The Dutch disease management funding approach

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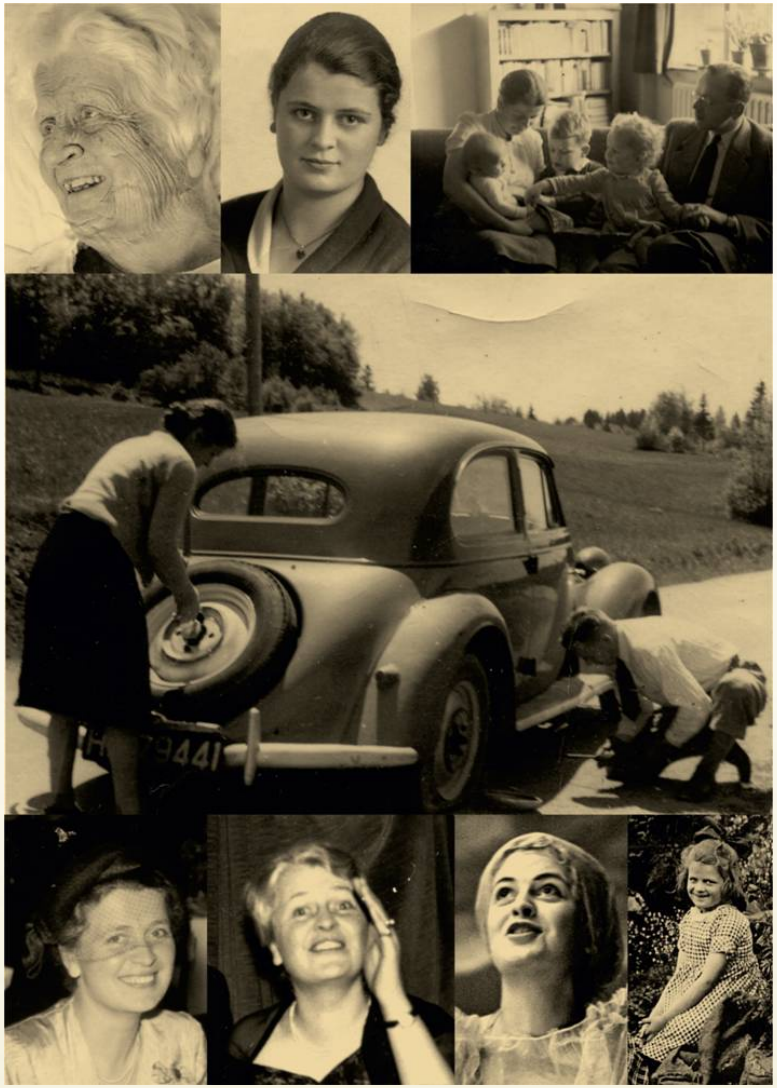
Consultant to the Ministry

