International Journal of Integrated Care

Dierckx E et al, 2023 Ageing well in place: EET as an answer to the need for integrated care and support. *International Journal of Integrated Care* 23(S1):409 DOI: doi.org/10.5334/ijic.ICIC23409

**POSTER ABSTRACT**

# Ageing well in place: EET as an answer to the need for integrated care and support

23rd International Conference on Integrated Care, Antwerp, Flanders, 22-24 May 2023

Eva Dierckx[1,3], Katrien Lauwereys[1,3], An Haekens[1,3], Katrijn Abrahams[1,3], Anne Beyen[2,3]

1: Alexianen Zorggroep Tienen, Tienen, Belgium
2: Regionaal Ziekenhuis Heilig Hart Tienen, Tienen, Belgium
3: Elder Expertise Team, Verbonden in ZOHrg, Elzoh, Belgium

**Background:** Older people prefer to stay as long as possible in their own home and environment. However, as people age, they are typically confronted with age-related declines on different domains; often leading to multidimensional (physical, psychological, social and environmental) frailty, which is associated with an increased vulnerability to adverse health outcomes and a decrease in wellbeing. In order to age well at home, one must shift from the (often) current fragmented, supply-driven support to a more integrated and multidisciplinary demand-driven support that focuses on the wants and needs of older people and their caregivers.

**The Elder Expertise Team in Tienen (Belgium):** Currently, as also mentioned by our stakeholders of informal caregivers, there is insufficient continuity and coherence between the different disciplines involved in the support and care at various echelons. This often leads to non-transparency, not only for older frail people but also for their informal and formal caregivers. As a result, the problems are not recognized, nor treated in time, leading to a threatening of the autonomy, participation in society, health and wellbeing and often leading to an admission into a residential care facility.

To address this need, in Tienen, the "Elderly Expertise Team (EET)" was established in 2019 with the objective of enabling frail elderly people to live at home for as long and as qualitatively as possible by offering the most appropriate care and support. The EET has a multidisciplinary, cross-sector and cross-organizational composition, using a network-oriented approach. In order to give an answer to multidimensional frailty, besides healthcare partners also partners from welfare are part of the EET.

The EET serves as a "single point of entry" which coordinates care and support across a network of different care and support providers. The EET uses a stepped-care approach: (1) one starts with giving (general) advice by phone, (2) if there is a need for additional case-specific support an assessment and/or screening is done, leading to case-specific tailored advice and a short-term treatment of up to 5 sessions is provided; (3) if necessary, a referral to more specialized care is done. Besides the care for older persons and their caregivers, the EET also provides coaching, trainings and intervisions for formal caregivers. This all results in better and integrated care and support, leading to reduced admissions to residential care and a better wellbeing for the older person and his/her context.

**Future:** Currently, the EET works mainly at the intervention level. However, in the future a more population-based approach using risk-profiles for multidimensional frailty and doing pro-active home visits might also lead to a better casefinding and prevention of frailty. Moreover, as the focus is now on clinical and service integration, the EET recognizes the need for functional integration by means of shared electronic patient records.