Patient satisfaction in innovating integrated care for older persons : towards care with personal value

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Chapter 7

Discussion

In recent decades, the medical care for older persons with multiple problems in the domains of somatic, functional, psychological and social functioning has become more of an organizational challenge. Increasing numbers of older persons living independently with an increased load of chronic diseases and ailments, and a care landscape with more numerous and specialized professionals against a background of financial restrictions, has given rise to new care concepts. The concepts 'integrated', 'value-based', 'multidisciplinary' and 'person-centered' have together formed a new paradigm. The overall challenge is to organize efficient integrated care on the one hand and, on the other, to ensure value for the individual older person. Patient satisfaction can be seen as a representation of this value. Patient satisfaction can be simply defined as 'an evaluation based on the fulfillment of expectations'. However, this definition only partly reflects the realization of these expectations, i.e. it also includes patient and provider characteristics, such as age and gender. In addition, it is influenced more by communicative provider skills than by care quality. (1-5) Despite reservations regarding the precise meaning of patient satisfaction, it is argued that only the patient can determine whether his/her needs and expectations have been met. (6, 7) Therefore, there is wide support for the relevance of patient satisfaction in the design and delivery of integrated care. (8-10)

The overall aim of this thesis is to provide an evidence-based proposal for incorporation of the opinions and values of older patients in the innovation of their care, by investigating patient satisfaction as an influencing factor in the innovation and implementation of integrated care. By summarizing and discussing the main findings of the previous chapters, this chapter addresses the challenge of using patient satisfaction to tailor care for older persons to fit their expectations and values and to implement this in our changing world. Supporting the title of this thesis: *'Patient satisfaction in integrated care for older persons. Towards care with personal value'* implies, ultimately, proposing practical applications for the use of patient satisfaction in the innovation of daily care.

MAIN FINDINGS

The study described in **Chapter 2** aimed at a better understanding of the seemingly contradictory finding reported by others, that increasing age is related to higher patient satisfaction while the age-related increase in morbidity is related to lower patient satisfaction. The conclusion of our study is that, in this population of older persons, satisfaction with the GP and practice does not increase with age. However, dissatisfaction with the GP practice is strongly related to the rising levels of complexity of health problems, independent of age and demographic and/or clinical parameters. The complexity of health problems is quantified using the patient's response to questions about perceived problems in the domains of somatic, functional, psychological and social functioning.

When exploring the association between the number of problem domains and the level of satisfaction, the expressed dissatisfaction showed more variation than satisfaction. Interestingly, there is a higher level of satisfaction in the group with zero problem domains. This level decreases with increasing complexity and gradually transforms into a predominance of dissatisfaction in the group with four or more problem domains.

This suggests that the positive relation between increasing age and satisfaction, as reported by other authors, may only hold true for populations with a low complexity of health problems. Implications related to our findings are: i) that when investigating the relation between individual patient characteristics and satisfaction, the complexity of health problems of older persons must be taken into account; ii) when the complexity load is greatest and, therefore, the demands on the healthcare system are largest, overall patient satisfaction will be influenced negatively; this effect should be taken into account when using patient satisfaction to evaluate care organization and delivery; and iii) dissatisfaction is a relatively infrequent but meaningful indication of the level of satisfaction.

The study in Chapter 2 does not answer the question whether the decreased satisfaction level with a higher complexity of health problems is related more to the health status of the patients themselves, or to the failure of the provided care to meet the expectations and needs of this group of patients. Therefore **Chapter 3** (also using ISCOPE data) addresses this question by investigating changes in patient satisfaction during implementation of integrated and patient-centered care, in relation to their perceived health state. In this population of older patients with a high level of complexity of health problems, the satisfaction level did not change after implementing patient-centered integrated care. During the implementation, no additional influence of the level of the perceived health status was found. Therefore, this study demonstrates that the perceived health state in itself does not modify patient satisfaction. The implication is that the decreasing level of patient satisfaction with increasing complexity of health problems, as reported earlier by others, is more likely to be an indication of a discrepancy between patient-need versus care organization than a result of a negative state of the mind and body of the patients.