EFMI Vice president IMIA

Dedicated to my mother who passed away on Sunday at age 95

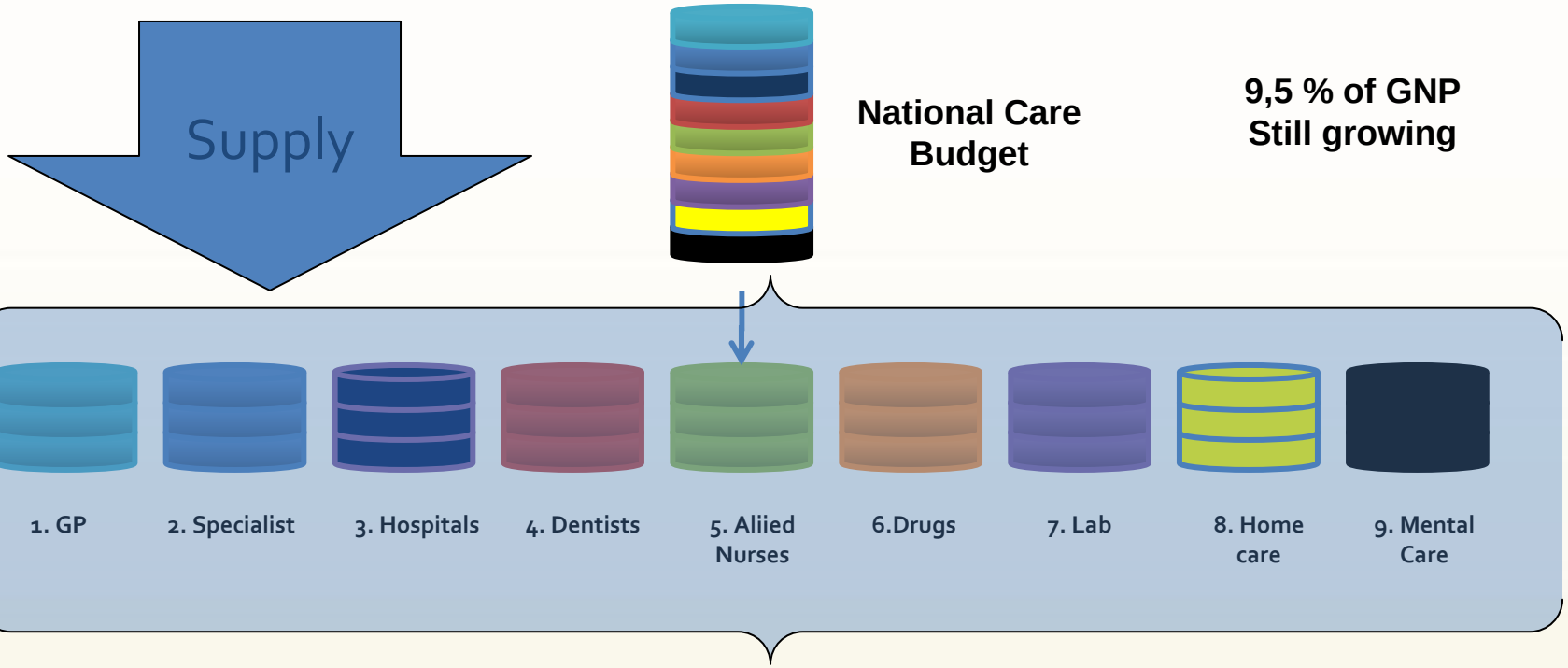


Life is a trip leading to the future generation

Introduction

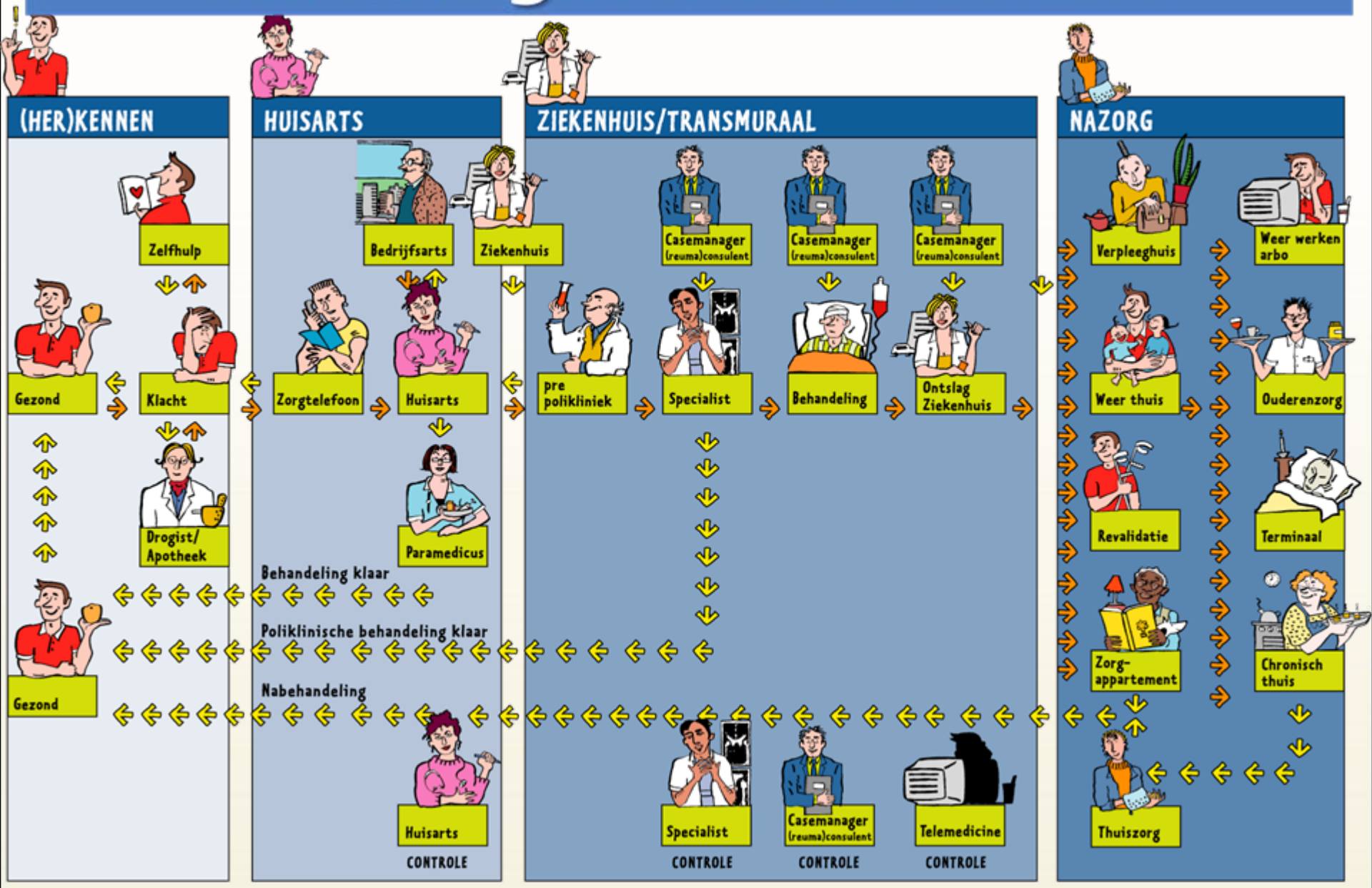
- The patient focused paradigm
- The shift from healthcare to health
- The Care Standard
- From solitary to multidisciplinary care
- The care plan approach
- IT requirements

The supply oriented HC budget



Citizens require Better health Outcome

Care fragmented in Silo's



We need a paradigm shift

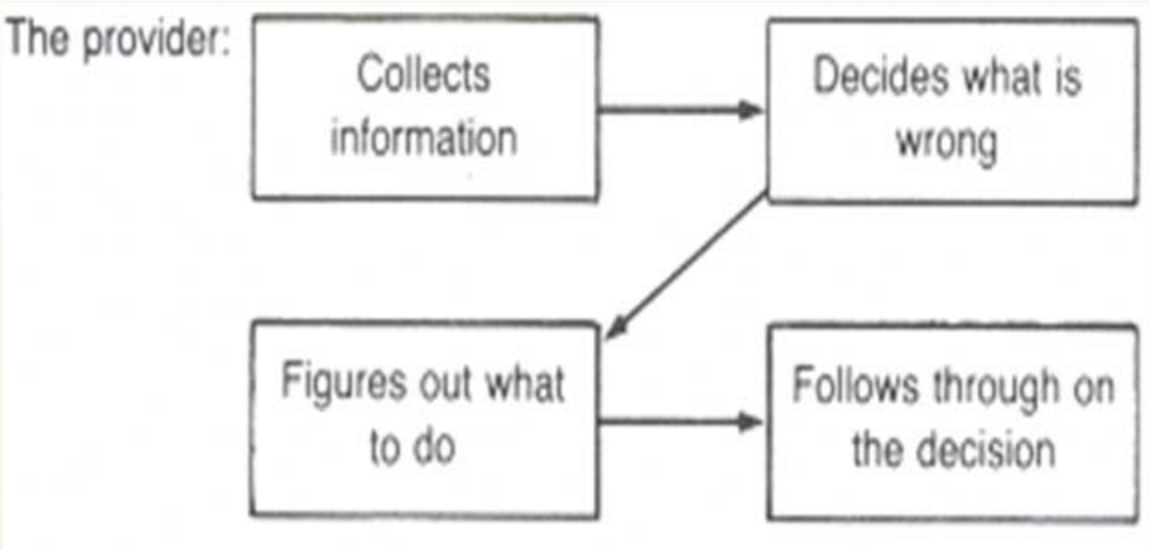
From Supply to Demand

It's the patient's problem , stupid !
Larry Weed

The Problem oriented approach

Subjective, Objective, Assessment and Planning

The clinical care process



Principles of the value chain

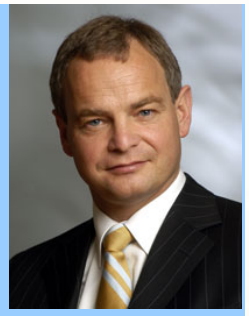
Quality

Focus on Outcome

will control

cost

Drivers of reform



From Budgets to contracts
Based on outcome
Focus on patients
A healthy workforce
Transparency and Governance

