UCLouvain
Institut de recherche santé et société (IRSS)

# Frailty and Interprofessional Collaboration within primary care level

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Belgian Frailty day
Sciensano
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# Belgian healthcare system challenges

- **The Belgian population** is aging (OECD, 2011):
- About 17% of Belgium's population is aged over 65 (OECD average 15%)
- 5% is aged over 80 (OECD average 4%)

Prevalence of frailty increases with age

- And suffering from chronic diseases (WIV-ISP, 2013):
- 28,5% of the Belgian population suffer from at least one chronic disease (2013)

Associated with having higher rates of comorbid chronic diseases and disability

# Increased use of emergency departments

**Globally**, the fastest growth has been observed among (Lowthian, 2011):

- Patients aged above 65 years, especially those above 80 years
- Patients with chronic illnesses

**In Belgium**: Survey assessing patient perceptions of continuity of care between their GP and the ED (2017):

| Characteristics of the participants | Category | total (N=501) |
|---|---|---|
| | | n (%) |
| **Morbidity** | Chronic disease | 235 (46,9) |
| | Acute illness | 259 (51,7) |
| | Missing | 7 (1,4) |
| **Age** | 18-64 | 276 (55,1) |
| | 65-79 | 120 (24) |
| | 80 et + | 102 (20,4) |
| | Missing | 3 (0,6) |

# Individual characteristics

**Proportions of patients with low perception of COC with regard to demographic factors (N= 501)**

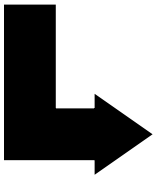
| | | Age | | |
|---|---|---|---|---|
| | | 18-64 | 65-79 | 80 and over |
| **Informational Continuity** | Professionals know my medical history | **36.7** | 26.7 | **17.7** |
| | | 23.1 | 17 | 16.8 |
| | My GP is aware of the instructions of the EP | **28.6** | 24.6 | **12.8** |
| | The EP is aware of the instructions of my GP | **34** | 23.3 | **21.1** |
| | | | | |
| **Management Continuity: Care Coherence** | My GP agrees with the instructions of the EP | 9.4 | 8.5 | **0** |
| | My GP and the EP communicate | **42.3** | 30.4 | **26.8** |
| | | 11.2 | 9.09 | 7.9 |
| | the EP repeats the tests | **66.9** | 58 | **50** |
| | | 10.4 | 19.1 | 12.7 |
| | | 17 | 11 | 8.7 |
| | | 12.1 | 9.4 | 6.8 |
| | | | | |
| **Management Continuity: Accessibility between levels** | My GP informs the EP of my arrival to ED | **49.4** | 38 | **35.2** |
| | | 10.2 | 12.5 | 17.2 |
| | | 21.2 | 24.5 | 19.1 |
| | | 18.6 | 21.2 | 22 |

- Older people are shown to express greater satisfaction with the care received (Bowling, 2013)
- They have more realistic expectations (Bowling, 2013)
- They have a better knowledge of the system (Aller, 2013)

