Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

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**

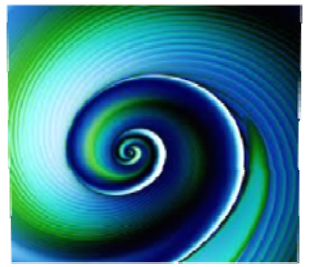
- **Literature:**
  - **KCE reports**
  - **Patient empowerment**
  - **New roles and functions**
- **Belgian situation:**
  - **Main initiatives**
  - **Analysis by experts and stakeholders**
  - **Coordination structures**

  ⇒ **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

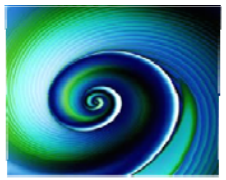
3. **Attractivity of nurse/GP professions**
   - Education
   - Working conditions
4. **Develop/recognize new functions**
   - Task delegation
   - Advanced practice nurse
5. **Care in the least complex environment**
   - Policies to encourage patients to stay at home
   - Support informal caregivers

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

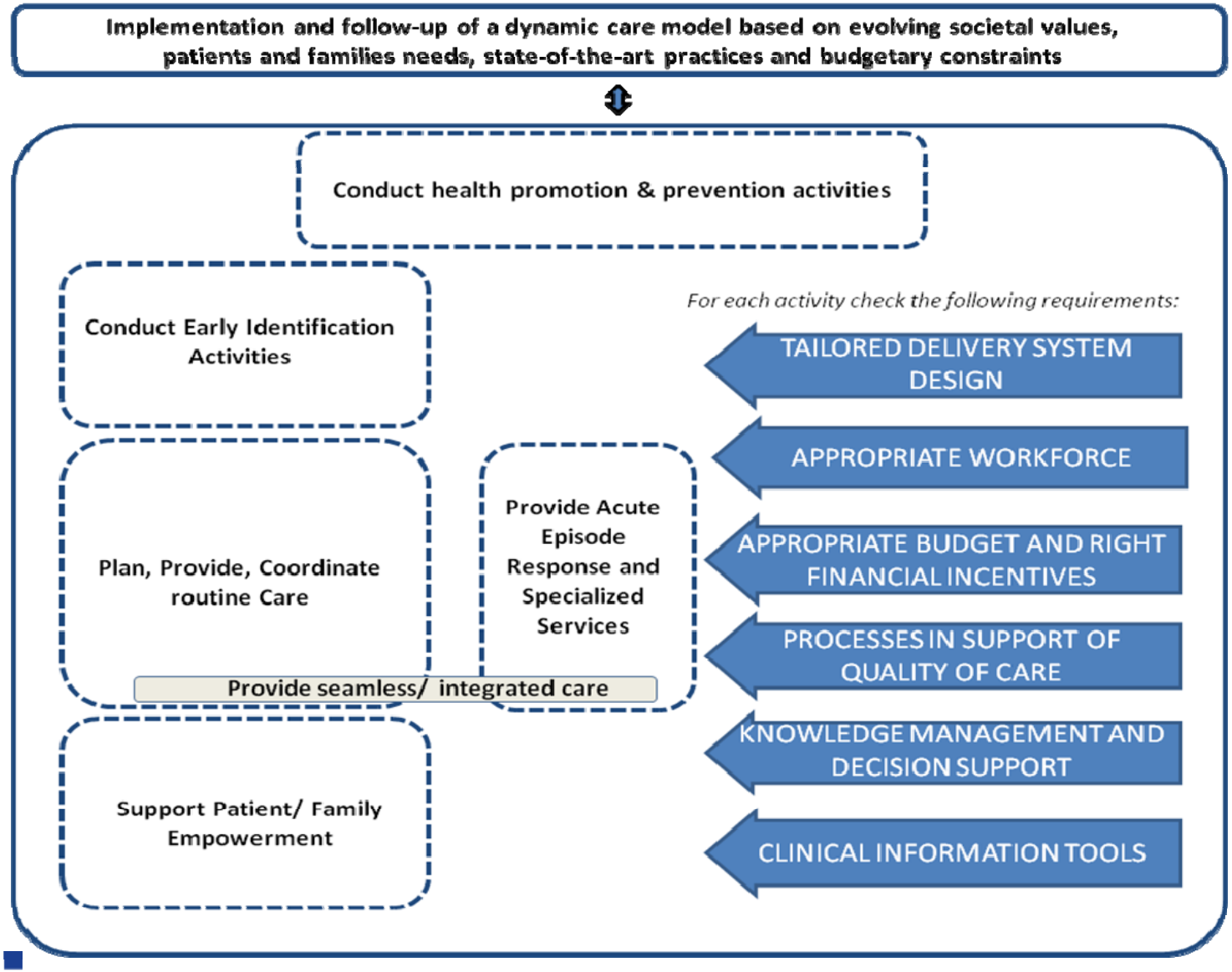
18. Evolution of payment systems :

- **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

Colophon

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Colophon

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