The Dutch Health Issue Approach Step 1

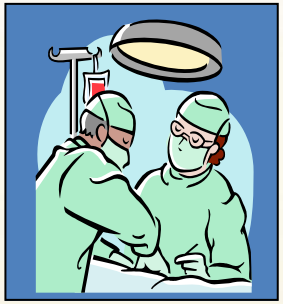
Health Issue

Intake

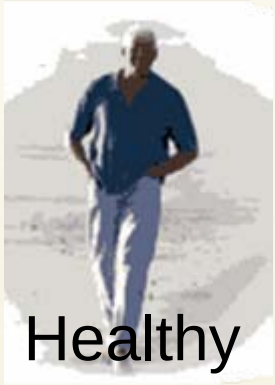
Diagnostics

Hospital care
Setting independent

Diagnose

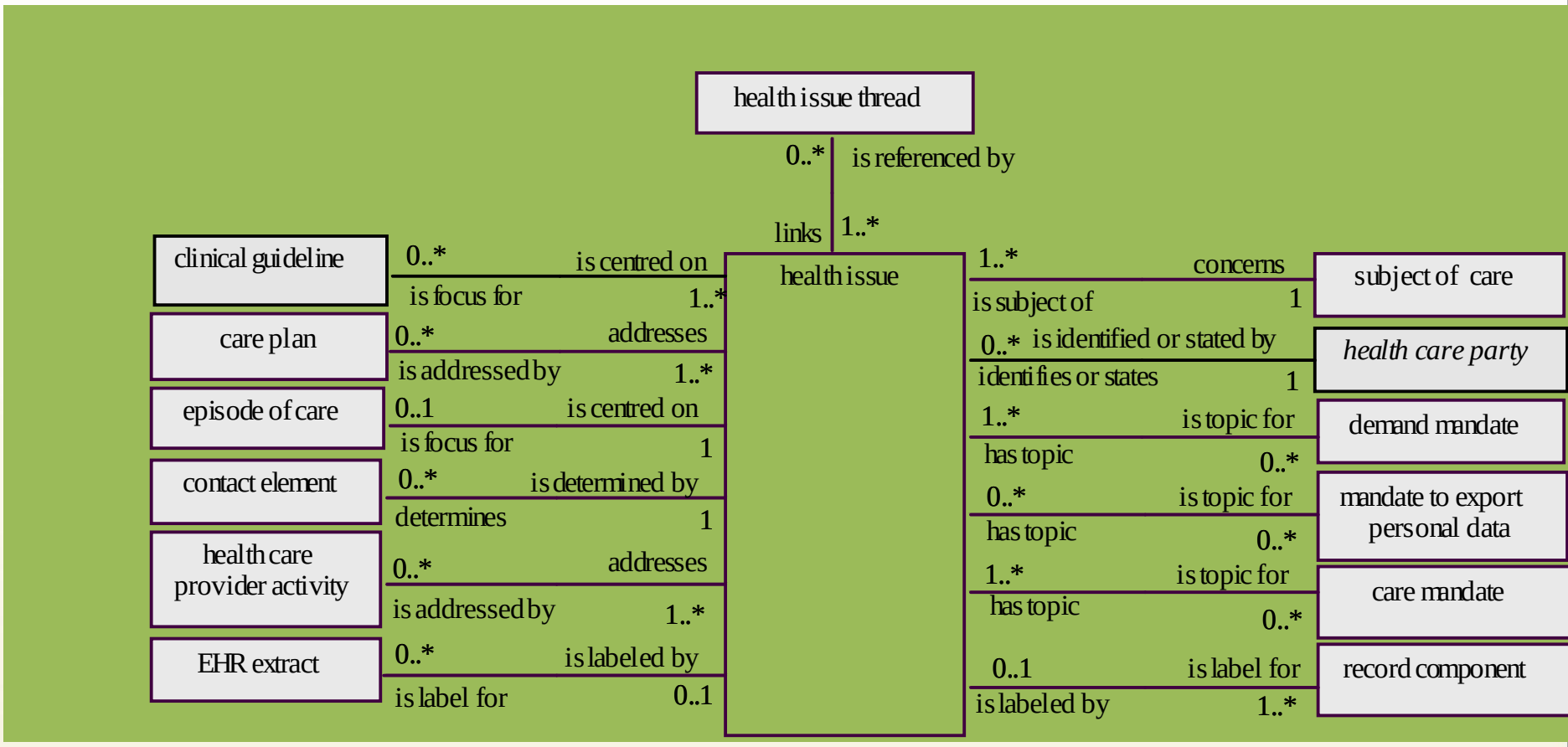


Therapy

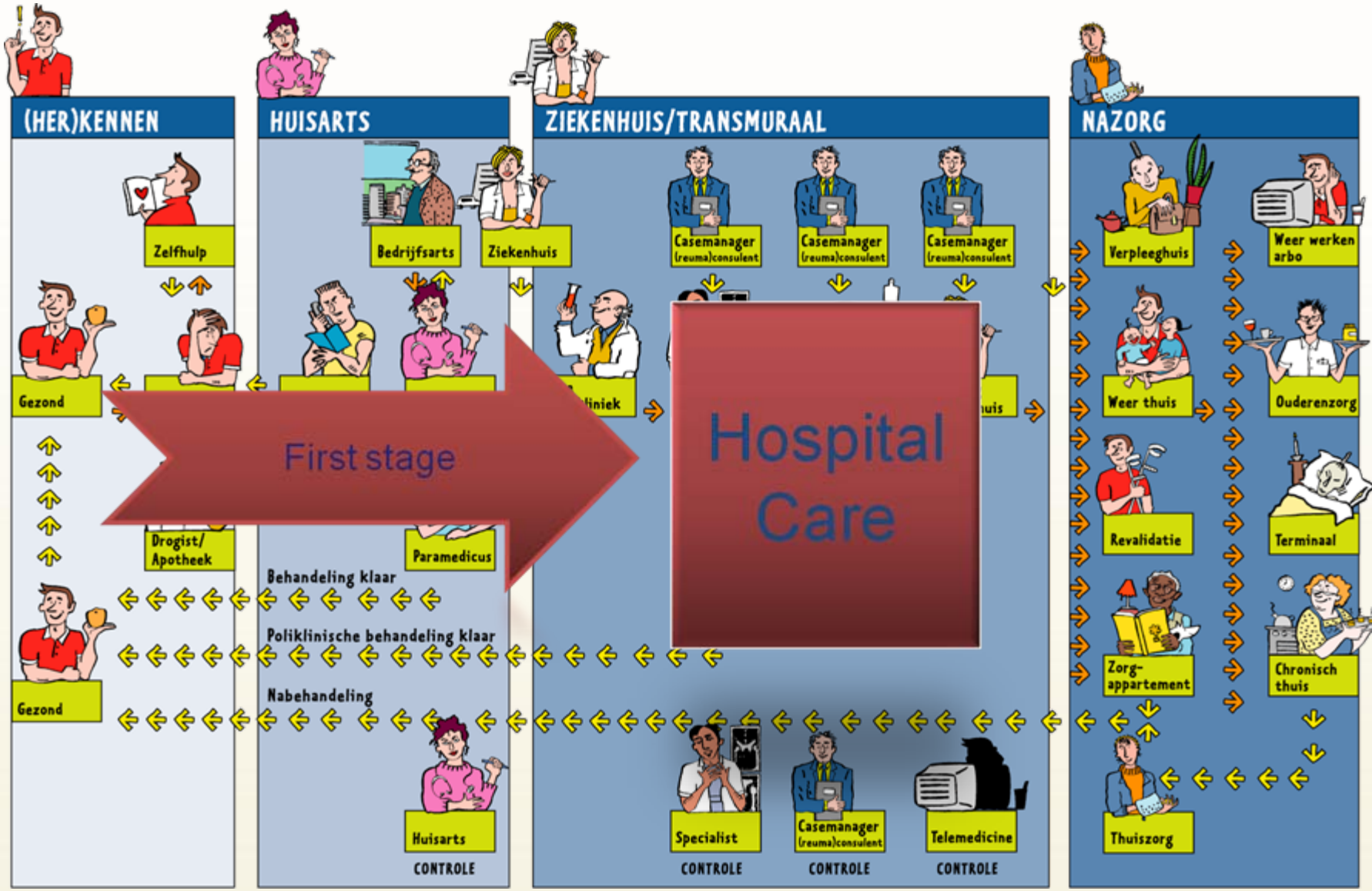


Healthy

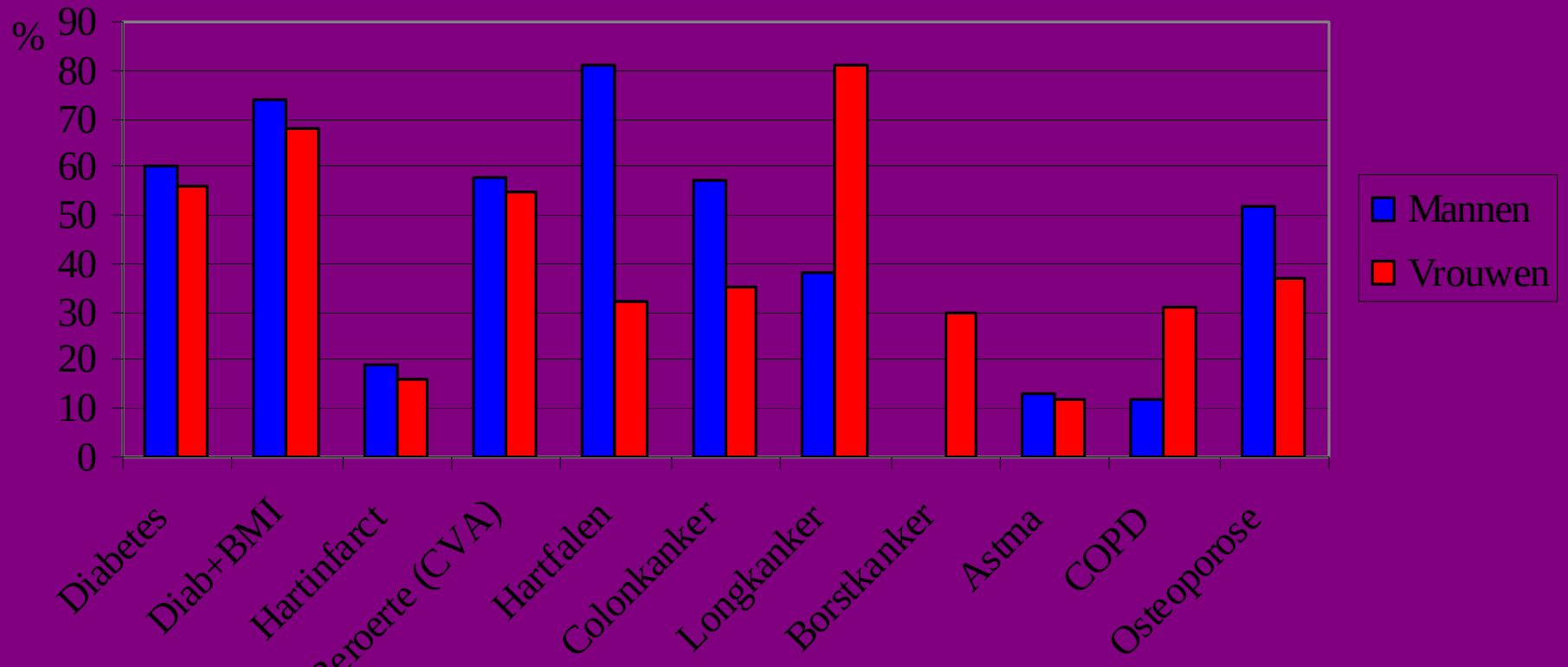
Health issue according to Contsys



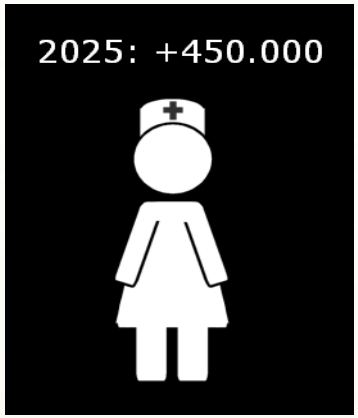
From budget to contract

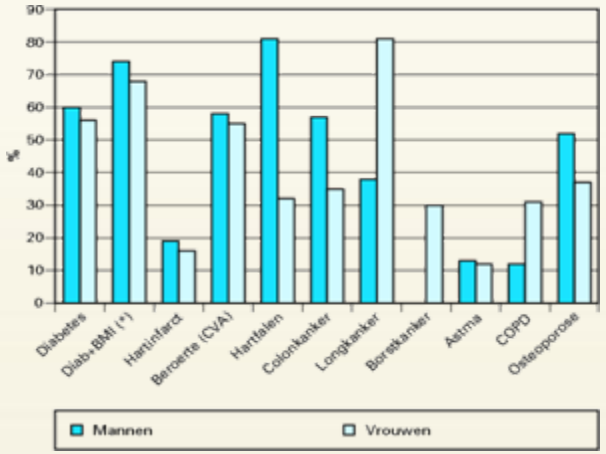


