



The long and bumpy road to integrated care: lessons from the Leuven integrated care project in Belgium.



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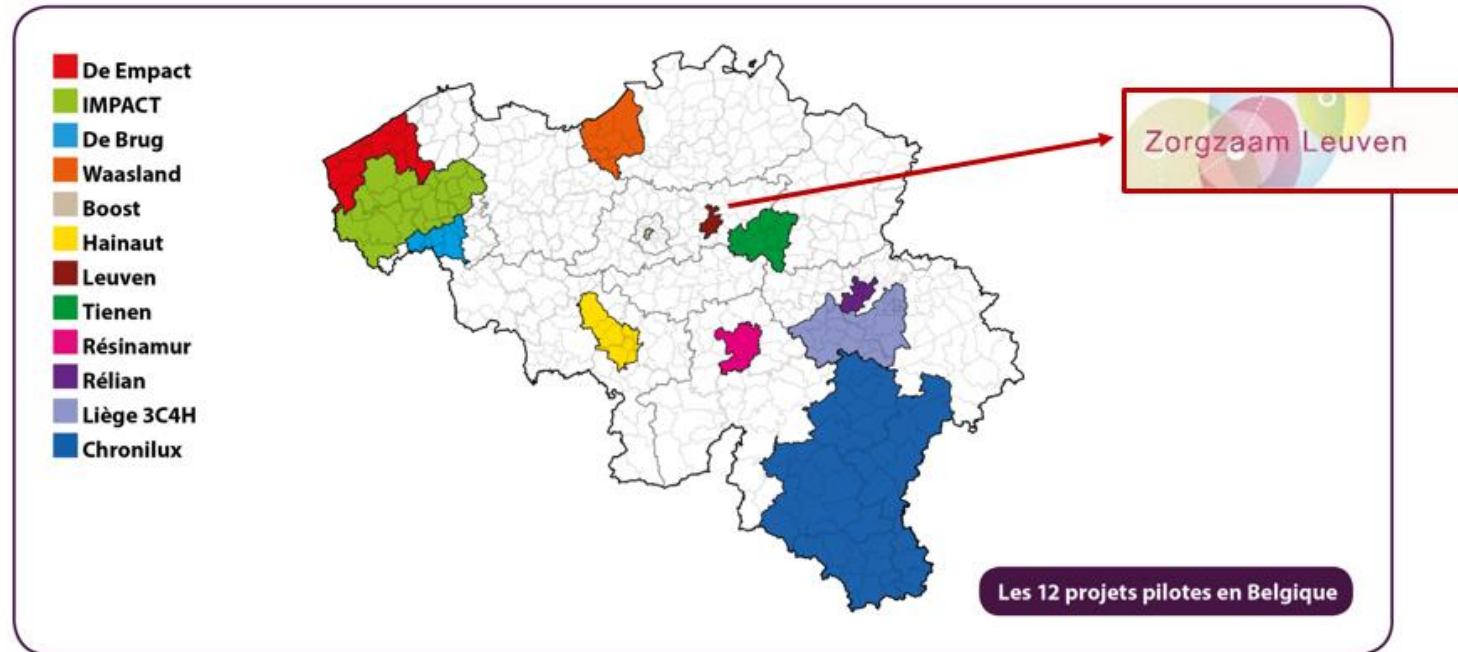


Prof. Dr. Gijs Van Pottelbergh

Twelve local pilots in Belgium to test different strategies for the implementation of integrated care



