

The general logic of my two interventions this PM

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Learning objectives :

- Trainees should be able to explain the...
- Determinants of successful transfer of care outside hospital which meet patient and caregiver perspectives and needs
- Suitability for different levels of care within the community
- Liaison with primary care and social services to facilitate successful transfer of care from hospital
- Systems of provision for social care, day care, respite care and caregiver support

Home care management of community-dwelling frail elderly

- From hospital to home....Care pathway or trajectory management: transition, multiple needs of care and its management
- At home, the development of a function...: case management
- Case management ... is contextual... so other way of doing things is needed

Integrated care in Belgium: perspectives

- from a generic definition to a bit more detailed explanation... shedding light on different priorities
- General principle on « how to? »:
 - Care integration for at risk population or for specific health problems with a focus on (relatively) well defined care episod
 - Care pathways – trajectories...But also territories...
- Not only territories but ... people, life course and communities
- Why territories? Governance, integration management? Administration?
 - Governance ...With a change of logic in decision making
- This is just a start....

Home care management of community-dwelling frail elderly

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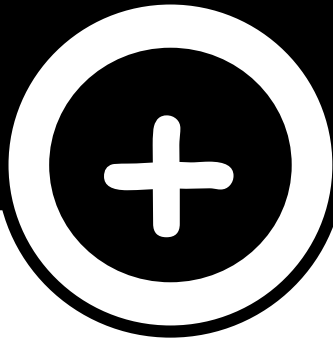
Home care management of community-dwelling frail elderly

- From hospital to home....Care pathway or trajectory management: transition, multiple needs of care and its management
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Care pathway or trajectory
management: transition,
multiple needs of care and its
management

... focus to avoid
over- or mis-use
of the hospital...





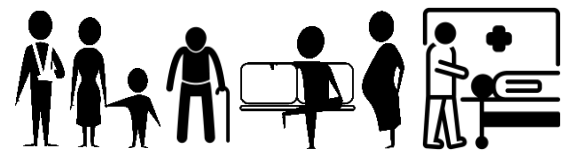
Soins intensifs



Hospitalisation

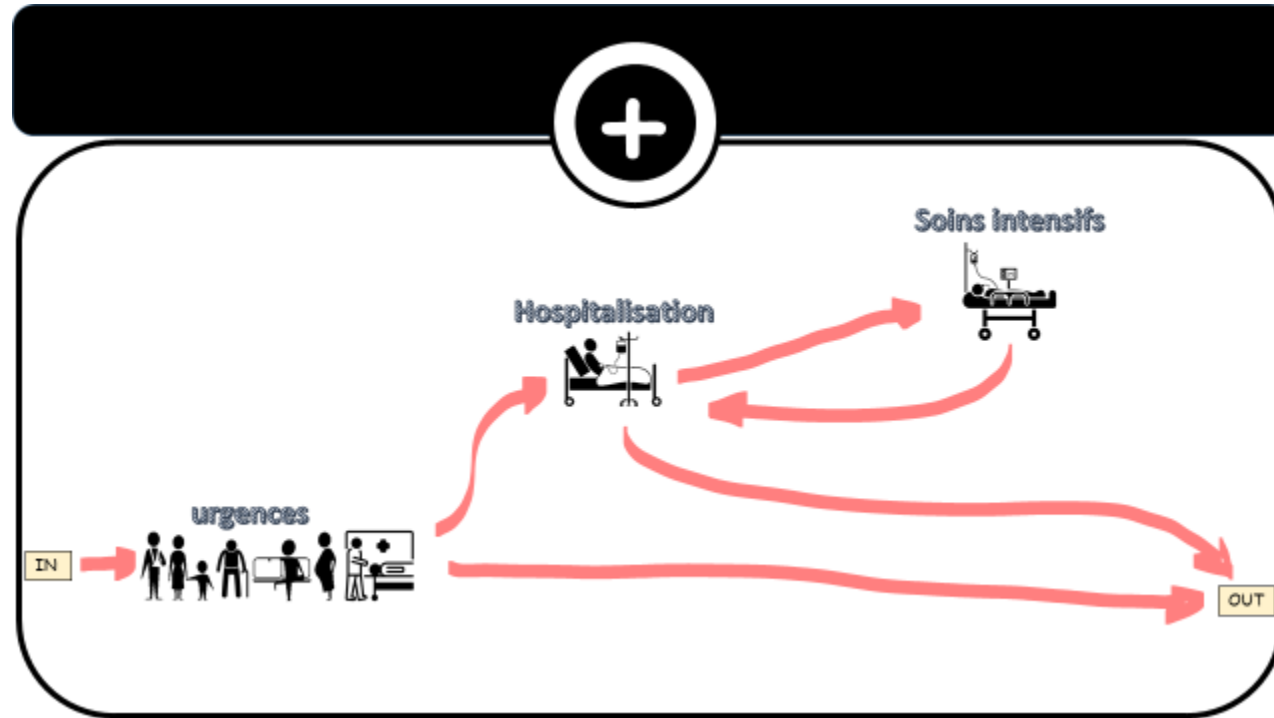
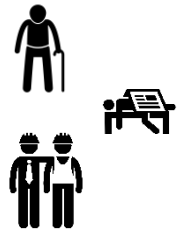


E.D.



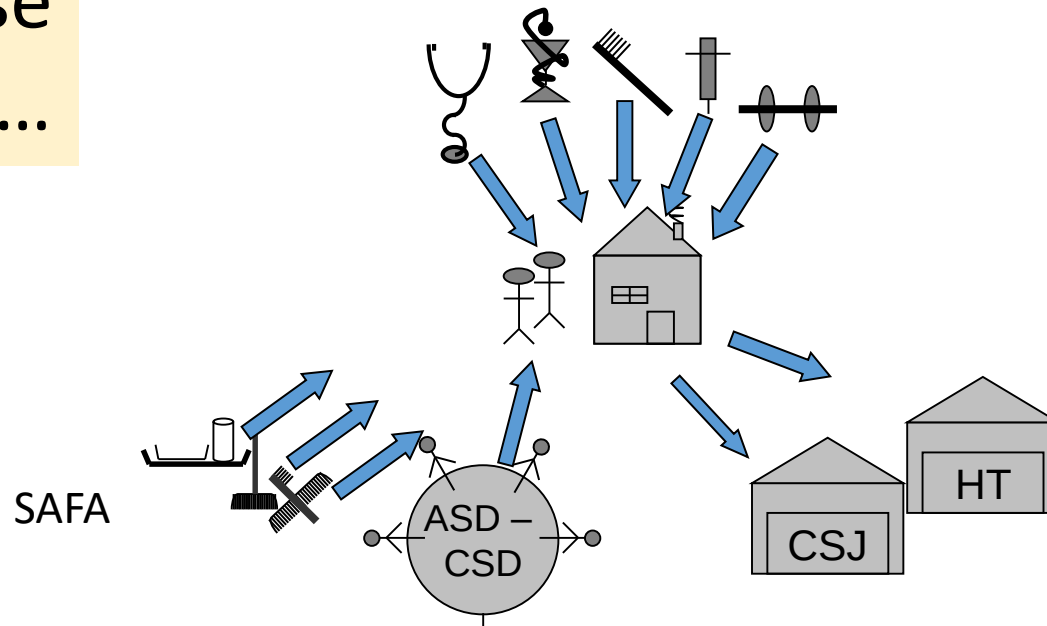
IN

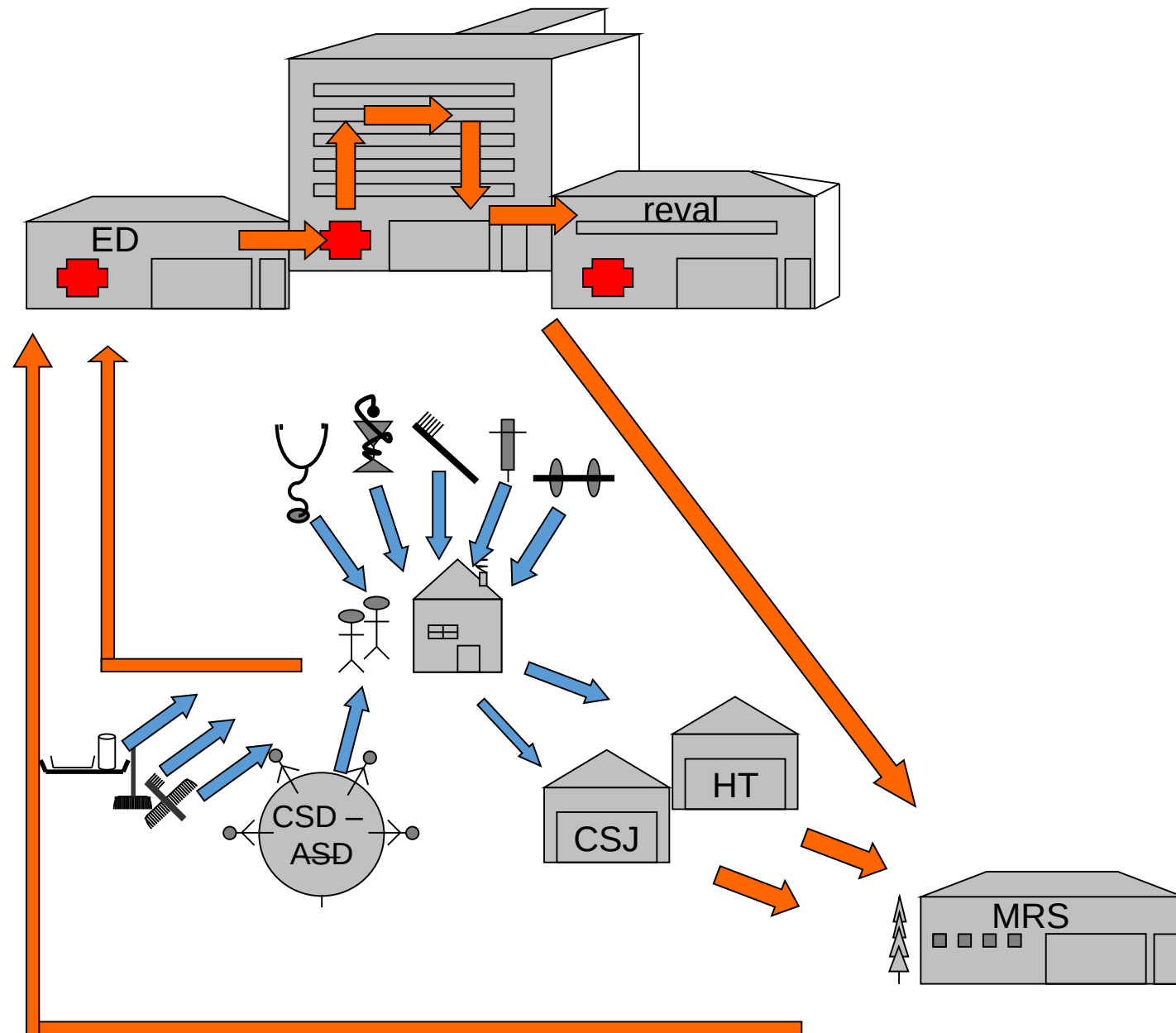
OUT



Care pathway or trajectory management

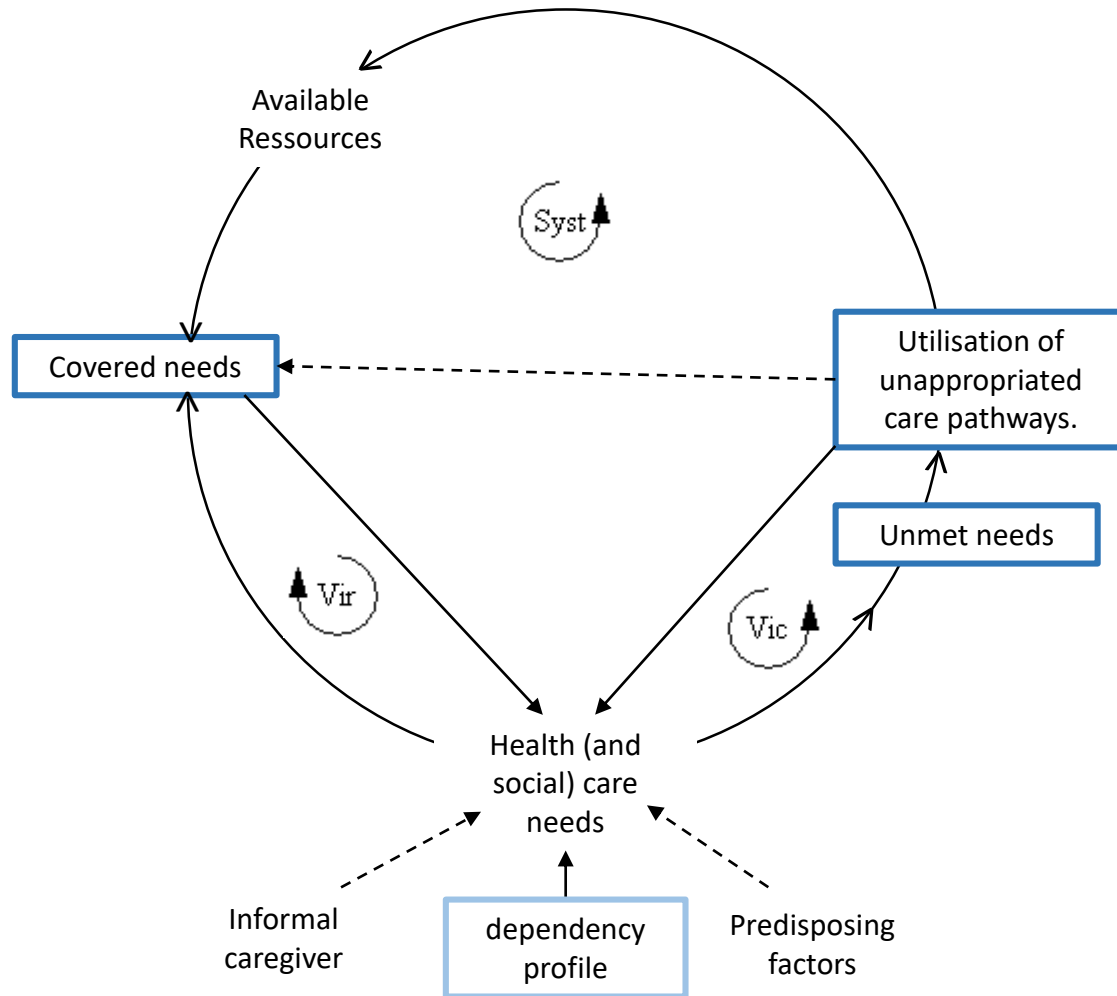
... focus from
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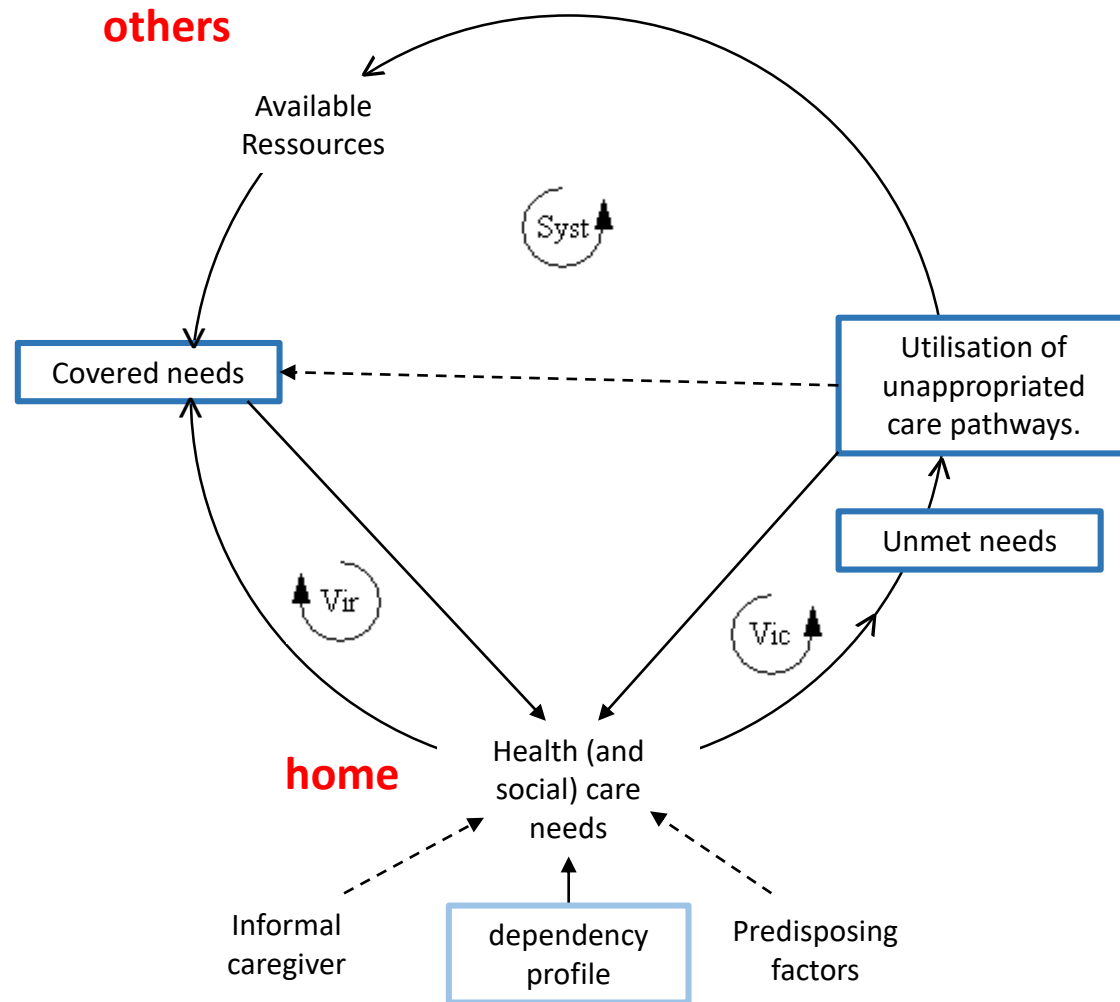


