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Aging in place: de specialist ouderengeneeskunde als community-geriatrician

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soon

Twee onderdelen:

- ***EUGMS presentatie: the Dutch changing geriatric landscape***

- ***Preview resultaten onderzoek Beter Thuis met huisarts en specialist ouderengeneeskunde***

21st EuGMS

REYKJAVIK, ICELAND

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New landscapes in geriatric medicine

EuGMS

European Geriatric Medicine Society

Fostering geriatric medicine across Europe

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Deel 1: The Dutch changing geriatric landscape

Overview

Aging in place

Background

Organisation (an reimbursement) of medical care for older adults in the Netherlands

Changes in geriatric medicine in the Netherlands

Training of future residents

Conclusion

Aging in place

WHO (2004) definition of the concept Aging in place

Meeting the desire and ability of people, through the provision of appropriate services and assistance, to remain living relatively independently in the community in his or her current home or an appropriate level of housing.
Ageing in place is designed to prevent or delay more traumatic moves to a dependent facility, such as a nursing home.

Aging in place

Global increase in number of older adults

- Older adults live more years with chronic morbidities

Increase in aging in place

- Preferred by older adults
- Benefits:
  - Improved quality of life
  - Reduced (healthcare) costs
  - Increased social connectedness

Challenges to aging in place:

- Accessibility proper (health)care and services

Background

Policy

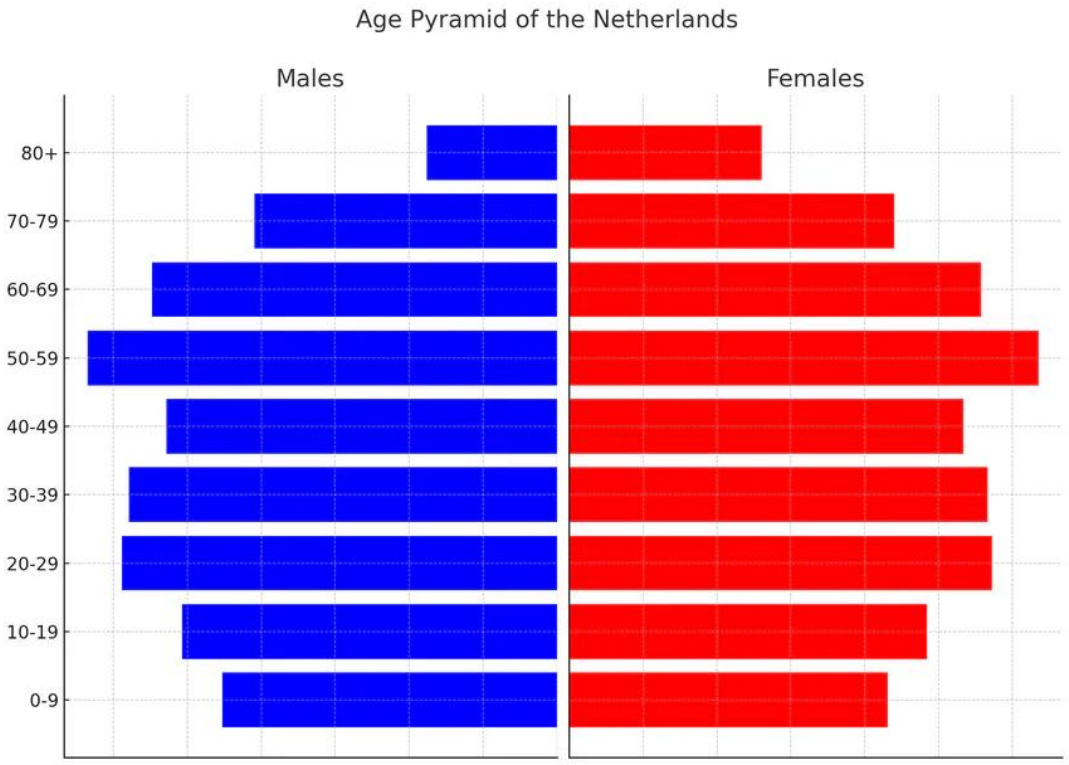
- The Dutch government like most developed countries promotes "aging in place“[1] and more home care services [2]
- Goal: Keep people out of institutions [1]

