Chronic care in Belgium: development of a position paper

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- Request from the Minister
- In collaboration with:

  - Steering Group
  - Observatory for chronic diseases
  - Experts and stakeholders

- Background:
  - International concern: growing burden
  - National programme « Priority for chronic patients! »

Development of the position paper

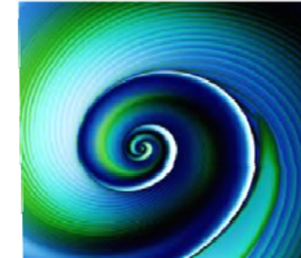
- **Papers International Organizations + 4 National Plans**

- **Literature:**
  - **KCE reports**
  - **Patient empowerment**
  - **New roles and functions**
- **Belgian situation:**
  - **Main initiatives**
  - **Analysis by experts and stakeholders**
  - **Coordination structures**

Structure of the position paper

- Routine care
- Specialized Services
- Early identification
- Patient and Family Empowerment
- Dynamic care model

Plan, Provide, Coordinate routine care



- Individualized care plan
  - Patient's life goals + needs
  - = Guide for all interventions

1. Multidisciplinary teamwork +
   - shared electronic medical record, incl. chronic care module
   - common tools: patient's evaluation
2. Training :
   - multidisciplinary work + set up of care plan

Plan, Provide, Coordinate routine care

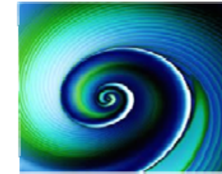
3. Attractivity of nurse/GP professions
    - Education
    - Working conditions
4. Develop/recognize new functions
    - Task delegation
    - Advanced practice nurse
5. Care in the least complex environment
    - Policies to encourage patients to stay at home
    - Support informal caregivers

Plan, Provide, Coordinate routine care

6. Quality: develop/implement a continuous Quality Improvement programme:
   - Framework, QI selection , data collection system, feedback

7. Coordination: support the GP for the management of complex situations
   - Case manager
   - Support networks for professionals

Provide acute Episode Response and Specialized Services



8. Role at critical moments (diagnosis, exacerbations, comorbidities) – continuum with the first line of care
9. Support of primary care team by specialists
10. Intervention integrated within the care plan
11. Hospitalisation // seamless care: shared protocols, shared medical record, discharge manager

Conduct Early Identification Activities

- Out of scope: health promotion / primary prevention

- Rec 12:
  - Orientation population screening programmes
  - development of broad detection skills for the identification of chronic conditions

  - Caveat overdiagnosis

Support Patient and Family Empowerment

13. Health professionals:

- **Importance of partnership with patients/informal caregivers**
- **Skills for patient empowerment**

14. Patient-empowering attitudes and actions integrated in routine care

Implementation and follow-up of a dynamic care model

15. Scientific know-how

- guidelines adapted to multimorbidity
- strategic cell to track the developments in chronic care
- + competence pool to optimize implementation (management, process engineering, legal, computer sciences…)

16. Optimize/create coordination structures:

- operational/strategic meso level
- highest strategic level

Implementation and follow-up of a dynamic care model

17. **Accessibility / equity for the chronically ill**

18. **Evolution of payment systems :**
    - **Towards mixed forms of payment**
    - **Reward quality**
    - **Gradual implementation with pilot testing**
    - **Invest in primary care**

Implementation and follow-up of a dynamic care model

19. High level planning of human resources based on needs and ongoing monitoring

20. Transform the recommendations and action points of this position paper into an operational chronic care plan, and evaluate their implementation (relevant indicators)

Implementation and follow-up of a dynamic care model based on evolving societal values, patients and families needs, state-of-the-art practices and budgetary constraints

Conduct health promotion & prevention activities

Conduct Early Identification Activities

Plan, Provide, Coordinate routine Care

Provide Acute Episode Response and Specialized Services

Provide seamless/ integrated care

Support Patient/ Family Empowerment

For each activity check the following requirements:

- TAILORED DELIVERY SYSTEM DESIGN
- APPROPRIATE WORKFORCE
- APPROPRIATE BUDGET AND RIGHT FINANCIAL INCENTIVES
- PROCESSES IN SUPPORT OF QUALITY OF CARE
- KNOWLEDGE MANAGEMENT AND DECISION SUPPORT
- CLINICAL INFORMATION TOOLS

Colophon

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