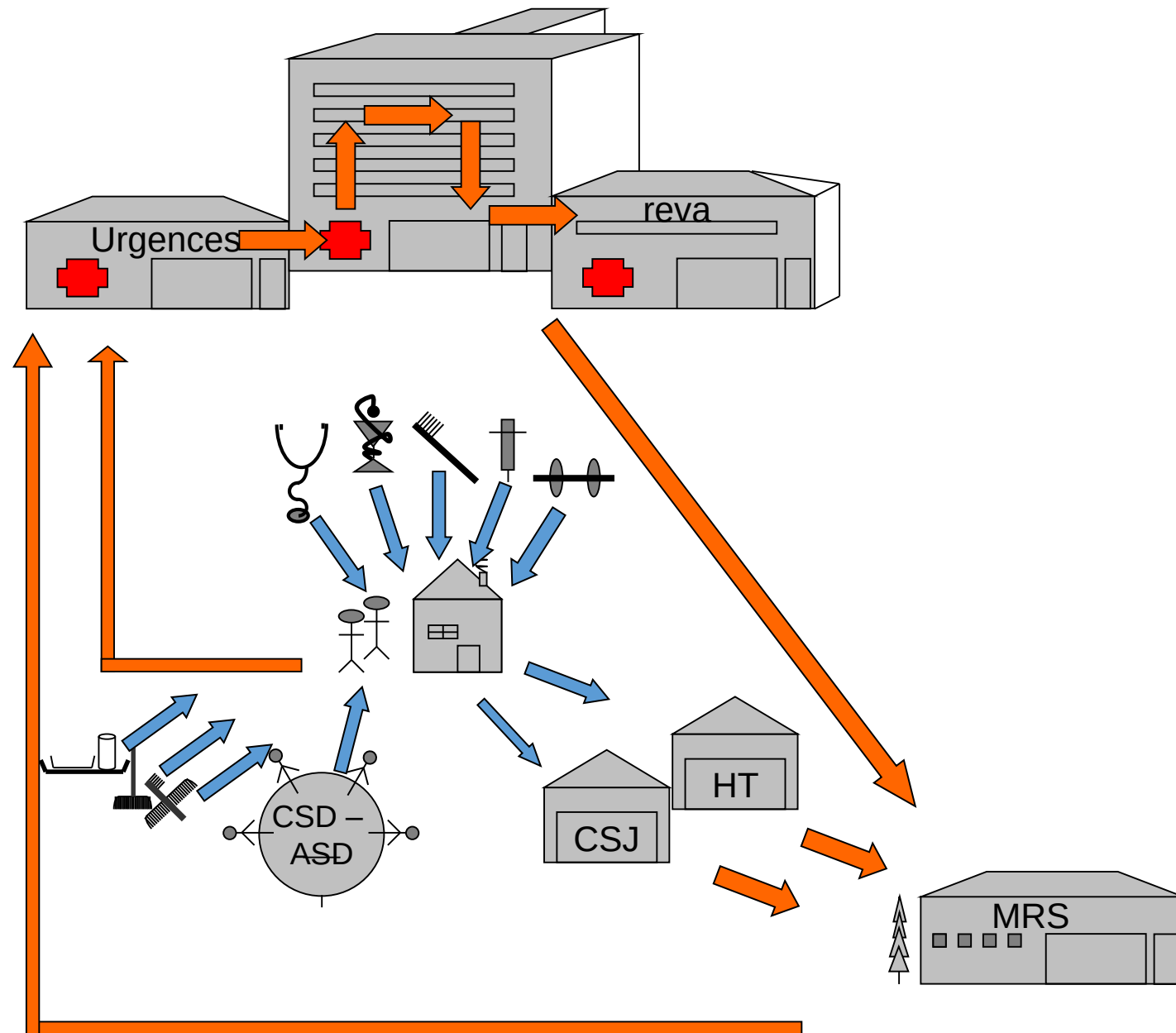
Inspired from Pierre Blaise

Home-hospital-nursing home pathways to care: a generic perspective

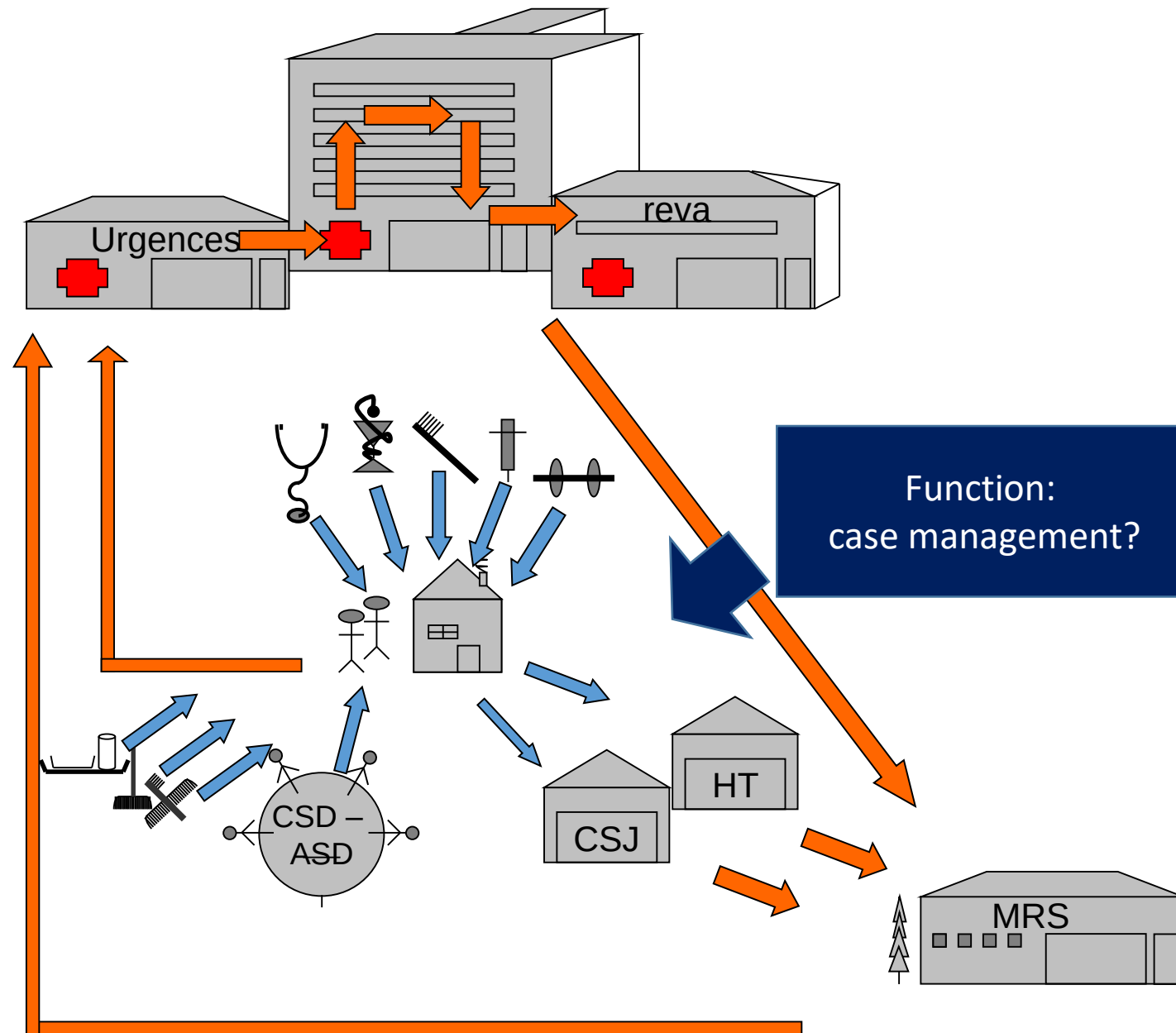


Home-hospital-nursing home pathways to care: a generic perspective





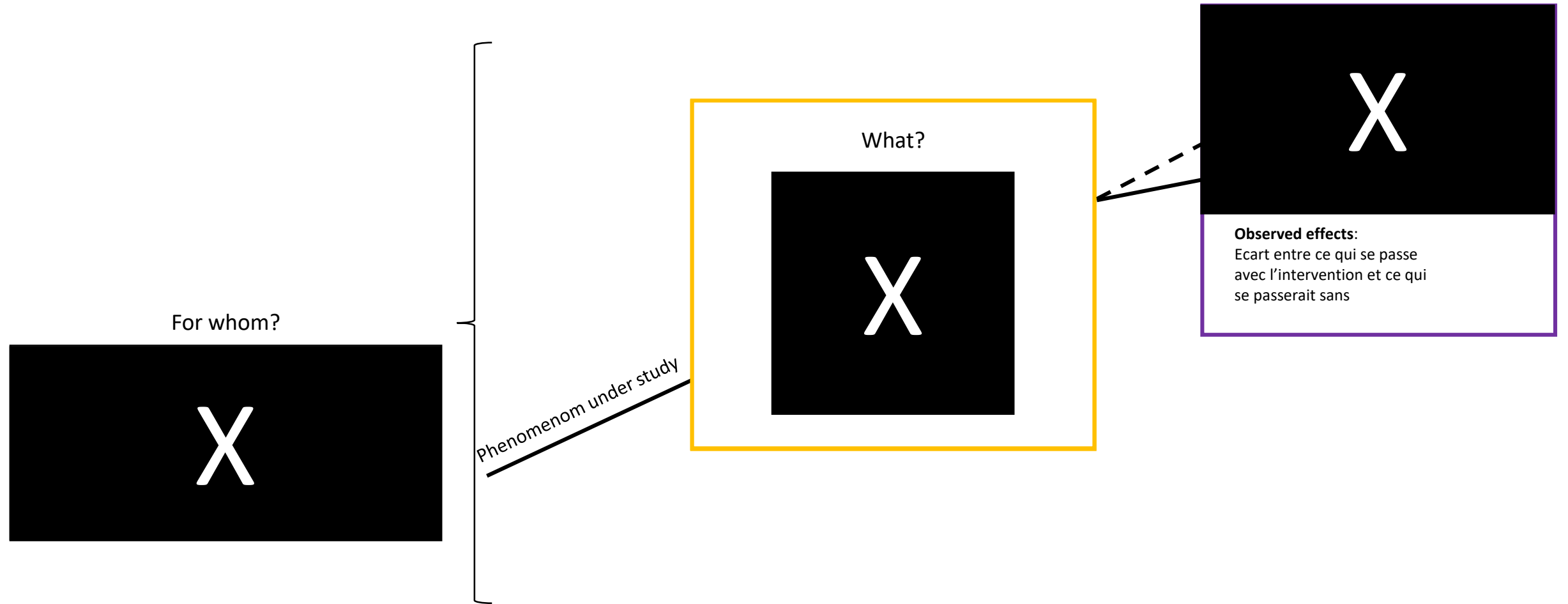
Inspired from Pierre Blaise



Inspired from Pierre Blaise

Functions: case management
etc

Summative evaluation of case management project (Protocol 3)



What? A generic definition of case management

- *“Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes.”* from <https://cmsa.org/who-we-are/what-is-a-case-manager/>
- In P3: “coordination”, “low intensity case management”, high intensity case management

Summative evaluation of case management project (Protocol 3)

For whom?

X

Phenomenon under study

Intervention: Case management

50 bottom-up and heterogeneous projects



2 criteria:

- Feedback au généraliste par le case manager
- Intensité de case management

3 types of « case management »:



Coordination

Case management de faible intensité

Case management de haute intensité

X

Observed effects:

Ecart entre ce qui se passe avec l'intervention et ce qui se passerait sans

Summative evaluation of case management project (Protocol 3)

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Case management de faible intensité

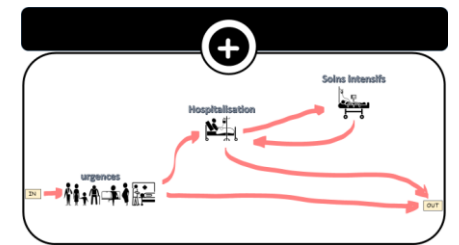
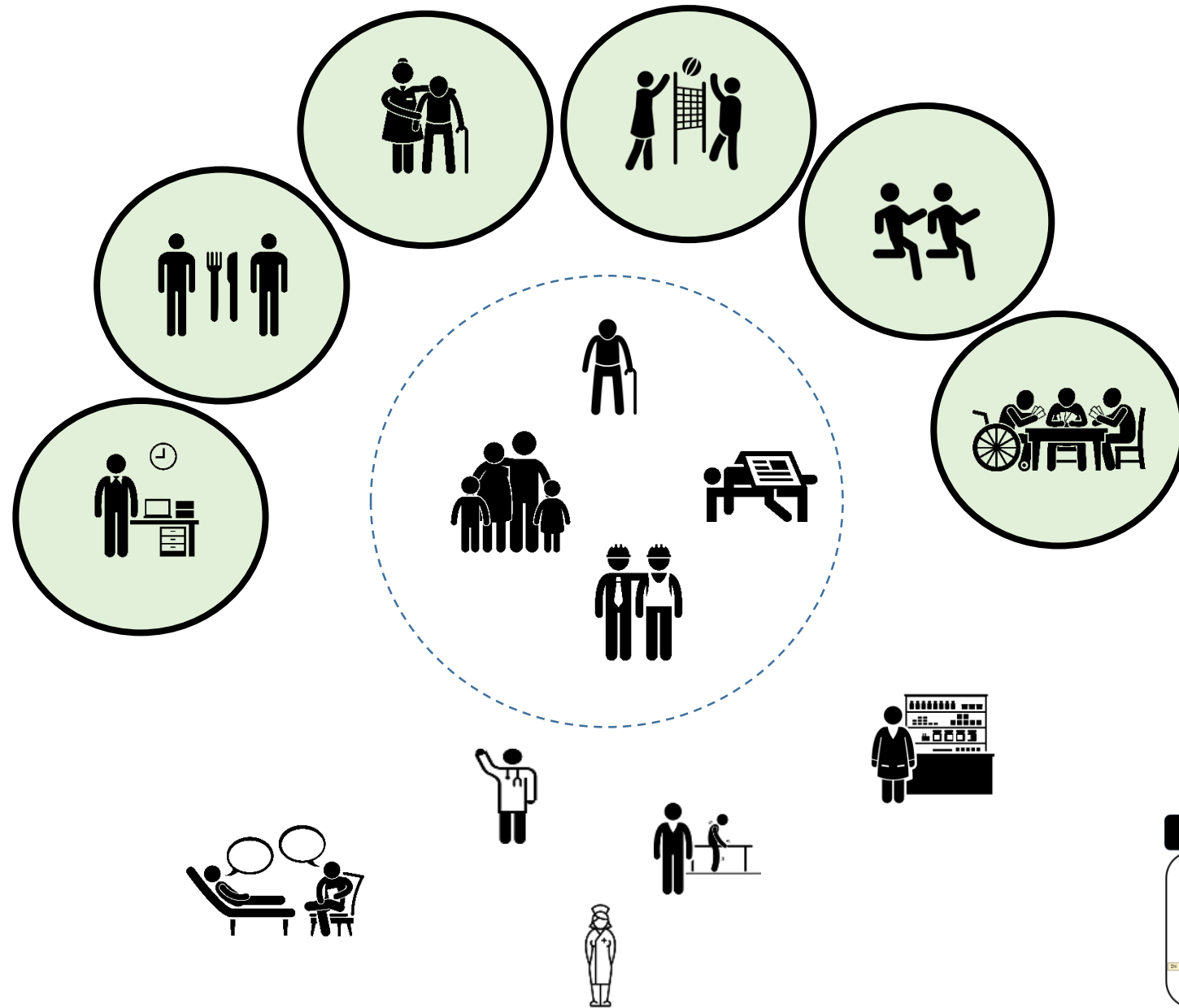


Case management de haute intensité

X

Observed effects:

Ecart entre ce qui se passe
avec l'intervention et ce qui
se passerait sans



5 Profiles of dependency within 65 ans and +

Méthode : Créer à partir d'échelles cliniques collectées via une évaluation gériatrique globale (BeIRAI)

Identification of need for specific services

Faible limitation

IADL, léger trouble cognitif



→ family help / ménagère

ADL functional limitation



→ nursing at home

ADL functional limitation
& cognitives



→ nursing at home + surveillance

ADL functional limitation
cognitives &
Behaviour troubles



→ nursing at home + surveillance 24h/24



Adéquation entre les besoins
et les services fournis

Summative evaluation of case management project (Protocol 3)

For whom?

Faible limitation	
IADL, léger trouble cognitif	
Limitations fonctionnelles	+
Limitations fonctionnelles & cognitives	+
Limitations fonctionnelles, cognitives & troubles du comportement	+

Phenomenon under study

Intervention: Case management
50 projets bottom-up et hétérogènes



2 critères:

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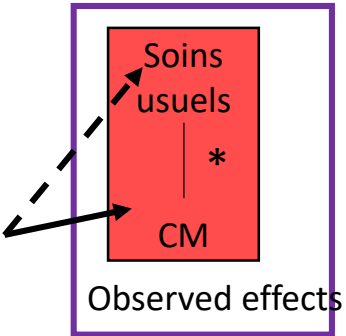
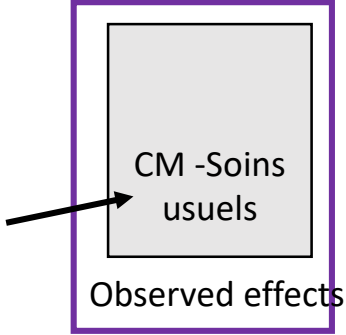
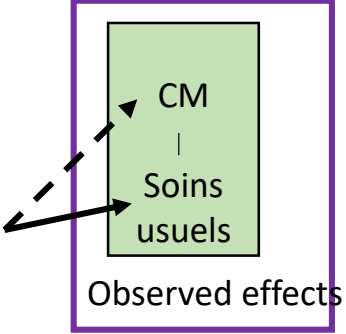
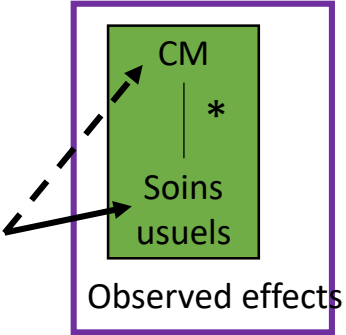
X

Observed effects:

Ecart entre ce qui se passe avec l'intervention et ce qui se passerait sans

Results of case mangement evaluation

	Profils de dépendance	IADL (cogn.)	Limitations fonctionnelles	Limitations fonctionnelles & cognitives	Limitations fonctionnelles, cognitives & trouble du comportement
	The most efficient	Coordination	Case Management low intensity	Case Management low intensity	Case Management low intensity
Clinique	Functional status				
	Depressive status				
	Quality of life				
	Caregiver burden cohabitant				
	Caregiver burden non-cohabitant				
Utilisation de services	Unmet needs for hygiene nursing care				
	ED use				
	Out-of-hour GP				
Coûts	Average mean cost for reimbursed health care (liés à la dépendance ou susceptibles d’être modifiés suite à l’intervention) pour l’INAMI / RIZIV				



Summative evaluation of case management project (Protocol 3)

For whom?

Faible limitation	
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Phenomenon under study

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50 projets bottom-up et hétérogènes



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Y1

Y2

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Not really convincing results when lookig at averages



Need to look at the context!

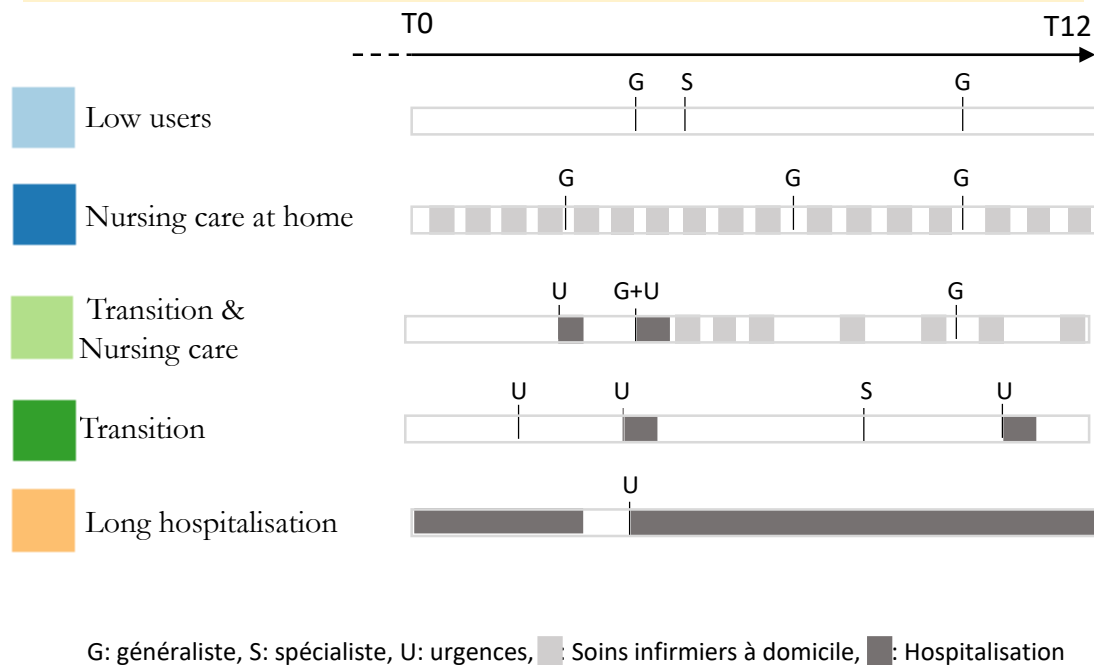
case management... nice but
it depends of

It depends of past use of health and social services... Care pathways profiles - different realities

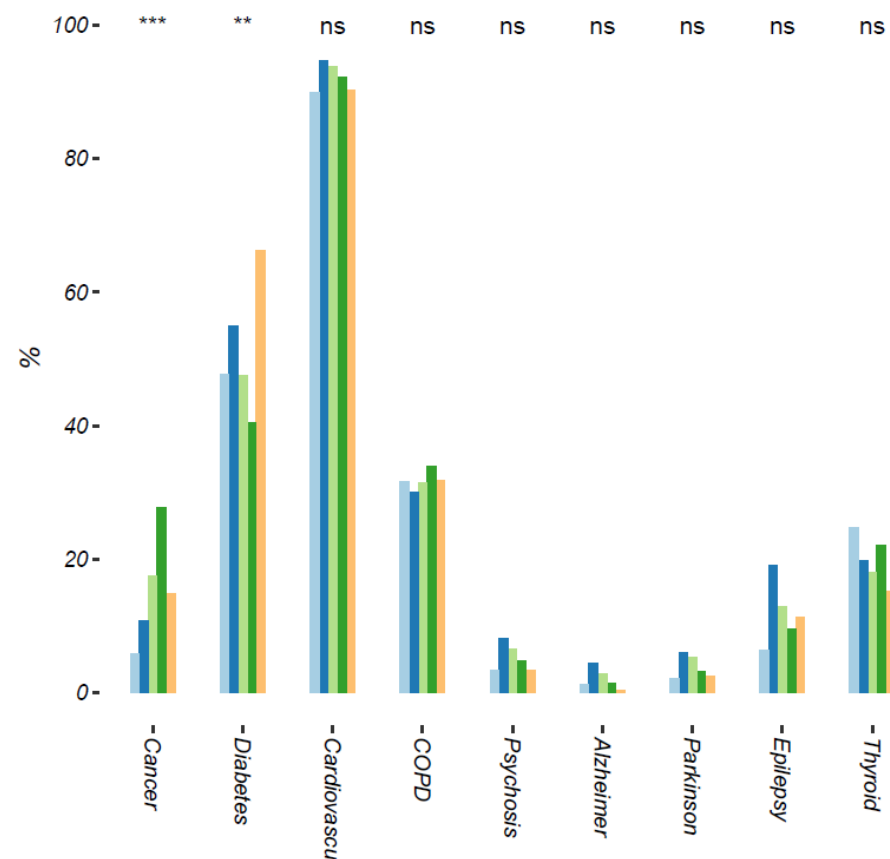
5 Profiles

Methods :

- Données de consommation de soins de santé (disponible en routine)
- A partir de trajectoires de soins

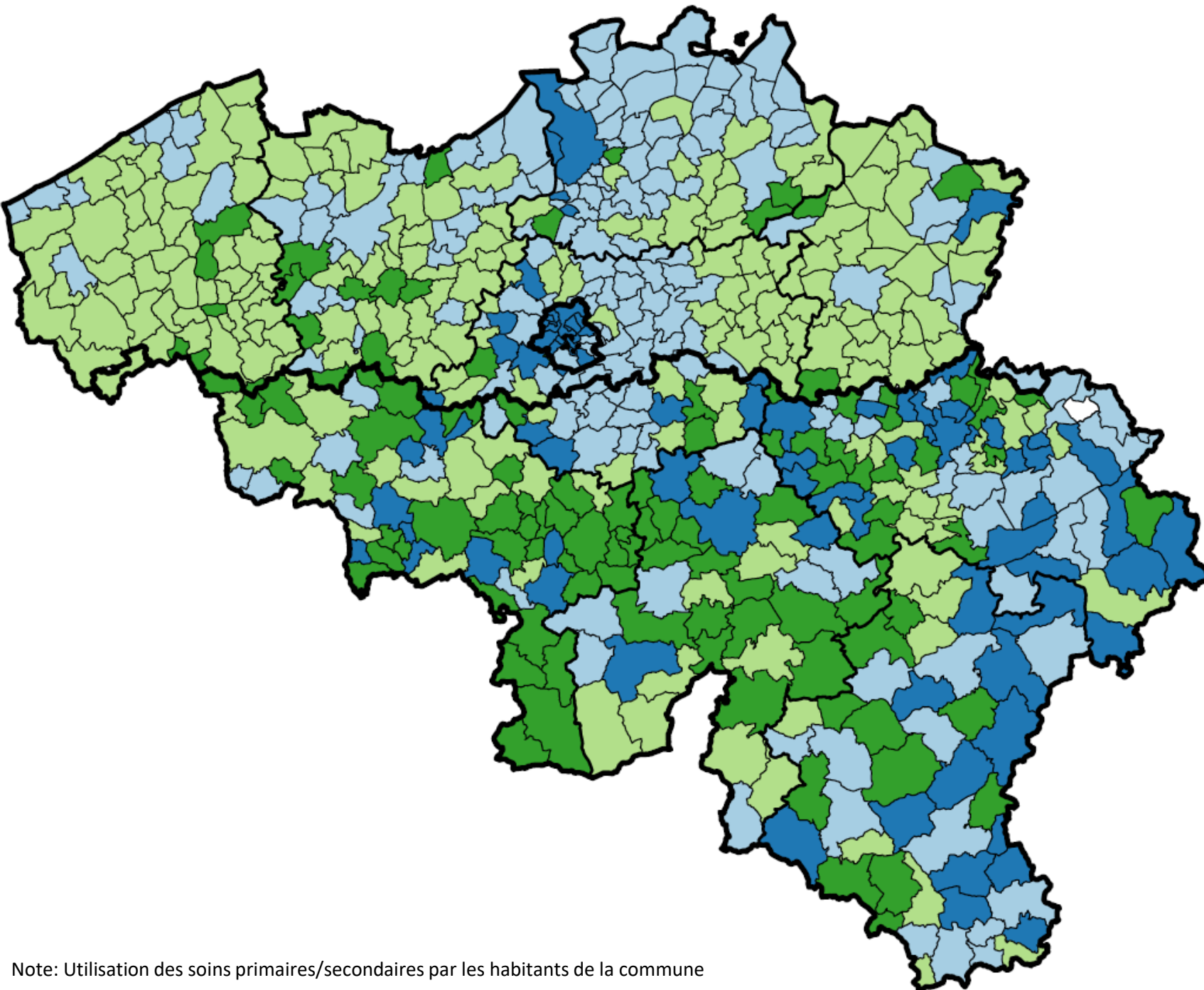


Identification de parcours de soins particuliers



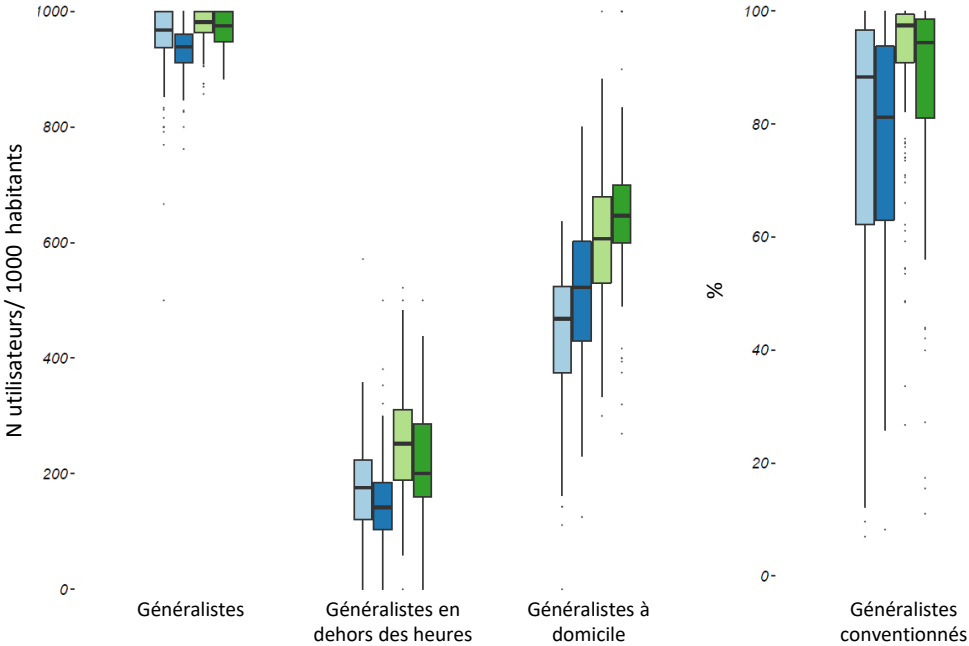
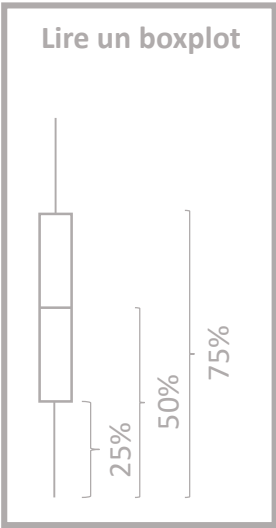
Diversity in healthcare utilisation

