25 Improvement Points – Position Paper on Strong medical care for vulnerable seniors

The position paper of the Royal Dutch Medical Association (KNMG) entitled 'Strong medical for vulnerable seniors' sets out proposed improvements to the care physicians provide to vulnerable seniors. These improvement proposals were put forward by general practitioners, geriatric care specialists and medical specialists themselves. The extensive description and explanation in the position paper can be summarised as the 25 improvement points set out below. The full position paper and more information on care for the elderly can be found in the KNMG's special web file.[1]

Vulnerable seniors living in their own home

1. Unless a counsellor has been designated, the *general practitioner will be the central contact person for vulnerable seniors*. The GP will always be the central contact person in the event of acute medical problems. In all hospitals *a physician specialised in clinical geriatric care always acts as contact person for general practitioners and geriatric care specialists*.
2. General practitioners assess potentially vulnerable seniors *(case finding for vulnerability)* by means of a *multi-domain analysis* (physical, mental, social aspects).
3. A *care&treatment plan is set up for every vulnerable senior*, which defines and aligns the objectives of the care (home care) and treatment (GP).
4. *Standardisation and automation* of multi-domain analysis and care&treatment plan for use in the general medical practice.
5. There is *one common electronic domain for everyone involved in care of the elderly in the home situation*, in which the multi-domain analysis, care&treatment plan and guidance are drawn up and/or laid down.
6. There is structured collaboration *("home team")* between the person responsible for the treatment plan (the GP), the person responsible for the care plan (e.g. the assistant practitioner, the home care nurse or the nursing home nurse, or the counsellor) and any other counsellor involved. All care&treatment plans are drawn up and updated within this collaboration.
7. *All vulnerable seniors are screened for polypharmacy at least once a year*; this is organised in all general practices under the responsibility of the general practitioner. The general practitioner also ensures that in *all existing cases of polypharmacy, the medication is optimised at least once a year*.
8. The general practitioner is responsible for *active intervention in (possible) cases of worrying care avoidance*.

Vulnerable seniors living in a nursing home

9. All residents of a nursing home are regularly and *systematically screened* for vulnerability and a *care&treatment plan is drawn up for every resident*. The general practitioner and the geriatric care specialist agree who is to be responsible for the treatment plan. The nursing home is responsible for the care plan. The general practitioner/geriatric care specialist shall call the nursing home to account if no care plan is in place.
10. General practitioners and geriatric care specialists *make agreements on the detection of epidemics in nursing homes*, and respond to signals.

[1] www.knmg.nl/ouderenzorg

11. It is the responsibility of the nursing home to establish *a multidisciplinary consultative team, similar to the home team in the home situation, in every nursing home*, to enable the realisation of the proposed solutions (standardized problem analysis, drawing up of a care&treatment plan, and establishment of guidance). The physician responsible for the patient's medical treatment plan shall call (the management of) the nursing home to account if no care plan is in place.
12. The patient's own physician is responsible for ensuring that *carers' observations are taken into account in the care&treatment plan*. General practitioners and geriatric care specialists make clear agreements with carers and helpers regarding the detection of health problems and act as a sounding board for physicians or nurses interpreting carers' health-related observations.
13. All general practitioners and all geriatric care specialists providing care to patients in any one nursing home will mutually cooperate to realise the aforementioned solutions. Upon *admission to a nursing home, patients will be asked to change doctors (once)*, to limit the number of physicians associated with each nursing home.

