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POSTER ABSTRACT

The perspective of frail elderly on their care networks in primary care.

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Sietske M. Grol[1], Henk J. Schers[1,2]

1: Radboud University Medical Center, The Netherlands;

2: Thermion, Academic Primary Care Practice

Introduction: Integration of care services is crucial for high quality elderly care. Multidisciplinary primary care networks who deliver integrated care to frail elderly consists of general practitioners, home care professionals, nursing home physician specialists, elderly counsellors, physiotherapists and others. It is known that soft factors of cooperation can influence the quality of care positively. However, little is known about the way in which patients experience soft factors such as culture (shared values), professionalism, team spirit and leadership. More is known about hard factors of cooperation. These factors regard to participants in the networks, interconnecting between participants and the strength of these correlations. In this research project we experimented whether it was possible to make professional care networks with frail elderly and reflect on hard and soft factors of collaboration.

Methods: We selected four primary care networks, which were known for their innovative way of organizing elderly care. From these, we interviewed 44 frail elderly about the composition and functioning of their care network. During these interviews, we used questionnaires to map background characteristics. In open questions we related to soft elements of cooperation between professionals. We asked the respondents about the hard factors of cooperation using a social network map. They were asked about the participants in their professional care and welfare network (including their most important informal care giver), the frequency of contact with the care professionals, the quality of the contact, cooperation between the members of the network and the quality of the co-operation. The interviews we transcribed verbatim and analyzed qualitatively with Atlas-ti 7.1.. The quantitative data were processed and analyzed with SPSS. The information about the professional networks of the elderly was analyzed using SPSS, entered into Excel and processed into network figures using UCINET.

Results: We were able to analyze 44 interviews (male/female 30%/70%, average age 84). The care networks consisted in average of nine care and welfare professionals. The frail elderly were well able to respond to questions about the hard factors of cooperation . They were able to mention the most important participants in their care networks spontaneously and reflect on their cooperation. Questions about the quality of cooperation proved difficult to answer. The GP is for frail elderly the central person in care. Most frequently, cooperation between the GP and home care professionals is mentioned. Elderly observe less cooperation from the

GP with the physiotherapist and the welfare professionals. The cooperation between the GP and the informal care givers differs between the four care networks (25-50%).

We found a little over one thousand quotes about soft factors of cooperation. It proved easier for the respondents to reflect on the quality of professionals and patient centeredness then on the way in which professionals work together or culture in multidisciplinary teams. One third of the respondents could tell us something about the existence of multidisciplinary team meetings. Only three elderly were able to tell us in detail about the cooperation between professionals.

Perceived quality of care was found to correlate with the experienced continuity of care. Negative experiences correlated with the absence of continuity in home care. Experienced continuity between the GP and the district nurse correlated positively with quality of care. We didn't find a relation between the presence of a care coordinator and the experienced continuity of care.

Discussion: It is possible to draw up professional care networks with frail elderly. With help of a trained interviewer they are able to tell something mainly about the 'hard' factors. Often, an overview of the organisation of their care is missing. It turned out to be difficult for respondents to tell us something about the soft factors of cooperation. Respondents usually related to questions on this matter in terms of an impression. It is easier to tell something about practical cooperation shown by references, letters, sometimes consultations on coordination of care. Much of what happened behind the scenes eludes the eye of the elderly.

Conclusion: This study was a case study and an experiment in gaining more insight in the way which frail elderly perceive hard and soft factors of collaboration. A next step would be to follow up the multidisciplinary teams in their improvement of integrated care for frail elderly, based on the outcomes of the interviews with their patients in a participatory action research approach.

Keywords: frail elderly; qualitative research; multidisciplinairy teams; primary care