	Primary	Secondary
	Faible	Faible
	Faible	Haute
	Haute	Faible
	Haute	Haute



Note: Utilisation des soins primaires/secondaires par les habitants de la commune

GP use



Primaires

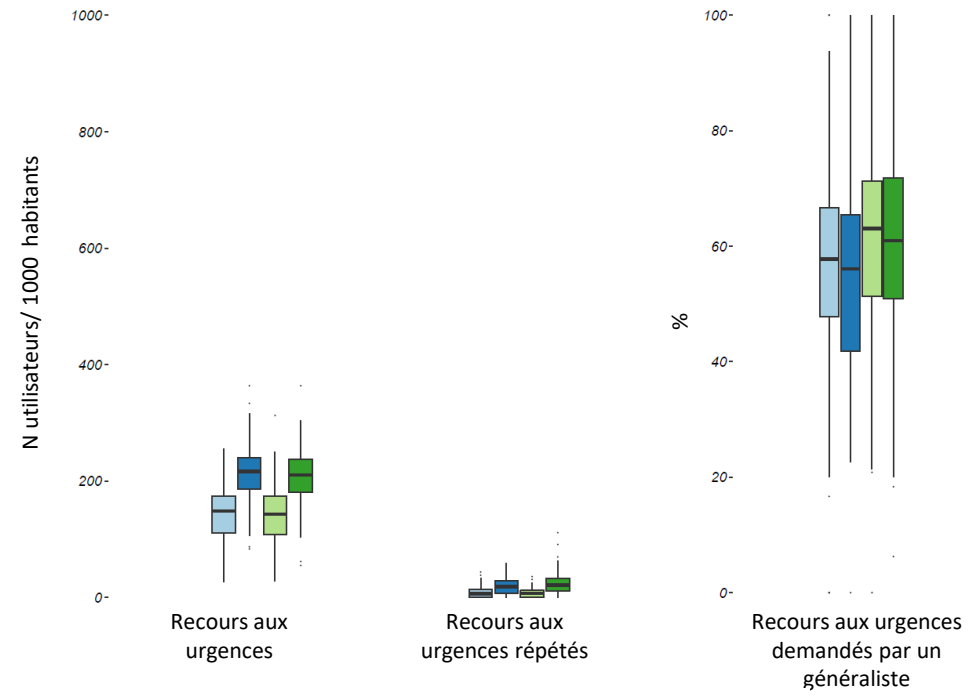
Secondaires



Faible
Faible
Haute
Haute

Faible
Haute
Faible
Haute

ED



Primaires

Secondaires

Faible

Faible

Faible

Haute

Haute

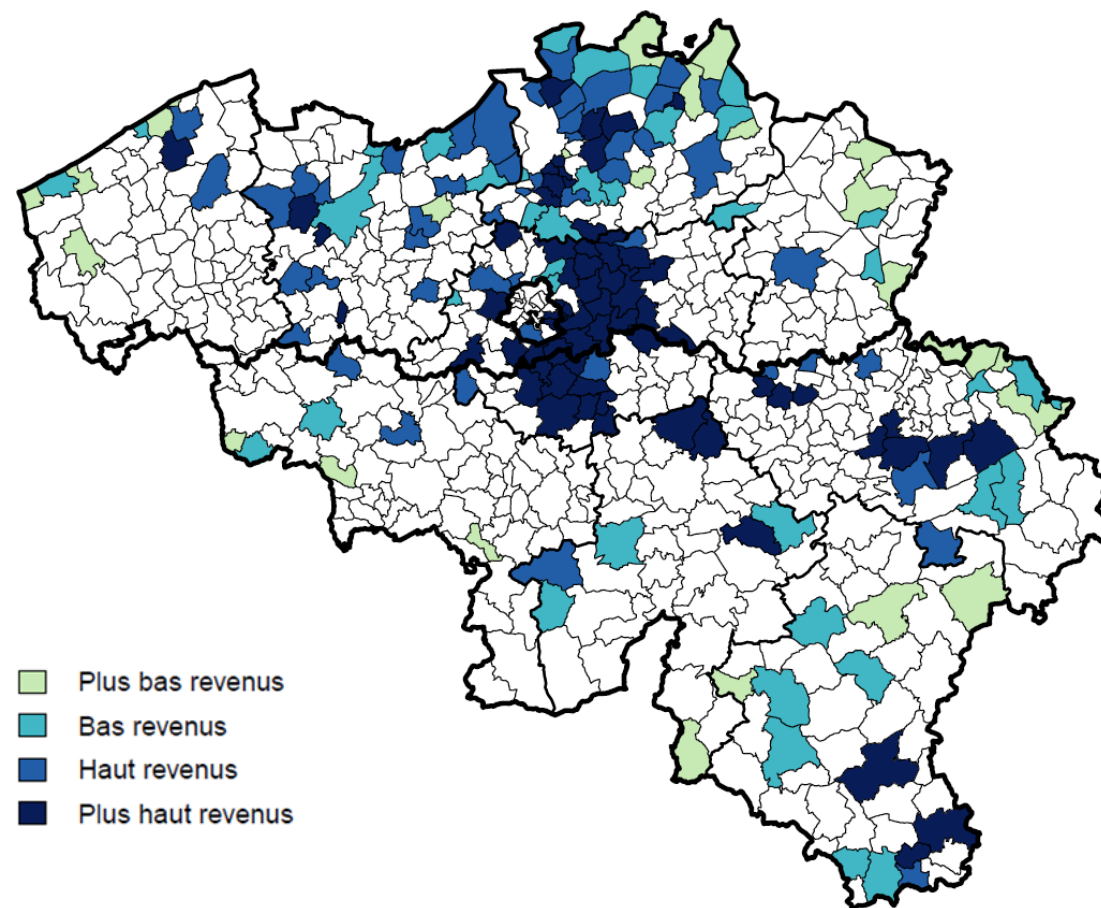
Faible

Haute

Haute

Mean income

Besoins en santé moindre ?



So case management adequacy
depends of care pathways profiles....
And that depends of the context
(population – provision general
adequacy)

Case management, coordination and ... referent... need of clarification

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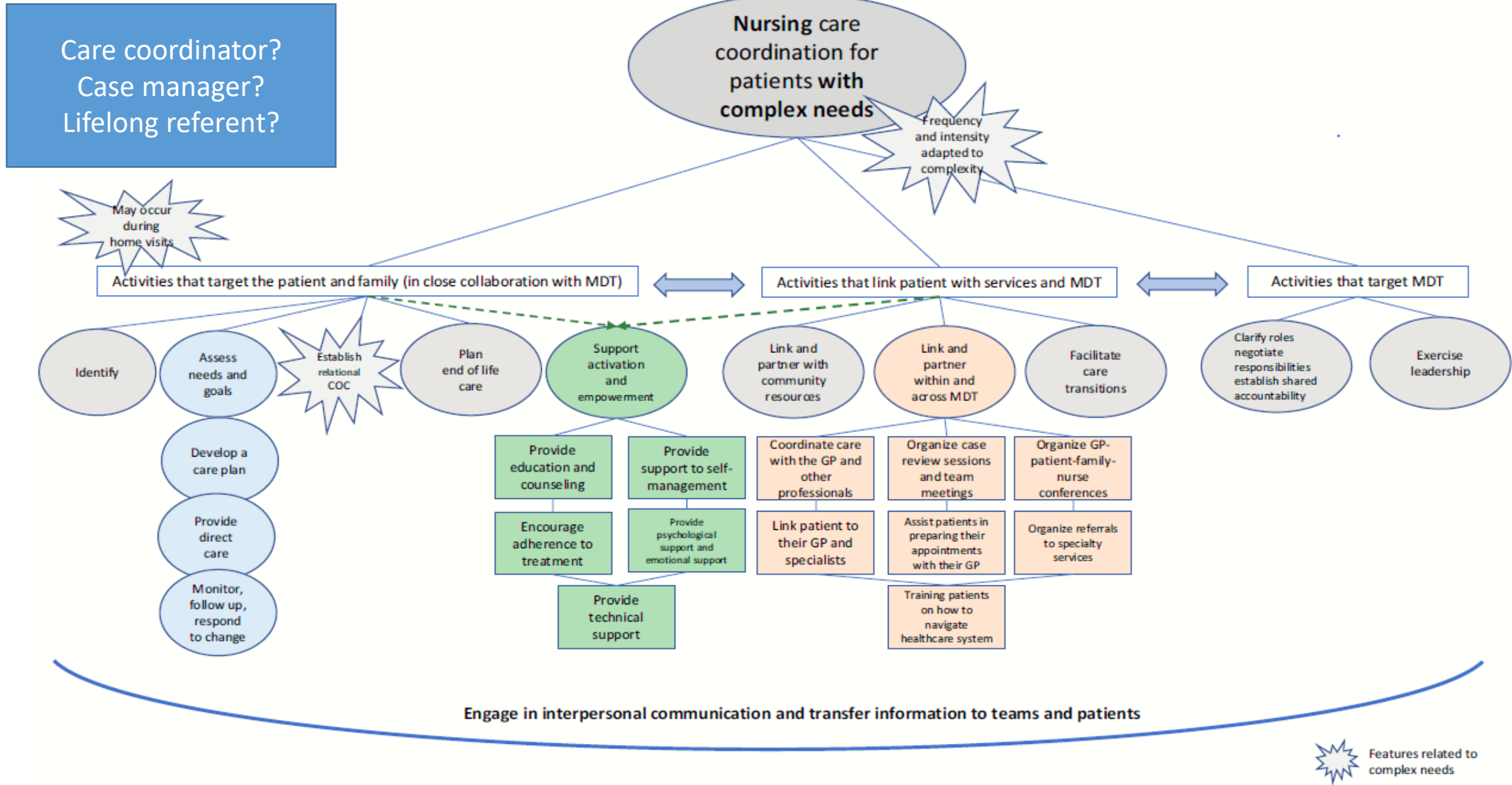
Coordination



Case management de faible intensité

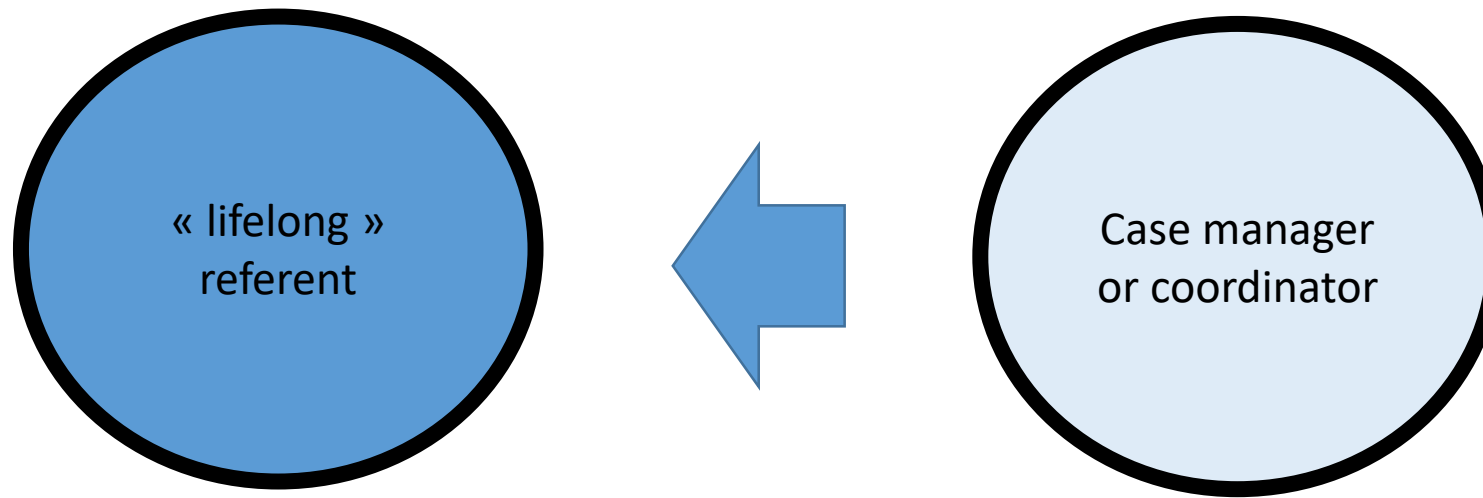


Case management de haute intensité



A model of nursing care coordination activities for patients with complex needs.

Karam, M., Chouinard, M. C., Poitras, M. E., Couturier, Y., Vedel, I., Grgurevic, N., & Hudon, C. (2021). Nursing care coordination for patients with complex needs in primary healthcare: A scoping review. *International Journal of Integrated Care*, 21(1), 1–21. <https://doi.org/10.5334/ijic.5518>



Beyond the focus on frailty: GOC

Boost and referent function

Referent function

- Identify and understand life goals of the person
- Strengthen people resources and autonomy
- Bridge between people and health –social care providers
- Help people to navigate within the healthcare system
- Ensure emotional support and relational continuity

Beyond the focus on health problem: GOC

- « life-long » health care referent
- Tools for elicitation
- Also positive health
- ...



So case management adequacy
depends of who plays what
« subfunctions » of case
management + referent

And...what about community?

- Inter-generational housing?
 - Abbeyfield
 - <https://www.mc.be/la-mc/vivagora/presentation-projet>
- Neighborhood approaches?
 - <https://www.quartiers-solidaires.ch/>
 - Maisons de quartier

Beyond older or at risk people... community at large.... Working on connections for better solidarity?

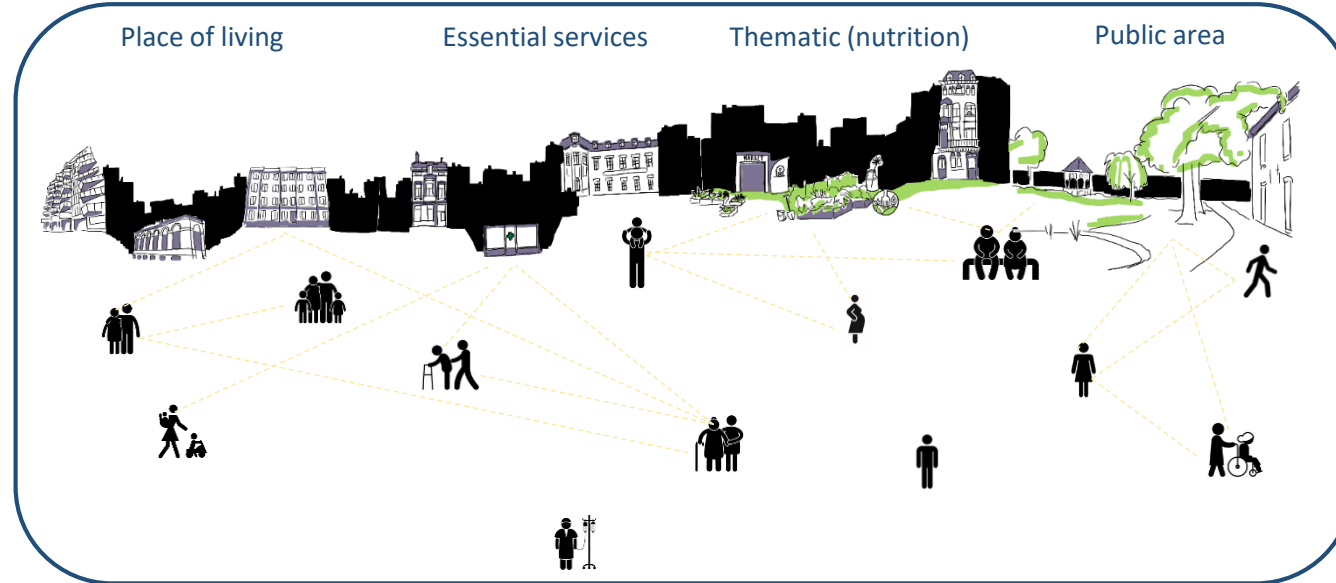
« dynamo de vie »

2 Working at new forms of « organic solidarity »

Connexions to shares resources in a logic of positive health

Connexion practices

Des nouvelles
manières de
faire ensemble



Des nouvelles
formes de
solidarité

Changement culturel pour une grande variété d'acteurs

So case management adequacy
depends of the way of living... with
other people.

Integrated care in Belgium: perspectives

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Integrated care in Belgium: perspectives

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- General principle on « how to? »:
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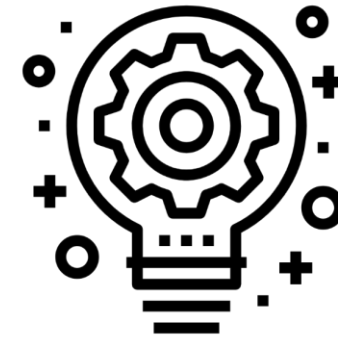
The generic definition (WHO)



- *“The management and delivery of health services so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of the health system.”*

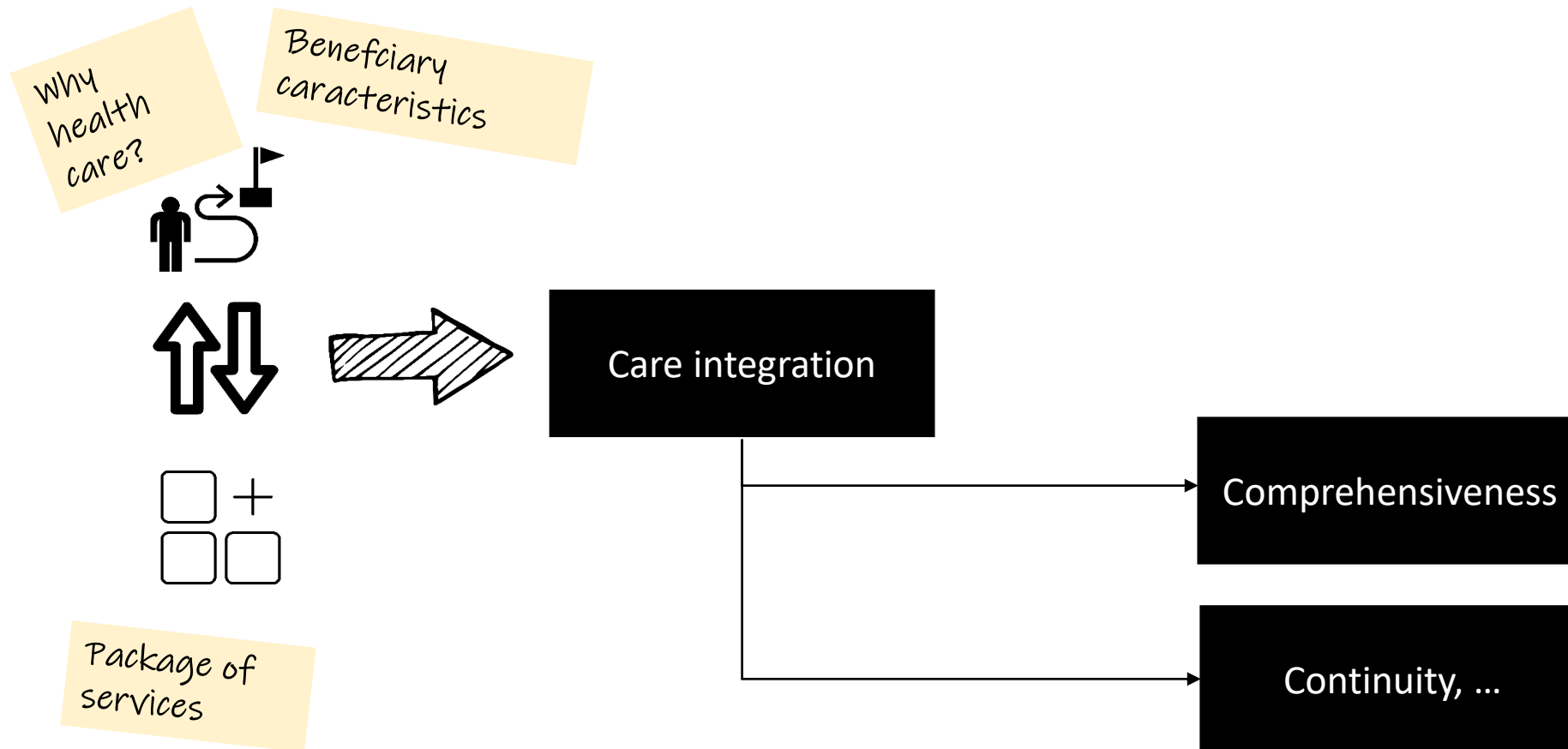
http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

- Nice but.... Shouldn't we be more precise?