Motivators:

- Quality of care: better for older adults/patients
- Demographics related: care need is rising steeply and workforce/financial resources are not keeping pace

[1] Ciacci, A. (2022). Cost-containment long-term care policies for older people across the Organisation for Economic Co-operation and Development (OECD): a scoping review. *Ageing & Society*, 44(9).
[2] Lee, J., & Kwon, S. (2022). Comparative Analysis of Long-Term Care in OECD Countries: Focusing on Long-Term Care Financing Type. *Healthcare*, 10(11).

Background



Life expectancy at birth, 2021: 81.4 years

Population aged 65 and over: 2021: 19.7%; 2050: 24.8%

Population aged 80 and over: 2021: 4.8%; 2050: 10.3%

Limitations in daily activities in adults aged 65 and over, 2021: Some Limitations: 42%; Severe Limitations: 8%

Adults aged 65 and over receiving long-term care, 2021: 11.7%

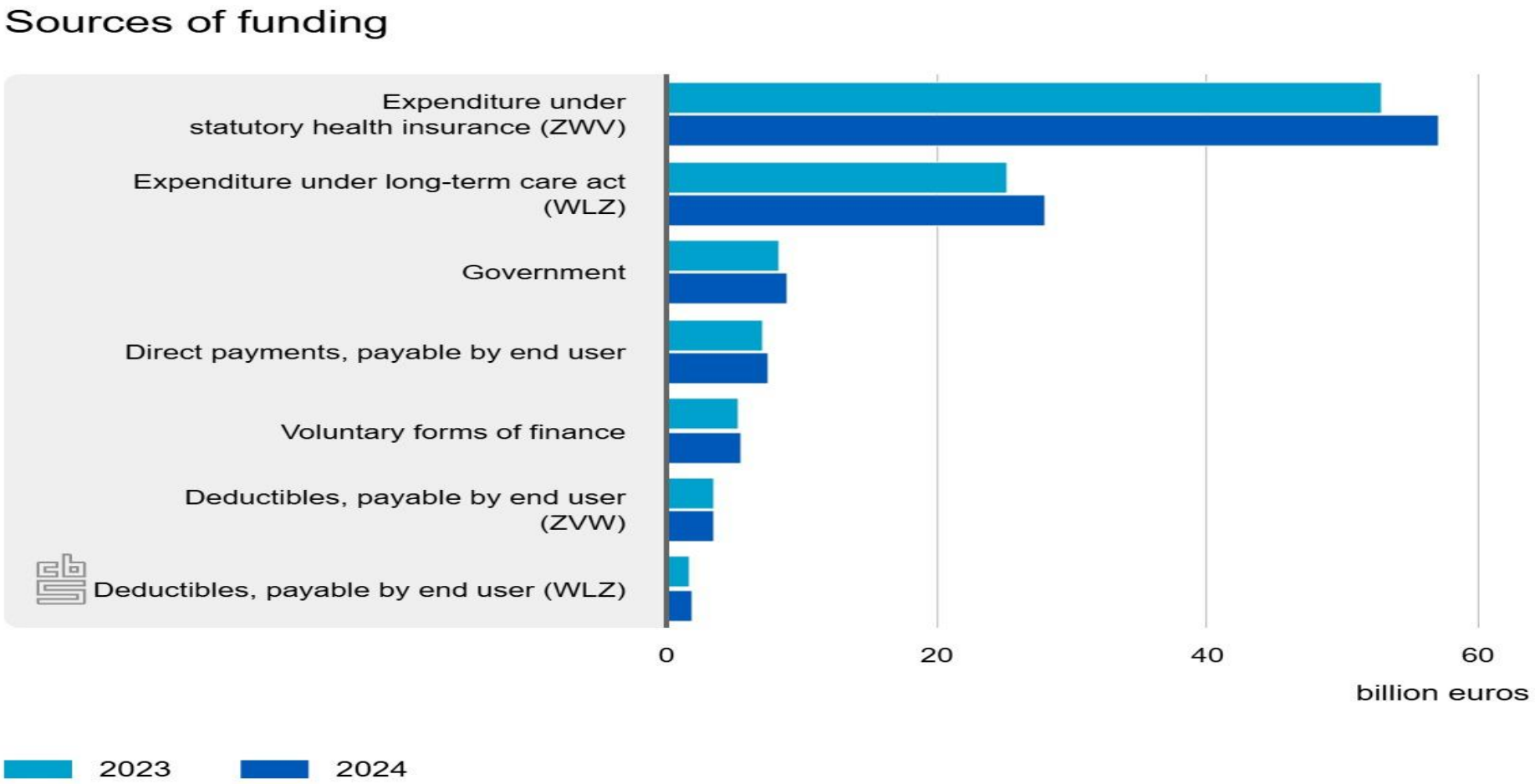
Source: OECD (2023), Health at a Glance 2023: OECD Indicators, OECD Publishing, Paris, doi.org/10.1787/7a7afb35-en.