# Mixed - Methods Approach

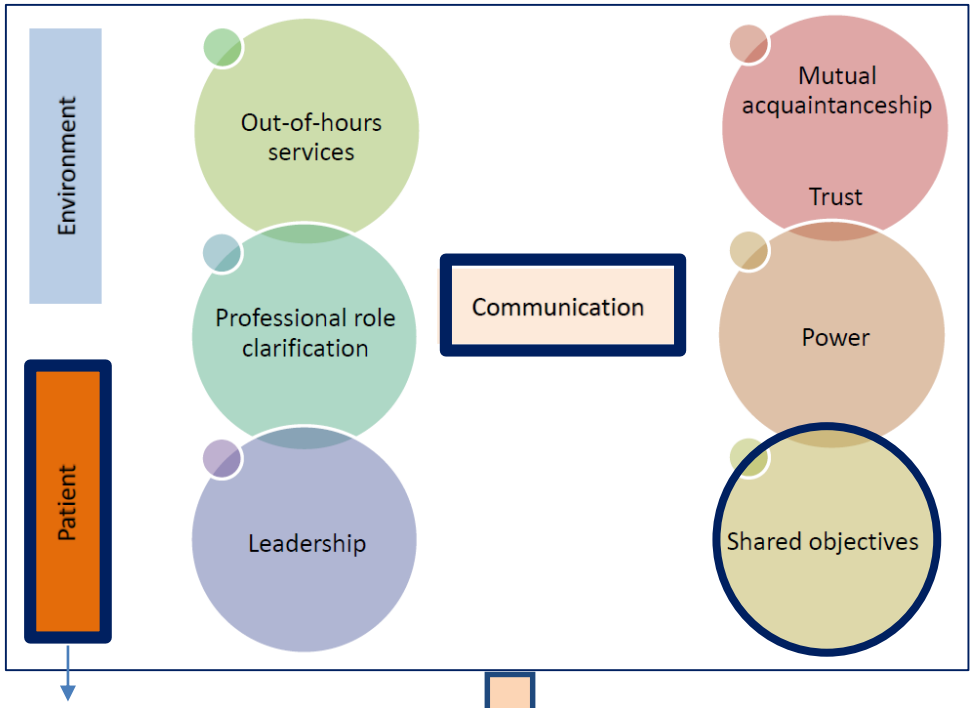
Qualitative analysis of interprofessional collaboration

What are the experiences of interprofessional collaboration between these two levels of care?



Quantitative analysis of patients perceptions

How do patients perceive the continuity of care between their GP and the ED teams in the French-speaking regions of Belgium?



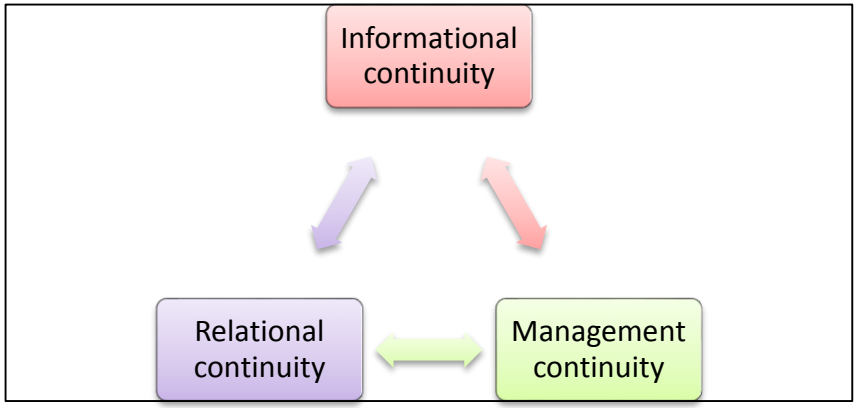

Older frail adults

- Negotiation and shared decision-making:

« *a positive experience is when they help us with the decision-orientation for elderly: … should the patient be kept hospitalized? discharge home? Does he have informal caregivers?...* » (ED)