The Dutch 2030 Long Term Care Crisis
Growing Chronic Care Patients
Decreasing Health workforce



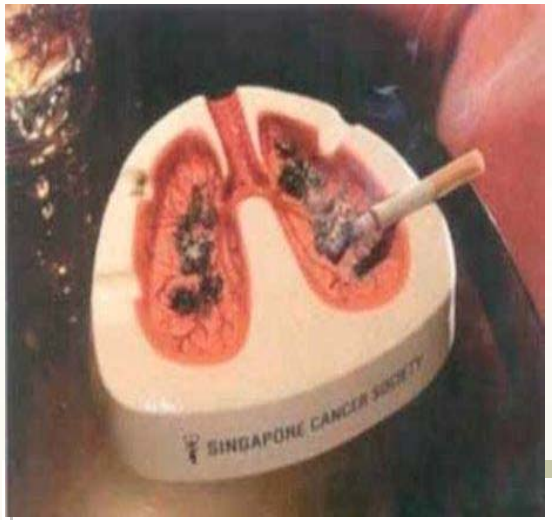
Towards a sustainable health care system





Challenges

Most caused by lifestyle starting at young age



3 risk factors – tobacco use, poor diet and lack of physical activity – contribute to the

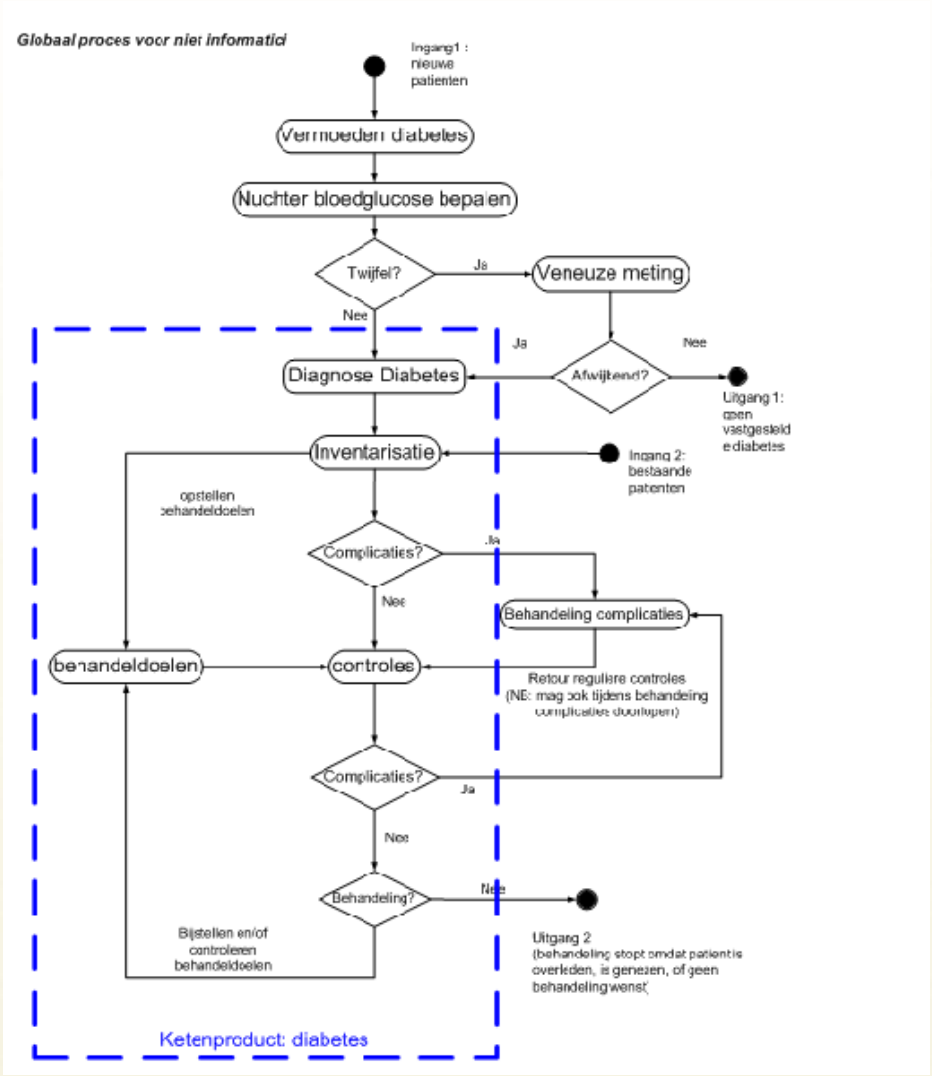
FOUR major chronic diseases – heart disease, type 2 diabetes, lung disease and many cancers – which a

50 per cent of deaths in the world.