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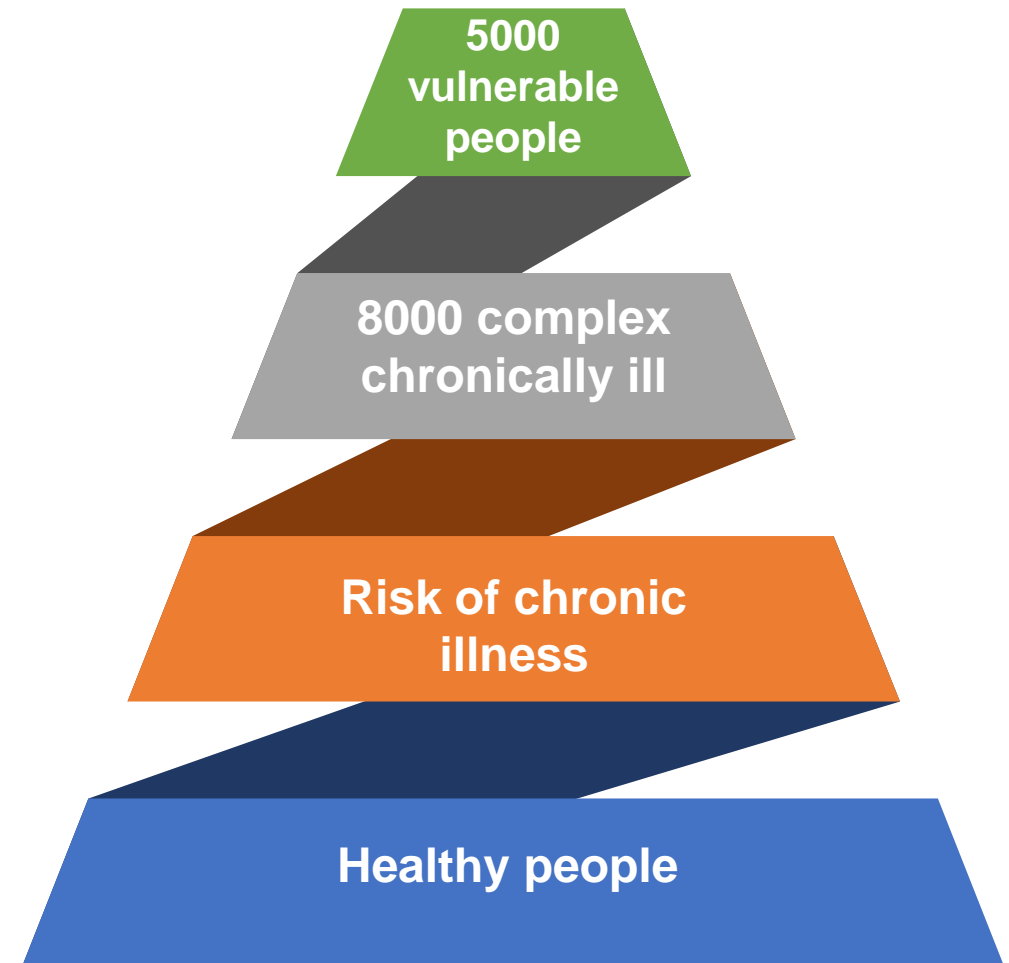


Mission of Caring Leuven

Movement towards a Caring city for 102 000 inhabitants



SOURCE: Matheny, M., S. Thadane, Israni, M. Ahmed, and D. Whicher, Editors. 2019. *Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril*. NAM Special Publication. Washington, DC: National Academy of Medicine.