Medical care for older adults in the Netherlands

GP (gatekeeper); hospital geriatricians (and other hospitalists); elderly care physicians (NHs/community); old age psychiatrists.

All of them work in teams with nurse specialists/PAs and with district nurses.

Medical care for older adults in the Netherlands



Non medical support at home is regulated by the Social Support Act, carried out by municipalities.

Changes in geriatrics last 10 years

Hospital geriatrics

- Specific care-units for frail older patients and for older patients with hip fractures (interprofessional collaboration)
- Experiments with community ‘hospital’ units outside the hospital
- Focus on out-patient clinics (for example: fall prevention, cognitive problems: geriatric giants)
- Focus on transferring care/follow-up to GPs when possible

Effects on hospital care use (2013-2023)

- Admitted persons (65-80y)/year: 300.000/year stable over time
- Total admissions (65-80y)/year: 465.000 >> 440.000
- Decline in mean stay : 6.2 >> 5.3

- Admitted persons (>80y)/year: 170.000/year stable over time
- Total admissions (>80y)/year: 248.000 >> 231.000
- Decline in mean stay: 7.3 >> 6.5 (>80Y)

Changes in geriatrics last 10 years

Geriatrics in long term care/community geriatrics

Long term care is increasingly provided at home and in small residential care settings as the number of NH places is not growing anymore

GPs and ECPs work increasingly together: GPs feel not equiped for providing care to frail older patients with complex and multiple domain problems who previously were admitted to NHs, but now Age in plce

Focus on ACP: anticipating and talking about the future

Focus on post acute care geriatric rehabilitation: specific care units within NH organisations

Effects on longterm care/community geriatric use (2015-2023)*

- Stable use of NHs places (123.000>>126.000 places)

- Increase in long term care use at home/small residential facilities in the community and collaboration of ECP and GP (0 >>100.000)

- Stable use of rehabilitation care about 75.000 older adults/year and stable mean stay

- Cost-reduction not really achieved: 2021: 12 billion; 2024: 18 billion
  (no correction for inflation and the increase in number of older people with care needs)

