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Conference Proceedings

Proceedings of the NIHDI 50th Anniversary Event

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Background

On 2nd April 2014, an invitation only event supported by IFIC and for the benefit of NIHDI and its members was held at the Academy Palace, Brussels. The meeting brought together policy-makers, managers, health care professionals and patient representative groups from Belgium, Germany, France, the Netherlands, Spain and the UK to debate the future of the care system in Belgium. Specifically, the event was used as an opportunity for international experts to examine and critique an orientation note entitled *An Integrated Vision on Care for Chronic Diseases in Belgium*. Prepared by the Belgian Health Care Knowledge Centre (KCE) with the Federal Public service for Public Health and NIHDI, this position paper set out the way in which the Belgian health care system should be organised in the future to meet the challenge posed by the growth in numbers of people requiring chronic and long-term care

Taking forward the principles for high-quality and effective care for the chronically ill as set out in the international literature, and especially drawing on the Chronic Care Model (Wagner et al, 1996), the position paper sets out its goal to provide to the chronically ill:

'a coordinated set of services with the following characteristics: personalised services, based on patient needs, geared towards an objective, planned and delivered by professionals. These services should include routine care for chronic conditions as well as the care needed for acute episodes of the disease. These high-quality services should be based on the best scientific data available. They should be easily-accessed and delivered efficiently and sustainably, while taking account of cultural specificities and promoting 'empowerment' of the patient, in the simplest possible environment which is still clinically appropriate. The aim is to improve quality of life for the beneficiary, helping him to function as best he can in a school, work and community environment.' (Paulus et al, 2012).

The principles underpinning the position paper included a commitment to empowering people to take more control over their needs and approach to system redesign that simplified the care system, enabled flexible responses to people's individual needs, enabled the sharing of information for

improved coordination and cooperation through the digitisation of medical records, and guaranteed the commitment to equity and fair access to affordable care services. Six specific areas for action were introduced, including:

1. The multi-disciplinary and digitalized patient file;
2. Case management;
3. Multi-disciplinary approach to care;
4. Education and training to promote new ways of working;
5. Quality improvement and assessment of care
6. Implementing, supporting and assessing actions potentially through a coordination unit to help steer strategic and operational aspects of the plan.

Within each of these areas, specific actions and objectives were set out with detailed notes on the processes, procedures and roles to be performed to achieve them.

About this report

This report provides a summary of the proceedings from the event held on 2nd April. The report provides an overview of the presentations and discussions made during the event in an attempt to pick out the key points of learning. The report concludes with a review of the key lessons emerging from the event and the suggested implications for the future of the Belgian strategy to develop integrated care for people with chronic condition.

Proceedings

Opening remarks

In his opening remarks, **Mr Jo De Cock, Administrator General, NIHDI** argued that there was a need in Belgium for better co-ordination and collaboration at both a policy level as well at the level of patient care if the demands of the growing numbers of people with chronic conditions were to be met in a safe and high quality way. This was especially important for people with multiple comorbidities. To achieve this is required:

- a motivated workforce with the rights tasks, roles and responsibilities;
- the right organisational arrangements;
- more involvement of patients;
- better communication and collaboration between health and social care; and
- a focus on holistic needs rather than on single conditions.

De Cock emphasised that integrated care should seek to benefit people through improved outcomes, better patient safety, greater efficiency and increased satisfaction. He reiterated the purpose of the workshop was to discuss how the plans in the orientation note could be best implemented through benchmarking it with good practices from abroad and opening the plans to critical appraisal to support guidance for further action.

In response, **Dr Hans Kluge, WHO Europe** welcomed the Belgian plans, especially related to equity and fairness, stating that the WHO remains committed to seeing health as a human right,

promoting solidarity, equity, citizen participation and universal health coverage. Kluge argued that the protection of such values was not a given fact, especially in times of economic crisis.

Kluge argued that a paradigm shift in health care was required to move from disease-orientated to people-centred care and population health. The ethos of being people-centred needed to be strongly advocated, with professionals asking ‘what matters to you?’ not just ‘what is the matter with you?’

Kluge also pointed to the importance of inter-sectorial action to achieve these goals, including the involvement of social care (for example, in supporting people with Parkinson’s disease to live well with their conditions); the role of inter-professional education to support people with frailty and multiple morbidity through team-based care; and the recognition that financing health care is not a ‘bottomless pit’ of wasted resources to be cut back, but a fundamental investment in the wealth of nations since good health is associated with economic growth.