The study in **Chapter 4** takes a closer look at modifiable factors in the GP-patient relationship that can influence patient satisfaction. In MOVIT (an integrated-care implementation project in care homes), a better GP-patient relationship, as perceived by the patient, is shown to be related to higher patient satisfaction among older patients. For example, a polite and kind GP scores well and is considered by older patients to be very important for the GP-patient relationship. In contrast, understanding the personal situation and paying attention to the older patient as an individual by the GP leaves room for higher satisfaction scores. The implication is, therefore, that all these potentially

modifiable aspects deserve particular attention from GPs in maintaining and possibly improving patient satisfaction.

The study in **Chapter 5** focuses on satisfaction during the process of implementing integrated care in the MOVIT project. The aim of this study was to investigate the changes in satisfaction with regard to aspects of integrated care among older patients and GPs, during regional implementation of integrated care in residential care homes. General satisfaction with the care received and provided does not show any relevant changes among older patients and GPs. However, satisfaction with specific aspects of integrated care does change, showing an emphasis on interpersonal aspects in older patients and organizational aspects in GPs. Interestingly, a measure to improve efficiency and safety (e.g. delegating tasks in medication logistics to nurses) decreased the satisfaction scores among older patients and increased satisfaction among GPs. The practical implications are that, if possible, the choice and nature of the changes should be tailored to accommodate the expectations and preferences of the specific groups affected. Proactively explaining what effects can be expected from particular changes, and why a tradeoff might be needed between aspects considered more important by one group than another, might avoid a negative effect on implementation. These process steps are particularly important when negative effects on satisfaction are expected for a specific group from a change which is, nevertheless, considered worthwhile.

In **Chapter 6** the focus shifts toward the process of implementation and patient satisfaction from an explicit to an implicit subject. A description is given how, retrospectively, a matrix was developed to capture and analyze the process of a pragmatic real-life integrated care implementation project. As in the previous study (Chapter 5), the MOVIT project was used. The matrix provides a basis for analysis of the identification and implementation of relevant factors. It shows that the main target of the implementation was the cooperation of professionals at both the individual and group level. However, the resulting changes had a much broader impact on the patients as a group and on individuals. The narrative revealed that: the professionals and location managers directly concerned with the delivery of care adopted the MOVIT approach, while the governors and general managers showed a reluctance to commit to further implementation. This observation suggests that the overall implementation strategy has failed to bridge the gap between professional motivation and adoption by the organization.

When using the matrix to visualize the levels and domains targeted and affected by the MOVIT implementation, the absence of planned interventions versus the presence of effects of the implementation in the 'patient domain' is striking. Therefore, although not a pre-specified topic in this study, patient satisfaction as a potential instrument in the involvement of the patient's perspective, at all levels of implementation, becomes apparent and the question arises whether its use might have helped to bridge the gap in adoption.

Key findings

1. In older persons, the level of patient satisfaction is lower in persons with a higher complexity of health problems, independently of age.
2. This inverse relation between patient satisfaction levels and complexity of health problems is related more to a discrepancy in patient need versus care organization, than to a negative state of the patient's mind and body.
3. Communicative aspects of the GP's behavior are related to patient satisfaction and are potentially modifiable.
4. While general satisfaction with the care received and provided may not change among patients and GPs, specific aspects can change and show different values.
5. In a multi-level and domain-implementation strategy, patient satisfaction can be used as an instrument for patient involvement at various levels.

Patient satisfaction in daily practice

Between 1987 and 2018, the changes in the care situation for the older couple, Mr and Mrs P. (introduced in the first chapter of this thesis) illustrate the changing role of patient satisfaction in daily practice.