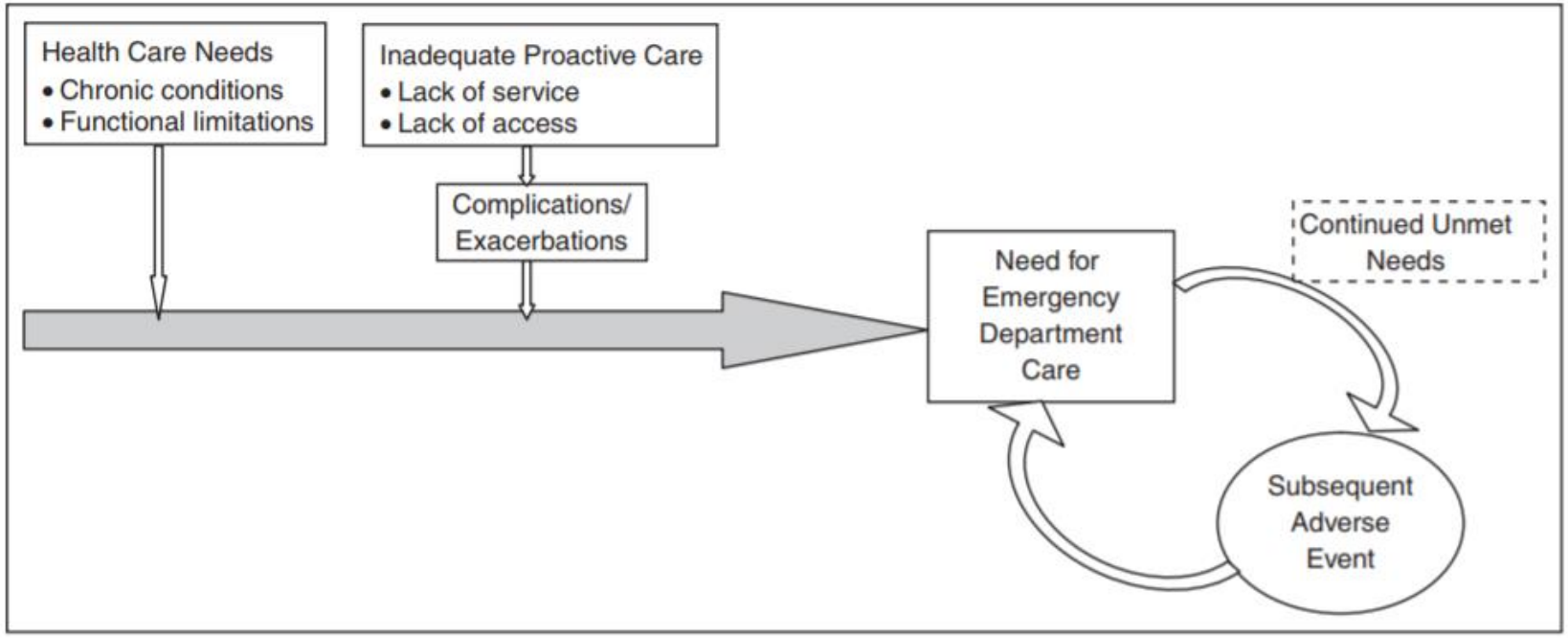
- Phone calls = direct interaction !

« *……it reassures him to be expected, to be taken seriously, and to know that his caregivers are discussing his condition and agree upon his care plan* » (GP)



A large proportion of older adults require hospital care at the time they present to the ED, yet lots of visits could be avoided through early prevention and increased access to primary care level:

Conceptual model illustrating factors that influence emergency department use by older adults




Gruneir, A., Silver, M. J., & Rochon, P. A. (2010). *Review: Emergency Department Use by Older Adults: A Literature Review on Trends, Appropriateness, and Consequences of Unmet Health Care Needs. Medical Care Research and Review, 68(2), 131–155.*

- Not having a GP or having a low degree of care continuity → higher rates of ED use
  (45% more lokely to visit the ED) (Ionescu-Ittu, 2007)
- 20% of ED visits by older adults in the community could be prevented with better primary care (Carter, 2006)
- Older adults with home care visit ED more frequently than older adults in nursing homes (70,1% vs 34,8%) (Wilson, 2005)
- ...

**A stronger primary care**

↓

improved population health

**lower** healthcare services utilization (and **ED use**)

providing the appropriate care for patients, at the right moment, and the right level of care, with the right human and material resources.

