Gezondheidsraad
Health Council of the Netherlands

To the State Secretary of Health, Welfare and Sport

Subject	: Advisory letter *Multimorbidity in the elderly*
Your reference	: DVVO-U-2598119
Our reference	: U-1098/RvdS/tvdk/782-I
Date	: September 11, 2007

Dear State Secretary,

On 26 October 2005, your predecessor asked the Health Council of the Netherlands to advise on co- and multimorbidity and aging and on a strong 'geriatric function', to be developed in the Netherlands for elderly individuals with multiple medical conditions. The Health Council and Council for Health Research jointly appointed a 'Multimorbidity in the elderly' Committee in order to address these questions, which will complete its advisory report late next year. In anticipation of said advisory report, upon the explicit request of the Long-term Care Department of your Ministry, we hereby present a number of the Committee's key conclusions and recommendations in order to allow them to be available for determination of policy. The advisory report itself will elaborate and support the recommendations further.

Scope and nature of the problem

Research performed on request of the Committee confirms multimorbidity is common in the elderly. About two-thirds of people between the ages of 65 and 75 have more than two chronic conditions that require medical treatment and care. In the very oldest (85 years and older) about 85 percent suffer from more than two medical conditions. The presence of more than one chronic disease is not always problematic. This is the case for mild stages of diseases, for example, or if conditions have few to no effects on daily functioning. However, the combination of multiple conditions regularly leads to disorders, limitations, handicaps and loss of well-being. This situation is particularly common among older patients, in whom vital functions and the capacity to compensate for the physical and psychological consequences of disease start to decrease. In these elderly individuals with complex multimorbidity, it is often difficult to unravel the causes of the problems, and the effects of treating individual diseases are often different than expected. Treatment recommendations for one condition may also be in disagreement with recommendations for another. The standard approach within our healthcare system (which focuses on the treatment of individual conditions) is unsuitable for this group. The required diagnostic investigations and treatment are often a huge burden. The concurrent help provided by various medical specialists

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and other care providers also easily leads to poorly coordinated care, which in some cases (polypharmacy) can even be a risk to the patient. Finally, only treating conditions is often not enough for this group. In these elderly patients in particular, a great deal of quality of life may be maintained by preventing further limitations to their normal daily activities and contacts with other people. In short, this group requires that additional attention be given to a variety of issues, such as the integration and continuity of medical and nursing care, preventing further limitations and social drop-outs, and the bearing capacity of the patient and his family and informal carers.

Four goals in care for elderly people with complex multimorbidity

The Committee notes that the health care system in the Netherlands is not tailored to elderly patients with complex multimorbidity. There is a clear separation between various levels within our health care system. The specialist second line is further subdivided into fairly autonomous subspecialties with a strong focus on treating one specific disease. As such, the system is less well equipped for monitoring interactions between various treatment regimes and setting treatment priorities taking into account the patient's well-being or with the aim of preventing problems of old age. In order to realise the integrated care and treatment so desirable for this target group, existing health care patterns will have to be reinvented. The professional care system is faced with the following four tasks.

a Timely signalling of health risks in complex multimorbidity.

Timely signalling of health risks is of major importance in order to prevent unnecessary loss of quality of life and initiate suitable care in time. Signalling may occur via existing care contacts, within specific screening programmes, but the family or social network may also play a role. As research to date into the possibilities for prevention has yielded varying results, the Committee feels significant further development is desirable in this area.

b Managing care for individual patients with complex multimorbidity in primary care.

Most elderly people live at home or in decentralised, small-scale housing. This is also true for those with multiple conditions. The care demands in this segment will increase. In order to achieve coherent care offerings in primary care, better management is required when defining the content and organisation of care. This care not only encompasses medical treatment, but also nursing care and support, home care, as well as all activities required for patient hand-offs between care providers.

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c Specialist advice from secondary and tertiary care.

In order to keep care provision in the primary care for as long as possible, care providers should be able to obtain targeted, coherent diagnostic and therapeutic advice from the specialised second line. This consultation of secondary care should be embedded structurally, and be directed from the departments of geriatrics/clinical geriatrics, in close cooperation with other specialties. It should be possible to briefly admit elderly patients (via day hospital or short stay admissions) for diagnostic testing or treatment recommendations. For recommendations about long-term care, a similar function should be created in tertiary care. In both cases, both general and mental health care should be safeguarded.

d Application of specific knowledge in a clinical setting.

Adequate care for elderly patients with complex multimorbidity assumes, in addition to knowledge of the typical conditions and problems of the elderly and their interrelation, specific knowledge of methods for maintaining and restoring the self-sufficiency of the elderly. This knowledge is multidisciplinary in nature, and focuses on effectuating the above-mentioned consultation in the first line, developing specific care pathways within clinical and ambulatory geriatrics/clinical geriatrics, and on liaisons with other fields in order to improve care pathways for people with multimorbidity there too.

Working towards coherent care for elderly with complex multimorbidity

Current care is not good enough for elderly patients with complex multimorbidity. Therefore, increasing numbers of initiatives are being deployed in the Netherlands, as well as in a number of surrounding countries, to improve care for the elderly with complex multimorbidity. Although further assessment research is required to determine how to best organise this care and possibilities are further strongly dependent on local and regional situations, it is clear that a facility addressing the four tasks -mentioned above must be created.