Methods: 6 building blocks

1

A large joint population oriented plan for the entire region

2

Multidimensional approach with care pathways and care programs

3

Multidisciplinary vicinity teams of primary care professionals

4

Data driven population management

5

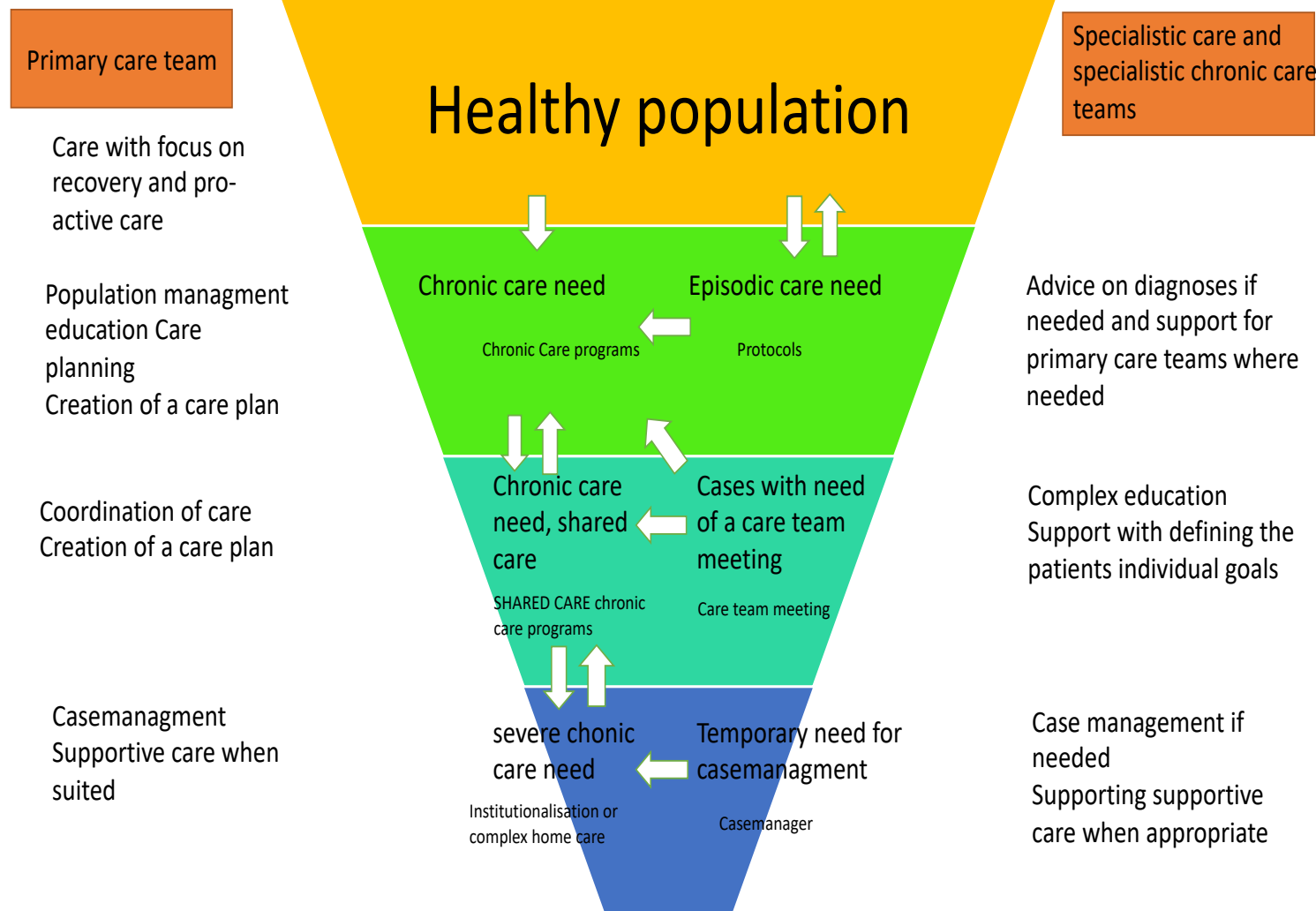
Financial incentives

6

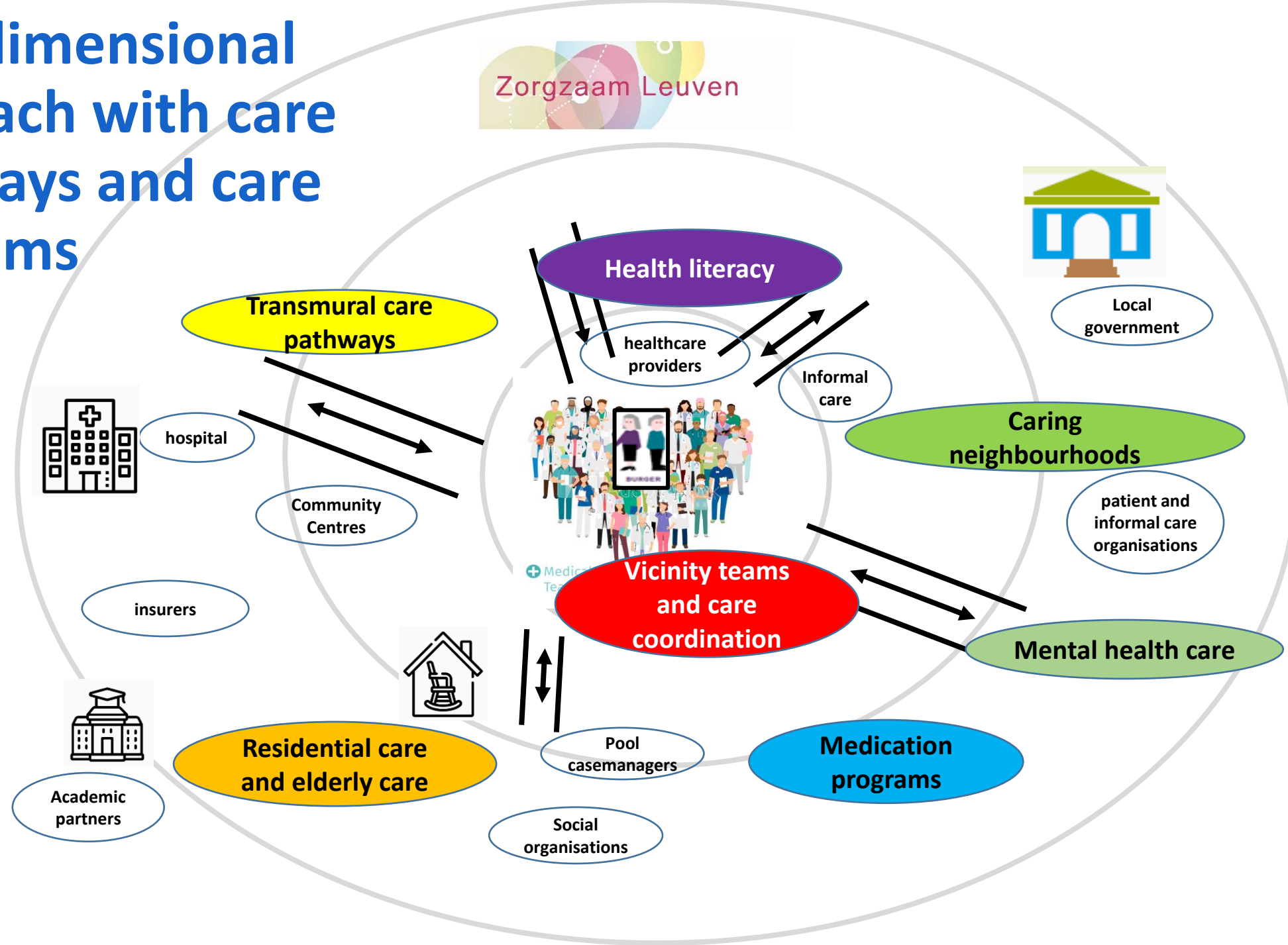
Supported by an integrator



One locoregional plan and one vision ensures that everything we do fits into a population-oriented vision