Kluge presented the work WHO Europe are leading to create a roadmap for the achievement of coordinated/integrated health service delivery and specifically seven ‘action areas’ where priority attention is needed:

1. Information and knowledge – effectively gathering, sharing and using information to enable relationship-building, shared-decision-making and effective management of performance
2. Competencies – cultivating a skilled, motivated and available workforce
3. Resources – aligning financial frameworks to ensure adequate and sustainable funding is in place and building human capital
4. Services – defining integrated care packages and pathways for the coordination of clinical and non-clinical care
5. Policy – developing a long-term political vision and associated governance and priority-setting to drive integrated care forward
6. People – engaging and motivating people in the planning and design of care systems, empowering communities and care professionals
7. Culture – transforming and fostering attitudes, values and organisational and professional cultures conducive to holistic and integrated health service delivery

Kluge challenged the audience in understanding how to lead and drive forward integrated care arguing that it needed both top-down and bottom-up drivers for change.

The Integrated Vision on Care for Chronic Diseases in Belgium

Dr Ri De Ridder, MD and Director-General, NIHDI provided an introduction to the health care system in Belgium and some of the challenges that it has presented for developing more effective chronic care. Dr De Ridder explained that Belgium had an essentially a fee-for-service type system with co-payments and co-insurance for patients. There was freedom of choice of care providers and high usage of GPs (mostly self-employed) through which to gain access to specialist care. The lack of differentiation within primary care, and between primary and specialist care, was identified as an issue of fragmentation together with disease-based vertical segmentation of care with a lack of emphasis on multi-disciplinary working and dealing with complex care needs (except for palliative care). De Ridder also highlighted other challenges to care integration in Belgium, including: the lack of an electronic health record through which to share clinical and managerial information; the lack of clinical

leadership to support integrated care objectives; and funding streams that did not promote effective primary-secondary care working.

In response to such challenges, De Ridder outlined some of the innovations undertaken in Belgium to promote more integrated care working including:

- schemes to support follow-up of patients with diabetes type 1;
- capitation funding to support care co-ordination tasks, such as software for medical record keeping;
- clinical guidelines and decision support tools to establish best practice care across care pathways;
- a national roadmap for e-health (to 2018);
- integrated care programmes within hospitals;
- a scientific committee on chronic diseases; and
- investment funds and new legal instruments to enable investment in new approaches.

A 2008 Plan had previously identified the importance of tackling chronic illness, though placed the emphasis of reform on reducing financing and administrative burdens promoting socio-professional integration; improving access to care; and promoting patient participation in policy-making through the creation of an 'observatory' on chronic disease.

To further demonstrate the history in Belgium in looking at new approaches to care, De Ridder then provided an overview of three specific projects:

- a care innovation project for frail older people;
- an initiative looking to develop care trajectories (pathways) to transform the relationship between GPs and specialists through care planning and multi-disciplinary team working; and
- 'article 107' providing a mechanism to re-use hospital budgets to develop mental health care in the community. Each had achieved some successes.

Dr De Ridder concluded with an overview of the history, rationale and contents of the position paper on chronic care (see above) stressing the importance of developing a more needs-based, goal-oriented approach to empower patients through an adaptation of the principles of the CCM. Dr De Ridder provided an outline of the 20 specific actions across care for persons with six chronic conditions and provided an overview of the feedback they had received during the consultation stage. The Plan was welcomed as a necessary way forward for Belgium with a good choice of key action areas, yet a number of challenges were identified by stakeholders to its implementation:

- the absence of any specific role for certain key care providers, for example mental health and pharmacy;
- the degree to which patients may really become empowered through case management
- whether the proposals really represented a simplification of the system, though this was a welcome objective;
- the potential undermining of the future role for hospitals and specialists in the new system;

- the role of the health insurance funds in determining health policy;
- the feeling that case management through nurses would duplicate existing activity and the strong belief that GPs should retain direct control over the work of case managers;
- the need for the actions to be more concrete in terms of setting out next steps;
- concern from the medical profession over a number of fundamental issues including: organisational upheaval; patient confidentiality; freedom of choice; replacing GPs with ‘less competent’ care professionals and the risks to patient care; the perception that care co-ordination was not actually necessary to improve the system: *we don’t believe that the chronically ill patient needs integrated care, they need free choice of providers*

In conclusion, De Ridder challenged the expert panel on how to overcome such implementation challenges in a social health insurance context – for example, on the balance between top-down and bottom-up initiatives; the worth of pilot programmes; and the need to gain consensus before implementation.

International Review of Strategy

This session provided the expert views on the draft Belgian position paper on chronic care from five key policy-makers and opinion leaders from different countries in Europe. Each speaker had 15 minutes to provide their views, and the summaries are provided below.

Dr Hans Vlek, a GP and Project Manager from Slimmer met Zorg and Expert, Vilans Centre of Excellence in Long Term and Social Care provided the first response from the Netherlands. Dr Vlek noted that the Netherlands had many of the same challenges as Belgium including ageing populations, growth in chronic illness, rising costs and fragmented services. Hence, there was a key need to find ways to achieve better care outcomes at less cost through integrated care.