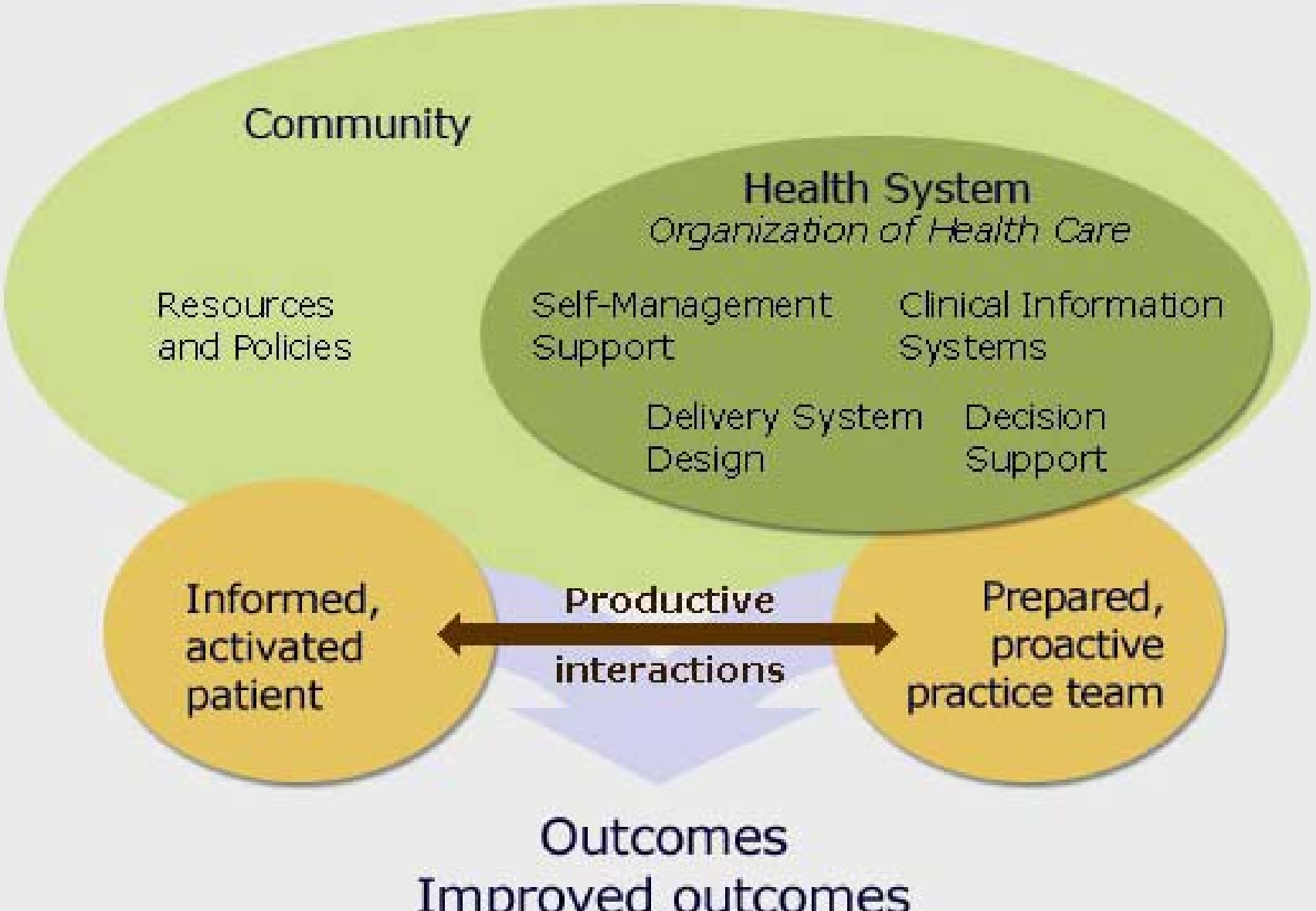
2003 Best practise defined by patients and providers

Diabetes Care Standard

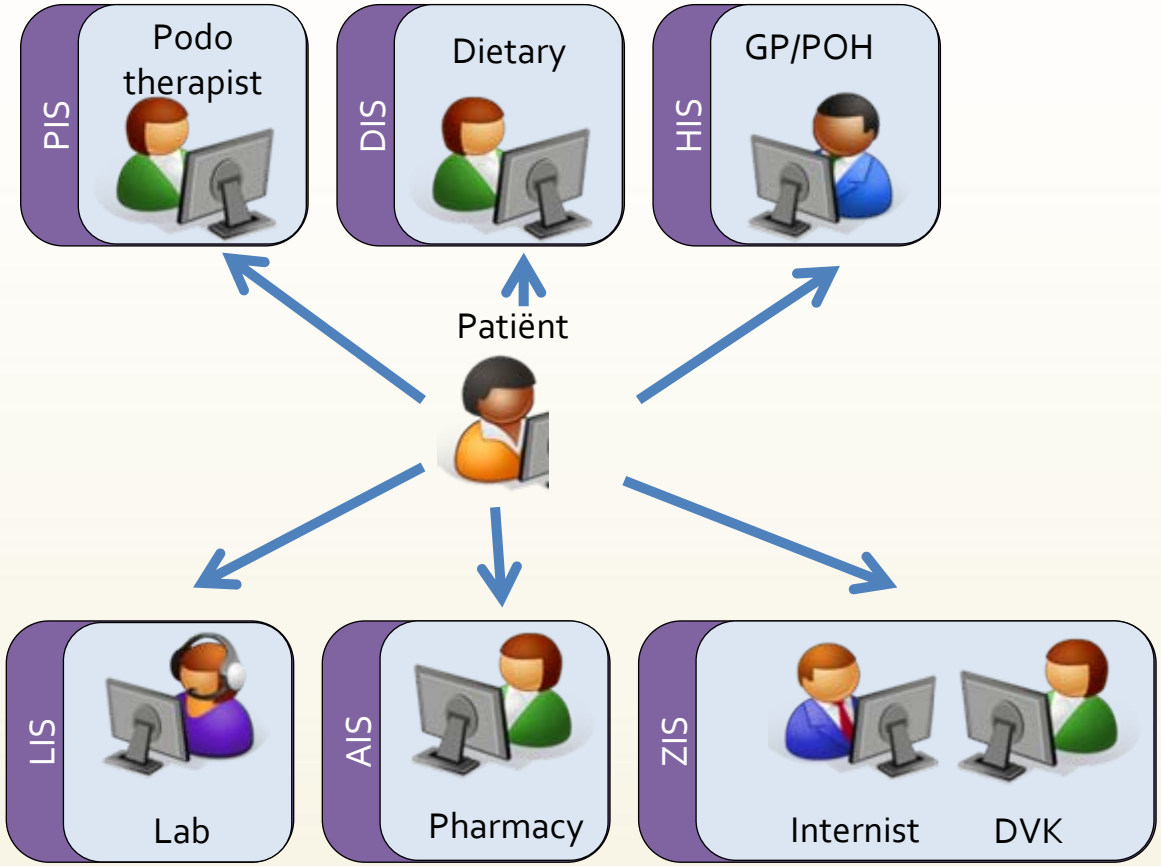
nederlandse diabetes federatie



Chronic Care Model



Traditional organisation



Who is accountable ?

The Care Group !