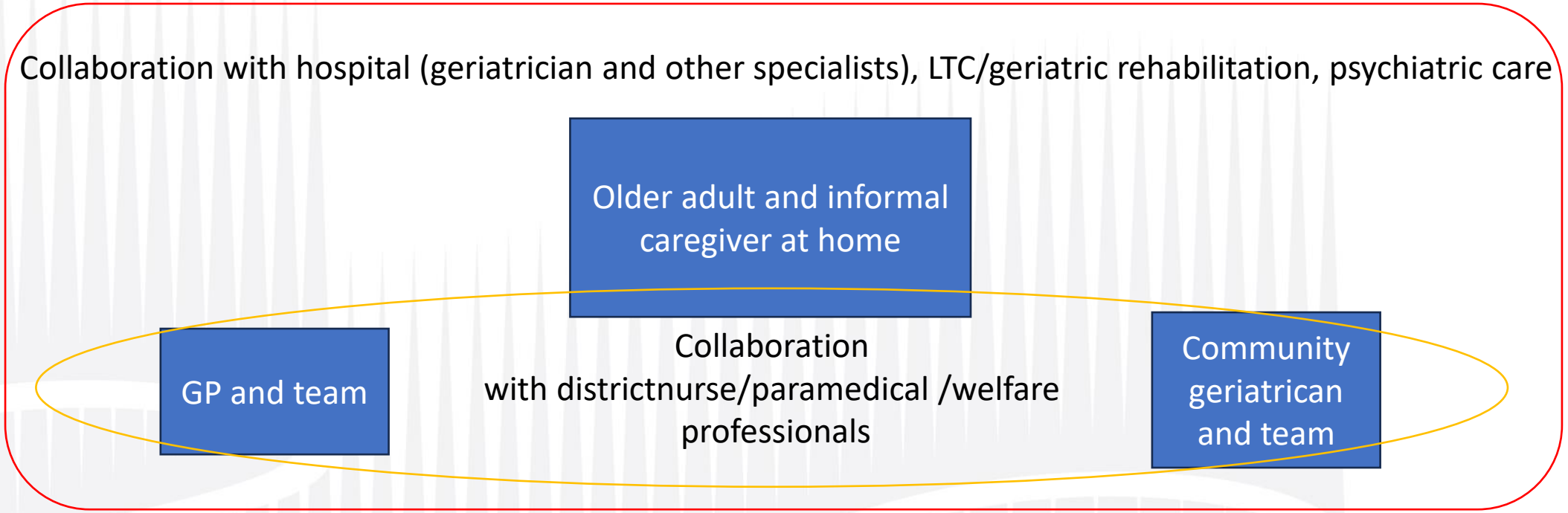
*Source: Statline, CBS, 2025; www.zorgcijfersdatabank.nl 2025

Challenges related to the recent changes

- Increasing crisis situations
- Frail older adults that stay longer in hospital or post acute care/geriatric rehabilitation than needed
- Home care availability and districtnurses availability
- Shortage of GPs and ECPs
- Shortage of psychiatrists
- Three acts regulating (medical) care for older people, with different out of pocket payments, hindering collaboration/efficiency
- No information about QoL of older adults ‘aging in place’ and their caregivers’ burden

What do we need/work on in the Netherlands?

A comprehensive integrated care system in which social welfare and (medical) care professionals work together with and for the older adult and his/her informal caregivers.



Conditions for an integrated care system

Citizens/families who care for each other (quite a challenge for the Dutch individualistic society)

Sense of urgency (care needs exceed our possibilities if we do not change): we have to act now to solve this problem

Belief in interprofessional collaboration as a way to contribute to solving the problem

Organisational structures that facilitate collaboration

EHRs that communicate mutually smooth and safe

Reimbursement-system that facilitates collaboration

Training of future geriatric physicians

New residency training programme ECP:

- community geriatrics/collaboration GP
- old age psychiatry
- hospital geriatrics
- geriatric rehab
- LTC care
- training in non clinical skills based on preference of resident: leadership; education; research
- interprofessional training in the residence programme

Residency training programme of hospital geriatricians also more focussed on interprofessional training/interprofessional collaboration and options for development of non clinical skills based on preference of the resident.

Post residency education

GPs and ECPs have also a combined post residency training of 1,5 year (20 days), that they do together to get extra training in community geriatrics, interprofessional collaboration and organisation of care for older people in the community.

Conclusions

Policy changes have for hospital geriatrics resulted in shorter hospital stays and less admissions of people > 65y

Policy changes have for LTC/community geriatrics resulted in stable number NH places and increase in of LTC /Aging in place in het community (own home/small scale facilities). Costs reduction was not really realized.