The first point made by Vlek was that the position paper needed to better articulate the outcomes to people and the system that the approach was seeking to achieve. Whilst it was important that the position paper stressed to move away from a disease-oriented approach, more was needed on the ambition to improve the quality of life of people through the use of multi-disciplinary teams and personal care records. There was a need to focus on ‘Triple Aim’ outcomes.

Vlek then had four key points:

- *Health functioning*: a need for a 7th action area on ‘healthy functioning’ with a definition of health that moved away from the absence of disease to the ability of people to adapt and to self-manage. In other words, a key to success was for people to live well with their diseases and that quality of life was more important than treatment. To achieve this, people needed to be empowered to take responsibility for their own health and that this could be supported through bringing other public sector agencies to support the process. The importance of inter-sectoral action was not strong in the paper.
- *Substitution*: the ability to enable the effective substitution of hospital-based care with primary and community-based alternatives, including encouraging specialists to work in community-based networks and support self-management. Whilst the orientation note discusses some of this, perhaps more could be said on the importance of substitution.

- *Nurse-led primary care*: delegation of responsibility away from GPs to nurses, for example in case management, was necessary to manage long-term chronic illness. Vlek argued that nurses were better placed than GPs to handle the ongoing management of chronic care and that the position paper should reconsider whether case managers should be assigned to a GP since they shouldn't be seen as their medical boss but as an equal partner in the care team. The shortage of GPs will, in any case, force the issue.
- *Involvement of professionals* was necessary to develop the necessary normative and cultural affinity to care to persons with a chronic condition agenda otherwise it would be hard to see how the strategy might succeed. More work needed to be done on this issue.

Dominique Polton, Conseillère du Directeur Général, CNAMTS, France found the paper relevant and interesting, but stressed how France was not a good example to draw from since care was fragmented and based on fee-for-service. Her focus was on issues in terms of implementing the plan. She pointed to four key issues based on French experience:

- *Organisational models*. There is a need for multi-disciplinary teams in the paper, but this has not been possible in France since the degree to which GPs and other professionals (nurses, therapists, pharmacists) co-operate is low given their independent status. Co-ordination between sectors is, however, a required function (e.g. through case managers or navigators) and so specific new agencies had been established to support this process – for example, to facilitate hospital discharge. For older people, new teams with a directory of available services through which to support navigation between care services have been created.
- *Tools*. Care plans, the training of professionals, shared information systems and the role of a care co-ordinator to support people with complex needs were all highlighted as possible solutions.
- *Step-by-step* approach needed to put the building blocks in place before seeking to apply the wider vision. For example, developing good information sharing before investing in electronic medical records, or developing disease-management programmes as a first step forward to something more ambitious. Therefore there was a need to articulate achievable first steps – currently, the position paper may seem overly ambitious.
- *Benefits to all?* The focus on risk stratification and targeting was seen as potentially exclusive and would work against the French culture of 'egalite'. The same cultural norms and values amongst people and patients in Belgium need to be taken into account to ensure that the use of ICT to stratify populations and target interventions is not seen as a way of rationing care.

Evert-Jan van Lente, an economist and consultant to the CEO/EU-Affairs, AOK Bundesverband in Berlin Germany congratulated NIHDI on its 50th Anniversary and welcomed the opportunity to share his views and to challenge a number of key issues. Mr van Lente argued that Germany faced many of the same issues as Belgium in terms of finding new care models to improve quality of life and promote home-based care whilst reducing demand and hospitalisations to support more sustainable care systems.

Van Lente specifically discussed the action area on patient empowerment arguing that, in the German context, there was little evidence for the effectiveness of approaches to patient empowerment since interventions were very complex, rarely centred the approach around the GP or primary care (rather being a separate stand-alone activity) and rarely focused on supporting carers and family members. Van Lente argued that there were many strategies that could be employed including: information provision, such as patient guidelines to support people living with chronic illness; telephone counselling; and health behaviour courses. Patient education, including

on-line tools, and technologies to support self-management of risk factors remotely were seen as potentially good strategies though had not always been successful.

Van Lente also focused on the problems of case management, specifically in how to target the right people in need of care. He argued that predictive models in Germany had primarily focused on reducing readmissions for heart failure patients post-discharge but were otherwise under-used. Van Lente also discussed the staffing requirements and the need for a specialist case manager or advanced care practitioner (e.g. a scheme called AGNES to support home visits in remote areas) and whilst larger practices had case managers the question of duplication vs. substitution was an issue.

Van Lente argued that case management could be cost-effective when deployed appropriately, but problems often arose in terms of the sheer numbers of patients to be managed, the additional management costs implied, the scarcity of nurses to meet demand, and the lack of a business model for independent companies to take on the risk of developing such schemes. Mr van Lente described an effective scheme in Germany called PracMan that asked GPs to use their clinical judgment to take 20 people from the top 50 people 'at risk' of hospitalisation and then provide them with personalised assessments and goal-based care plans.