In 1987, at the individual level, the content of care was determined by an implicit form of shared decision-making and based on the locally available resources and personal interactions between patient, professionals and informal caregivers. The care package was composed of (more or less) coordinated mono-professional care by the GP and community nurse, together with voluntary contributions from family and community. Financing was either a simple fee-for-service settlement between GP and patient, or a capitation fee paid to the GP by the medical insurance company (*Ziekenfonds*). Costs of the nurse were covered by membership of a church-related nursing organization (*Kruis vereniging*). Expectations were clear on both sides, since the roles of both the patient and the professionals were stable and mutually accepted. Patient satisfaction was neither an explicit determinant nor an outcome of care organization.

The situation of the same older couple in 2018 is much more complicated. The individual patient interacts with multiple professionals and shared decision-making has become an explicit tool. Primary care has become horizontally integrated, implying that various professional and informal caregivers cooperate to provide a comprehensive care arrangement. (11,12) Specialist medical care has become vertically integrated, implying that various professionals provide separate components of the diagnosis-based care chain. (11,12) In the Netherlands, financing is a mixture of out-of-pocket, fee-for-service, and capitation provided by the patient and the insurance organization (*Zorgverzekeringswe*t), the local council (*Wet Maatschappelijke Ondersteuning*) and the government (*Wet Langdurige Zorg*). (13) Society, professions and care organizations are constantly in transition. In healthcare, this transition is guided by concepts such as 'patient centered-

ness', 'value-based care' and 'triple aim'. (6,14,15) These concepts have in common that the patient is accorded an important position, as is his/her perception of the value and quality of the provided care. Patient satisfaction is widely used to evaluate value and quality in care innovation initiatives. (16,17) This provides patient satisfaction with a formal and practical status from the individual up to the policy level.

Patient satisfaction in care innovation

In 2018, integrated care in the Netherlands is provided by multiple professionals, working in various organizations, within a context of legal and financial structures. Part of the financial and legal structures are nationally applicable, others vary regionally. All the named professional, organizational and contextual factors change intermittently, influencing each other. Top-down political policy changes, financial and legal regulations comply, and professionals and organizations adapt. Bottom-up, consumer expectations and professional consensus develop, influencing organizational change and, eventually, policy.

In terms of implementation science, this can be seen as a Complex Adaptive System (CAS). (18) Innovating care in such a system means deliberately planning changes in health care with an intended outcome by applying interventions and influencing context factors. (19) The process of such an innovation is adaptive, implying that it is shaped by the behaviors and actions of participants while interventions and context are flexible and influence each other. (20) Within such an adaptive process, patient satisfaction expresses the perceptions of an essential group of participants and can, therefore, be seen as behavior influencing both process and outcomes.

Interpreting patient satisfaction

Patient satisfaction is related to expectations (21). To understand satisfaction responses, the closely related concept of 'expectations' needs to be considered. Particularly relevant findings for the interpretation of satisfaction in older patients are the following: i) older patients do not have explicitly formed expectations concerning the technical and logistic aspects of care; the expectations they do have largely concern the conduct of caregivers (22, 23), ii) expectations can change as the care is experienced; these expectations are influenced by feelings such as gratitude and ideas of equity (21), and iii) satisfaction is sometimes distinguished from care experiences, such as waiting time.

Although care experiences can be regarded as more objective than satisfaction, even these are influenced by expectations. (24) For example, the perception of waiting time can (like satisfaction) be influenced by characteristics of the patient, caregiver, health and environment, as well as by ideas of what is to be expected. (25) Statistically one study shows that only 4.6% of the variance of patient satisfaction is caused by characteristics of the care process itself and, particularly in older patients, the levels of satisfaction are

uniformly high. (5,26,27) Further qualitative investigation has shown that as a response to a question regarding satisfaction, both 'neutral' and 'satisfied' have been found to mean (more or less) 'as may be expected'. 'Very satisfied' means 'better than expected'. Dissatisfaction is rare but is not awarded lightly and is, therefore, highly relevant. (28)

Therefore, it can be concluded that satisfaction requires cautious interpretation as a quality indicator; however, the expression 'very satisfied' is an indication of superior care while each response of 'very dissatisfied' warrants individual qualitative investigation as being a possible indication of care failure.