Aging in place appears to have been realised, but effects on QoL and on caegiver burden and on careprofessionals workload/worksatisfaction are largely unknown.

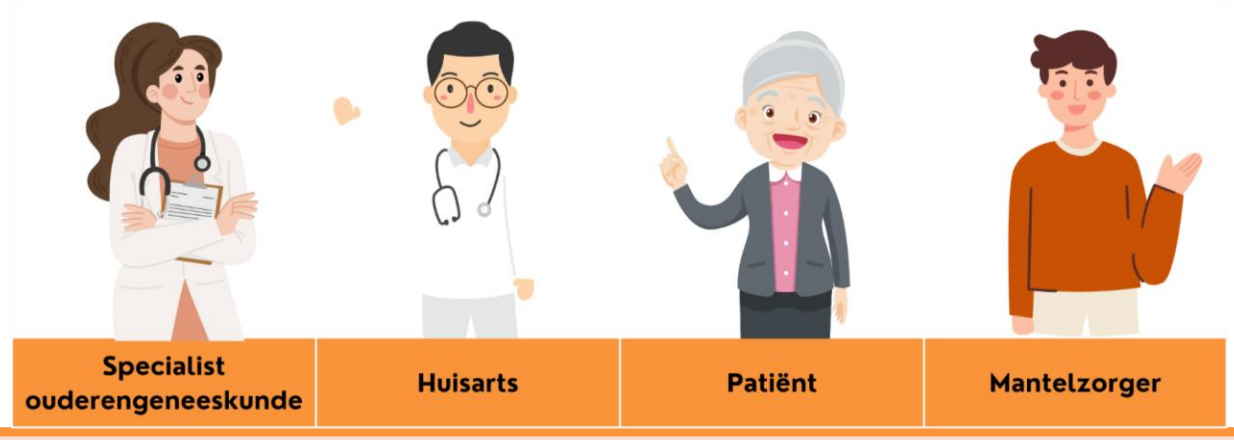
There are challenges that remain and work to be done:
plans have been made but realization depends upon us and future physicians in geriatrics.

Deel 2: Beter thuis met huisarts en specialist ouderengeneeskunde

18 november 2025

Milou Angevaare
Marieke van der Heide
Ien van Doormalen
Franka Meiland
Jos Schols
Suzanne de Kort
Ferry Bastiaans
Martin Smalbrugge

Methode



- Kwantitatieve data
  - 99 casus in prospectieve cohort van 5 organisaties (2024)
  - 25/50 retrospectieve casus van 4 (1) organisatie(s) in 4 regio’s
- 36 (korte) interviews
- +/- 10 focusgroepen over 5 onderwerpen in lerend netwerkbijeenkomsten