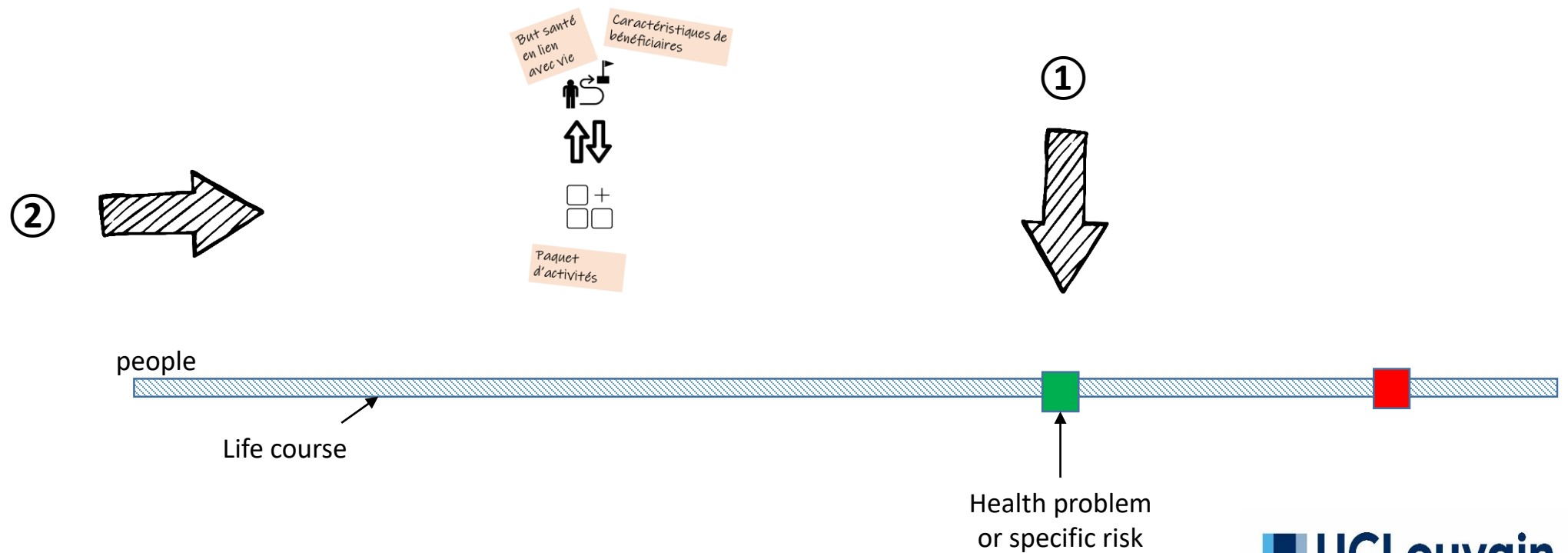


A bit more detailed... shedding
light on different priorities

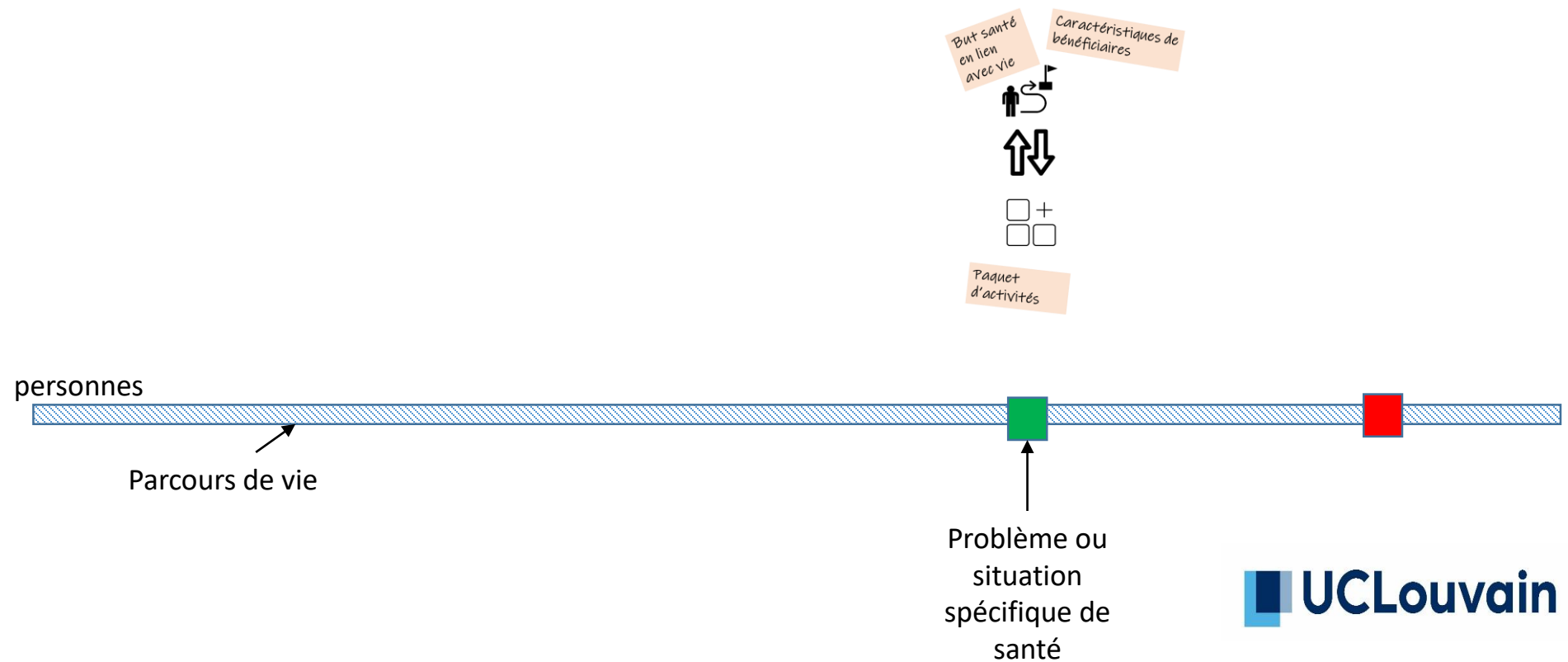
Care integration



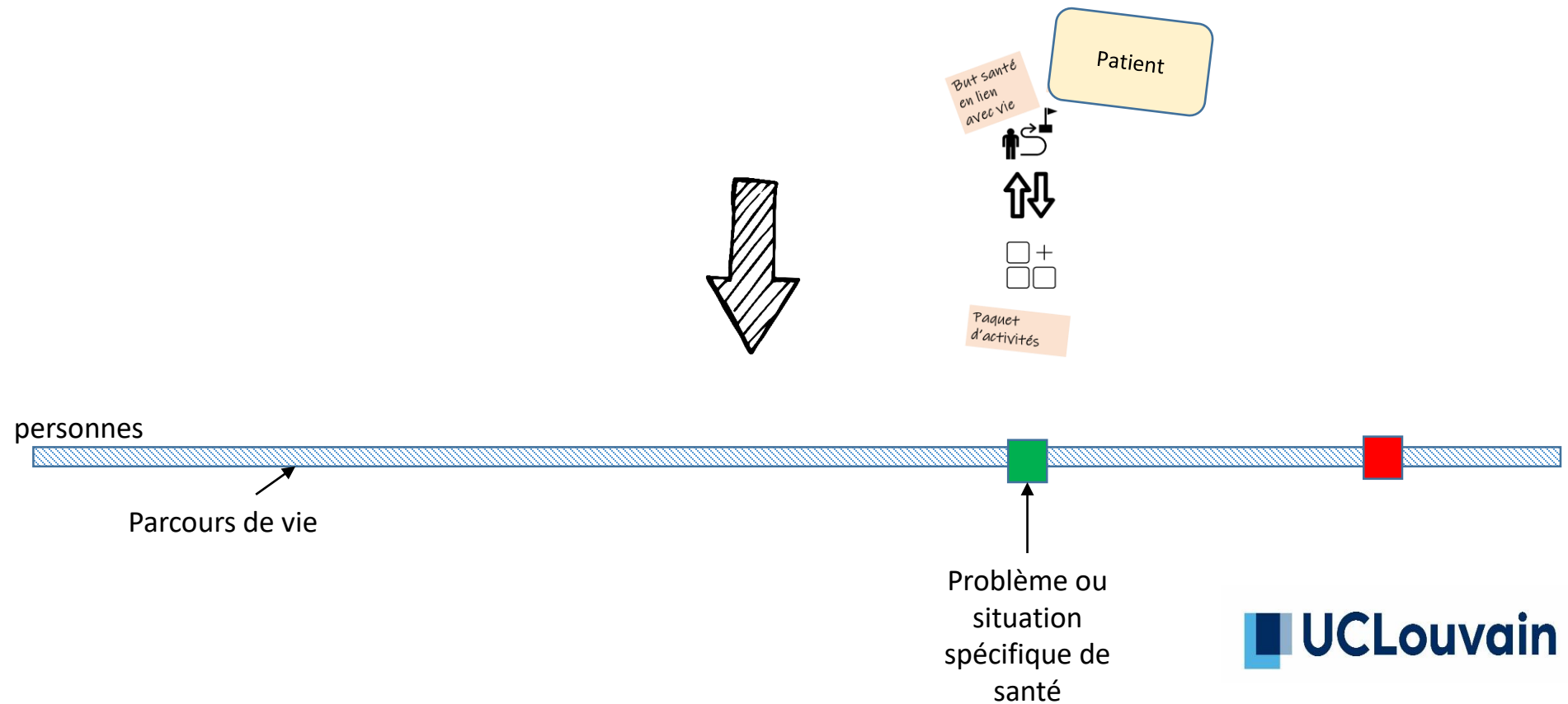
Why integration?



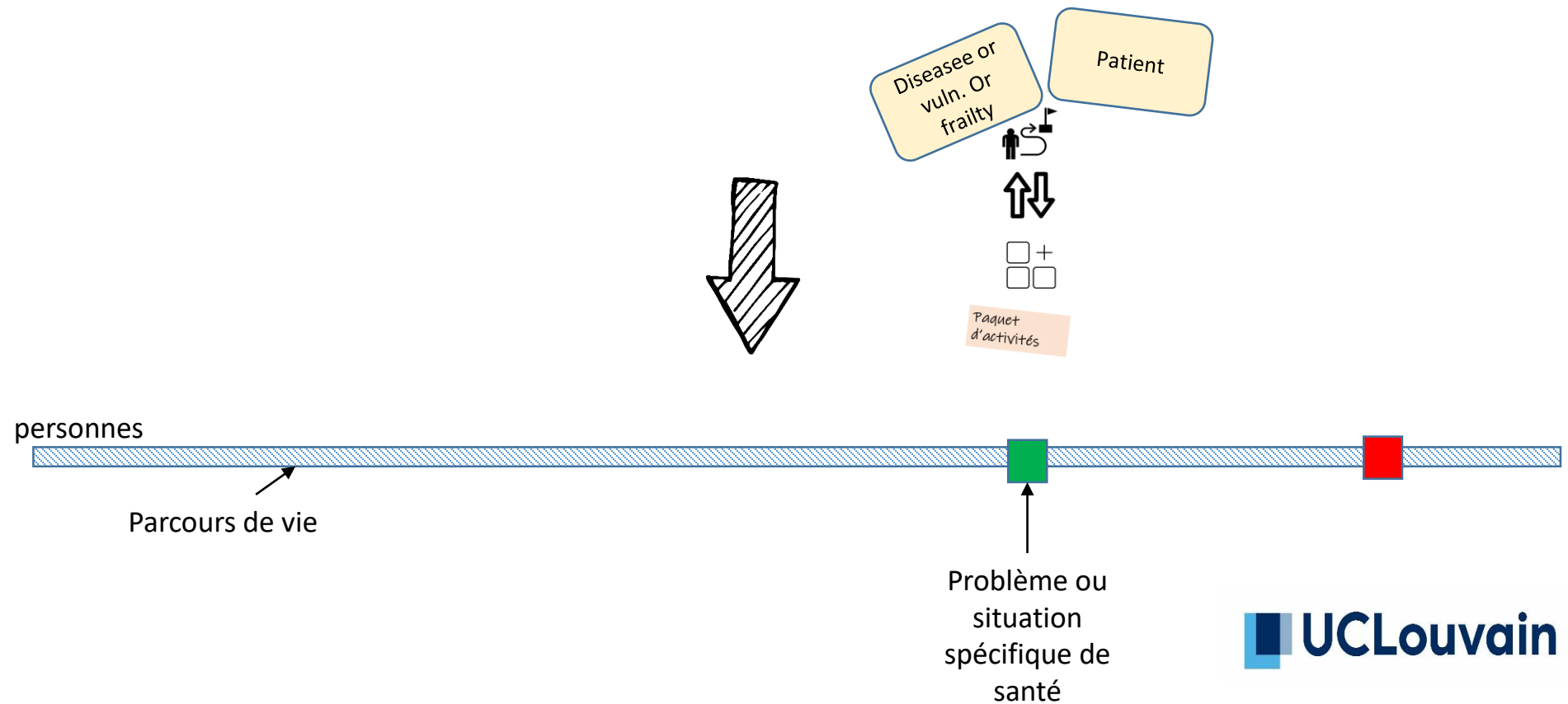
Why integration?



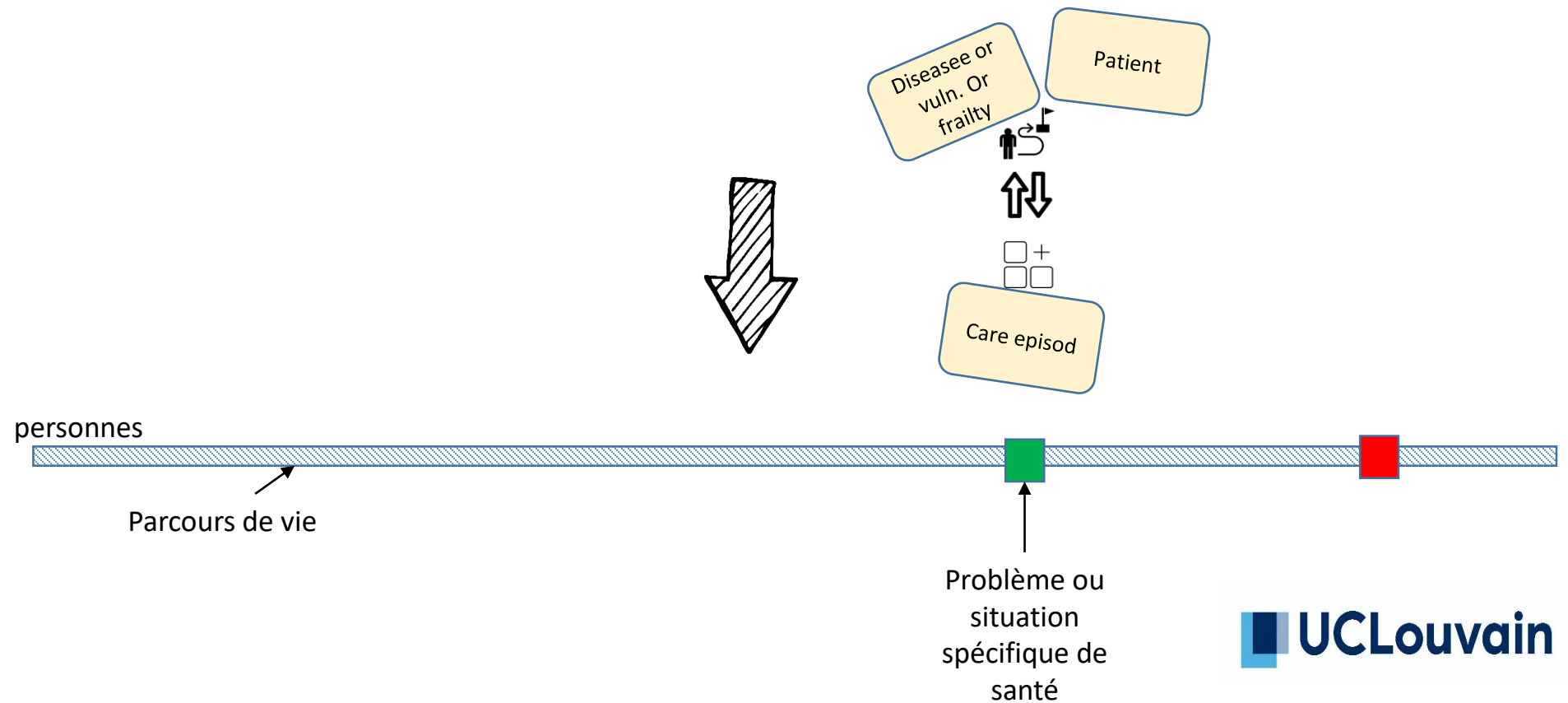
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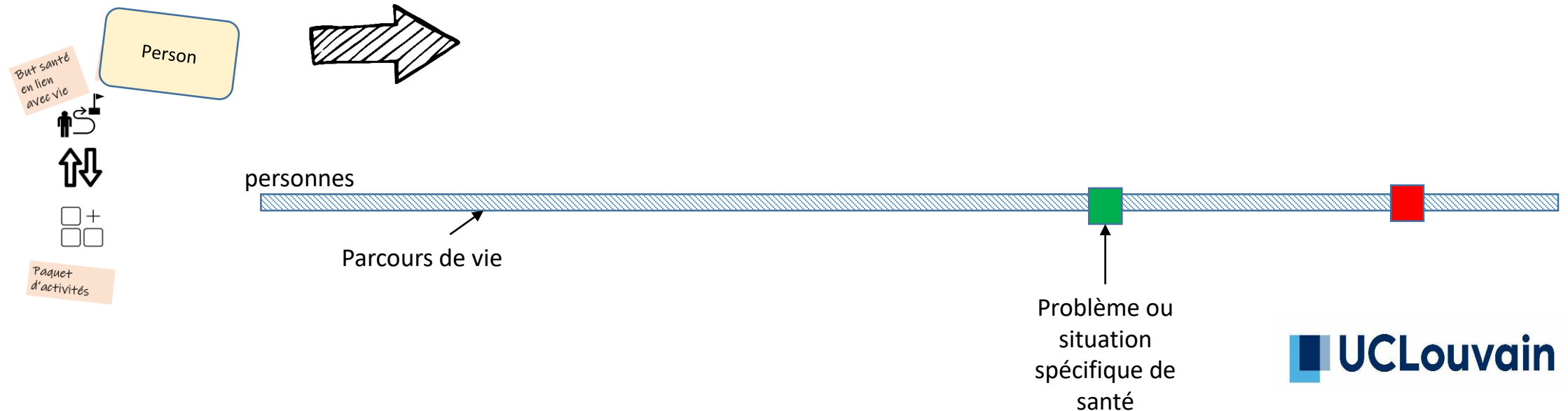
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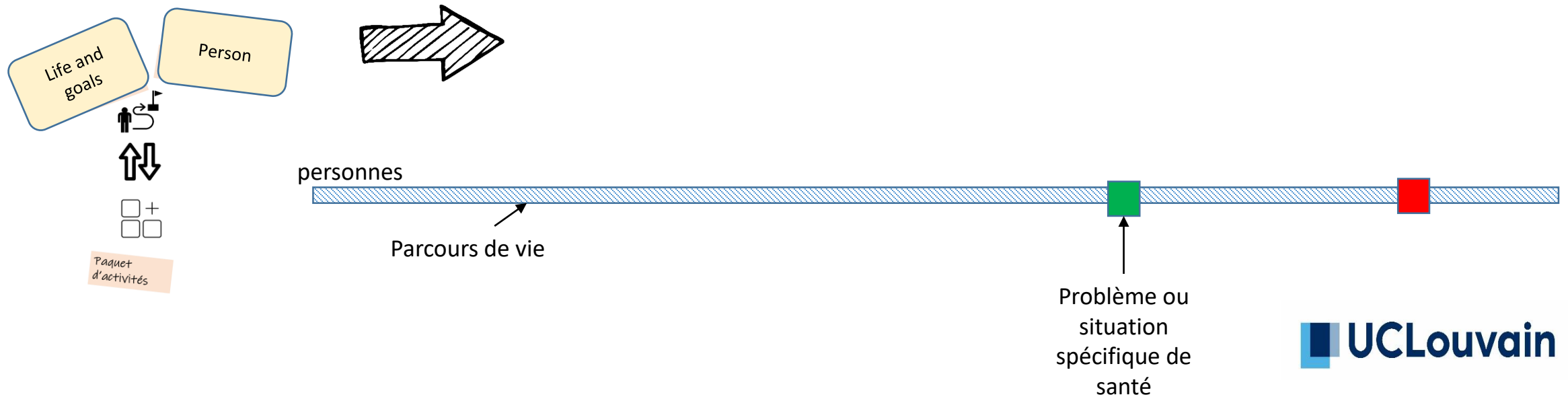
Why integration?



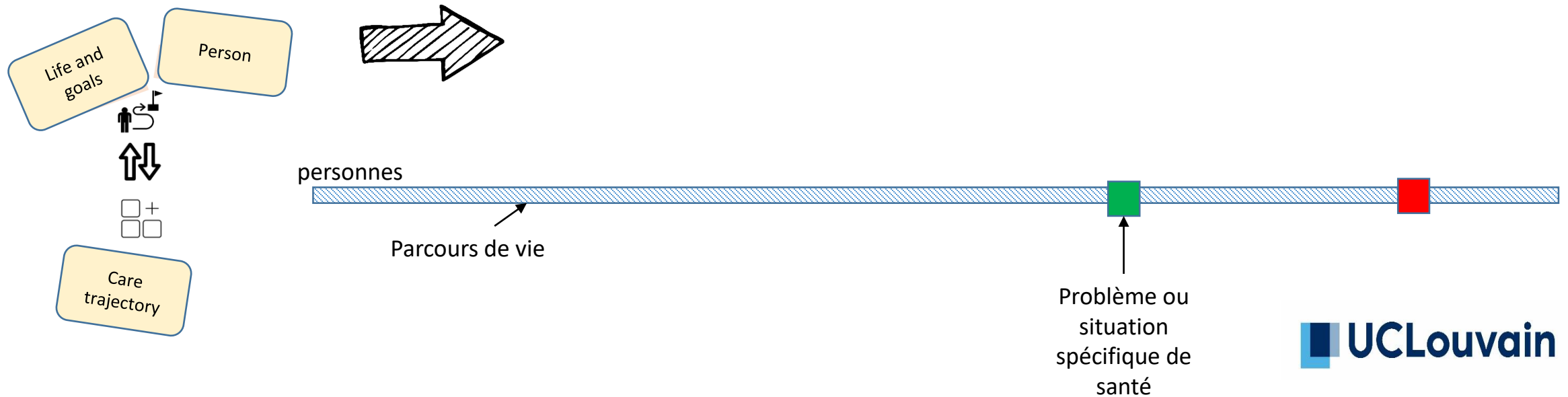
Ce qui est recherché dans l'intégration?



Why integration?



Why integration?

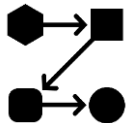


Improving integration?

From...

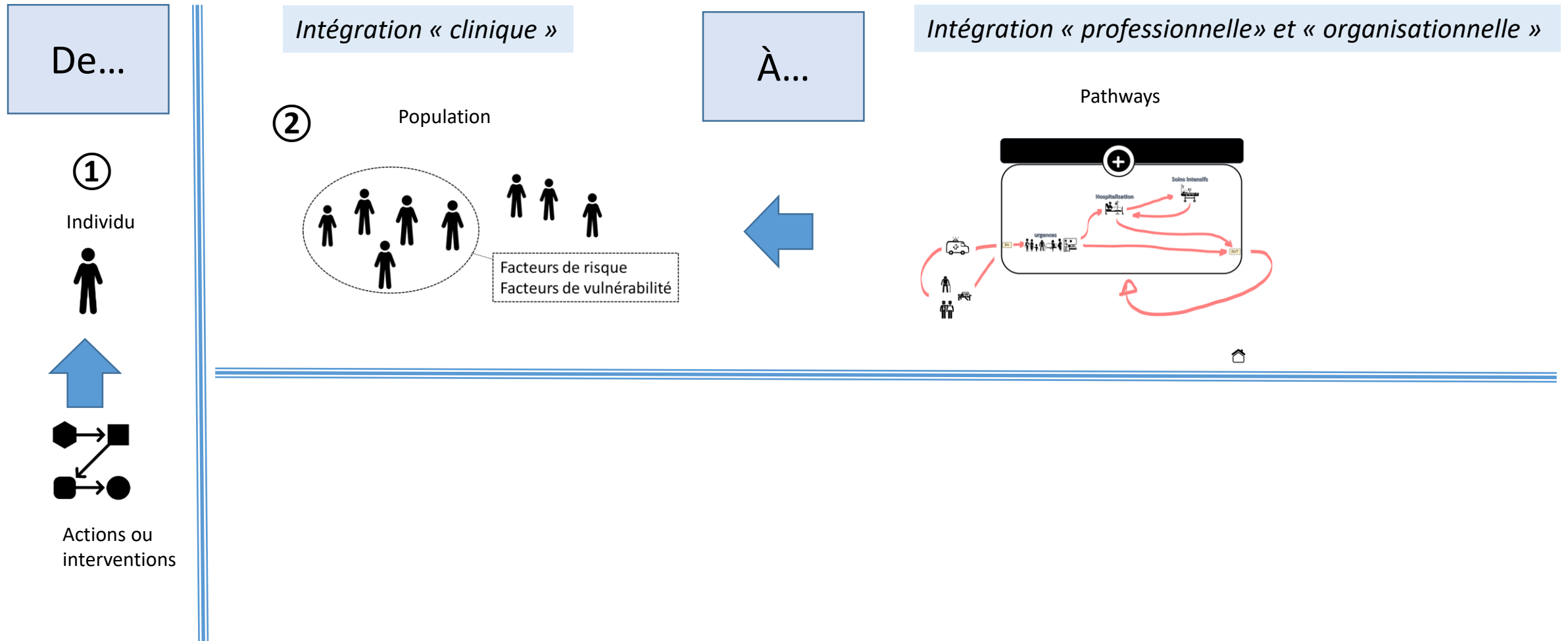
①

Individu

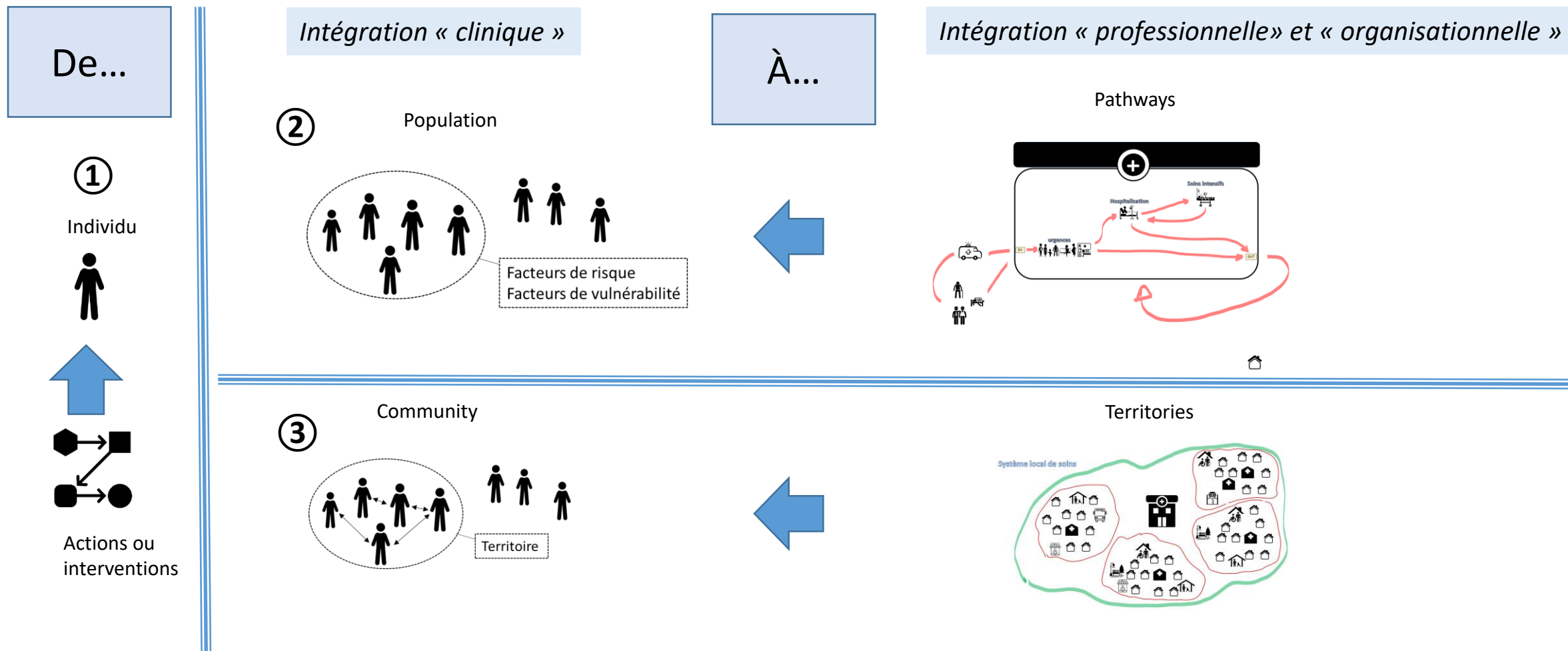


Actions ou
interventions

Improving integration?