Insurer

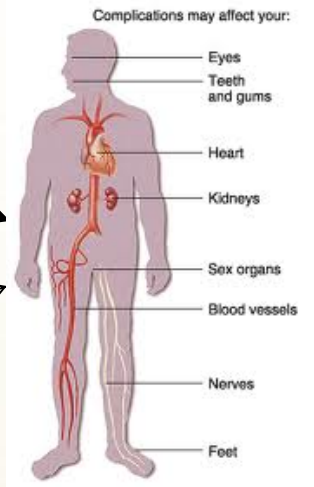
Care Standard

Structure
Process
Outcome

Care Group

Market 1

Market 2



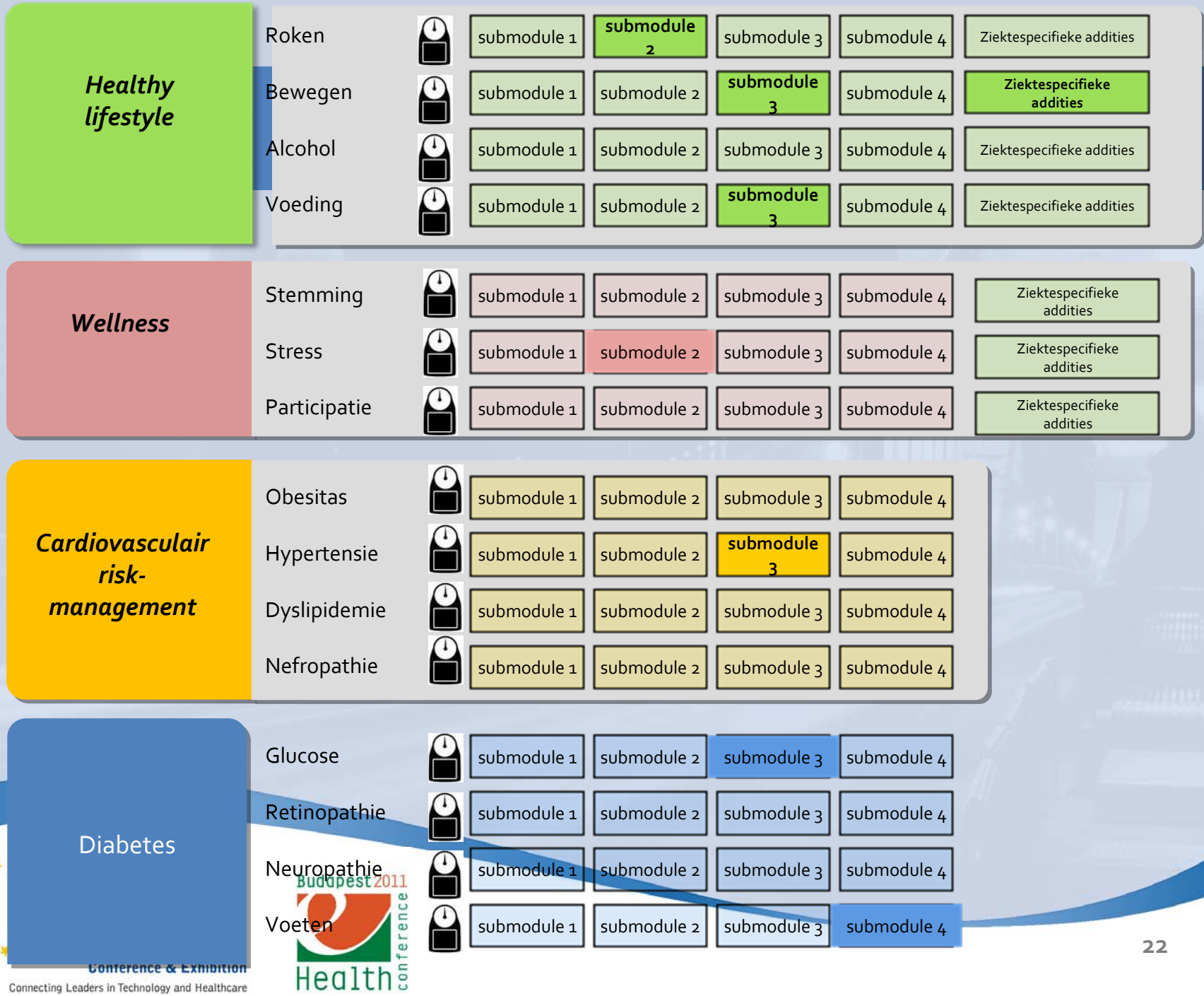
Nurse

GP

Dietary

Internist

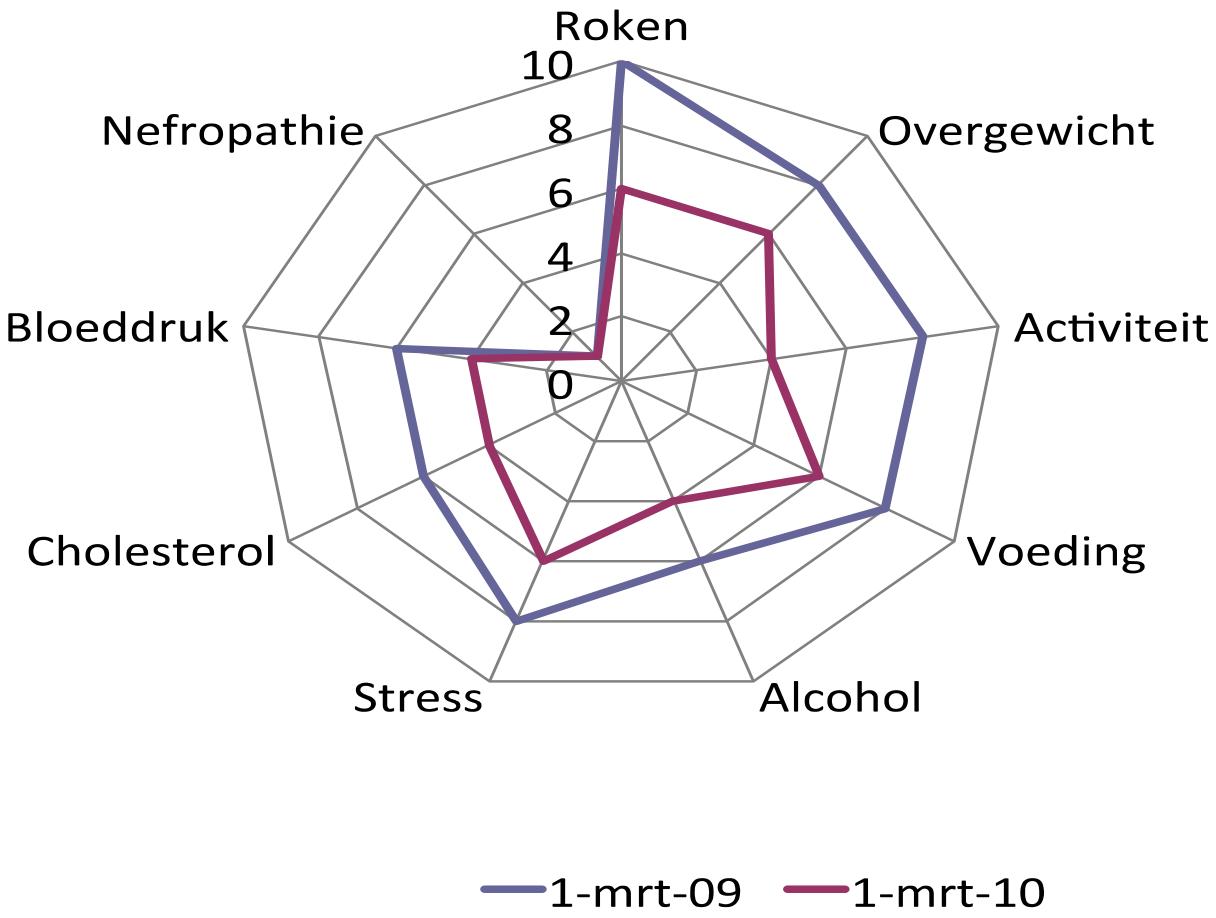
Integrated Care Program !


Healthy lifestyle
Roken
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Bewegen
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Alcohol
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Voeding
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Wellness
Stemming
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Stress
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Participatie
submodule 1
submodule 2
submodule 3
submodule 4
Ziektespecifieke addities
Cardiovasculair risk-management
Obesitas
submodule 1
submodule 2
submodule 3
submodule 4
Hypertensie
submodule 1
submodule 2
submodule 3
submodule 4
Dyslipidemie
submodule 1
submodule 2
submodule 3
submodule 4
Nefropathie
submodule 1
submodule 2
submodule 3
submodule 4
Diabetes
Glucose
submodule 1
submodule 2
submodule 3
submodule 4
Retinopathie
submodule 1
submodule 2
submodule 3
submodule 4
Neuropathie
submodule 1
submodule 2
submodule 3
submodule 4
Voeten
submodule 1
submodule 2
submodule 3
submodule 4