Medical care for elderly patients with complex multimorbidity living at home is, in the opinion of the Committee, primarily a task for the GP and other primary care providers. The Committee shares the position of the Dutch College of General Practitioners (NHG) that the GP should ensure a care and treatment plan is developed for these elderly patients. This plan records how to offer treatment and care in a coherent fashion via a care network of primary, secondary, and tertiary care. Of course, the GP must be able to obtain advice from medical specialists and other care providers.

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Recommendations

The Committee believes that professionals within a certain region (such as GPs, nursing home doctors, clinical geriatrists/geriatric internists, geriatric psychiatrists) and organisations (hospitals, pharmacists, home care organisations, nursing/care homes, geriatric mental health institutions) should make regional agreements together with insurers about the content and organisation of care pathways for elderly patients with complex problems with regard to the tasks above. The initiative for creating these agreements may be taken by a variety of groups or organisations. A possible option is for university medical centres and larger training hospitals take the initiative, as they have access to the required expertise. Another option could be for one or more professional groups to take the initiative and make agreements with the organisations and institutions involved about the content of care and who will coordinate the required care pathways.

In order to support such initiatives and the further development of the geriatric function, the Committee recommends taking or reinforcing initiatives in the following four areas: information infrastructure, training and follow-up education, scientific research, and preconditions for the desired geriatric function.

a Availability and accessibility of information.

A first recommendation is accessibility of relevant medical information about the patient for all care providers involved. The availability of an accessible, up-to-date electric medication dossier is of vital importance, even if only taking into account the potential risks of polypharmacy, which can already be present in cases of mild multimorbidity. Developments in this area are promising and should be stimulated strongly. Of course, accessibility of data other than medication use is equally important. Developments in this area are less swift, but regional care agreements must also include clear agreements about the content and execution of medical information exchanges. Both the content-level and technical development of the electronic patient dossier (EPD) should, in the opinion of the Committee, be stimulated even more strongly.

b Training and follow-up education.

Coherence and coordination of care for the elderly with complex multimorbidity assumes specific medical and nursing expertise in the this area in the professionals involved. This requires additional training and (follow-up) education. Joint training modules have proven extremely suitable in promoting interdisciplinary cooperation. The Committee therefore recommends that additional education on multimorbidity be offered in an interdisciplinary setting, accessible to not only doctors (GPs, nursing home doctors, clinical geriatricians, geriatric internists, geriatric

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psychiatrists, surgeons, neurologists) but also nurse practitioners, paramedics and psychologists. This training should – in addition to medical content (such as possibilities for maintenance and recovery of function in the elderly and medical options for typical geriatric conditions) – also address cooperation in a care pathway and, in particular for GPs, how to realise the directing or coordinating role.

c Research.

During the course of its work, the Committee noted that scientific evidence for both content and organisation of medical and nursing care for the elderly with complex multimorbidity is exceedingly scarce. The Committee therefore recommends initiating a coordinated research effort to address the largest gaps. In its advisory report Research into medical care for the elderly (2006), the Advisory Council for Health Research outlined the requirements. In the specific field of care for the elderly with complex multimorbidity, the following topics have priority:

- knowledge about the scope, nature and determinants of complex multimorbidity and targets for prevention
- instruments/methods for timely signalling of complex multimorbidity
- diagnostic methods and treatment strategies in patients with complex multimorbidity, for example somatic-psychiatric multimorbidity.

In addition to developing new medical and care knowledge, the systematic development and scientific assessment of care models is of vital importance. In order to develop a more evidence-based geriatric function, it is desirable for intensive cooperation to develop between good research groups and clinical institutions. Strengthening cooperation between practice and research fields, such as the development of academic workplaces and the ZonMw proposal for a national Geriatric Care programme, deserves strong support.

d Preconditions for the desired geriatric function

Particularly in the early stages, building up the desired regional care pathways and realising cost-effective coordination will require additional time and means. In order to permanently offer the desired geriatric function, additional means will also be required in the longer term. For example, the GP will have to be able to give this group of elderly patients a longer consultation. Furthermore, sufficient numbers of well-trained nurses will have to be available to perform the required care, and the advice and consultation desired will require additional efforts from the secondary care. This is also true for the desired scientific assessments and the experiences garnered.

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The Committee recommends that the government stimulate initiatives in this area by ensuring the required financial support is provided. A number of conditions can be set, for example about the nature of the functions that must become available and the readiness for systematic assessment.

Costs and benefits

The Committee believes the realisation of the care pathway described above can lead to cost savings in the longer term. For example by preventing various parallel ambulant care chains, limiting the number of hospital admissions and swift re-admissions, preventing or postponing intensive care-dependence due to previously inadequate medical treatment and care, or by more cost-effective deployment of professionals. However, targeted investments will be required in the short term in order to develop a widely available, effective geriatric function.

In closing

During the period the advisory report was being drafted, various organisations expressed their interest in working towards improving care for the elderly with complex multimorbidity. The recent positions from various scientific and professional organisations, as well as a joint statement from the university medical centres indicate that ‘the field’ is willing to initiate developments. The task is now to make this willingness concrete based on the above-mentioned recommendations. The professionals themselves have the most important task in this process. The government may be expected to provide them with the necessary support, and the Committee trusts its recommendations will help in doing so.

Yours sincerely,

(signed)
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(signed)
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