Derek Feeley, Vice-President at IHI in the USA and former Chief Executive of NHS Scotland, reported that he had seen (and written) many strategies in his time and that the Belgian position paper was a 'good strategy – clear, unambiguous and with ambitious and stretching goals' that were appropriate. Many of the core principles in the paper were important, including: the need to move from a disease-based to a needs-based approach; the focus on prevention and lifestyles; and the need to empower people who will spend the vast majority of their lives caring for themselves in any case.

Feeley had specific concerns about how the plans and principles in the strategy might be transferred into action arguing that most strategies are never implemented just as most pilot schemes don't spread. Part of the reason behind this was the lack of emphasis on building the guiding coalition to take things forward amongst all stakeholders, but especially medical professionals and service users. Mr. Feeley noted that the document needed to include a change management strategy, including identifying a dedicated resource to enact the plan and someone, or team, to make it happen (the 'integrator').

Feeley also noted that more in the document was needed on developing a learning system to measure outcomes, understand what is working and what is not, and make adjustments over time. Whilst investment in research was important, too often evaluations were used to justify changes rather than examining the changes to inform the evaluations. Formative evaluation and tools for quality improvement are required so that care systems can adapt over time. Mr Feeley also warned about developing too many targets and standards through which to measure quality arguing that only 50% of standards are met 50% of the time. There was a need to go beyond standards and examine the 5 or 6 things that the system should seek to do reliably and well.

However, Feeley also suggested the need for stretch goals and an indication of how much needs? to happen and by when? Goals and timescales were missing from the document, but there was an opportunity to engage people in setting these aims as part of building the guiding coalition to support the implementation of the strategy. Specific measurable goals were needed to drive system performance, but it was important not to worry too much on the measures – the aims and objectives and methods of providing care were needed to be developed first.

Feeley also felt more was needed on the methods through which certain action areas could be achieved, for example pointing to Scotland's Breakthrough Collaborative Series for younger people as one example of an approach. Finally, Feeley stressed that it was important to simplify the process and

make change an attractive proposition for people to get engaged with, so focusing on positive messages (e.g. quality improvement) rather than negative ones (e.g. cost containment).

The final set of reflections from **Mr Rafael Bengoa**, former Minister of Health in the Basque Country, Spain, reiterated that the position paper was saying all the right things in terms of the necessary focus on chronic care – i.e. population management, metrics, multi-disciplinary teams, training, empowerment and engagement etc. However, Bengoa was more concerned with the challenge of 'how to' implement such a vision and the change management journey required.

A key message from Bengoa was to take the change to a policy-level for ratification or agreement with parliament since incentives on the ground would be unlikely of themselves to move the agenda in the direction required. Bengoa said that the tools to support chronic care at a service level needed to develop simultaneously with a positive political environment over a period of at least 4-5 years where consistency was required.

Bengoa also stressed that the position paper needed a stronger argument, or burning platform, as to why change was needed and also its inevitability to get medical professionals to listen. It was important in the process to not alienate GPs and primary care in the process, especially since they will be tasked with leading the change, but find time (4-5 months) to build the rationale for change with them and get them on board and enthused about change. For this, Bengoa stressed the importance of moving away from technical language such as 'integrated care' but to develop a more compelling vision on how people and professionals will get a better deal from the change. Engaging people and having their voice in the vision was important in the process. To support this, more thought could be given to communication strategies in how the vision should be articulated to people.

As a final set of comments, Bengoa argued that it was important to show how the 6-7 action areas ought to be combined to create a better outcome rather than see them as separate strategies. It was also important to realise that leaders will continue to have two agendas – dealing with 'resist' cultures that focus on cost-containment without changing the system, whilst focusing on transformational change requiring both a top-down and bottom-up approach. Finally, achieving scale was unlikely to be achieved through pilots, but through a process of transformational change and self-discovery.

Discussion

Prof. Guus Schrijvers, Chair, IFIC led the discussion following the presentations from international experts and focused the conversation on case management. Gathering views from the audience, a range of doubts about case management were raised including: the lack of a good evidence-base for its effectiveness; fear that it may create more paperwork and bureaucracy; and questions over whether the approach was equitable and processes for how you choose who receives care. The issue of substituting GP with nurse roles was also questioned, with arguments suggesting GPs should retain professional overview of the process and not be de-skilled and disenfranchised since caring for chronic patients requires medical expertise as well as ongoing care management. Hence, case management should be seen as a 'function' of primary care and not a 'role'!