Levels in patient satisfaction in care innovation

It has already been stated that at **the individual level** shared decision-making between the older patient and caregiver is an important approach to ensure that the individual patient's care meets his/her needs and wishes. There are numerous statements of individuals and authorities confirming the importance of engaging patients and evidence to support this standpoint. (6,8,9,15) Based on the same principles, but applicable at the **group and policy level**, patient engagement is a promising approach. (28-32) Engagement has been broadly conceptualized as: 'Patients, families, their representatives, and health professionals working in active partnership at various levels and across the healthcare system - direct care, organizational design and governance, and policymaking – to improve health and health care'. (32) Although client representation is already commonplace and compulsory by law in medical institutions (like hospitals and nursing homes) and even anchored in the Declaration of Human Rights, it is still rare and not even compulsory in primary care. (33) Even when in place, patient engagement still has a low level of influence in shaping care organization, leaving a lot of room for future development. (28)

TOWARDS CARE WITH PERSONAL VALUE

By combining the findings of the studies in this thesis and the theoretical perspectives on implementation and patient satisfaction, answers can be proposed to the central question: How can patient satisfaction be used to tailor care for older persons to fit their expectations and values, and implement this in our changing world?

Our research shows that quantitative representation of older patient's satisfaction about their GP provides information which can be used to steer care innovation and implementation. This has to be done with caution since the general level of satisfaction is lower when the complexity of problems is higher. This inverse relation seems more related to the fit of the provided care than to the mood of the patient. Patients' responses regarding satisfaction, reflect specific organizational details and affective

aspects of the GP-patient relationship which offer room for improvement. Analysis of a real-life integrated care implementation project highlights the domain in the strategy into which patient perspectives can be placed at all levels, from individual level up to policy level.

However, we also encounter difficulties in interpreting satisfaction responses. For example, the predominance of the 'satisfied option' which statistically overshadows the particularly relevant 'dissatisfied' and 'very satisfied' options. The mystifying result of what we assume to be the effect of changing expectations of patients during care innovation. Examples of this phenomenon are the decreasing satisfaction about the GP on increasing the role of the nurse in medication logistics and the greater satisfaction decrease in the group receiving more intensive integrated care than in the group receiving usual care.

Placing these findings concerning patient satisfaction in the context of patient engagement in general, shows the limitations of quantitative patient satisfaction use only. This leads us to the conclusion that it is useful in pinpointing aspects of care requiring specific attention but cannot stand alone without more qualitative details. Similarly, we conclude that satisfaction analysis (quantitative and qualitative) can support, but not replace, patient engagement.

Combining levels of patient satisfaction

To illustrate the combination of ingredients which can be used to tailor both the daily integrated care and innovating care organization to the individual values of older patients in a continually changing world, the analogy of a 'cupcake' is used in the following paragraph. Cupcakes have a wholesome cake base, a distinctive colorful sweet icing and a finishing touch, such as a cherry, which makes them complete.

The base

The wholesome base of integrated care, as it always has been, is the personal process of care and shared decision-making. Even in a new organizational setting of multiple disciplines and providers, the responses of patients emphasize the value of this personal interaction. Our research shows the value that patients attach to the personal conduct of their GP and that this can conflict with organizational changes, even when these are considered to be organizational improvements. Certain aspects of GP conduct related to the patient perceived 'GP-patient relationship' can be singled out. Likewise, particular organizational changes can be predicted to negatively influence this relationship, such as delegating GP tasks to supporting staff. We propose that, both in daily practice and in innovating care, particular attention should be paid to this aspect. In practical terms, this means training all caregivers to be aware of this patient value and ensuring that it is

clear to the patient and to the caregiver who can be approached regarding this personal aspect. When trade-offs have to be made in the choice between predictable positive or negative value options in the interest of, e.g., organizational efficiency, this value has to be taken into consideration and, if necessary, explained to the patient. Future, particularly qualitative, research could investigate the effect of adapting GP conduct and tasks in integrated care to patients' expectations regarding patient satisfaction and care outcomes. Attention could specifically be paid to in-depth understanding of the meaning of negative satisfaction responses. The consequences of this for GP training programs also require further investigation.

