
CONFERENCE ABSTRACT**Digital aid for talking more about death and dying: incorporating advance care planning to integrated care management tools**

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Introduction: Governments put health-system strengthening as priority. They particularly strive for person-centred health-systems. Integrated Care is seen as the way forward to achieve this. To improve patient experience and health outcomes, healthcare should be organised ‘horizontally’ around the patient and should be ‘vertically’ integrating services in various levels and settings. The Queen Elisabeth Rehabilitation hospital (KEI), encompassing 165 beds, wants to play a role in better healthcare for patients with specific and complex rehabilitation needs (cardiopulmonary, locomotor and neurological) and strives to centre its services on the needs of the patients, their families and the broader community.

Methods and aim: In order to formulate a well-articulated strategic plan, KEI critically scrutinised its current work by studying available data. Since KEI developed a high level quality control management-plan, data from 2021 could be extracted from the patients records and analysed.

Results: KEI, driven by a holistic vision on rehabilitation (medical, functional, social and psychological) intensively puts efforts in interdisciplinary team-integration (specialist-physicians, dietitians, occupational, speech- and language-, physiotherapists, psychologists, nurses, assistant nurses) supported by electronic patient-records and grounded in patient-participation. Also preventive (mostly ambulatory) coaching is offered (e.g. smoking cessation, tackling malnutrition and obesity). Patients admitted to KEI in 2021 (n= 1215) were transferred from hospitals (9% university-hospitals/83% non-university), from home (7%) and from nursing-homes (1%). They are discharged towards home (74%), nursing-homes (11%) or back to a hospital (11%). After discharge, extensive ambulatory follow-up was conducted with 2178 ambulatory

consultations. This means that KEI extensively collaborated and exchanged information with stakeholders in the region: regional hospitals, primary care, nursing-homes. To fulfil its supra-regional task, KEI collaborates also with university-hospitals throughout Flanders. Several official agreements and care pathways are in place to organise all this collaboration.

Discussion and conclusion: Aiming to improve patients/informal caregivers' experiences, KEI developed pre- and post-trajectories, which is only possible through well-integrated care and good cooperation with other facilities, e.g. acute hospitals, care for the older persons (nursing-homes, assisted-living facilities) and primary care. KEI has expanded this diversity within the own facilities, but also with other partners. In this way, KEI is today playing a local as well as a supra-regional role, but strives to upgrade his part as legitimate, recognized, complementary and responsible partner in transversal collaboration towards integrated between micro-, meso- and macro-level. Although Integrated Care is an explicit task the Flemish government directed towards rehabilitation-hospitals, it is hard to really integrate care around the needs of patients and informal caregivers, mainly because of insufficient 'vertical integration' since services are not organized under one management umbrella. The locoregional acute hospital networks in development might be a step forward since they allow the formation of alliances and arrangements on a local level, though rehabilitation-hospitals are not part of it. Several challenges still lie ahead such as the search for a common reason of being, i.e. understanding the needs from a population health goals; common mission and strategy; joint funding and planning with shared outcomes. Also strong leadership with trust in each other and clear governance arrangements are needed.