Multidimensional approach with care pathways and care programs



Multidisciplinary vicinity teams of primary care professionals

1

2

3

4

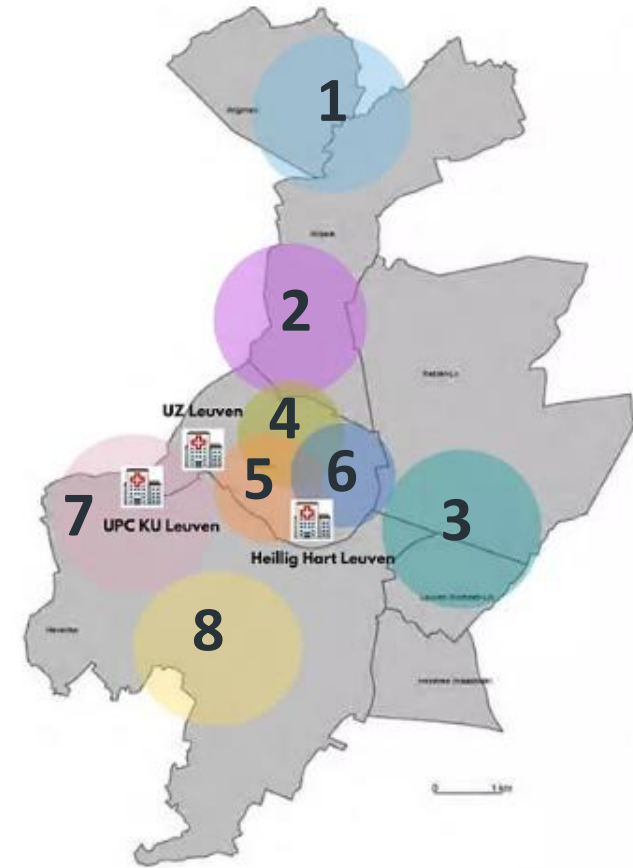
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6

8 vicinity teams to
structure primary care



Nursing home as a special
primary care team



Data driven population health management (PHM)

1

2

3

4

5

6

A proactive approach to manage the health and wellbeing of a population.

Aims to incorporate the total care of needs, costs and outcomes of the population.

To move away from the provision of reactive, demand-led care.

3 Fundamental steps to consider:

- 1) Know your population's health needs
- 2) Engage with your population
- 3) Manage your population

For now: focus on diabetes
First steps within the cure sector



Financial incentives

Close gaps in the current payment system



No payment or not sufficient payment in the regular financing model



Caring Leuven pays €100 per patient needing integrated care to close gaps in the financing system

- As a surplus on top of the regular fee-for-service (FFS) system.
- The vicinity networks are self-steering and free in allocating their budget within a general framework.

Supported by an integrator



An integrator > 40 people who work from the partner organizations (back office) to realize integrated care in the region

- one back office for healthcare professionals
- support neighborhood teams and transmural teams
- clear communication
- system for self-evaluation and quality culture
- data system for population management
- financial system

1

2

3

4

5

6

Methods

Results

1

A large joint population oriented plan for the entire region

31 innovative actions: a joint agenda with broad support in the region. Consortium with 73 local care organisations

2

Multidimensional approach with care pathways and care programs

Care pathways are implemented for large groups of patients with chronic diseases and make integrated care concrete for care providers

3

Multidisciplinary vicinity teams of primary care professionals

8 multidisciplinary primary care teams

4

Data driven population management

Caregivers are stimulated with data driven audits and feedback at the level of multidisciplinary teams

5

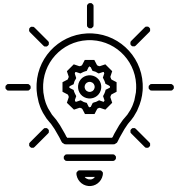
Financial incentives

Small changes in financial support that work nudging wise to motivate healthcare providers and organization

6

Supported by an integrator

Care givers and patients are actively engaged in the integrator, they function as ambassadors who can convince others



Take home messages

The road to integrated care is long and bumpy

However, the model implemented in Zorgzaam Leuven is **a first and realistic step** towards integrated care, in the complex health care system of Belgium.



Thank you for your attention!

Zorgzaam Leuven is supported and funded by the Federal Government of Belgium

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