Vulnerable seniors receiving care in hospital (clinical or as an outpatient)

14. With regard to clinical or outpatient treatment and post-hospitalization care *data should be pooled* for the patient's physician (general practitioner or geriatric care specialist). Conversely, information regarding primary health care treatments and primary health care policy should also be pooled for the benefit of the hospital.
15. The primary practitioner of vulnerable senior patients living independently (general practitioner or geriatric care specialist) is responsible for ensuring that an *up-to-date core file* (1 A4) is kept *for every vulnerable senior*, containing core information (problem list, medication, emergency policy including reanimation policy). This core file must be accessible in acute situations. The actual form of the file will depend on where the patient is living (own home, nursing home) and the options available at that location.
16. The *medical policy during hospitalization should be in line with the existing primary medical policy*. A clearly defined discharge procedure and after care programme is in place for vulnerable patients, including after care as an outpatient. A patient is not to be discharged until care and treatment have been agreed with the referring practitioner. Hospital physicians are to have 24/7 access to the referring practitioner's patient file.
17. Every hospital should provide *a one-stop service for integrative care under the direction of a medical specialist with clinical and geriatric competencies*. He or she will ensure that a patient's medical care (diagnosis and treatment) is organised, arrange for the provision of integrative (medical) care and make arrangements with the referring practitioner with regard to the coordination and cohesion of the care provided.
18. Vulnerable elderly patients with serious (semi)acute somatic problems combined with psychiatric or functional problems are to be admitted for diagnosis and treatment *in a clinical department led by a medical specialist with clinical and geriatric competencies*.
19. Upon admission to hospital *all patients aged 65 and older are screened for vulnerability* with the aid of a screening instrument. The objective of this is the early identification of vulnerable patients and the timely implementation of measures aimed at avoiding complications. The care focuses on preserving functions and, in particular, on preserving independence.
20. At least *the 'organ specialist' and a generalist with clinical and geriatric competencies* must be involved in treatment of every vulnerable elderly patient in the hospital. They agree who is to act as contact for the patient and family, who is to have final responsibility, and who is to be responsible for care coordination. In the KNMG model, these three responsibilities are borne by the organ specialist during the acute stage and the generalist (a medical specialist with clinical and geriatric competencies) during the post-acute stage.
21. Hospitals set up *geriatric teams*: multidisciplinary teams in which care providers involved in the geriatric hospital care collaborate closely to enable the provision of integrative care. The geriatric team could be expanded to include external consultants such as a geriatric psychiatrist or a geriatric care specialist. The geriatric team is responsible for the daily monitoring of the most suitable time to discharge the patient; the team starts this monitoring as soon as the patient is admitted. A decision on when to discharge the patient is

22. only taken in consultation and agreement with the referring practitioner. The geriatric nurse practitioner plays a key role in the geriatric team by monitoring the optimal circumstances for the implementation of the care and treatment plans.
23. Hospitals provide a *senior-friendly environment* to enable as speedy a recovery as possible in terms of somatic, psychic, functional and social aspects. In this environment, extensive consideration is given to the limitations that come with old age. Important decisions are always assessed on the basis of these principles. It is essential that the hospital has a geriatric department that, at least, includes outpatient, day-clinic, consultation and hospitalization facilities.

Information exchange between (primary) referring practitioner and (secondary) practitioner.

23. The referring practitioner will provide a (written or electronic) *referral for hospitalization*, giving relevant information about the (treatment of the) patient and the agreements between the referring practitioner and the practitioner regarding the (method and frequency of) communication between them, consultation, coordination and file creation. At least the referring practitioner will be appropriately informed on the days of admission and discharge, any radical changes to the medical policy / care&treatment plan will always be discussed with the referring practitioner, and any changes to the medical policy / care&treatment plan will be clearly noted upon discharge.
24. The referring practitioner will provide a (written or electronic) *referral for an outpatient visit*, giving relevant information about the (treatment of the) patient. The referring practitioner will be informed of any changes to the medical policy / care&treatment plan within 10 days after the first outpatient visit. In the event of subsequent outpatient visits, this is once every three months. Any radical changes to the medical policy / care&treatment plan will always be discussed with the referring practitioner.
25. If a vulnerable elderly patient is *admitted during the locum tenency* of a primary practitioner, the medical specialist concerned will telephone the patient's general practitioner / geriatric care specialist the next day to agree the care&treatment plan and to complete the referral information.