Recruitment and retention of GPs

- recognizing the essential role of GP,
- reinforcing general practice,
- improving working conditions,
- providing financial incentives,
- Re-thinking the current payment system

Improving the availability of material resources and diagnotic facilities

Patient/ Community participation

Investing in workforces' skills and expanding the role of nurses

Promoting Interprofessional collaboration within primary care level

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Interprofessional collaboration between general practitioners and home nurses in Belgium

1. Assessing IPC between GPs and nurses

2. Identifying target priorities for improving IPC

3. Endorsing participants' improvement projects.

Diversity of practices, payment systems, environment, and resources

| | Neufchateau | Bertogne | Wanze | Ciney | Gilly | Mons |
|---|---|---|---|---|---|---|
| **Province** | Luxembourg | | Liège | Namur | Hainaut | |
| **GPs** | Solo | Solo | Mono group | CHC (FFS) | CHC (capitation) | Mono group |
| **Nurses** | Group/ multi | Solo / multi | Mono group | | | solo |
| **GPs density/ 1. 000 pop** | 0,53 | 1,14 | 0,72 | 1,04 | 0,8 | 0,75 |
| **Rural/urban** | rural | rural | urban | rural | urban | urban |
| **Poverty** | | | | | ++ | ++ |

Each group performed a **SWOT analysis** of their collaborative practice

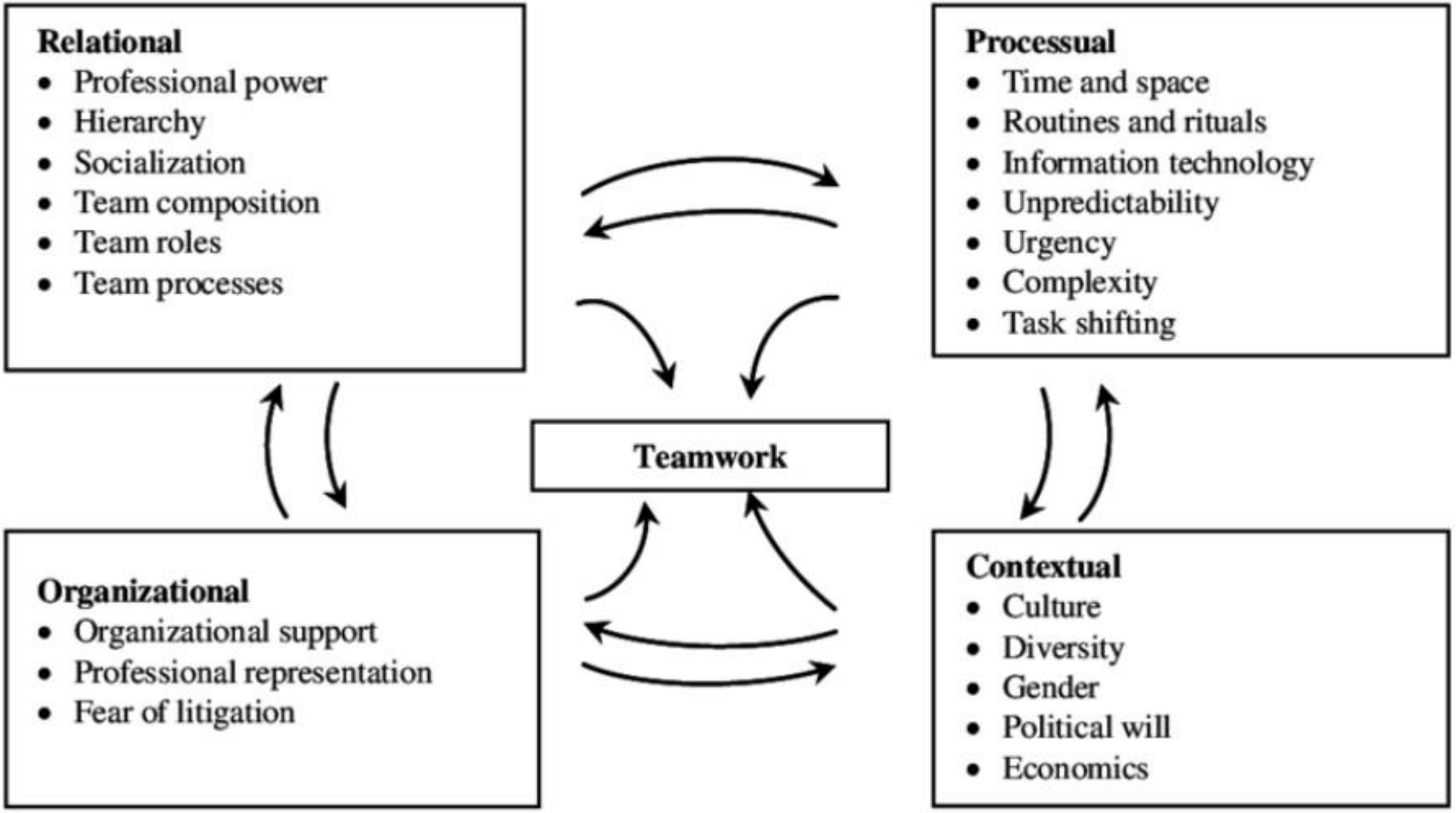
Each group **prioritized an action** to be undertaken within their specific context