A key discussion was also made on the need to empower people as a first principle of care management as well as to understand and influence the socio-economic issues that cause people to become chronically ill in the first place. **Nick Goodwin** argued in discussion that the evidence on case management is mixed because often the design principles of good quality case management have not been observed, for example:

- having effective inclusion criteria to choose those people who can be best supported to live well with their conditions and so reduce propensity for hospitalisation or nursing home placements;
- being pro-active will initially increase demand for specialist services that cannot be managed in community care, so there can often be a spike? in admissions;
- a lack of focus on empowering patients and promoting continuity of care may see care experiences decline in case management, so it should not be seen primarily as a technocratic exercise in disease management and admission avoidance;
- the inability to draw upon services 24/7 often leads to spikes in admissions at night and weekends when service are not available, so there is a need to ensure an effective and responsive service to patients with complex needs at all times;
- the lack of responsiveness or availability of services in the community outside those provided by case managers and multi-disciplinary teams (MDTs) can undermine efforts to support people effectively;
- there are specific skills to the care co-ordinator/case manager role that require attention ranging from clinical skills in managing illness; relational skills in providing continuity of care to patients and families; advocacy skills in bringing together care providers to meet the agreed goals within care plans, including within the MDTs. Hence, the care management function is a specialist skill requiring a range of competencies.

Ehud Kokia from Maccabi Health System in Israel mentioned that in his system nurses and GPs worked closely together in group practices and were paid and encouraged to provide care management. The importance of nurses was they were better, and had more time, in building therapeutic relationships with patients, listening to their needs, and educating them to manage their care. Hence, teams of GPs and nurses require clear roles and responsibilities to overcome the potential for duplication.

Hans Vlek also advised that care needed to be undertaken as simply as possible, supporting personal and holistic care plans, attention to medical care and healthy functioning, supporting and empowering people through shared decision making on care and treatment options.

Jo De Cock was then asked to provide a short summary of his impressions of the discussion and the morning session. His initial conclusions were as follows:

- that the position paper was broadly supported by the international experts as going in the right direction, though more work was needed in building specifics into how the plan could be implemented;
- that there was a need to make change attractive and specifically to spend more time on involving doctors and other stakeholders in the vision; and
- that case management was a 'function' and not a specific clinical role but that care co-ordinators, were important.

Toward integrated care in Belgium: key implementation challenges and practical solutions

The second half of the 50th Anniversary event was dedicated to examining four key implementation challenges, with possible solutions, facing the plans and vision for the future of chronic care in Belgium. Comprising two expert speakers the four challenges discussed were:

- **Challenge 1: Patient engagement and empowerment.** What should care systems do to better empower people and communities to transform the patients' experience?
- **Challenge 2: Organisation of care at a clinical and service level.** How can care be best coordinated around the needs of people with complex chronic ill-health?
- **Challenge 3: ICT and integrated care.** How can information and communication technologies best be deployed to promote integration between organisations and professionals, and promote integrated care to patients?
- **Challenge 4: Governance and financial arrangements.** What are the most effective governance and financial incentives that help to support and embed chronic care?

Challenge 1: Patient engagement and empowerment

The first challenge provided a facilitated discussion with **Kaisa Immonen-Charalambous**, Senior policy advisor, European Patients Forum (EPF) and **Robert Johnstone**, International Alliance of Patient's Organisations (IAPO) and National Voices, UK.

Immonen-Charalambous presented a paper examining the importance of empowering patients and a key message that the purpose should not simply to support the management of chronic conditions but to support people who are vulnerable – i.e. dependent on access for support; reduced ability to work; those with low incomes or living in poverty; those who are discriminated against or whose illnesses come with stigma (e.g. dementia). There is an indirect as well as direct cost.

Immonen-Charalambous described how, for many people, gaining access to care and support was an 'impossible maze' and that focusing on people as part of the solution was necessary. This required a needs-based and goals-based approach, not disease-based. Care should be provided in the least medicalised way as possible.

In reviewing the position paper, Immonen-Charalambous reported that it was providing the right messages in terms of the need for: multi-disciplinary teams; medical and non-medical care; involvement of patients, family members and carers; and self-management. However, she raised concerns that the paper had a limited definition of empowerment and that more needed to be included on the importance of shared decision making and a better power balance between professionals and patients/people. People should be seen as co-producers of health and the approach to care needed to nurture and be enabling, rather than (as is too often) see people as a burden or to blame for their own ill-health.

A second key message was to focus more on promoting health literacy to improve the ability of people to access, evaluate and relate to information about their own situation and so help them make healthier choices. In the position paper, the importance of information and communication to patients and people was missing – a clear and comprehensive communication strategy, in culturally sensitive, empathetic and clear language, was needed on: lifestyles; diagnosis/symptoms; treatment options and evidence; and safety and quality concerns. Such communication should be designed *with* people.

As a final key point, Immonen-Charalambous talked about the need for activated patients as a valuable learning resource in health systems, and how systems should be co-designed with people – in terms of: prioritising needs, planning care, designing delivery, co-producing health, evaluating outcomes, and improving quality.

Mr Robert Johnstone reiterated the point that integrated care is not a relevant strategy unless it starts with empowering patients. He described how clinical care might often be good, but how the care process was often an alienating and counter-productive experience. Hence, as an activated patient, it was often the case he had to find ways to navigate the system in order to get what he needed with little co-ordination or support – others less empowered would be unlikely to be able to do this.