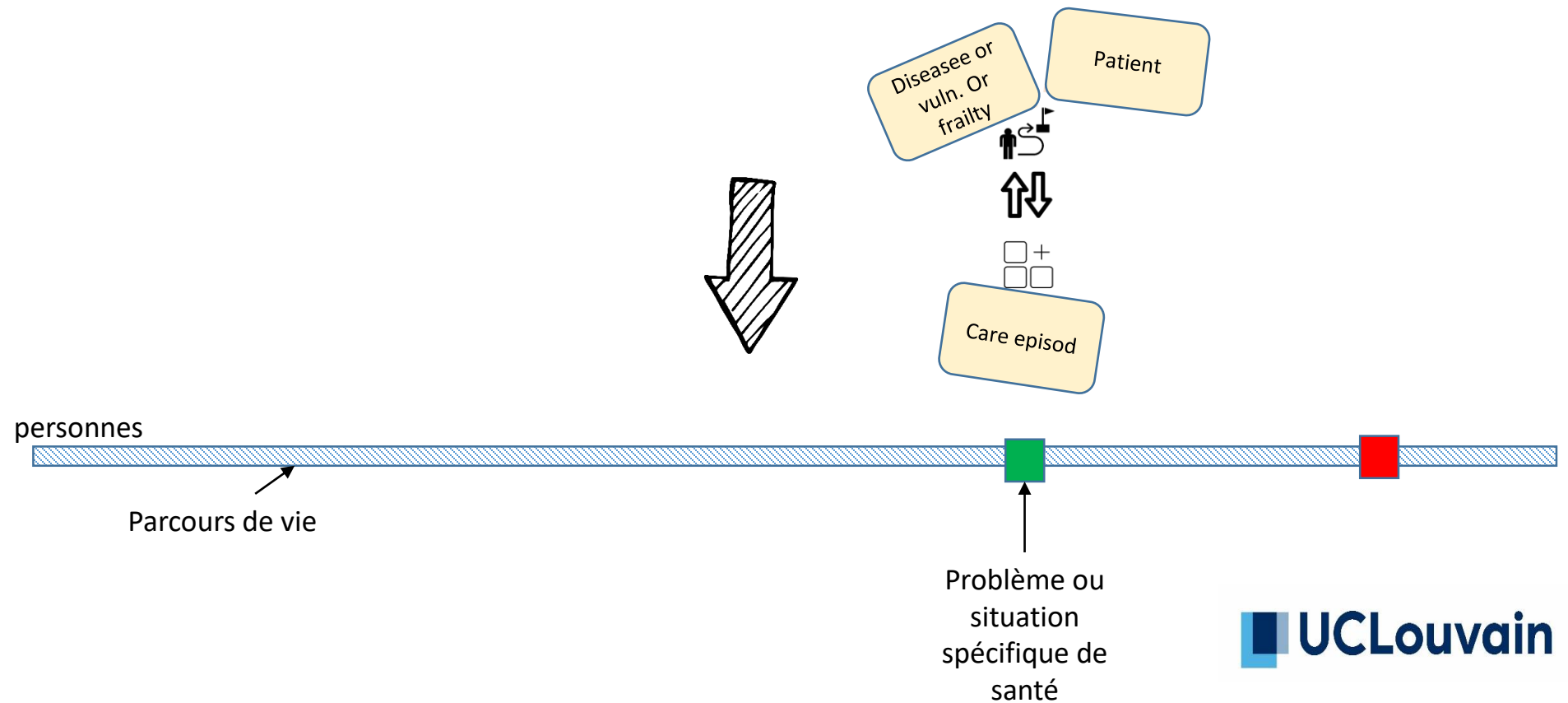


Improving integration?



General principle on « how to? »
Care integration for at risk population or for
specific health problems with a focus on
(relatively) well defined care episod

Why integration?



exemples



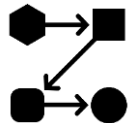
- Patient diabétique
- Patient avec pathologie psychiatrique sévère
- Personnes âgées fragiles

Improving integration?

From...

①

Individu



Actions ou
interventions

Summative evaluation of case management project (Protocol 3)

For whom?

Faible limitation	
IADL, léger trouble cognitif	
Limitations fonctionnelles	+
Limitations fonctionnelles & cognitives	+
Limitations fonctionnelles, cognitives & troubles du comportement	+

Phenomenon under study

Intervention: Case management
50 projets bottom-up et hétérogènes



2 critères:

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- Intensité de case management

3 types de case management:

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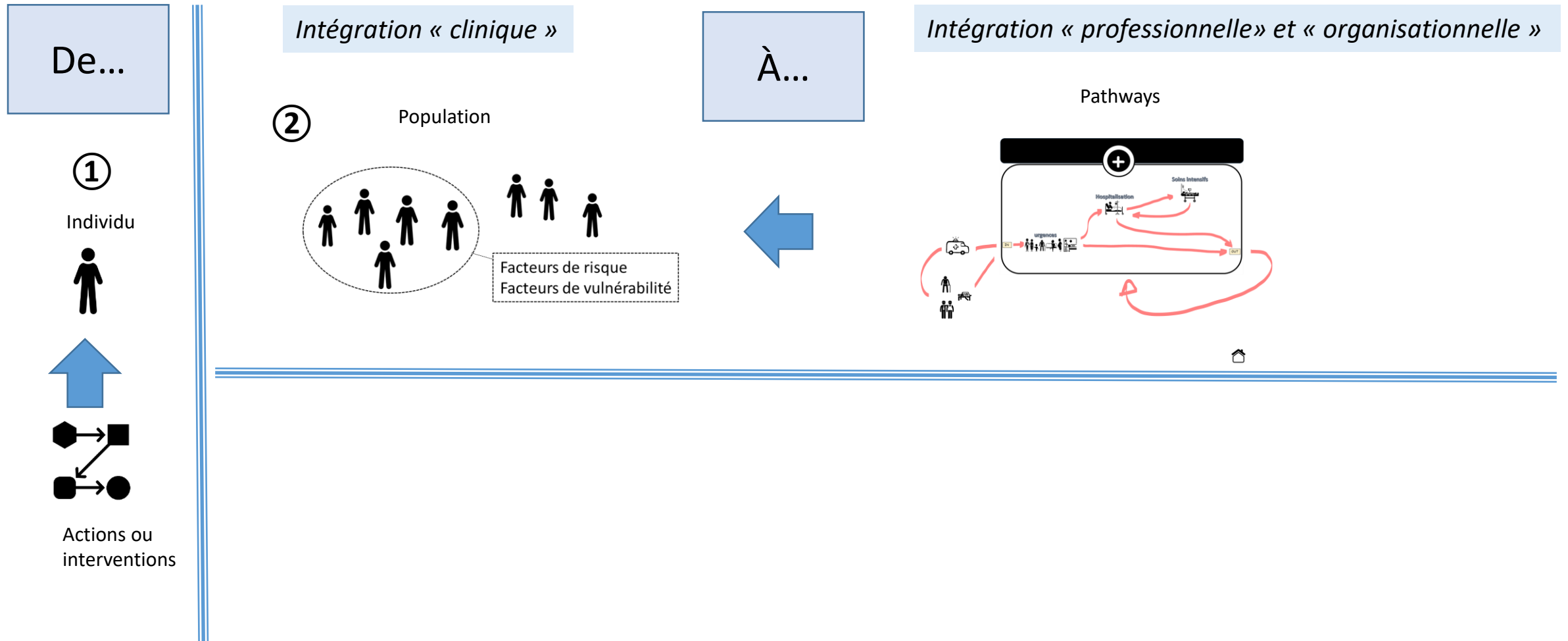
Y1

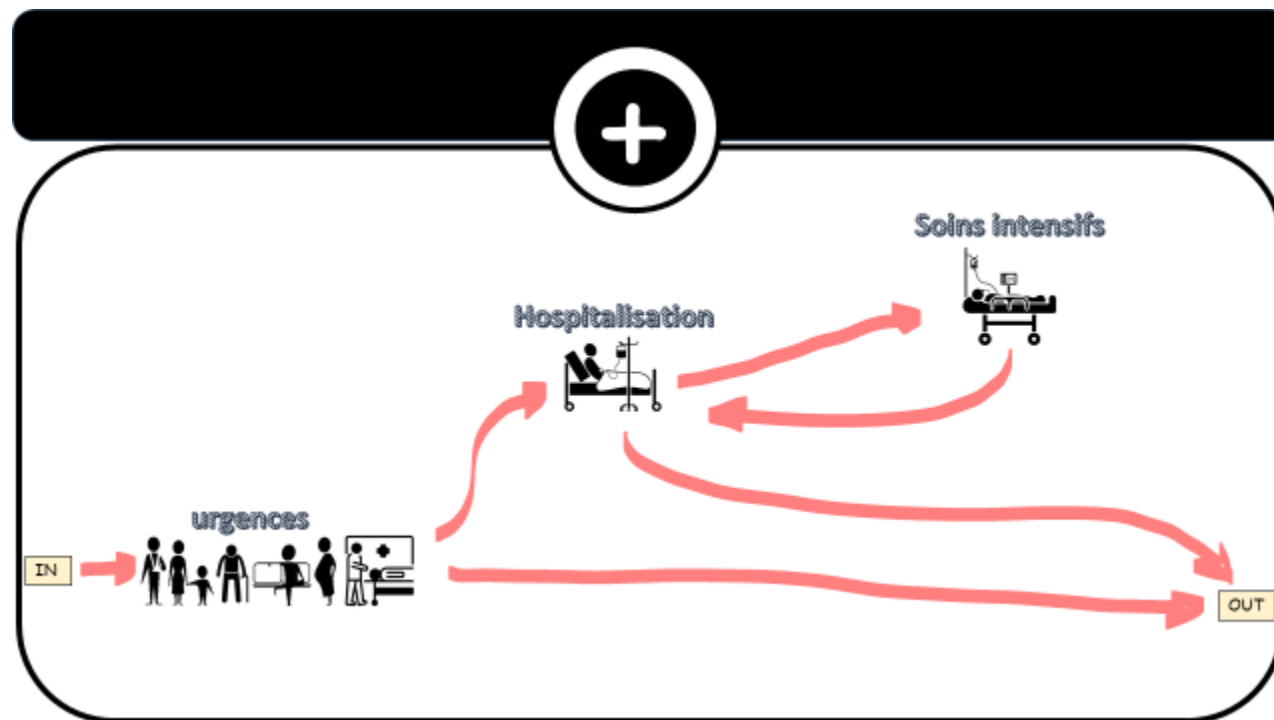
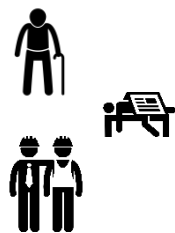
Y2

Observed effects:

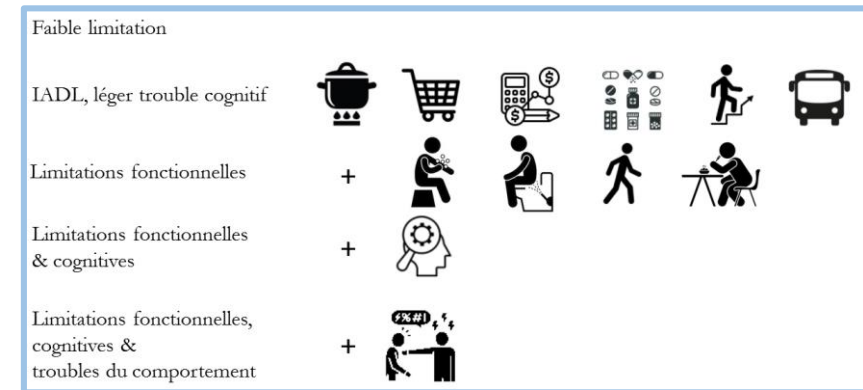
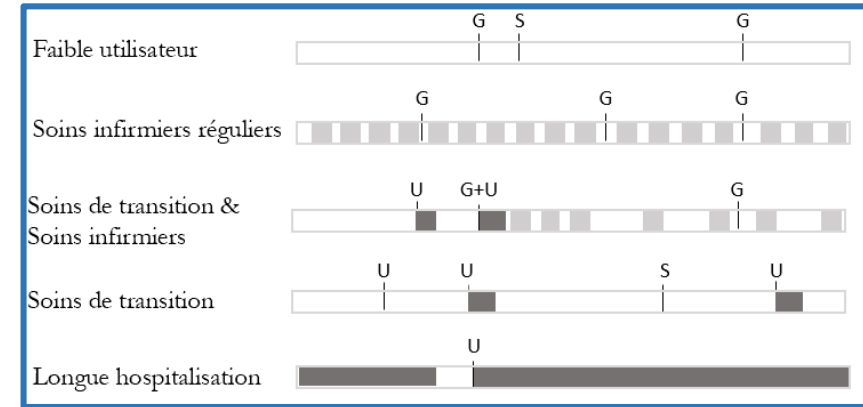
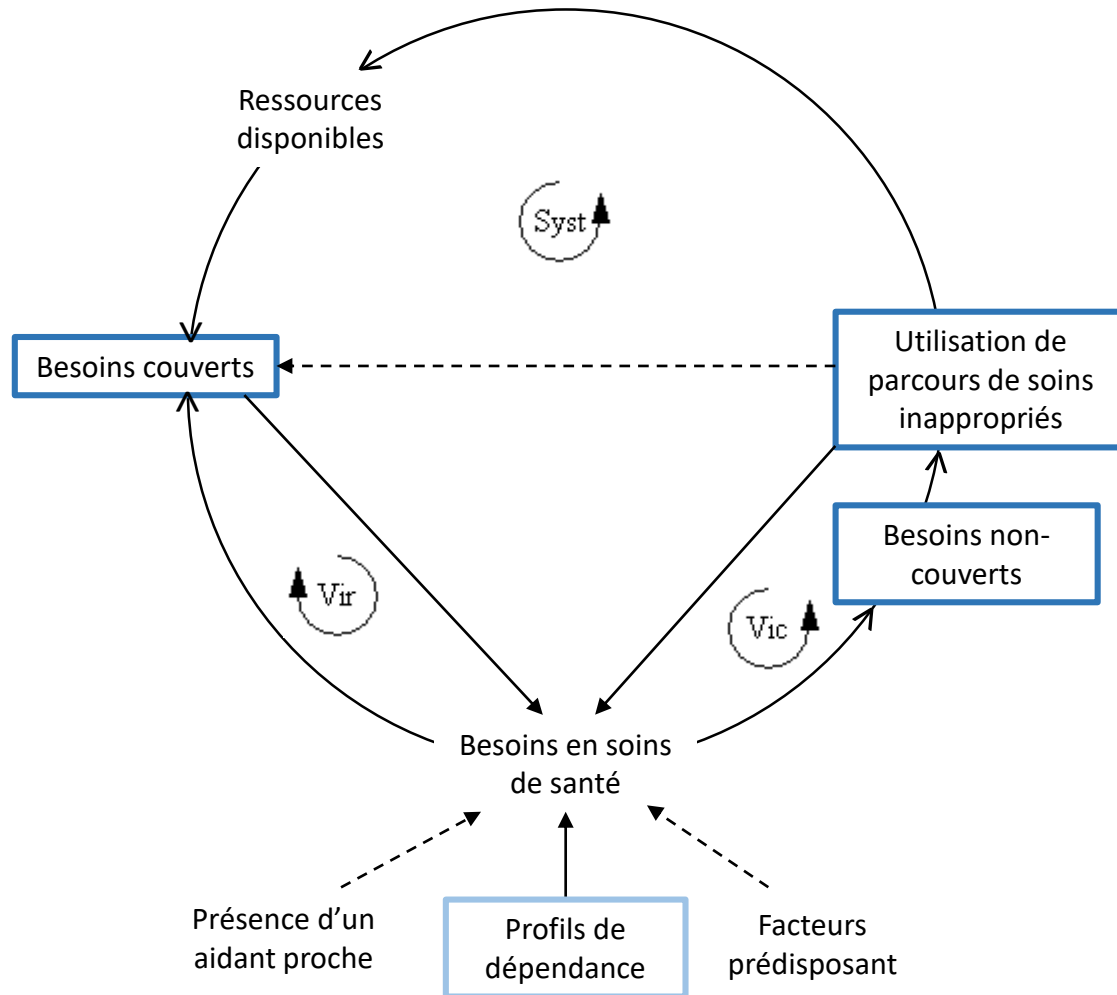
Ecart entre ce qui se passe avec l'intervention et ce qui se passerait sans

Improving integration?



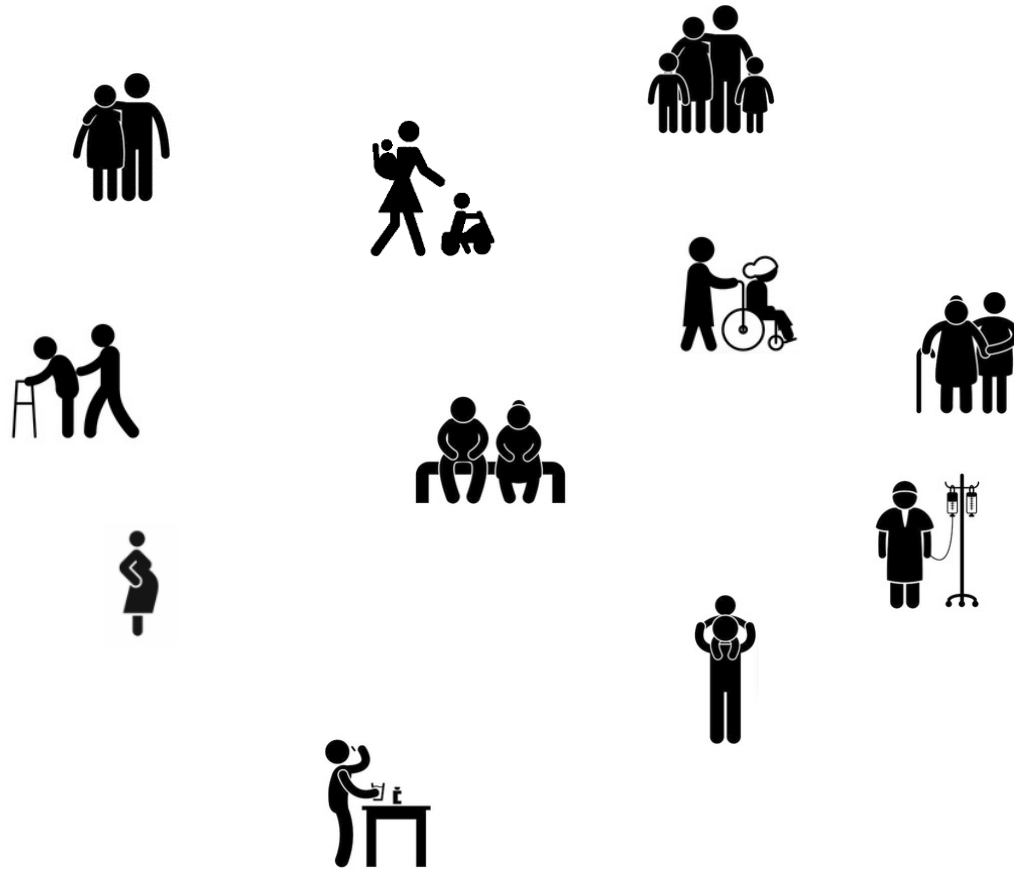


Population stratification: healthcare and capacities



General principle on « how to? »
care pathways – trajectories...But
also territories...