The icing

Distinctive icing on the cupcake represents the use of systematically collected satisfaction responses. When first planning an innovation of integrated care for older persons, existing evidence on patient satisfaction (e.g. complexity level and expectations) can be used to design the innovated care. Once started, patient satisfaction responses can be collected and used to tailor and evaluate the innovation process. 'Tailoring' means using patient satisfaction as an instrument in the adaptive innovation and implementation process. This implies that satisfaction evaluation should be available during the implementation process and facilitate the choice to either adapt care innovations or to more adequately explain aspects to participants if required. When evaluating the innovation, patient satisfaction responses can be seen as a measure of the success of the tailoring of the care to the values of the older persons.

More experience and research are required in collecting patient responses and strategically applying them during an adaptive implementation process. This could be combined with examining the value of the proactive use of the matrix described in Chapter 6.

The cherry

Making the cupcake complete, the cherry represents the process of engaging and empowering individuals, families and communities to be more active participants in healthcare planning and governance. Although this can be seen as a basic ethical necessity if the goal really is patient-centered care, evidence is still being sought to demonstrate that patient engagement does indeed have an impact. (29,33) The fact that this has not yet been established: '*… does not indicate an absence of impact; rather it indicates inadequate reporting with a lack of valid and reliable tools to capture the impact*'. (30)

In 2010, 40% of the general practices in the UK had patient participation groups (PPGs). The general practice contract of 2015 requires all general practices to establish PPGs.

(31) The activities of PPGs can range from consultation (least engaged) to partnership and shared leadership (most engaged). In the Netherlands, the engagement of older persons in research and care development was a priority of the National Care for the Elderly Program and still is of its successor, the '*Beter Oud*' program. (34) It has also been applied in an optional framework in numerous local care projects; however, in contrast to the UK, there is no formal obligation in Dutch general practice. (35)

The MOVIT and ISCOPE projects provided additional experience regarding the engagement of older persons. It seems warranted to further develop this experience and study the impact of engagement at all levels of implementation, from the individual patient to the policy level.

Application in practice

The GP practice of Mr and Mrs P. continues to strive towards improvement of their care for their older patients. The collective ambition of the staff is to provide state-of-the-art care and be at the forefront of relevant medical and societal developments. They are actively involved in the training of all their professionals and have a close working relationship with the primary care department of a nearby academic institute. Care improvement and innovation projects are performed within the practice and, when possible, they also take part in regional initiatives and research projects.

Mr P. is satisfied with the GP practice. The GPs, nurses and assistants work hard and, compared with family and friends elsewhere, he thinks that his practice offers enough services so that he and his wife rarely have to visit a hospital. However, they find that they do see many staff members and are not always sure who to discuss some of their personal issues with. At regular intervals, they are asked to evaluate aspects of the service of their GP practice by filling in a questionnaire. Mr P. once used the open space in a questionnaire to complain about the terse reaction his wife had received from a staff member when she had forgotten an appointment. Shortly after venting his complaint, he was visited by one of the senior GPs and they had had a very satisfying personal talk. The GP had explained that the reaction of the staff member was not personal but was related to the way the practice had delegated various tasks and responsibilities. He promised to discuss organizing things differently during a staff meeting, but without personally criticizing that particular staff member. Mr P. is not sure whether anything has actually changed, but he thinks it might have because he also mentioned the matter to his fellow card club member who sits in a patient participation committee of the practice.