Mr Johnstone argued that whilst shared decision-making and patient empowerment were included in the Belgian position paper on chronic care, the wording still described people as part of the problem rather than part of the solution. Using patients, and the knowledge and expertise they represent within communities, was an untapped resource.

Challenge 2: Organisation of care at a clinical and service level

The second challenge was supported by presentations from **Dr Nick Goodwin**, Co-Founder and CEO, International Foundation for Integrated Care and Senior Fellow, The King's Fund, London, UK and **Prof. Bert Vrijhoef**, Professor of Chronic Care at National University of Singapore & Tilburg University.

Dr Nick Goodwin examined the evidence for how best care could be co-ordinated around the needs of people with complex chronic ill-health. Nick reinforced earlier comments, using the example of a carer supporting their husband with dementia, the significant challenges of meeting people's needs:

- a lack of ownership from the range of care providers to support 'holistic' care needs, driven by silo-based working and separate professional and organisational systems for governance and accountability;
- a lack of involvement of the patient/carer in supporting them to make effective choices about their care and treatment options or enabling them to live better with their conditions through supported self-care and empowerment strategies;
- poor communication between professionals and providers, exacerbated by the inability to share and transfer data, silo-based working, and embedded cultural behaviours;
- care and treatment by different care providers for only a part of their needs, rather than seeing the person as a whole and managing all of the needs;
- the resultant simultaneous duplication of care (e.g. repeated tests or re-telling of a person's medical history) and gaps in care (e.g. as appointments are missed or information and follow-up is not applied);
- a poor and disabling experience for the service users as information is hard to get hold of, differing advice and views are presented, confusion is created in the next steps of a course of illness;
- reduced ability for people to live and manage their needs effectively; and ultimately
- poor system outcomes in terms of the inability to prevent unnecessary hospitalisations or long-term residential home placements

In examining the evidence for supporting more effective care, Goodwin stressed the importance of: a holistic rather than disease-based approach to care management; the importance of influencing risk factors and promoting healthier lifestyles, such as through supported self-care; medicines management; and non-clinical interventions enabling people to be functionally dependent so they could live well with their conditions as opposed to a focus purely on the medical problem itself.

In reflecting on the 6 action areas in the position paper, Dr Goodwin suggested all were important but that it was important to stress certain points under each area as follows:

1. Action: Multidisciplinary HER - ICT is a tool, not an end in itself. Give people access to their records

2. Action: Case management - but learn the lessons from past successes and failure for success
3. Action: Multi-disciplinary teams - including pro-active care co-ordination and involvement of the community
4. Action: Education and training - inter-professional working and new roles and skill mix
5. Action: Quality and assessment of care - make sure that the process focuses on continuous quality improvement not performance management. Quality-based pay and incentives could be included
6. Action: Implementing, supporting, assessing - evaluation of outcomes to build evidence and support QI is important. The focus on supporting the change process is welcome

Goodwin concluded that it was undoubtedly right for the position paper to focus on people who require a flexible health and social care response, and also to avoid organisational restructuring and instead seek to simplify processes. Goodwin stressed the importance of building a compelling case for change and a common vision *with* key stakeholders from the outset, including clear and measurable objectives over an agreed timescale. Goodwin also felt the vision could be strengthened with a greater focus on: active care co-ordination; empowering users and the community; delivering holistic care in the home environment. Inter-sectoral action was the key to success, meaning that they had to be prepared to work through the roles of GPs and the hospital sector since the approach challenged the dominant medical model.

Prof Bert Vrijhoef focused more on the strategy of implementing the vision outlined in the position paper and had one key message based on early lessons from an ongoing EU project (Project Integrate – www.projectintegrate.eu) examining how approaches to integrated care could be best built: *Think Big, Act Small*.

Vrijhoef described how the vision for change needed an implementation strategy that took forward the comprehensiveness of the challenges facing Belgium but 'grew' this from the bottom-up through focusing on many smaller challenges as a pathway to meeting the bigger challenge. Undertaking a situational analysis to understand how change might be driven and achieved was needed since the challenge to making the vision operational needed consideration of the needs and views of patients, people and professionals within their social context and the context of existing organisational, political, economic and systemic structures.

Prof. Vrijhoef also described how the vision needed to be clear on what it meant by care co-ordination arguing that it should be a deliberate and pro-active process to bring care around people's needs. This would need to include four key players working together: the patient, carer and family; care professionals; and the wider care system.

Vrijhoef also gave an interpretation of the vision set out in the position paper by comparing it to the key components of the expanded chronic care model. He concluded that it focused on most of the core components required including: stakeholder collaboration, leadership and vision; shared data and performance measurement; engaging consumers and improving care delivery. However, Vrijhoef was less clear on how the vision would seek to align both financial incentives and system governance mechanisms, and what strategy would be in place to mitigate against those who might oppose change given that winners and losers would emerge.