Various life and health situations





Within a specific territory

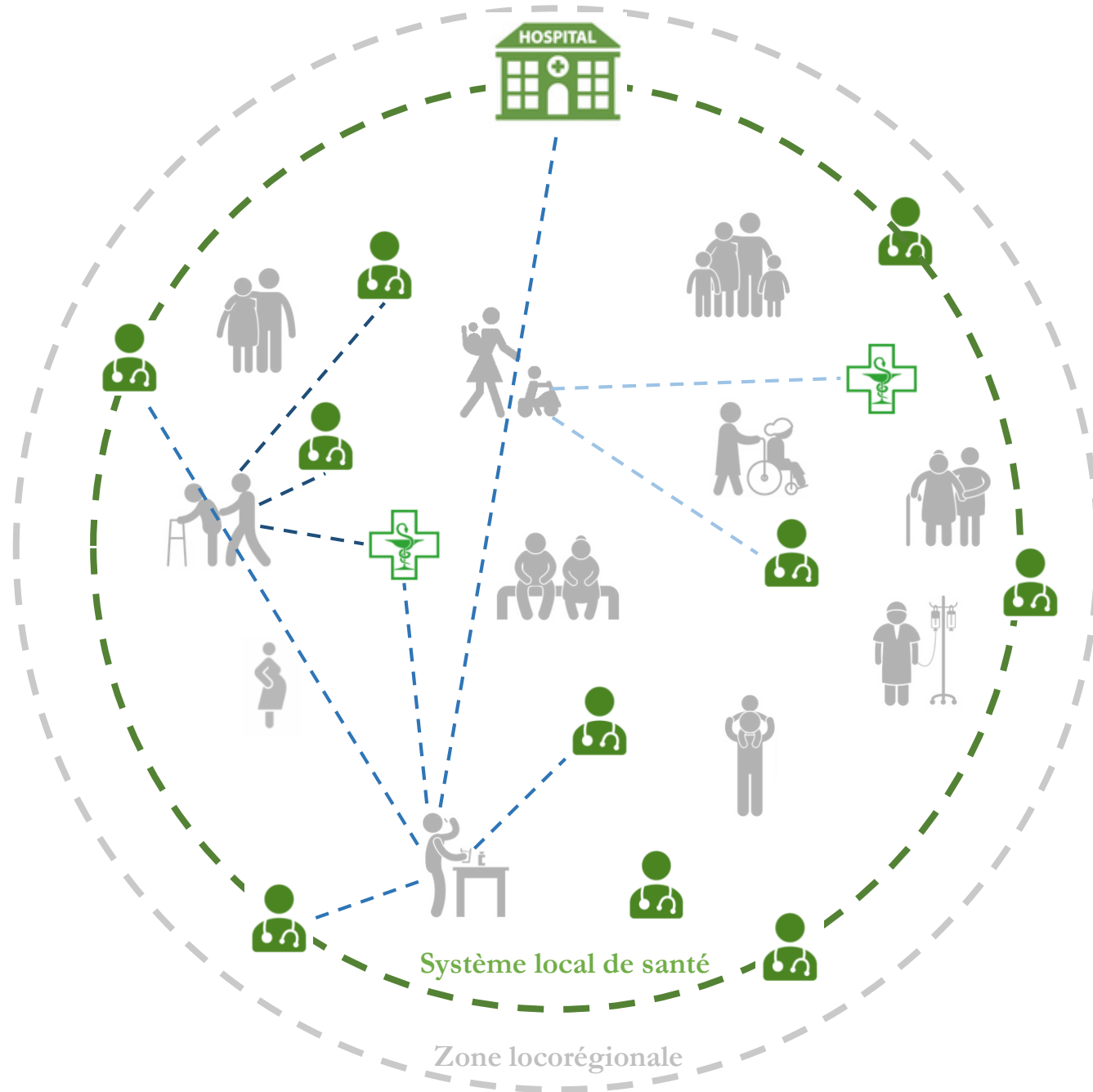
Neighborhood < **Zone locorégionale** < Région



A local health system

Niveau méso

Niveau micro



A local health system

Niveau méso

Niveau micro:
Interaction avec le patient



Belgian health system

Macro level : cadre politique

Niveau méso

Niveau micro

Système local de santé 1
Zone locorégionale 1

Niveau méso

Niveau micro

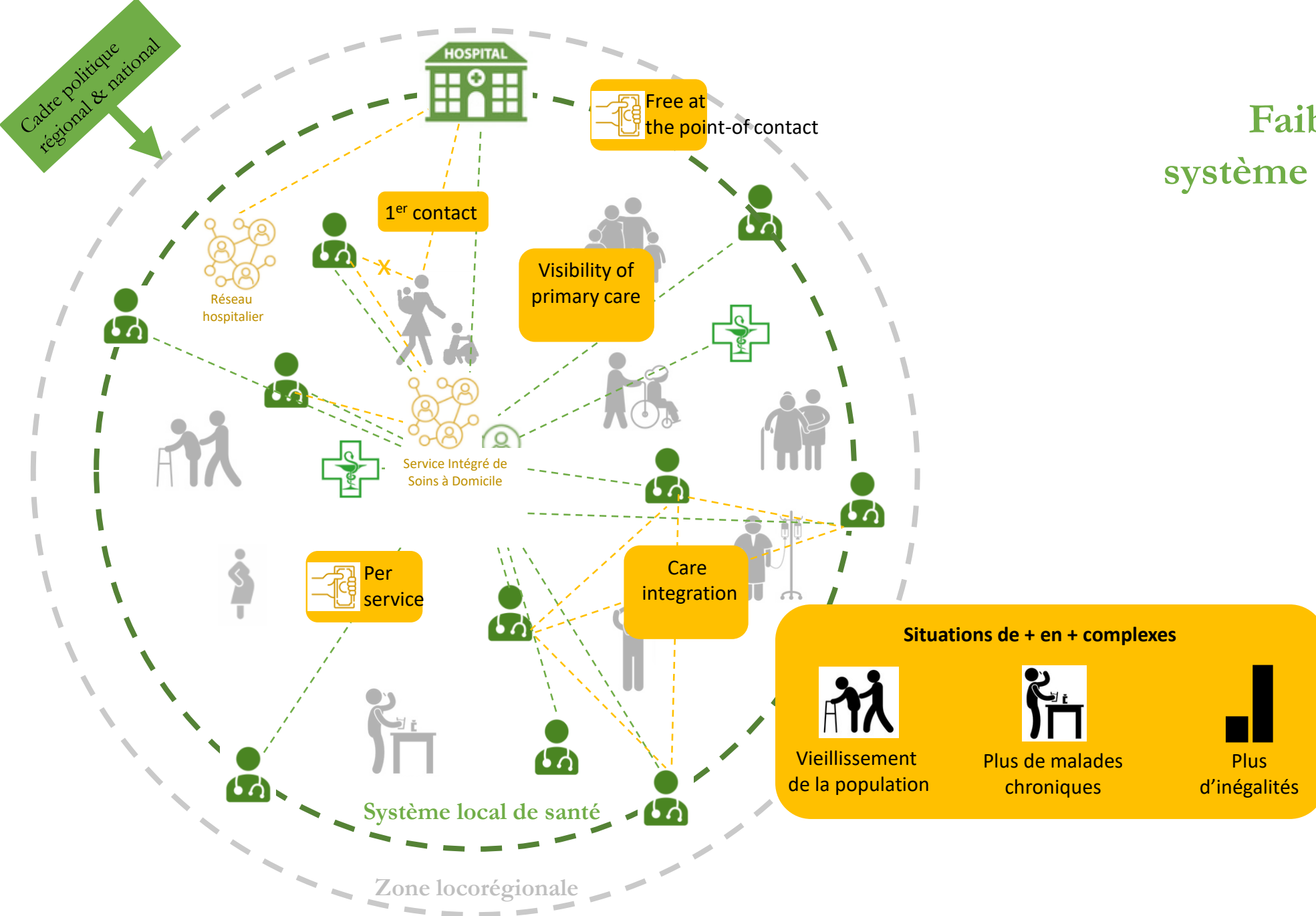
Système local de santé 3
Zone locorégionale 3

Niveau méso

Niveau micro

Système local de santé 2
Zone locorégionale 2

Faiblesses du système de santé belge



Un niveau méso wallon : structures multiples sur des zones locorégionales variées



Réseaux hospitaliers

- Nord-Est Liège
- Liège Ouest
- Charleroi
- Hainaut Centre
- Plaine
- Namur
- Vivalia
- Communes partagées entre deux réseaux



SISD: Service Intégré de Soins à Domicile



Cercles de médecins généralistes



Projets soins intégrés en faveur des malades chroniques



RML: Réseau multidisciplinaire local



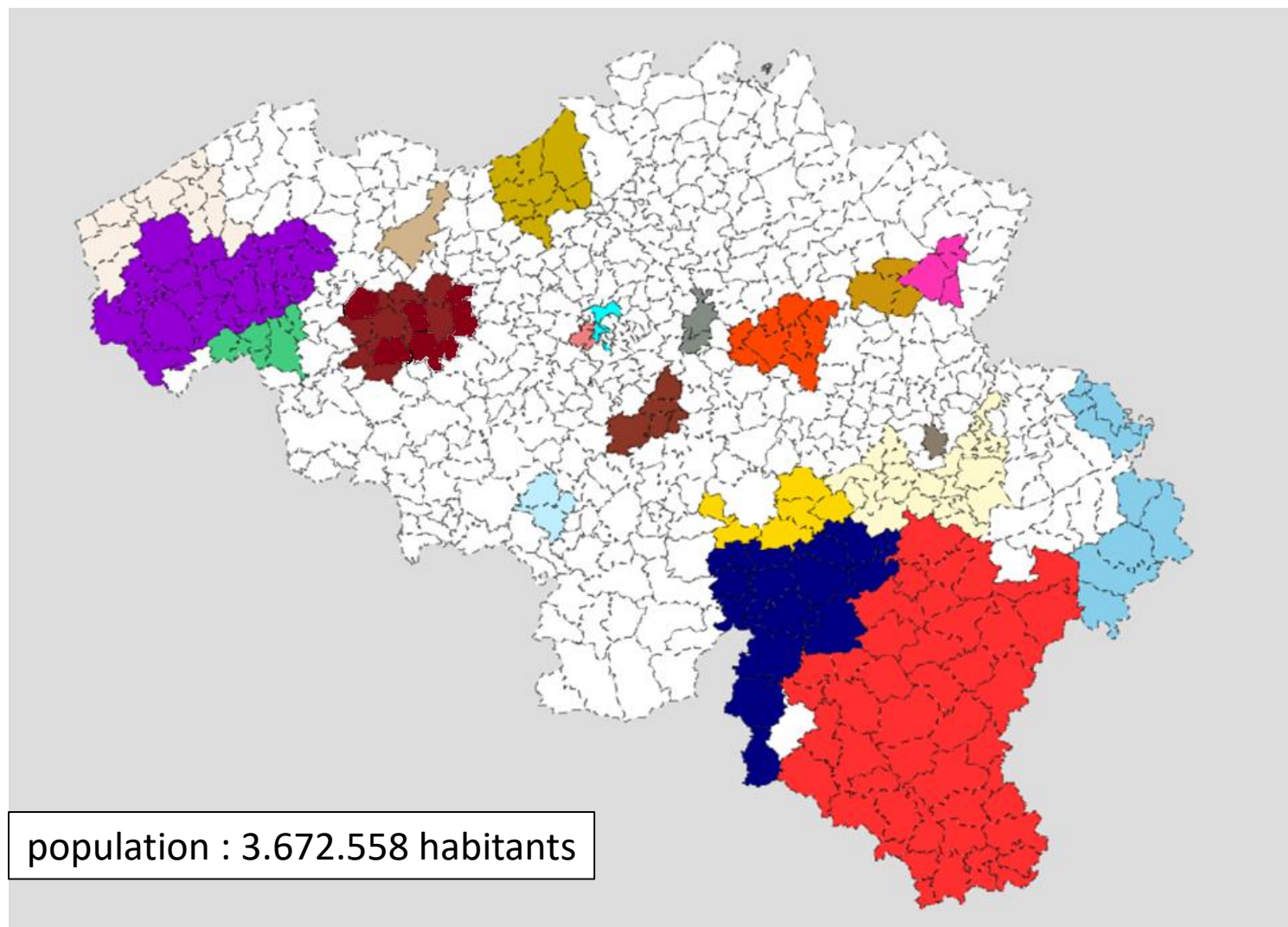
Zone santé mentale (Réforme 107)

travailler l'intégration en fonction de Problème de santé et d'épisode spécifique de soins



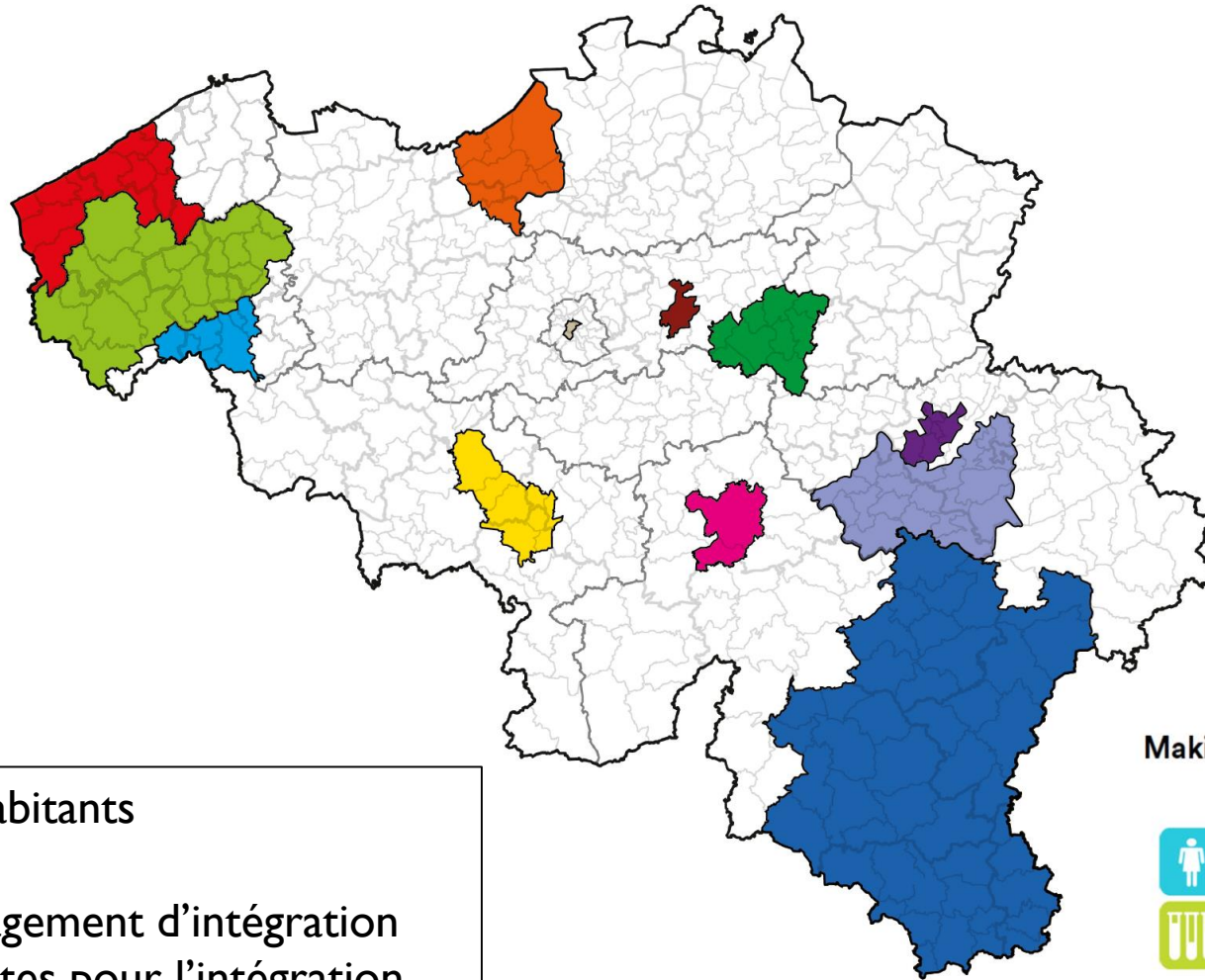
- Trajet de soins diabète
- Réseaux 107
- Protocole 3
- Projets soins intégrés

« soins intégrés pour une meilleure santé »



19 projets étaient candidats 12 ont démarré la phase d'implémentation en janvier 2018

- De Empact
- IMPACT
- De Brug
- Waasland
- Boost
- Hainaut
- Leuven
- Tienen
- Résinamur
- Rélian
- Liège 3C4H
- Chronilux



Population : 3.672.558 habitants
Financement
Le Fédéral finance le management d'intégration
Les autres actions innovantes pour l'intégration
devront être financées par des gains d'efficience
Souplesse réglementaire

Making the transition to value-based care



Volume-based health care

One problem with the volume-based model is the incentives between providers, insurers and patients are misaligned. Fee-for-service and volume are about individual services: The more services you provide, the more you get paid.

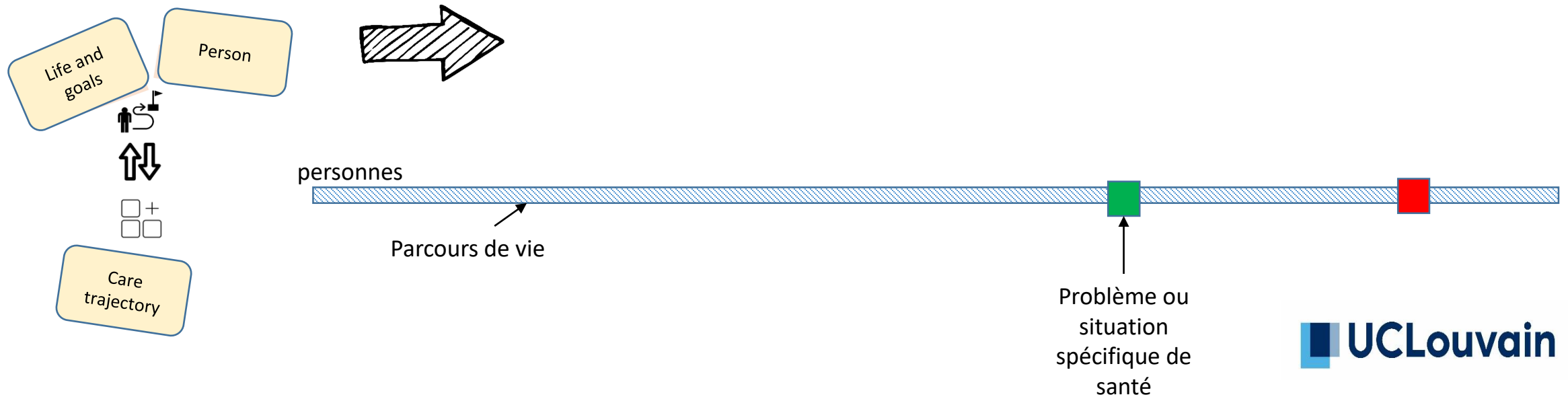


Value-based health care

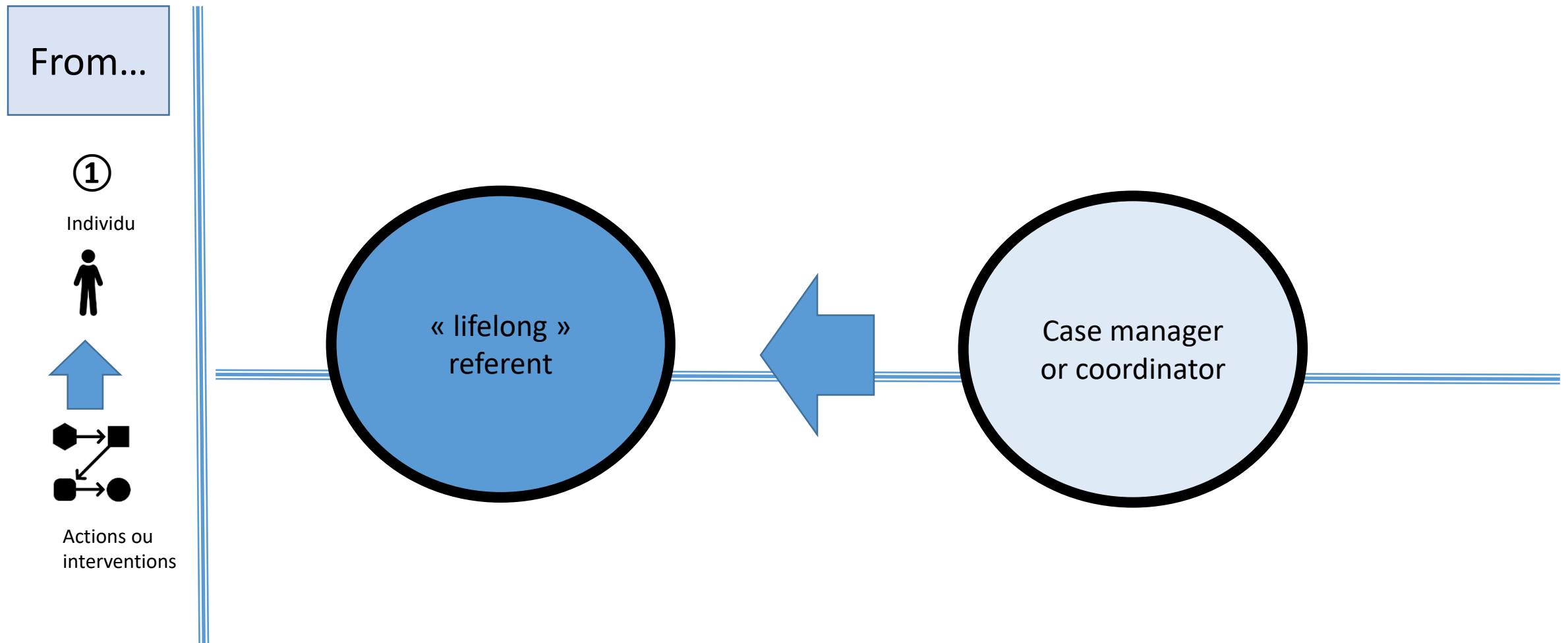
In a value-based system, the core measurement is no longer units of service, but population count. Providers will be paid according to how healthy their patients are, held accountable for cost and quality, and measured on performance.

Not only territories but ... people, life course and
communities

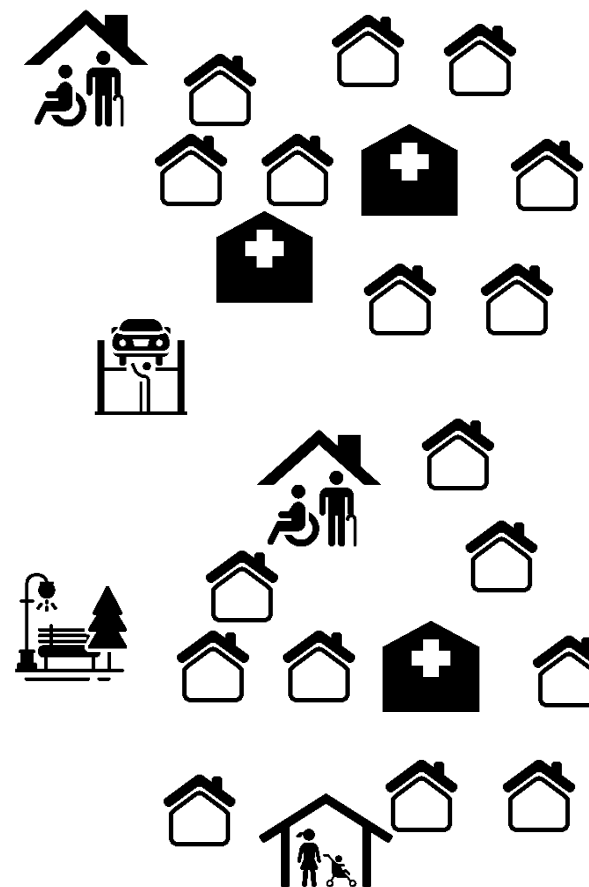
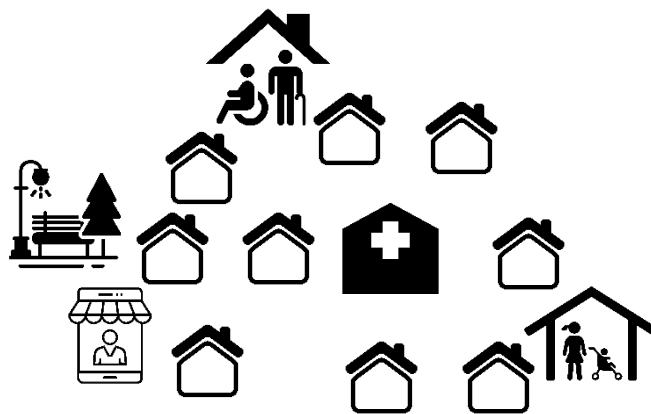
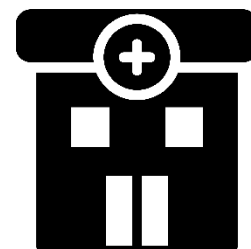
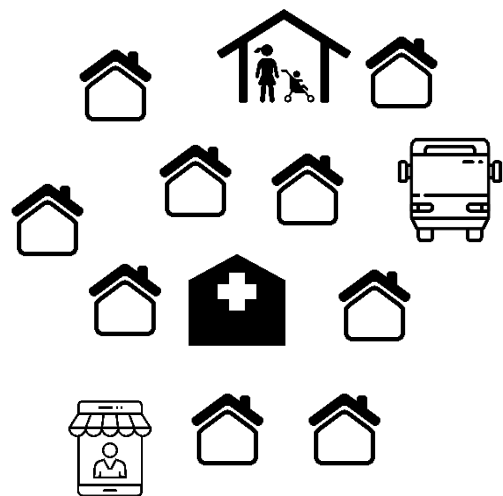
Why integration?



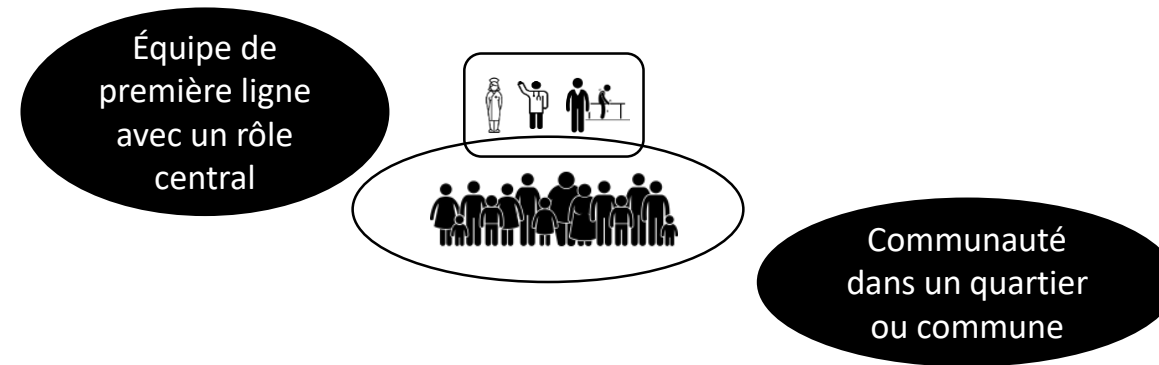
Improving integration?



