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CONFERENCE ABSTRACT

A Joint Danish – Dutch Chronic disease plan killing the silos

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In the Danish region Zealand two years ago an innovation initiative was taken aiming for elucidating and testing of a truly proactive and personcentric health service system for people with a chronic condition. The project is named PreCare and is responsible for the quality of care provided to chronic patients to improve the care for the most severe COPD patients. The famous top of the population health management pyramid, the top 5% patients requiring half of the budget. The potential of eHealth with a dedicated nursing workforce was used to create a patient centered approach. Both hospital and primary care managed at a regional level were involved together with homecare at a community level. Core in the approach was to involve the patient as an active partner in the care provision with the help of tools to measure essential COPD parameters and sharing these with the ECM system, so dedicated nurses could act based on actual patient data.

In 2005 the Dutch Diabetes Federation adopted the Diabetes Care Standard, which described appropriate multidisciplinary diabetes care from a patient perspective. Core of the approach was taking the heterogeneity of the population into account by individualizing care based on specific needs and share decision-making with the patient. The base for this endeavor was the Chronic Care Model of Wagner. However, the implementation of the Care Standard required a paradigm shift in the care delivery model. Therefore, the Dutch Ministry of Health started a pilot to test the implementation of the Integrated Diabetes model for primary care (2007). The main result was the introduction of the Care Group (Zorggroep), the Dutch equivalent of the Integrated Practice Unit. As it was seen as a first step, hospital care for diabetes was left out of the model. After the implementation phase the concept was evaluated by the RIVM, showing that the patient focused approach improved the care for Diabetes patients . Consequently, care standards were developed for more chronic conditions. To prevent the creation of new silo's, the Ministry of Health developed a framework in which all care standards could be connected. This concept of an integral care program has been developed by ZonMW. The INCA health issue spiderweb offers a great visualizing tool for patient and practitioner, offering a base for shared decision making and challenging the patient to go for improvement, the Δ. In the INCA approach all care health or social care services are organized and coordinated around the patient .

The challenge of INtegratedCAre to generate input for the spiderweb from actual patient data can be met by introducing the solution created by the Nearclinic-ECM model. Since the Near-clinic wants to extend their COPD model with Diabetes and CVRM, the INCA Chronic Care Program can be of help. So both teams want to join forces to solve challenges related to the IT infrastructure and Innovative funding. In the presentation we will present our joint approach based on our shared vision.