Challenge 3: ICT and Integrated Care

The third challenge comprised a facilitated discussion with Prof. dr. Ehud Kokia, former CEO, Maccabi Healthcare Services, Israel and Dr Dirk Colaert, Chief Medical Officer, Agfa HealthCare, Belgium

Kokia provided an overview of the Maccabi health system in Israel to examine the similarities, differences and key points of learning from their experience in developing an ICT-enabled managed care system. Key elements to the Maccabi system approach to care were: comprehensive coverage; capitated budgets; managed care arrangements; and a commitment to empower people, physicians and other staff in decision-making.

Kokia argued that good chronic illness care required well-functioning multi-disciplinary teams working with activated patients in a flexible model allowing for complex needs to be met. In order to support this, integrated ICT was a key enabler – for example, to have single registry of patients, decision-support systems and patient-level reminders. Web-convenient, home-based and portable access to ICT from a patient's viewpoint was a key to providing a virtual 'one stop shop' to support care and self-care. Kokia noted that the Belgian vision was strong on EHRs, but weaker on the use of technology as a tool to support the remote management and promotion of self-care to people in their own homes.

Kokia, however, outlined the typical and often negative response from medical professionals and organisations to the deployment of new technology, this include lack of trust; greater costs and administrative burdens; the failure to see the need or value in remote monitoring and support; the loss of the human touch; the likely failure of the technology itself; that it was for employees and not for them. In response, Maccabi had provided financial incentives to participate – for example, in developing registries; supporting data and information flow, and using data to benchmark performance and stimulate quality improvement.

Dr Dirk Colaert reiterated the challenges in developing ICT-based solutions, including psychological, behavioural, organisational, and financial.

Colaert, however, described the importance of designing ICT infrastructures that could cope with the complexities of people's needs, and the complexities of the service response required – hence, he argued that patients should not be 'squeezed' onto the same linear pathways and that a different approach was required to enable diverse and flexible clinical and non-clinical workflow in response to the changing needs of patients (e.g. through using GPS technology).

Hence, any ICT infrastructure should have the following qualities:

- adapted for a specific purpose;
- integrates information from prevention, diagnosis, therapeutic, care and follow-up;
- just-in-time to support real time decision making;
- be used to support self-care and education – e.g. to help coach, educate and support patients and professionals also;
- share data and information between stakeholders;
- minimise burden and optimise time;
- support benchmarking of data for quality improvement purposes.

Challenge 4: Governance and financial incentives

The fourth and final challenge was presented by **Mr Helmut Hildebrandt**, CEO, OptiMedis AG and Gesundes Kinzigtal GmbH, Germany and Board Member, Bundesverband Managed Care and Treasurer, International Foundation for Integrated Care and **Prof. Guus Schrijvers**, Co-Founder and Chair, International Foundation for Integrated Care

Hildebrandt argued that the purpose of integrated care for people with chronic illness should seek to meet the Triple Aim goals: improved population health; improved care experiences to people; and promote cost-effectiveness. A key to meeting such a goal was to change to financing system in order to pay for the achievement of better health outcomes and not activity. Though there was a real challenge in finding the right approach to support this, an important principle to the success of integrated care was to align governance and financial aspects so that all professionals, providers and insurance companies worked together and moved in the same direction.

Hildebrandt provided the case example from Kinzigtal, Germany to demonstrate how this was being achieved through a partnership between a physician network and a management partner that rewarded investment in better health outcomes and with a shared savings contract. Hildebrandt pointed to five key success factors in the Kinzigtal approach:

- Goals based care focusing on people's holistic needs and in their social context;

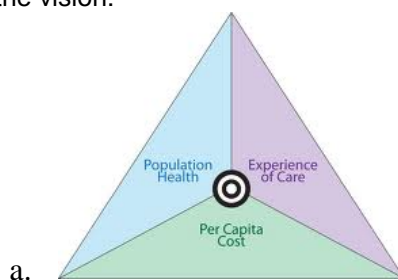
- Activating people and patients and promoting interactions and shared decision making with professionals – including use of media, social networking and building the ‘value-added’ patient
- Inter-professional education and training to develop new skills and mindsets;
- Evaluating and publishing outcomes (needing access to all data);
- Improving public health through inter-sectoral partnerships and involvement

Hildebrandt demonstrated that their approach has reduced mortality and improved health status amongst enrolled members, improved professional cooperation and people’s trust in the system, and been attractive amongst professionals as a place to work.

Prof. Guus Schrijvers provided his interpretation of the position paper and emerging Belgian strategy for care for persons with chronic conditions from an economists perspective. Specifically, Schrijvers argued that in the context of current economic constraints in Europe far more prominence should be given to Action 19 (i.e. to encourage mixed financing systems) as what was presented was not detailed enough.