Two issues were co-identified as common priorities and studied in depth (qualitative method, survey, experts consultation)

**Communication**

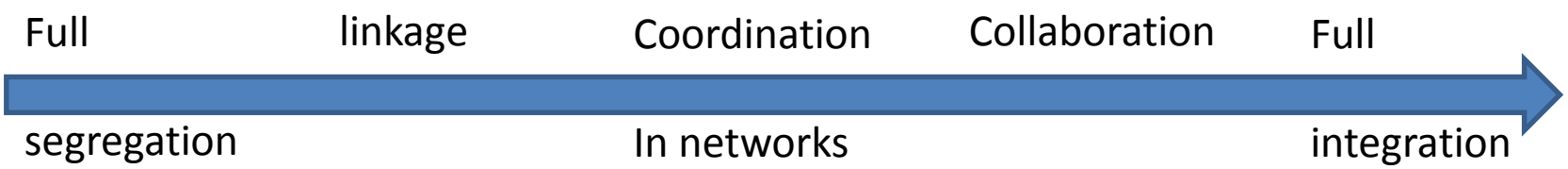
**Task delegation**

# Combined SWOT analysis




Source: Reeves et al.(2010). Interprofessional Teamwork for Health and social care

- Collaborative practice between GPs and Nurses is **variable**



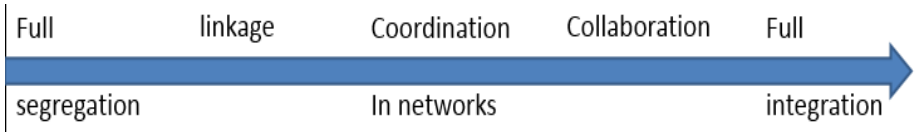

- Shared patients list
- Shared health records
- Pooled resources
- etc

# Results

**Relational**
- Professional power
- Hierarchy
- Socialization
- Team composition
- Team roles
- Team processes

**Strengths**
- Shared power and responsibilities
- Knowing each other
- Trust
- Shared values
- Previous positive experiences of IPC
- Recognition of each other's competencies and specific roles
- Small size of a team

**Weaknesses**
- Hierarchical relations
- Lack of trust, lack of consideration
- Lack of responsibilities clarification



# Results

| Strengths | Weaknesses |
| --- | --- |
| • Shared procedures and clinical guidelines<br>• Communication tools: coordination notebook, emails, shared EHR, regular meetings…<br>• Shared spaces | • Lack of shared patients list<br>• Difficulty in identifying patient's caregivers<br>• Informational discontinuity |

**Processual**

- Time and space
- Routines and rituals
- Information technology
- Unpredictability
- Urgency
- Complexity
- Task shifting

# Results

**Organizational**
- Organizational support
- Professional representation
- Fear of litigation

| Opportunities | Threats |
| --- | --- |
| • Access to clinical guidelines<br>• Access to continuing education programs | • Heavy workload |