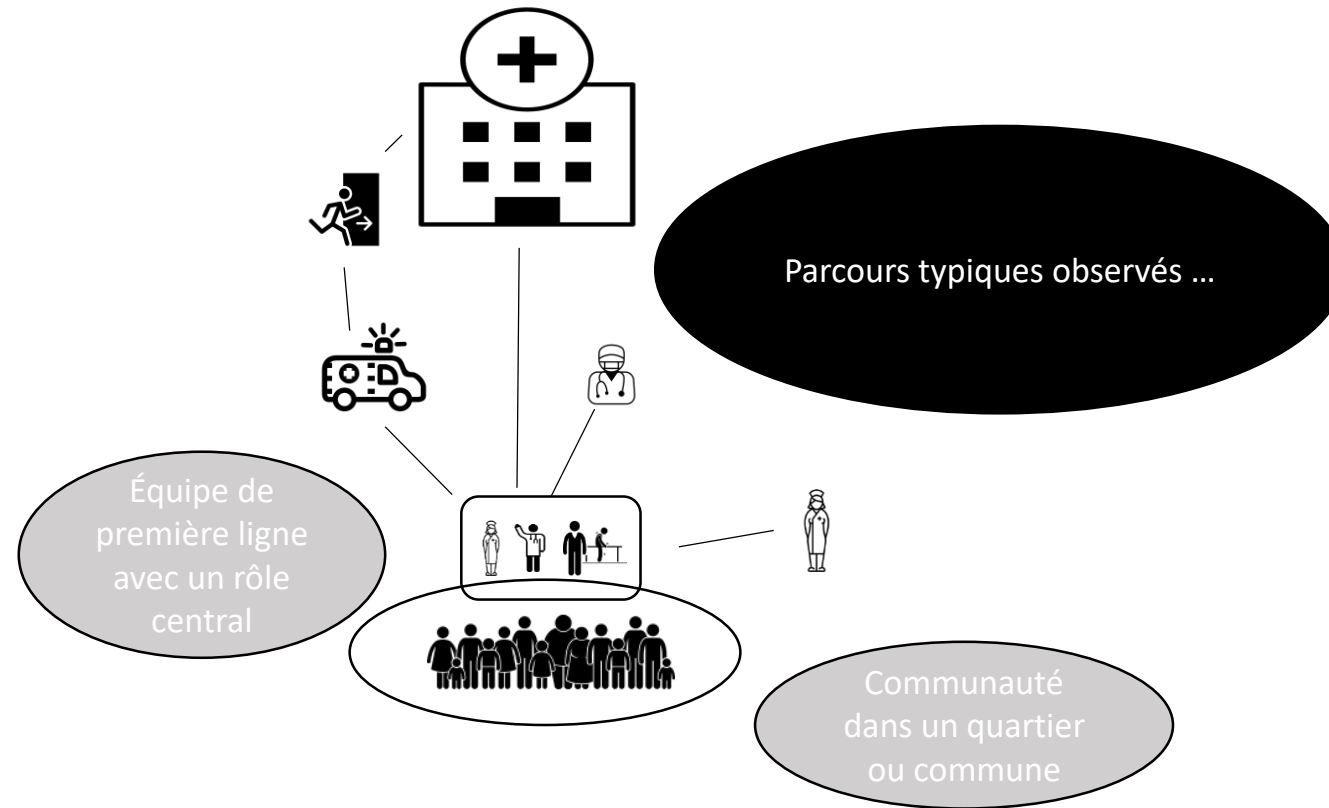
Territoire de soins primaires
(ou de première ligne)



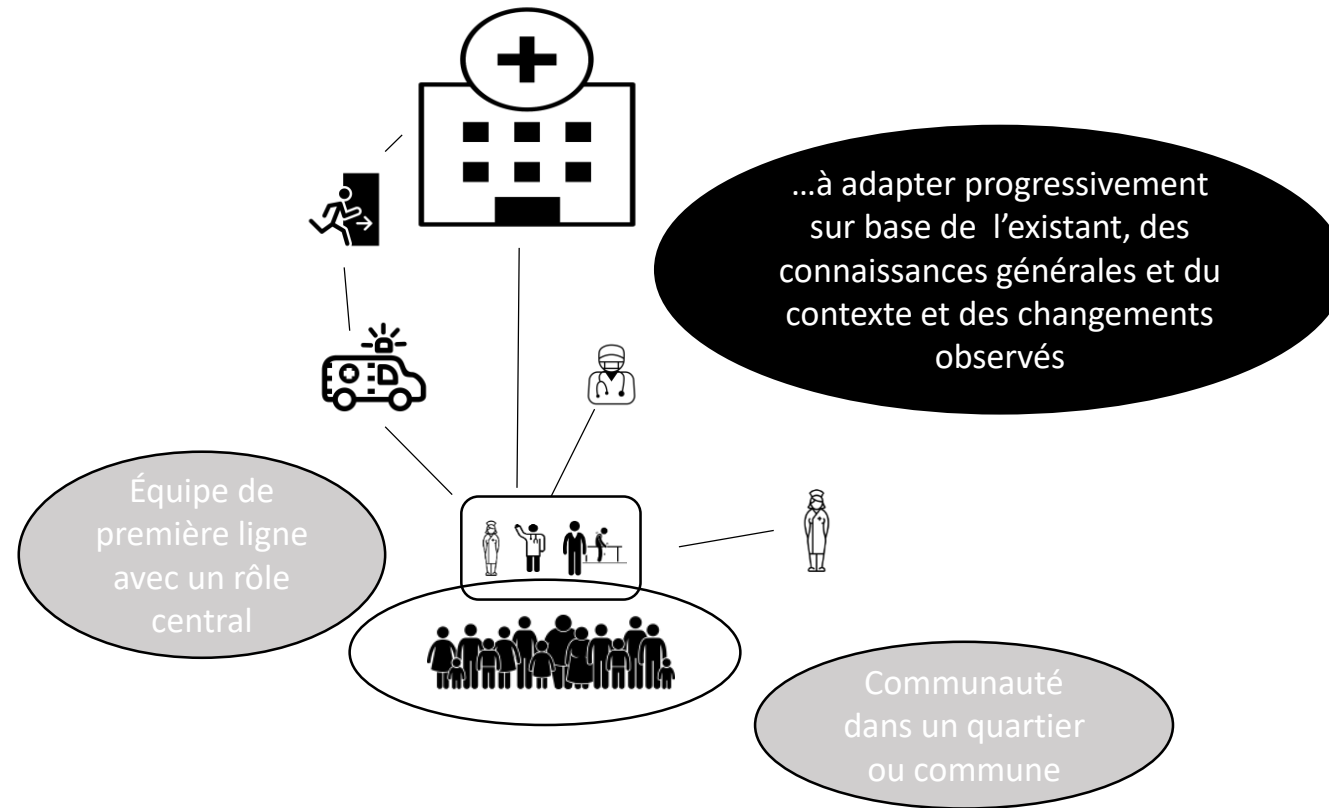
Le futur? Des soins intégrés en fonction du contexte et des personnes (avec maladies chroniques)?



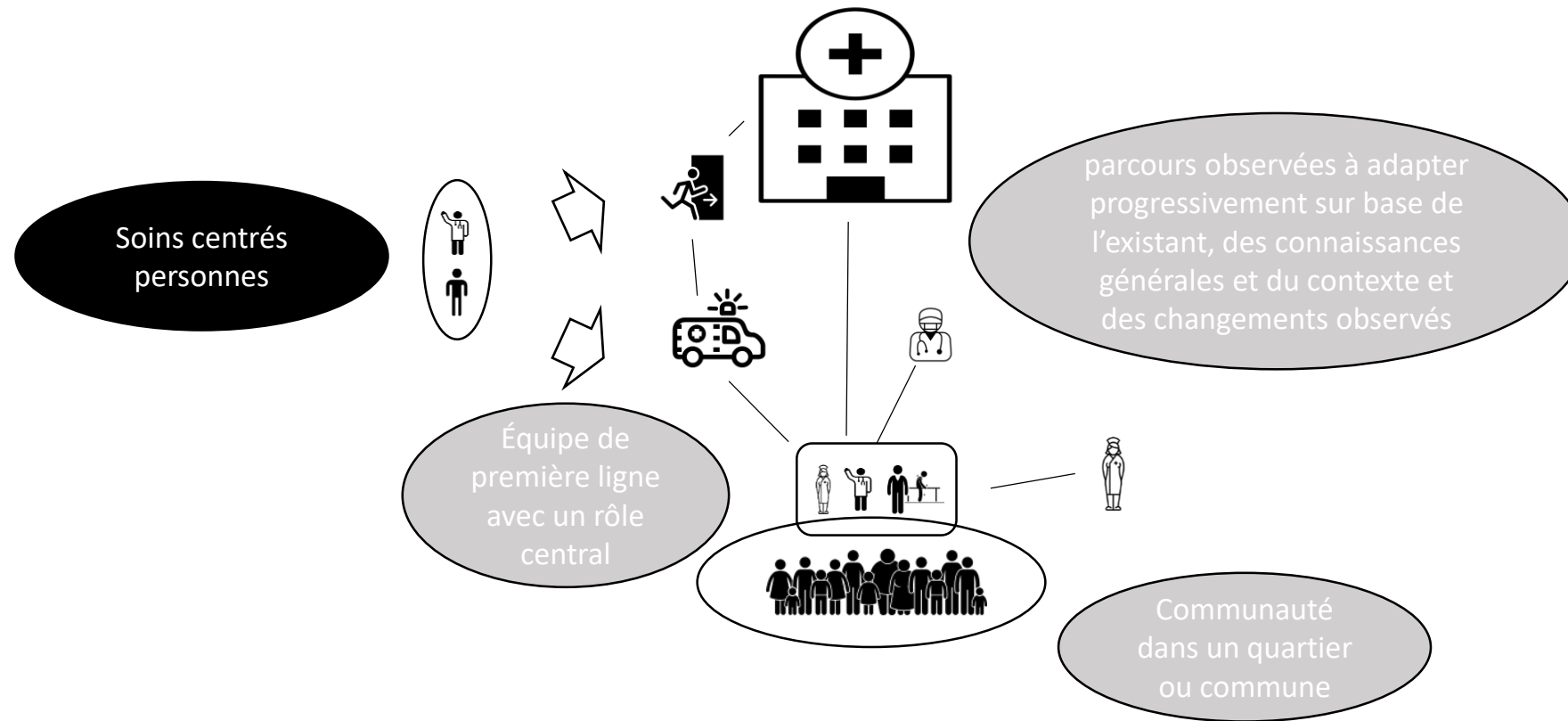
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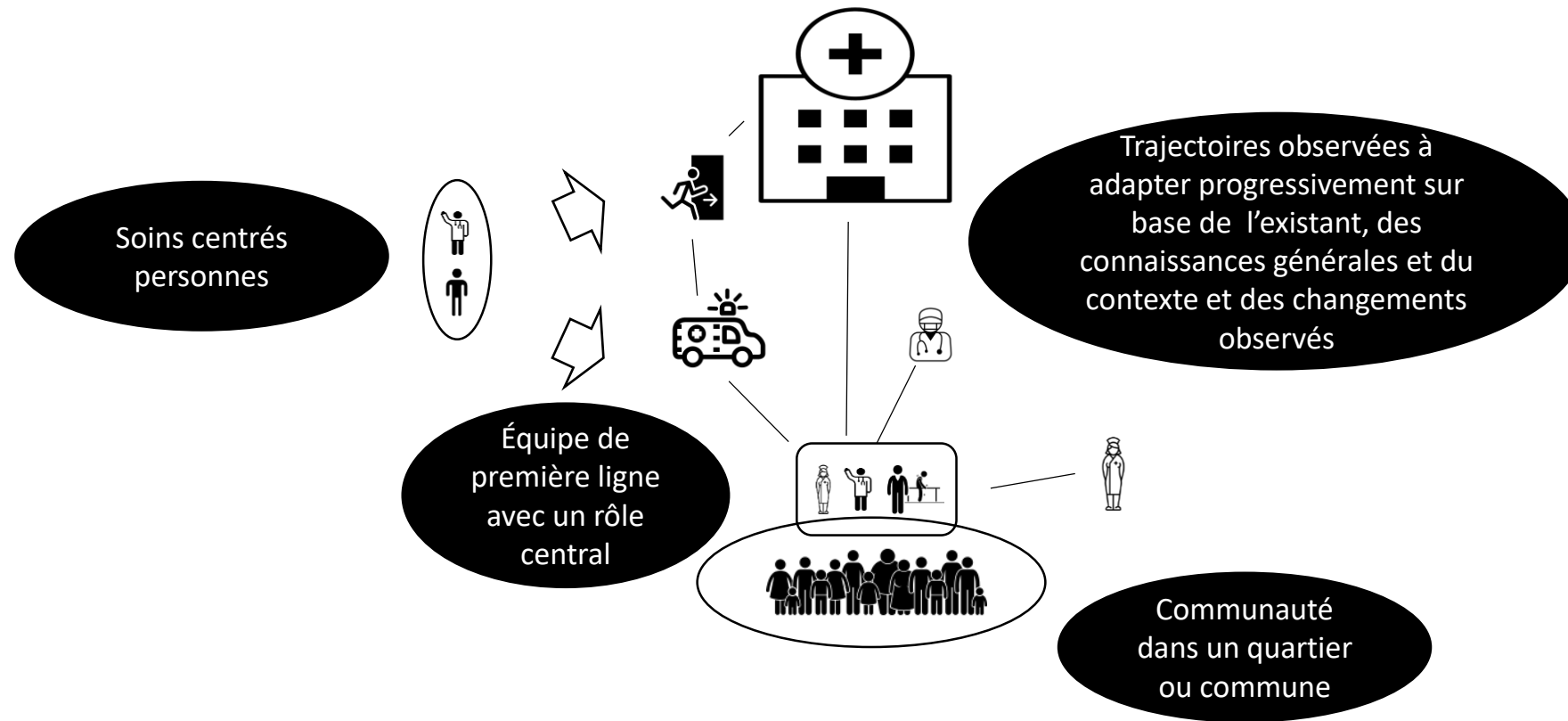
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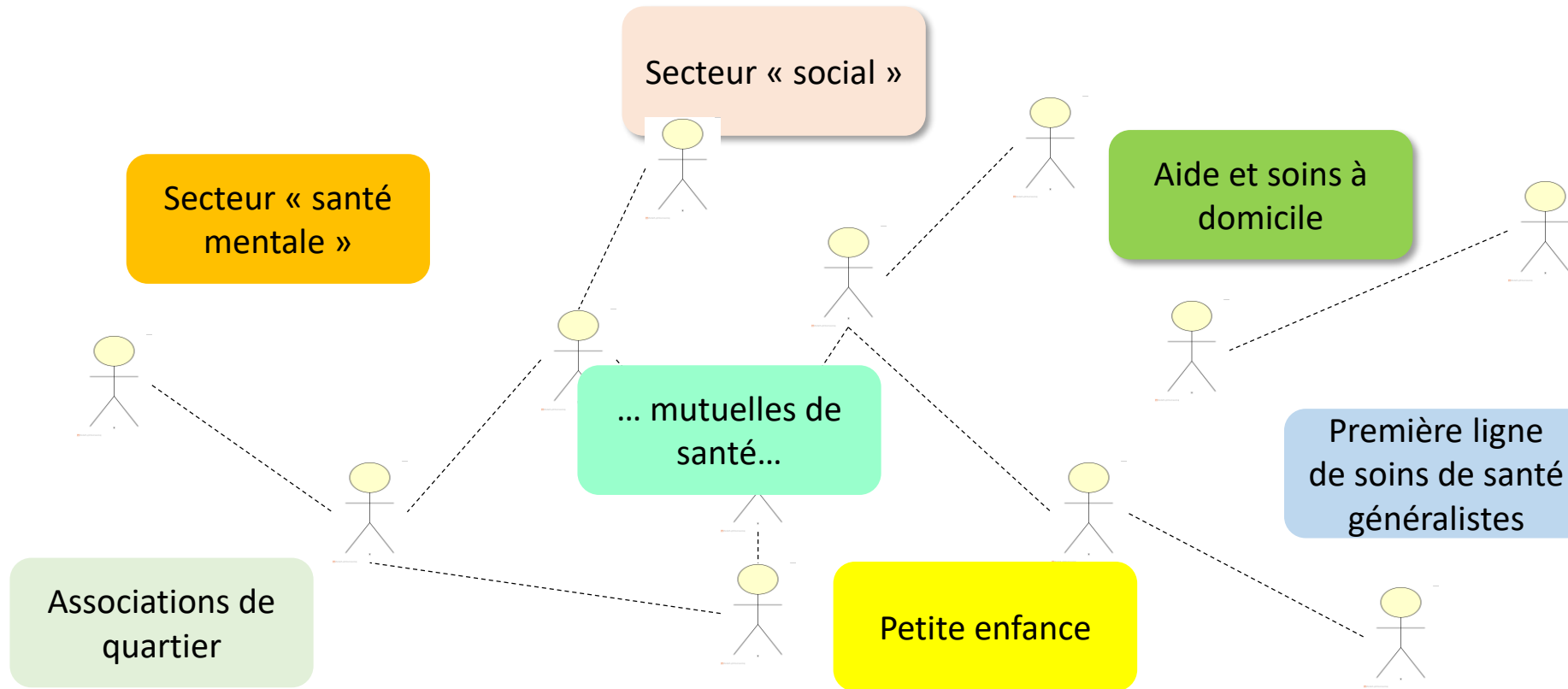
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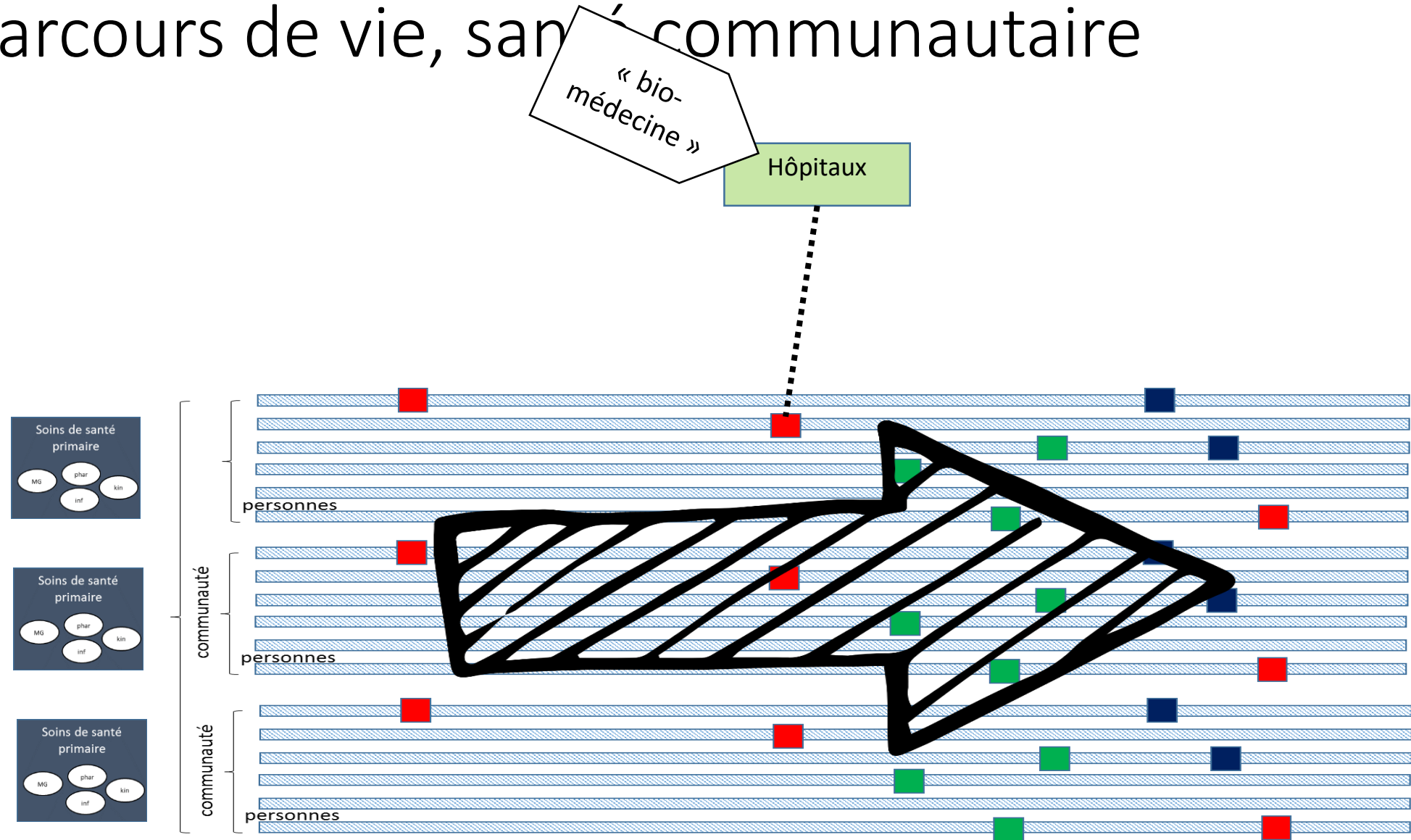
Le futur? Des soins intégrés en fonction du contexte et des personnes (avec maladies chroniques)?