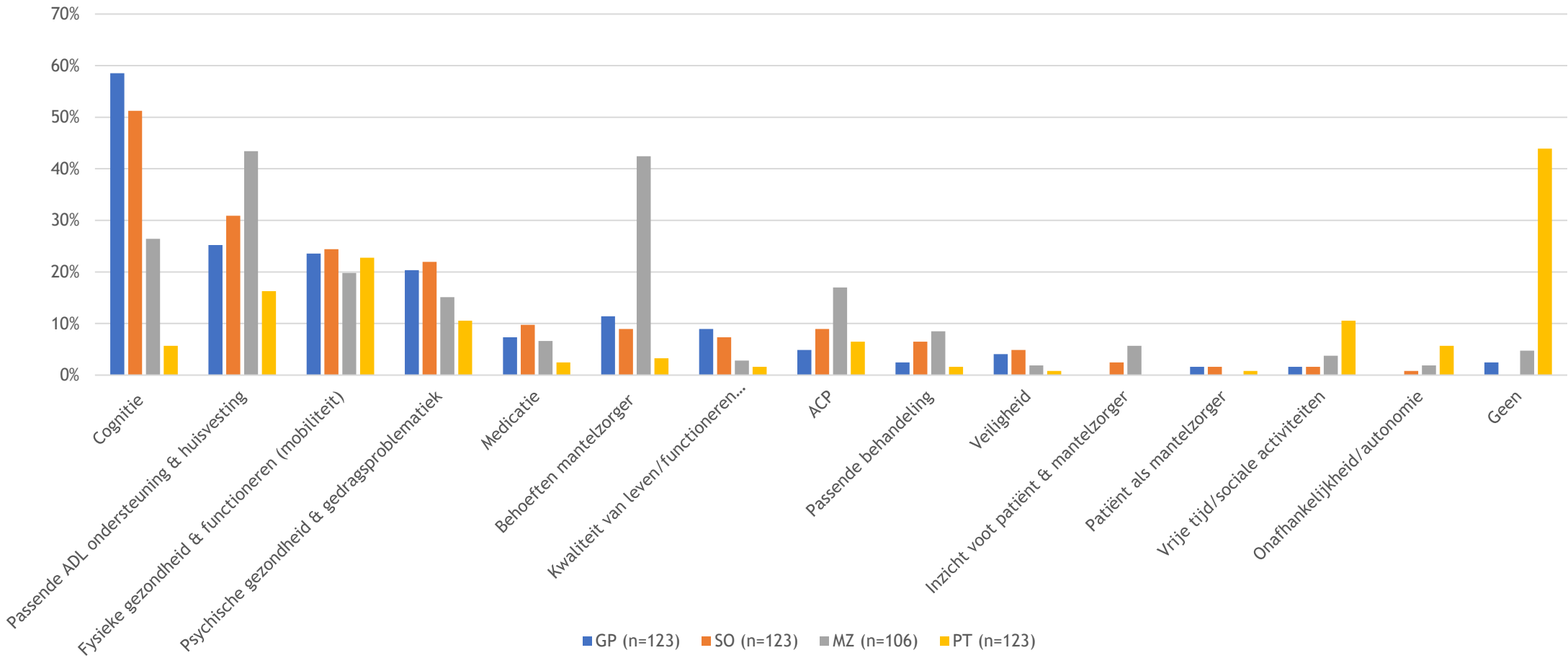
Kenmerken patiënten

	Prospectief (n=98)	Restrospectief
Leeftijd	82.6 (sd: 7.4, 56-99)	82.8 (sd:6.7, 73-98)
Vrouw	69%	40% vrouw
Aanwezigheid mantelzorger	94% (daarvan 59% kind, 33% echtgenoot)	96% (daarvan 58% kind, 25% curator/mentor)
Polyfarmacie	65%	76%
Co-morbiditeiten (15 total)	3.5 (sd: 1.6)	3.2 (sd:1.3)
Medebehandeling	11%	100%
Zorgmomenten/week	5.2 (sd: 8.0)	3.2 (sd:4.1)
Alleenstaand	61%	
Wilsbekwaam ter zake onderzoek	77%	

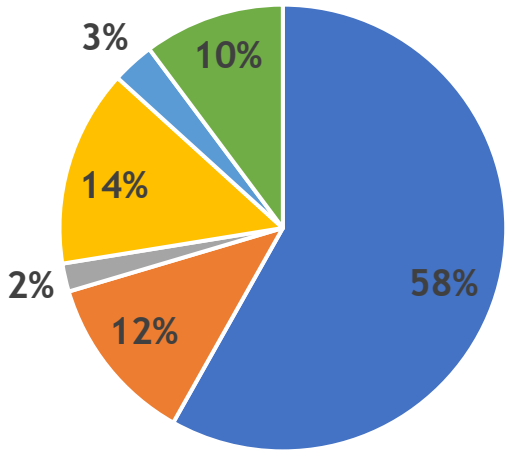
Soorten vragen/problemen:	Aandeel
Cognitie	51%
Passende ADL ondersteuning & huisvesting	31%
Fysieke gezondheid & functioneren (mobiliteit)	24%
Psychische gezondheid & gedragsproblematiek	22%
Medicatie	10%
Behoeften mantelzorger	9%

