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
  - Conceptual framework
- Literature:
  - KCE reports
  - Patient empowerment
  - New roles and functions
- Belgian situation:
  - Main initiatives
  - Analysis by experts and stakeholders
  - Coordination structures
  - Submission to +/- 100 experts and stakeholders
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
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