Overall considerations

The underlying question of this thesis about the use of patient satisfaction to tailor innovation of care for older persons to fit their expectations and values arose when the MOVIT project group was impressed by the role that patient satisfaction could play - when given the opportunity. The MOVIT project offered the flexibility to expand, test and study the role of older persons in implementing integrated care and the ISCOPE study offered the volume and data to investigate specific aspects relevant when interpreting satisfaction responses.

Combining theory and practice

The underlying question means addressing the theory of at least the three inter-related major concepts: patient satisfaction, integrated care and implementation. In science, the concepts patient satisfaction, integrated care and implementation each have a considerable body of theory and evidence in their own right. Keeping the practical underlying question of this thesis in mind, theory and evidence has been cited as required. In the first chapter, a brief theoretical introduction is given of each of the three concepts and expanded on (as needed) in the subsequent chapters. The challenge of this thesis is to combine contributions to the in-depth knowledge of these individual concepts with their combined application in the day-to-day, patient-centered improvement (organization) of care. By focusing on this combined contribution, the key findings of our studies show that even the quantitative representation of patient satisfaction can reflect the patient needs and preferences which can be incorporated in a care improvement initiative. By translating the results to a proposal for practice, we hope to have strengthened the case for a role for patient satisfaction which goes further than an 'audit tool', by directly supporting patients in their engagement in the design and implementation of care.

Focus on the GP

The presented studies focus on the role of the GP as one of the main care providers in integrated primary care for older persons. While our focus on the GP reflects the prominent role the GP plays in the eyes of older persons, other professionals (e.g. nursing staff, elderly care physicians, pharmacists) are equally important in the ISCOPE and MOVIT projects. This was particularly the case in the inter-professional working groups of the MOVIT project (see the narrative description of the MOVIT project in Chapter 6). Although some of the patient responses were specifically examined in relation to the GP, we also see them as an example for the role of the professional care provider in general. Also, we regard the satisfaction of patients about the role of their GP in integrated care as relevant to the whole of integrated care. It is important to establish whether the findings concerning the GP also apply to other healthcare providers.

Aspects of Integrated care

Integrated care is: 'The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system'. (12) To provide integrated care both the management and delivery aspects have to be addressed. These two different aspects of integrated care for older persons in primary care are presented in this thesis: i) as an organizational aspect the MOVIT project presents teams of GPs, elderly care physicians, pharmacists and nursing staff, defining and developing steps on their own route towards organization of improved integrated care in residential care homes; and ii) as a delivery aspect the ISCOPE study presents the training of GPs and practice nurses in formulating and carrying out care plans together with individual community dwelling older persons with complex care needs (Chapter 2 and 3).

These two operationalizations represent the different, but partly overlapping, aspects in integrated care. They differ in that care plans (ISCOPE) are a basic tool in providing integrated care and an inter-professional cooperation in a team (MOVIT) is a requirement in organizing integrated care. They overlap in the fact that a common goal in developing integrated care of (MOVIT) teams is to enable and perform care plans and that, in order to perform care plans, inter-professional cooperation is necessary.

Changes in organization of care

At the time of the performance of the ISCOPE and MOVIT projects (2008-2013), there was no fundamental difference between medical care for older persons with complex care needs inside and outside residential care homes. In both cases the GP was the central professional and patient-centered care plans, and developing and organizing inter-professional cooperation were common themes. Since 2013, traditional residential care homes as a form of sheltered living for older persons have almost disappeared in the Netherlands; most older persons are now living in the community independently in newly appearing forms of sheltered living, or are admitted to nursing homes when they have severe care needs. The elderly care physician is starting to play a more prominent role in the medical care for community-dwelling older persons than was previously the case in the residential care homes. Welfare support is increasingly recognized as an important contribution to integrated care, and forms of integrating medical care and welfare support are being developed. Patient-centered care plans and inter-professional care development remain important ingredients of integrated care in the current community-based situation with a more important role for the elderly care physician and welfare support. We have tested this conclusion in applying the 'MOVIT approach' in a number of pilots in the community with the added elements of active engagement of older persons and welfare workers (MOVIT-XM). These pilots have not yet been evaluated and fall outside the scope of this thesis.