Prof. Schrijvers presented ten tips as follows:

1. Make an assessment of current payment systems and their pros and cons;
2. Change the assumption on 3-5% growth in money to assume that better outcomes can be done with the same money – creates a burning platform for change
3. Seek to reform fee-for-service based payments if possible
4. Put Triple Aim thinking into the vision:



5. Experiment with new governance models of care provision – e.g. integrated care organisations (e.g. ACOs) or local co-operatives of people and professionals where payments are based on improving health outcomes and financial reimbursements and savings are shared
6. New pilots should begin with financial integration and shared savings
7. But, don’t start with outcome-based financing
8. Empower patients, potentially experimenting with some financial incentives (e.g. a remuneration for following a course of treatment)
9. Potential to copy the ‘drawing rights’ approach in The Netherlands
10. Develop the ‘Cappuccino Model’ for mixed payments:
 - a. Capitation fee (c.80%)
 - b. Fee for service (c.10%)
 - c. Innovation in care (10%)

Round-table discussion

Prof. Liesbeth Borgermans, Professor of Chronic Care, Department of Family Medicine, Vrije Universiteit Brussel, led a round-table discussion that provided a wide range of delegates with the opportunity to provide their key personal lessons from the event. In her opening statement she suggested that the key issue of system leadership and empowerment of patients and people were important themes, but also the fundamental need to change both the existing medical and economic paradigm.

A summary of the comments made by the audience is as follows, with names provided where recorded:

- **Christian de Coster** argued that the Belgian plan was ambitious, but that it was right to start with a patient-led argument and approach. Empowerment was the key, together with co-ordinating services around patient needs;
- **Ri de Ridder** stressed a key lesson in building from the 'bottom-up' to achieve change over time within an overarching framework to enable this to happen. More emphasis and work was needed in building a guiding coalition to support the direction of travel. Partnership and collaboration would be essential;
- Electronic health records, shared by patients, were important for information sharing and the current Belgian strategy seemed to be leading in the right direction;
- **Jo de Cock** stressed the importance of framing the argument in the Strategy around the Triple Aim objectives and to promote ownership of the vision and plans amongst different stakeholders before its implementation – without such support it would be problematic to implement;
- **Derek Feeley** suggested to start with early wins and build momentum;
- **Walter Sermeus** also pointed to the need to achieve small changes as a path to making the bigger changes, but suggested that the Strategy contains more emotional content on why the approach was necessary to improve people's lives in order to win 'hearts and minds'. The behavioural and 'soft' aspects of strategy implementation need attention;
- An efficient multi-disciplinary primary care team would be needed to implement the plan, but this does not currently exist in most parts of Belgium. Hence, there was a need to educate, train and support new ways of working;
- As a GP, any changes would need to remain attractive to the profession. There is a need to take people with the strategy and not to create 'wars';
- As a specialist in hospital a key concern was that good chronic care would not be possible without good ICT;
- **Robert Johnstone** argued that empowering people needs investment in the strategy;
- There was little in the document or at the meeting on the importance of mental health and mental health reform – this was a deficiency that needed to be addressed;
- As an academic, there was a need to expand on Action 17 so that an evaluation culture was developed and that information be pro-actively used to drive quality improvement;
- **Evert Jan van Lente** suggested there was a need to develop a platform to support discussions on the way forward and engage people. He stressed the importance of aligning financial incentives;
- From a pharmacy viewpoint, there was a need for all stakeholders to co-create solutions and feel ownership of the vision. Some of the vision feels threatening and non-inclusive so there is a need to stress the Triple Aim objectives and commitments to quality and equity

- Professionals will need protected time to engage
- Use the best available evidence, but do not use the excuse of a lack of evidence as a reason for doing nothing.

Closing remarks

Mr Jo de Cock provided the closing remarks to the 50th Anniversary event and felt inspired by the good number of positive recommendations, tips, networks and advice received.

De Cock took home a number of key messages, but specifically that the orientation note had hit upon the right issues and messages but that more needed to be done as this was turned into a more detailed Strategy. In terms of points to consider for the future of the Belgian strategy on care for persons with chronic conditions, Mr De Cock pointed to the following recommendations:

- have a change management strategy to positively influence behaviours and overcome people's fears to change promote solidarity and focusing on meeting the needs of the most vulnerable in society with both physical and mental health needs within an uncertain economic context;
- develop a vision with a focus on the Triple Aim objectives – to create a better deal for people; provide the best care possible based on evidence available; improve health outcomes without adding to the burden of cost;
- reform financial incentives to develop mutual interest and buy-in that builds bridges and leads to shared accountability, but be careful with the methodology used;
- continue with the e-health roadmap as a priority;
- make the care system simpler, not more complex;
- focus on people and empowering patients – e.g. promoting healthy living and independence, holistic care assessments and effective case management
- develop a coherent plan for Ministers and stakeholders alike