	Aantal vragen/problemen per betrokkene	
	Mean	Range
Huisarts	1.69	0-4
Specialist Ouderengeneeskunde	1.81	1-6
Mantelzorger	1.95	0-5
Patiënt	0.88	0-6

Aandeel per betrokkene groep



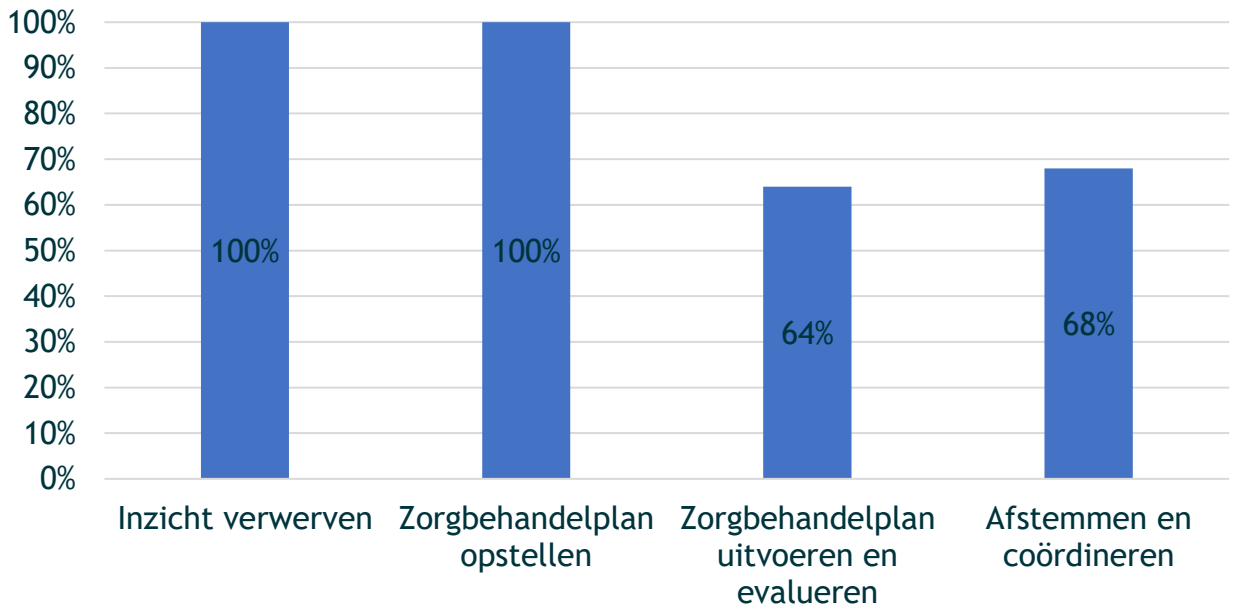
Alternatieve zorg HA (n=99)



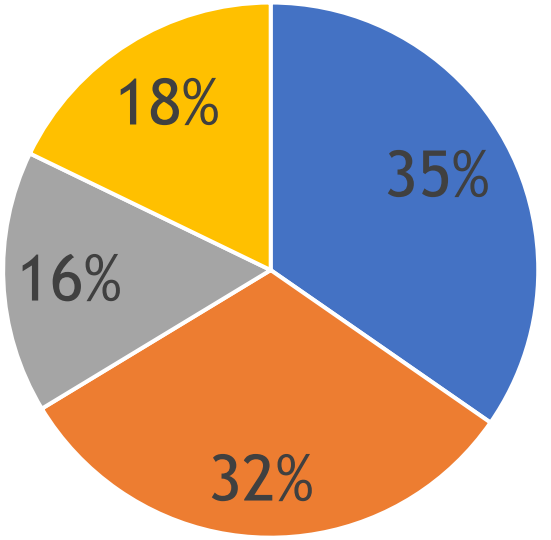
Samenwerking leidt tot minder verwijzingen naar 2e lijn: 72% van de patiënten was door HA anders verwezen naar medisch specialist

- Klinisch geriater
- Overige medisch specialist
- Combi 1e lijn & medisch specialist
- Zorg in de 1e lijn
- (Tijdelijke) opname verpleeghuis
- Geen verdere zorg

Hoe werkt de specialist ouderengeneeskunde?