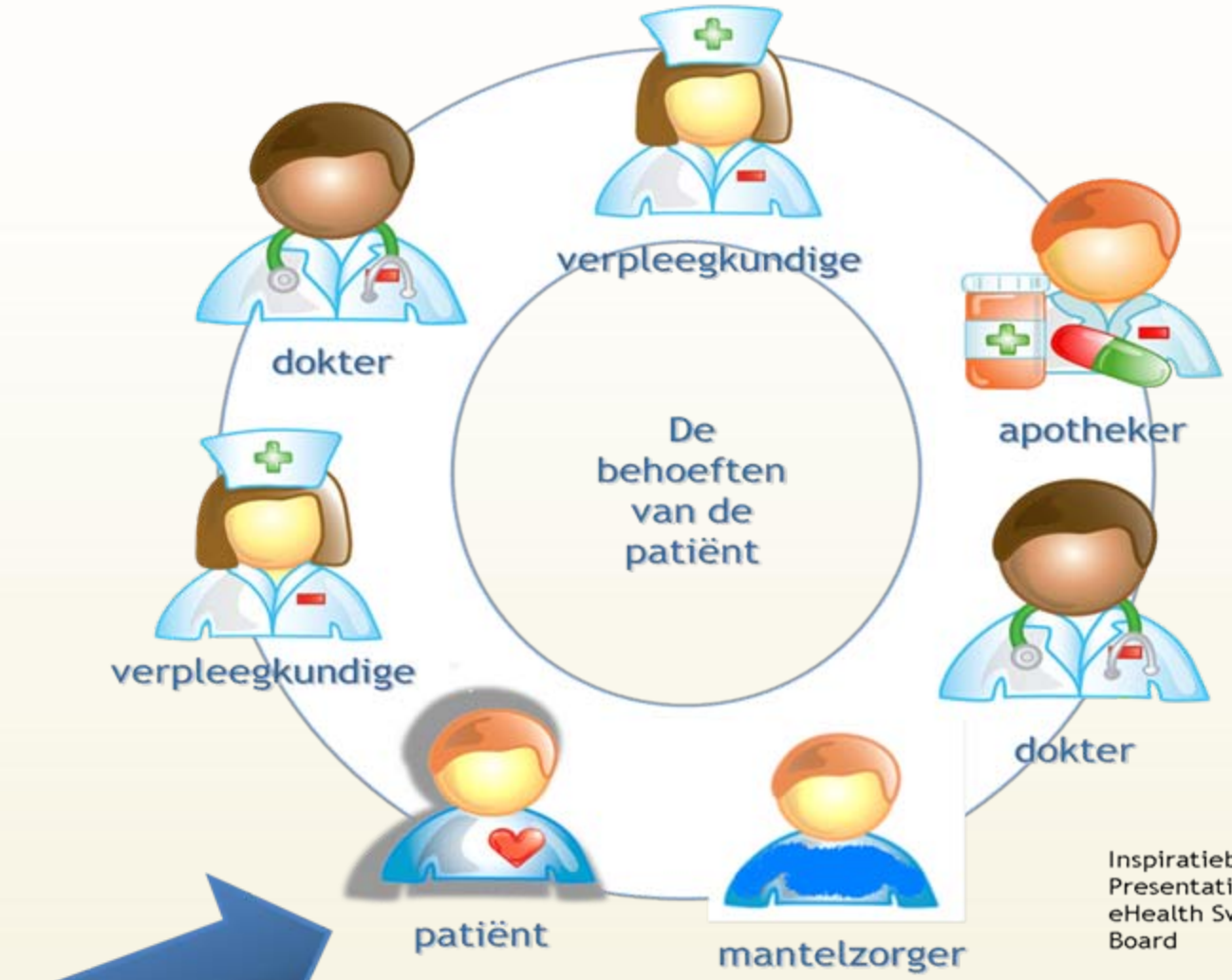
From model to patient !

Norm	Care group	Patient
Care-standard	Care-program	Individual Care Plan
Clinical & Process Parameters	Interoperable Systems	Coordination of care
Clinical Datasets	Indicators Process Outcome	Quality

The issues of the patient !



Involve the patient in the team!



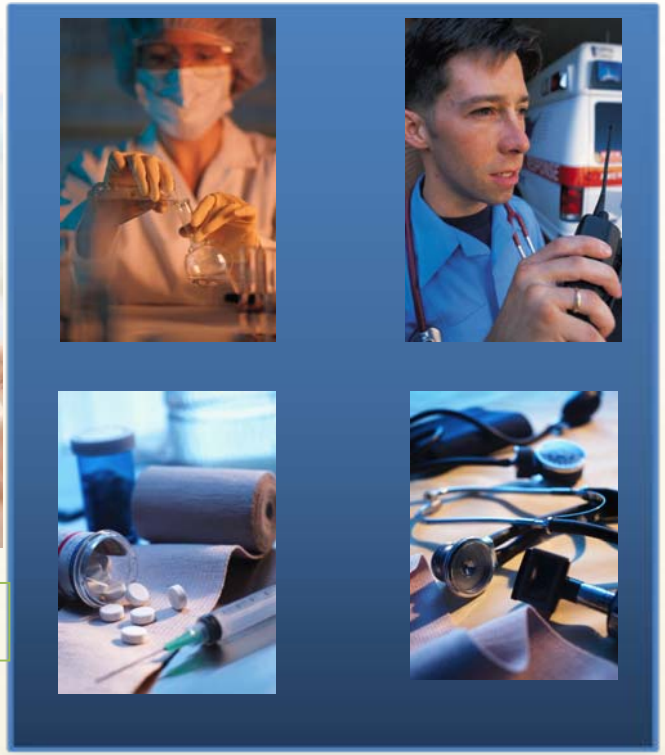
Inspiratiebron:
Presentatie van het Centre for eHealth Sweden, Architectural Board

Individual Care and Self management plan

Multidisciplinary team

Central Care Provider

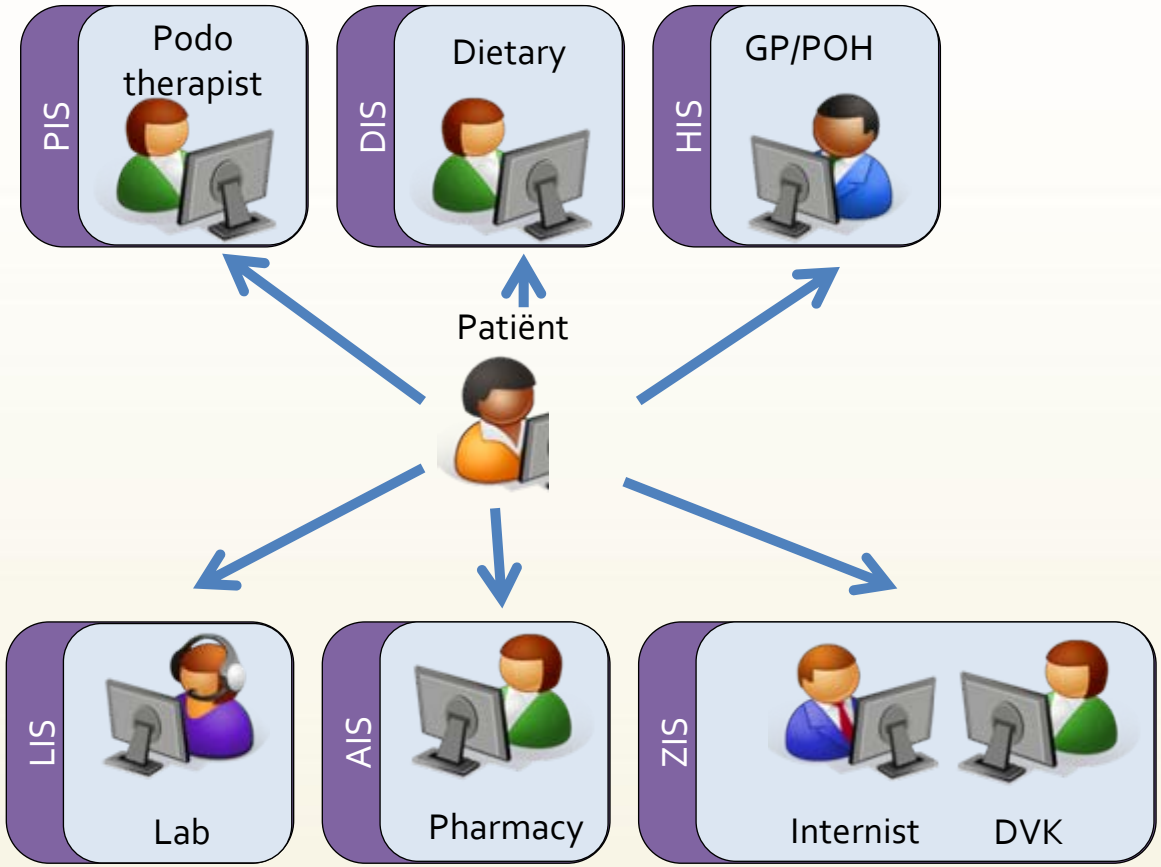
Patient



Integrated care requires !