Scénario 2 - Promouvoir une approche de santé positive individuelle, communautaire en renforçant le « maillage » local

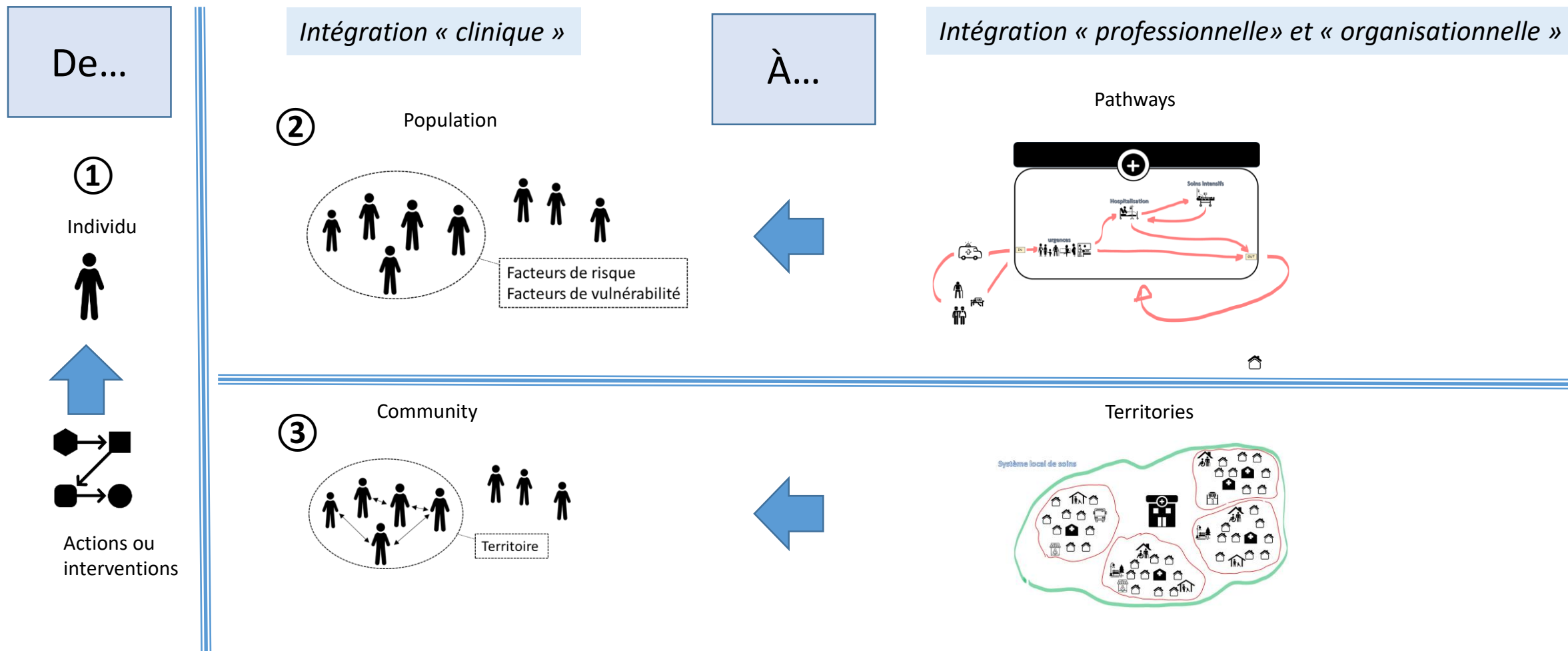


Problème ou situation de santé, santé individuelle et parcours de vie, santé communautaire

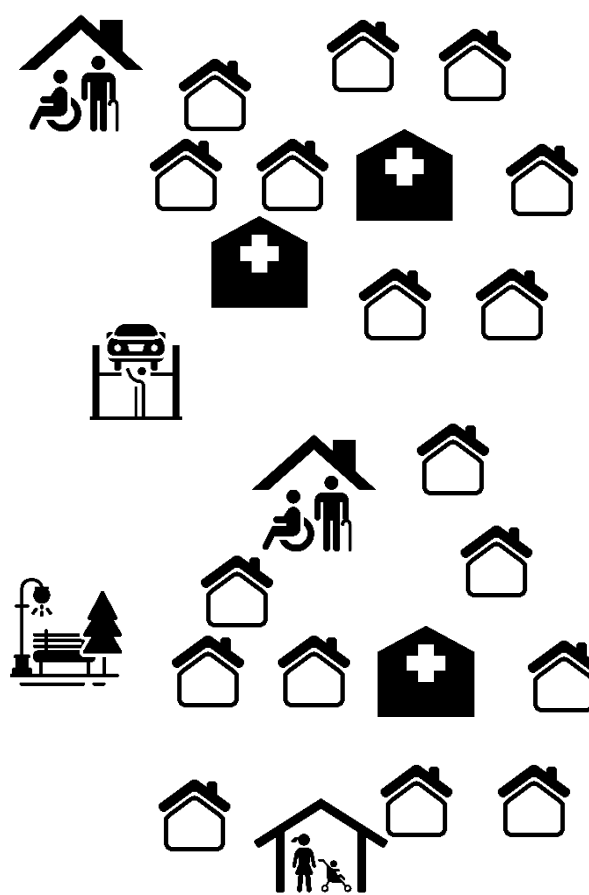
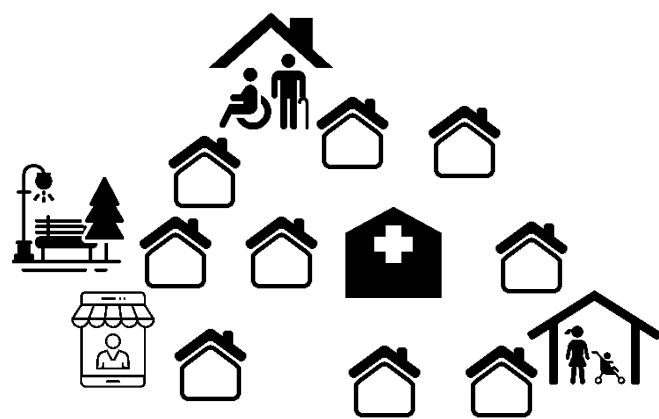
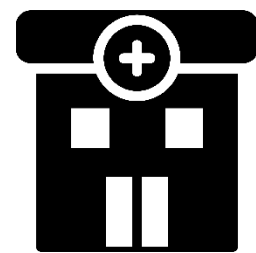
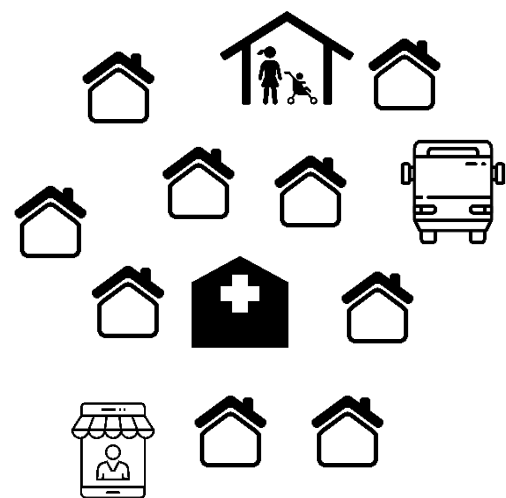


Territories ... towards a synthesis

Improving integration?

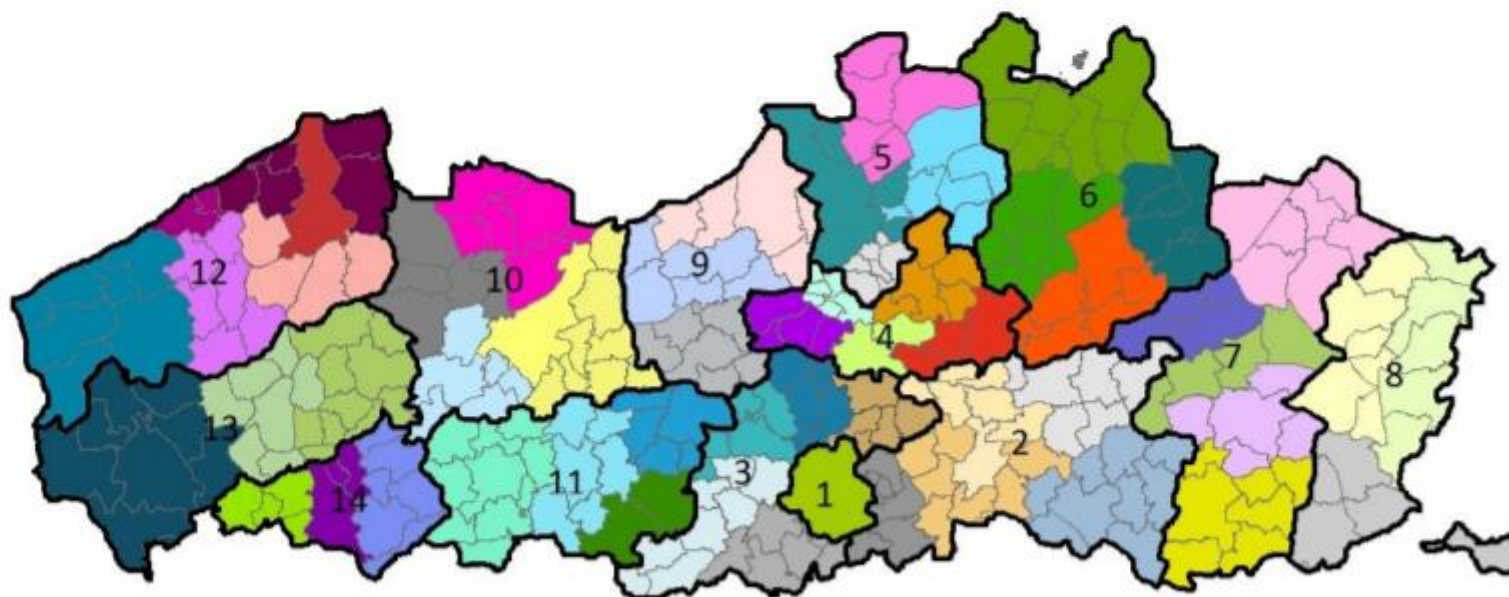


Local health system



In flanders

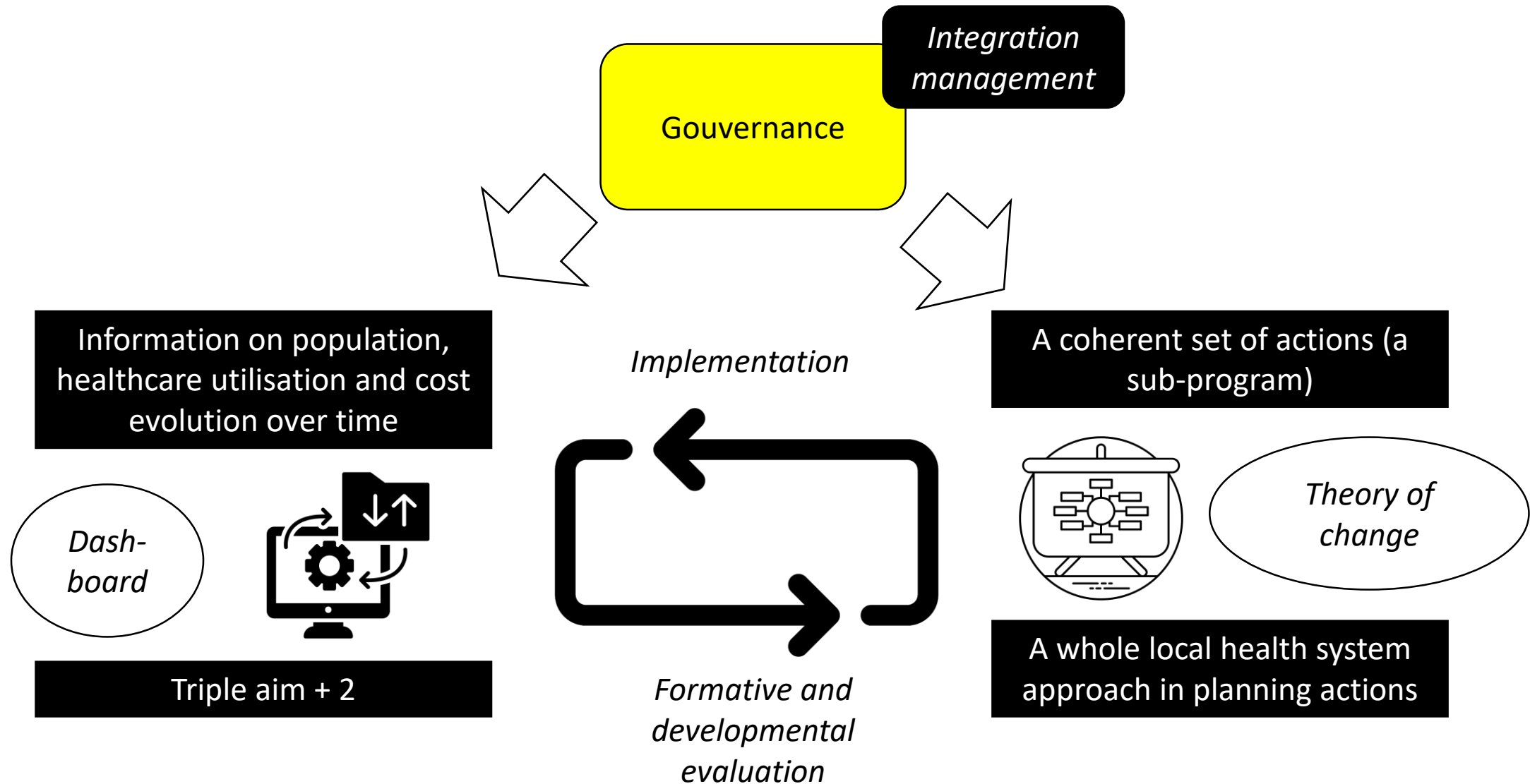
VOORSTEL VAN AFBAKENING REGIONALE ZORGZONES



From <https://www.zorg-en-gezondheid.be/>

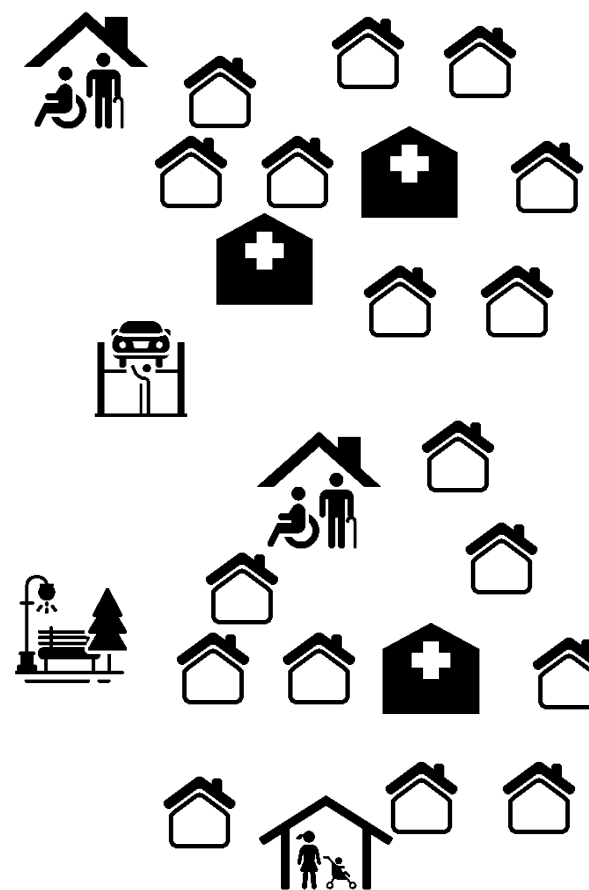
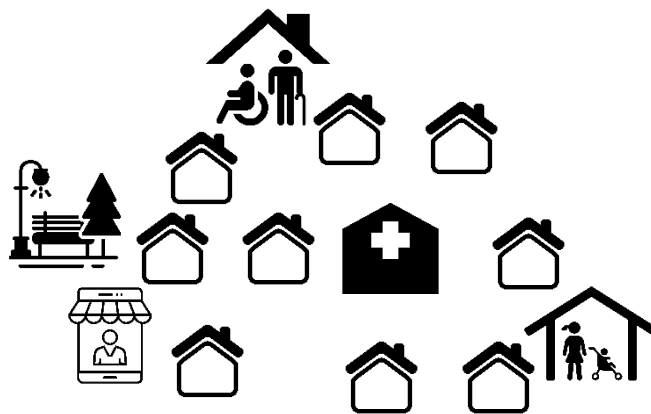
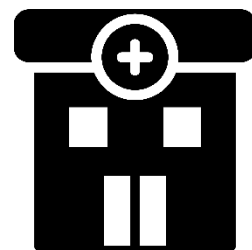
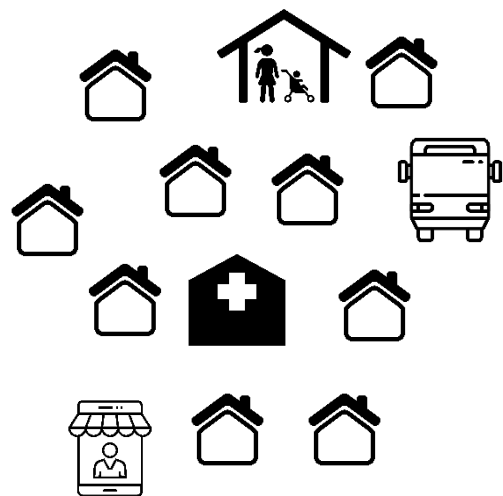
Why territories? Governance, integration management?
Administration?

Local governance



...With a change of logic in
decision making

Système local de soins

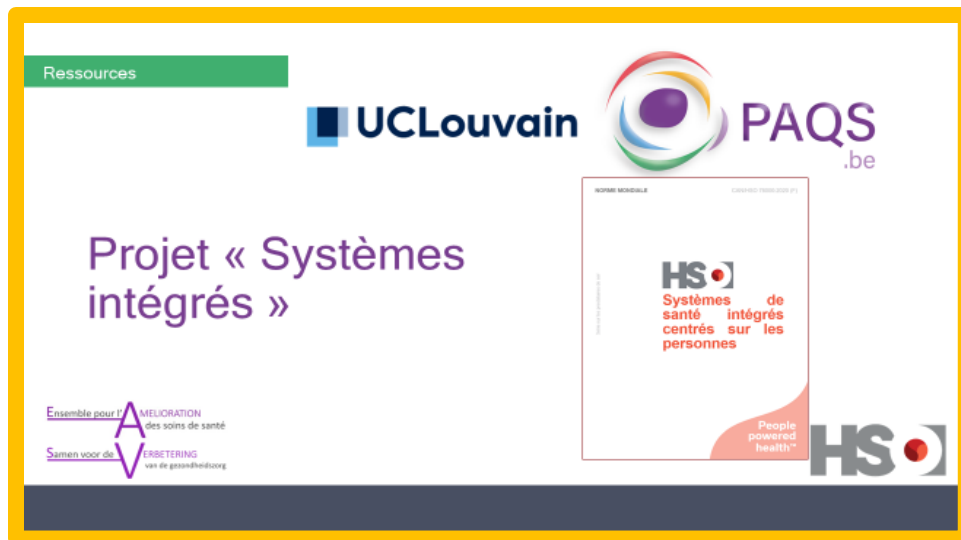


Finally, this is just a start....

Two work in progress

Méso-macro

- A referential to structure de deveelopment process



Micro-méso

- a MOOC to « co-learn »

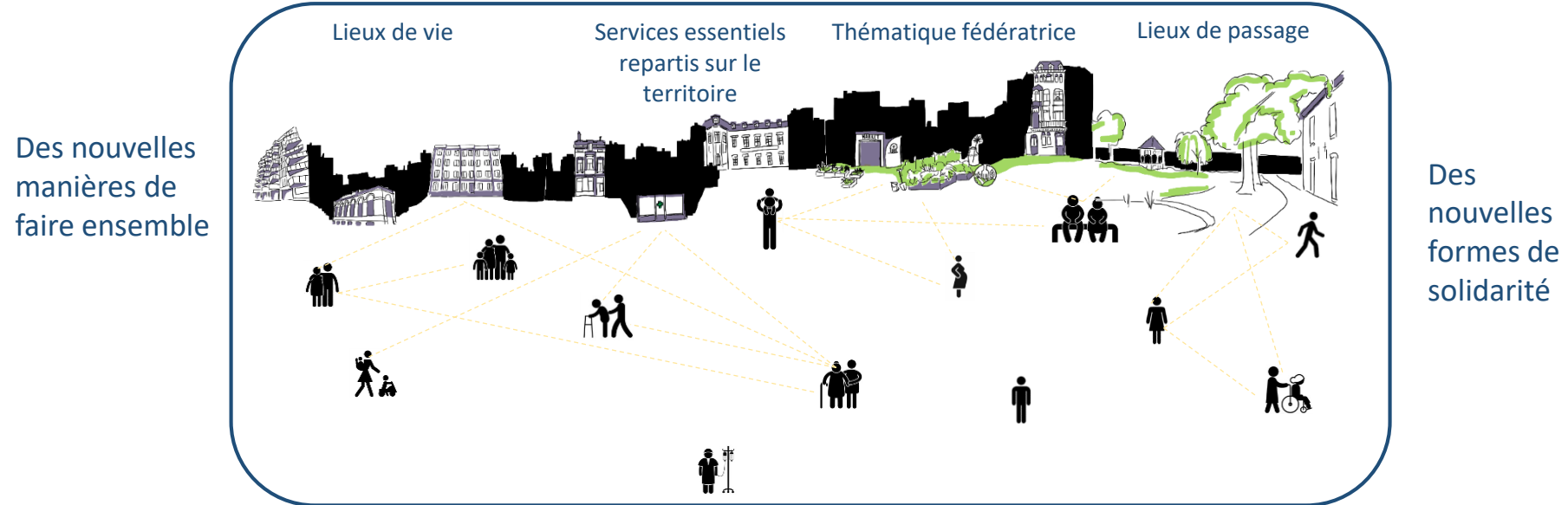


with « living labs »?

2 Qui soutient une dynamique de changement

Créer du lien et du sens, à l'échelle d'un quartier vécu, pour construire la **santé positivement**, en développant

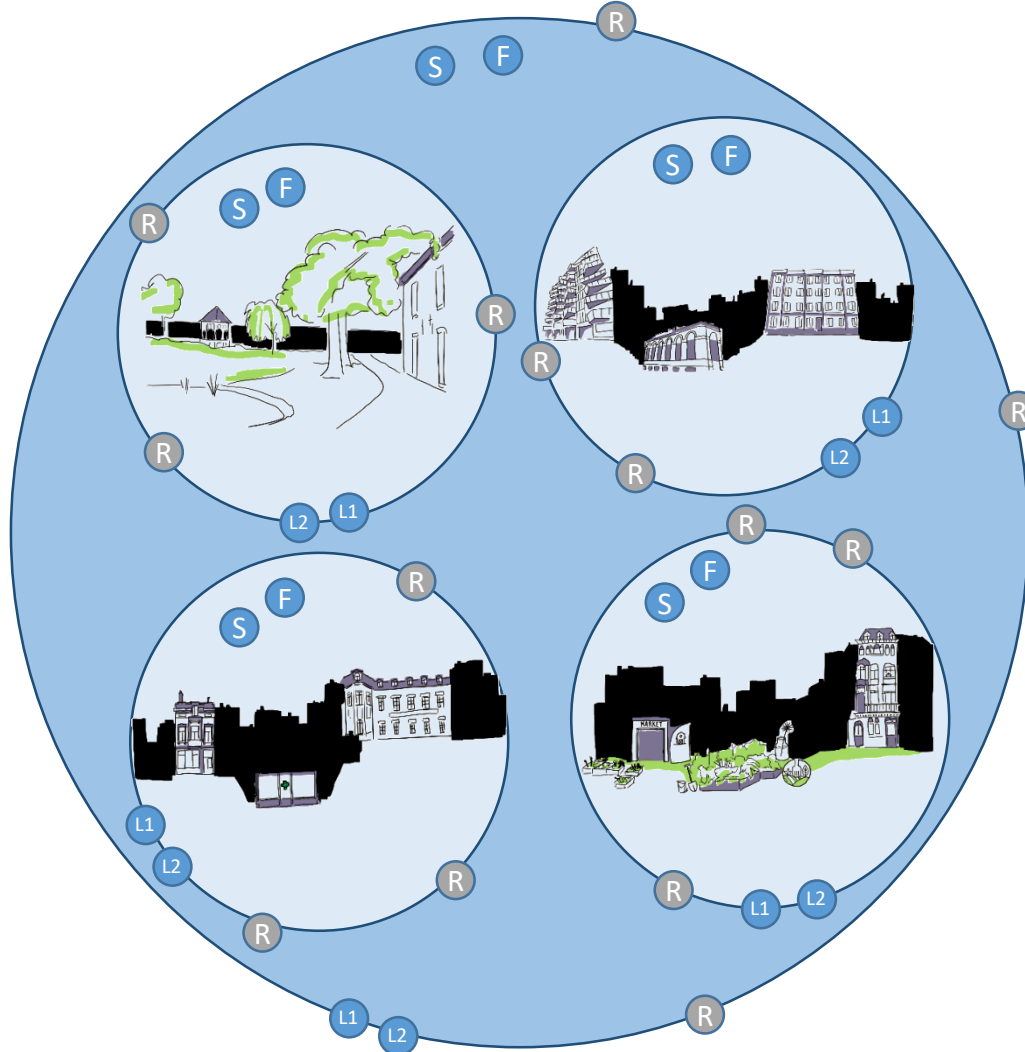
A travers des pratiques de connexion



Changement culturel pour une grande variété d'acteurs

2 Qui soutient une dynamique de changement

Changement culturel pour une grande variété d'acteurs



Notre modèle de gouvernance

Un chemin à parcourir qui repose sur:

- Une raison d'être commune
- Un fonctionnement commun :
 - règles du jeu
 - cadre de sécurité

Une gouvernance partagée composée:

- D'un cercle central: espace central
- De sous-cercles : pratiques de connexion

Chaque cercle se structure autour de 4 rôles structurels :

- Facilitateur (F)
- Secrétaire (S)
- Premier lien (L1)
- Deuxième lien (L2)

Des rôles opérationnels seront progressivement développés pour répondre aux besoins liés aux activités du cercle (R)