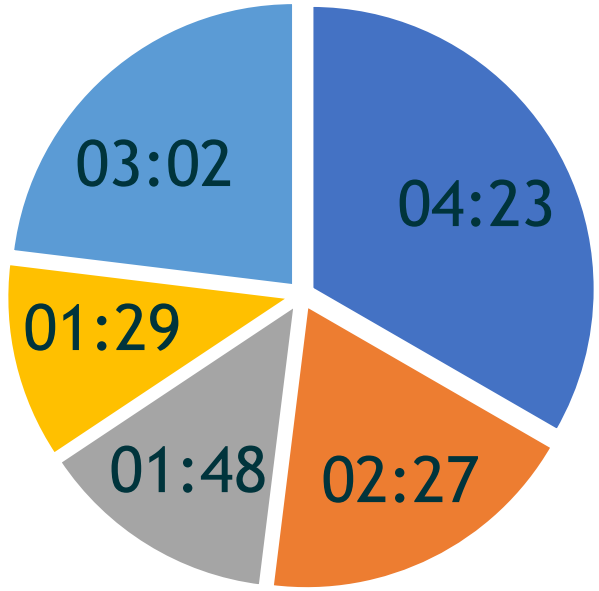


Duur betrokkenheid SO



0-1 mnd
2-3 mnd
4-6 mnd
>6 mnd

Tijdsinzet team SO



SO-inzicht verwerven
SO-plan ontwerpen
SO-plan uitvoeren en evalueren
SO-afstemmen & coördineren
team

Kwaliteit van leven: rapportcijfer

Kwaliteit van leven	Gem. voor inzet team SO	Gem. na inzet team SO	Gem. (paired T-test p)
Patiënt (n=58)	6.62 (1.54)	6.84 (1.68)	0.224 (0.142)
Patiënt door mantelzorger (n=81)	5.56 (1.67)	6.02 (1.48)	0.469 (0.005)
Patiënt volgens patiënt door mantelzorger (n=80)	6.06 (2.0)	6.58 (1.9)	0.513 (0.010)

Tevredenheid

Initiatief (n)	SO- gem (sd)	HA-gem (sd) (n=92)	PT (n=55-82)	MZ (n=82-84)
Hoofddoel behaald	8.3 (1.3)	8.1 (1.5)	62%	76%
Tevredenheid samenwerking	8.0 (1.2)	8.5 (0.99)		
Tevredenheid geboden zorg	8.1 (0.98)	8.2 (1.2)	7.6 (1.5)	7.9 (1.3)
Tevredenheid contact met team SO			7.7 (1.2)	8.0 (1.1)

Conclusie

Veel variatie in organisatie van samenwerking, maar ook veel overeenkomsten: algehele beschrijving

- Kern samenwerking: goede wederszijdse informatievoorziening en elkaar kennen en vertrouwen
- Kern inzet SO: SO ontrafelt en pakt de complexiteit in de breedte aan, waarvoor een basis van vertrouwen en goede communicatie essentieel is

Over het algemeen waren betrokkenen positief over de inzet van de SO/de samenwerking

Kwaliteit van leven patiënt blijft stabiel/verbetert (0.5 punt) tijdens inzet SO

Mantelzorglast blijft stabiel tijdens inzet SO

Samenwerking leidt tot minder verwijzingen naar 2e lijn: 72% van de patiënten was door HA anders verwezen naar medisch specialist

Tot slot: tijd voor een andere naam?

Community-geriatrician ipv elderly care physician?

Dank voor jullie aandacht!

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