a consultant,' says Jos van de Water. 'They can rely on our team, besides a GS we also have a geriatrician and psychiatrist in it. 'And there are proven results', says Hodes. 'The GS did 33 consultations. Otherwise 22 cases would have been referred to the hospitals.'

Patient central

The results from the pilot are encouraging. Cooperation Zorg Nu starts a follow-up in the beginning of April with a subsidy from ZonMW. Twenty GP practices will join. Patients and their main relative also gain access to Portavita. 'Via the secured Portavita Digital Logbook they can see their own patient file,' says Aloys Langemeyer. 'Here they can see their results and read back what was discussed during consultations. And the messages they send become part of the personal dossier.' This puts the patient even more central in the chain, according to Hodes. Langemeyer adds: 'You can share information anywhere. The general practitioner or specialist is the director, who works together with the patient or caregiver who is involved in the care.'<<