Research methods

Sitzia and Wood warned against the tendency to use satisfaction as an audit tool, in which large-scale surveys appear to be the most effective approach. (3) Since the reality is that, in real-life implementation, quantitative satisfaction audits are still widely used as outcome, we have chosen to investigate this phenomenon quantitatively in four of the five studies presented in this thesis. However, the theoretical context in which they are placed is, to a large degree, qualitative. It is also clear that in order to understand the meaning of, particularly patient (dis)satisfaction, the voice of the individual patient needs to be heard and explored. In research terms this means that qualitative methods are needed. In practical terms, we have stressed the importance of the voice of the patient in shared decision-making at the individual level, and patient involvement at the organization and policy levels.

Ongoing activities

We regard the absence of qualitative research as a limitation of the present work, which we have started to remedy as part of our ongoing activities by using a wider range of research methods. Based on the studies and results presented in this thesis, our research group has outlined new studies to further examine the background and mechanisms related to the satisfaction of older persons with their GP.

Our first ongoing study is dedicated to community-dwelling older persons who experience hindering health complaints that disturb daily activities. If GPs are unaware of such complaints, this could lead to a mismatch in expectations, provided care, and low satisfaction. To investigate how older persons experience hindering health complaints, how they deal with them, and what they expect from their GP, we are currently performing a qualitative study. Community-dwelling older persons (aged ≥80 years) with pain and/or problems with walking/standing according to a written screening questionnaire were invited to participate in a (group) interview about hindering health problems and their expectations from the general practice and GP. The qualitative analyses using the framework method are currently in progress.

In parallel to this study with older participants, we are also performing a qualitative study with GPs as participants. The main question of this study is how GPs can improve integrated primary care for older persons, with special attention paid to hindering complaints in daily life. The findings from the focus groups with older persons are introduced and explained in these focus groups with GPs to fuel the qualitative discussions on innovation possibilities to improve primary care.

Combining the qualitative results of those two studies will provide further insight into the needs, expectations, and experiences of older persons in primary care and the possibilities of GPs to responds to these.

Based on the 2017 standpoint of the Dutch College of General Practitioners for elderly care, we are currently developing a self-evaluation instrument for GPs which they can use to compare their own perception of their performance on the various dimensions of integrated care for older persons with the perceptions of their patients. (36) This instrument was developed to specifically measure patient satisfaction and is intended to help GPs recognize possible gaps between their own perceptions and those of their patients and thereby prioritize patient-centered improvements in their care.

The future

There is broad consensus as to the desirability of patient centeredness and integration of care for older persons with complex care needs; however, both can be further improved. Continuing development of policy and practice in these directions is, therefore, a necessity. However, questions remain as to how to design and implement this integrated care in a way that best fits the wishes and needs of older persons.

In this thesis, we indicate how patient satisfaction can be used in our changing world to tailor care for older persons to fit their expectations and values. As these findings are based on evidence and systematically described experience, this thesis supports not only the relevance of patient satisfaction but also the feasibility of its use. While encouraging the use of patient satisfaction as a tool, we also need to warn all care providers about the reluctance of older persons to express dissatisfaction; this implies that we encourage them not to be complacent with a score of 7 out of 10 on a satisfaction scale, but to strive for at least a 9 out of 10 and to investigate any score lower than average on an individual basis.

Our research group recognize that inter-professional cooperation in integrated care for older persons in the community can be improved. We aim to contribute to this improvement by prioritizing this in the training of General Practitioners and Elderly Care Physicians. This means not only providing inter-professional training for these two groups of trainees, but also developing links with the training of medical specialists, nurses and social workers; our group is currently implementing initiatives to realize these goals. With an aim to collect further experience and evidence, an ideal situation could be a cooperation between older person representatives, research and teaching departments and clusters of GP practices so that care innovation, teaching, patient participation and research can be optimally combined.

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