# Results

| Opportunities | Threats |
| --- | --- |
| • Capitation payment system<br>• Political will to tackle the challenge of shortage | • Lack of integration strategies (…)<br>• Lack of clear vision of primary care level mission and role<br>• Lack of a nursing order |

**Contextual**
- Culture
- Diversity
- Gender
- Political will
- Economics

# Recommandations

**Communication** could be supported locally by improved ICT tools, and dedicating time for multidisciplinary team meetings

On a more macro level, recommandations include:

- Promoting the existent information sharing system
- Creating opportunities for multidisciplinary concertation
- Promoting multidisciplinary group practices (shared patients population, communication tools, spaces and resources, capitation payment system, …)

# Recommandations

**Task delegation** is a more challenging issue to address

Recommandations include:

- Promoting and supporting group practices
- Establishing care trajectories/pathways for chronic patients within the PC level
- Skill development (Bachelor level, specialisation, and advanced practice nurses)
- Facilitating task delegation from nurses to nurse aids
- Creating a legislative framework for Advanced Practice Nurses

# Conclusion

"*Integrated health care for seniors, and especially for frail seniors, requires competency in three broad areas:*

- ✓ *geriatrics,*
- ✓ *interprofessional practice,*
- ✓ *and interorganizational collaboration*" (Ryan, 2013)

- Interoganizational Collaboration poses an even bigger challenge than promoting interprofessional collaboration
- Putting people together within the same organizational walls is not sufficient
- First steps shall include getting to know each other and developing a **shared vision on primary care level mission and role, but also on frailty.**

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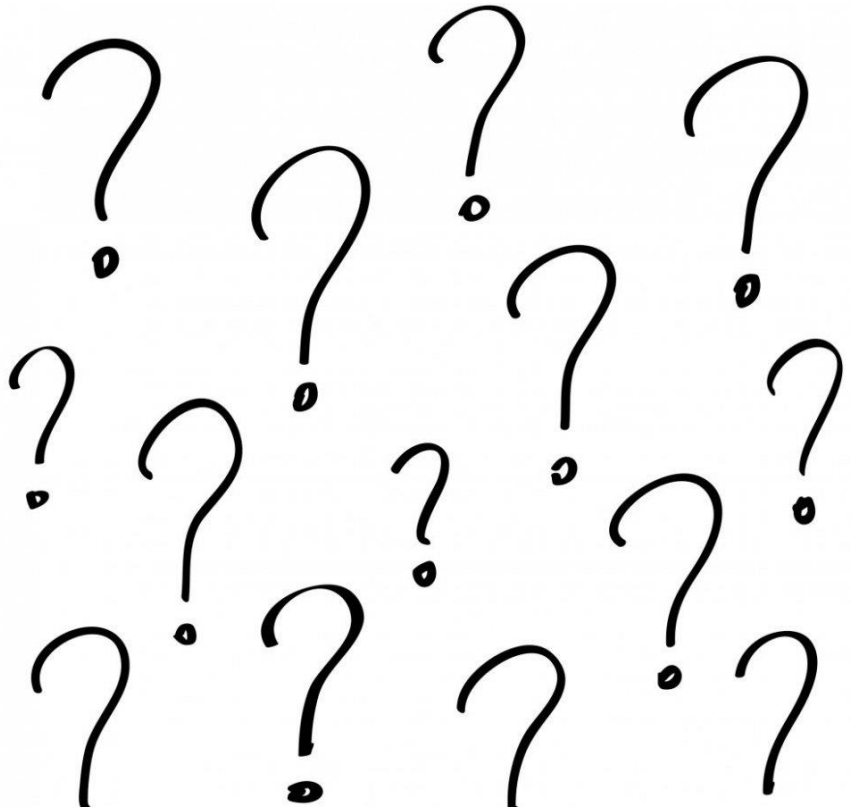

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