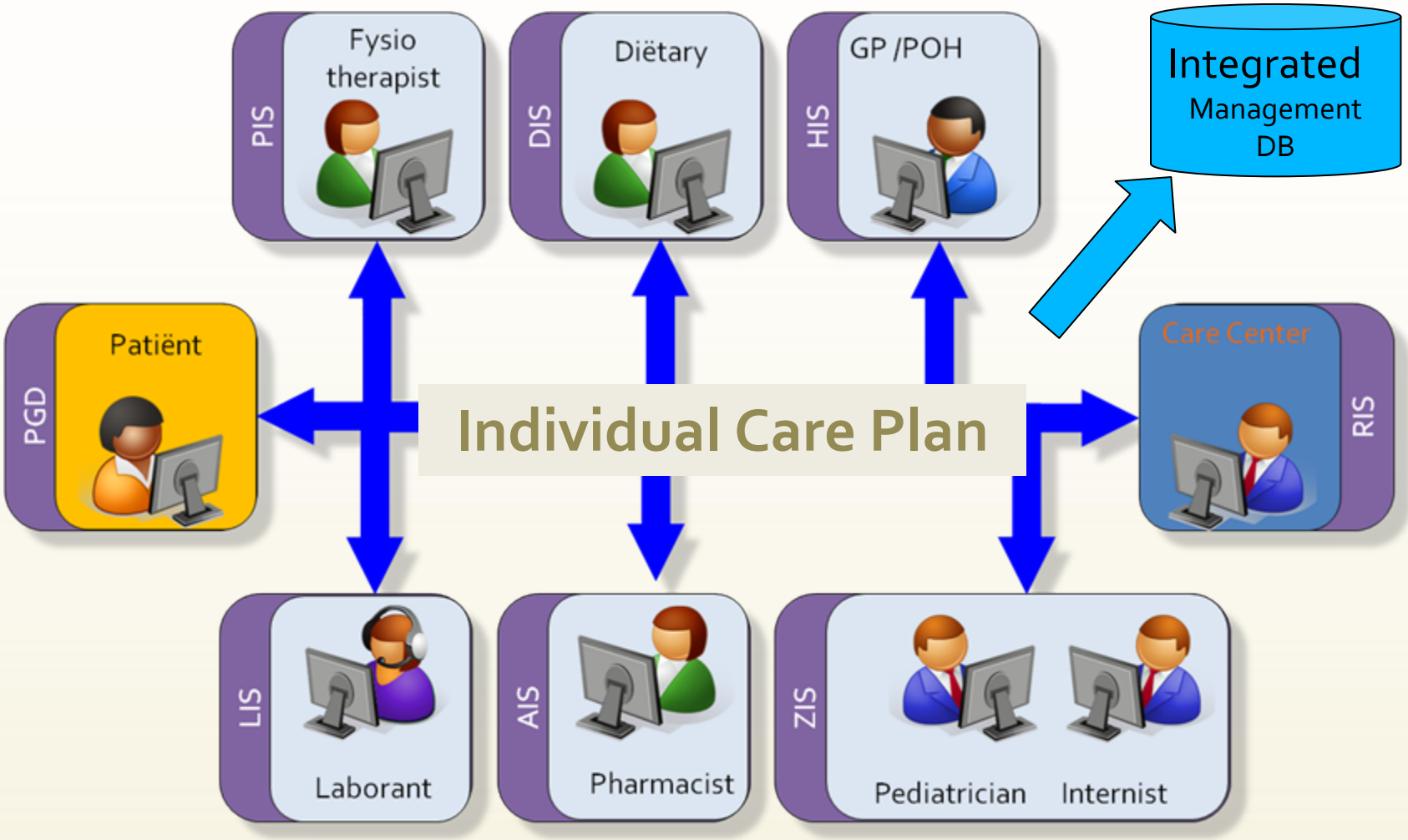
- Individual care plan with Objectives
- Multidisciplinary Care Coordination
- Based on best evidence / practise
- Patient is Active, Informed and Self Managing
- Clinical Quality and resource management

Traditional IT dimension

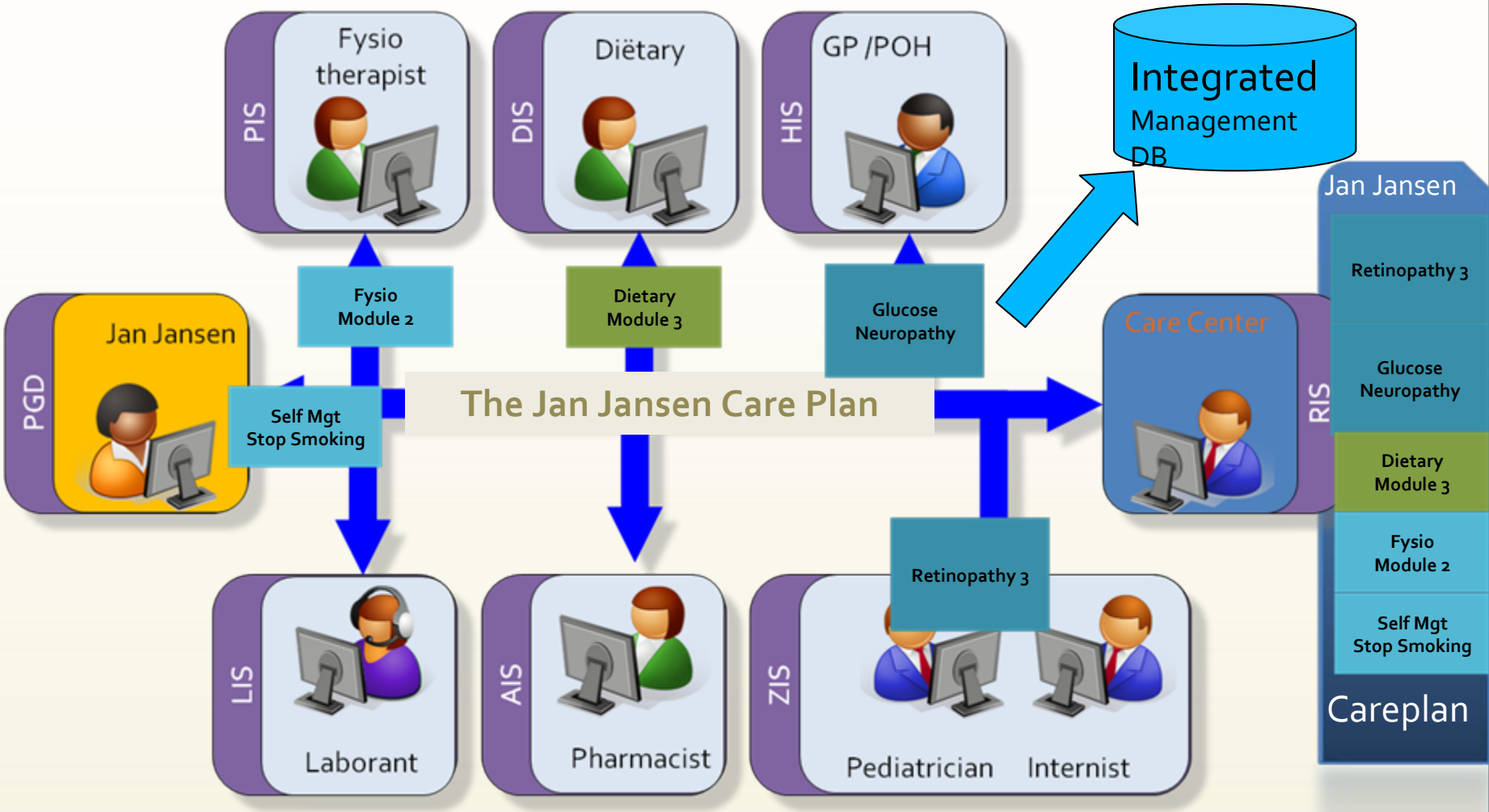


Single provider systems

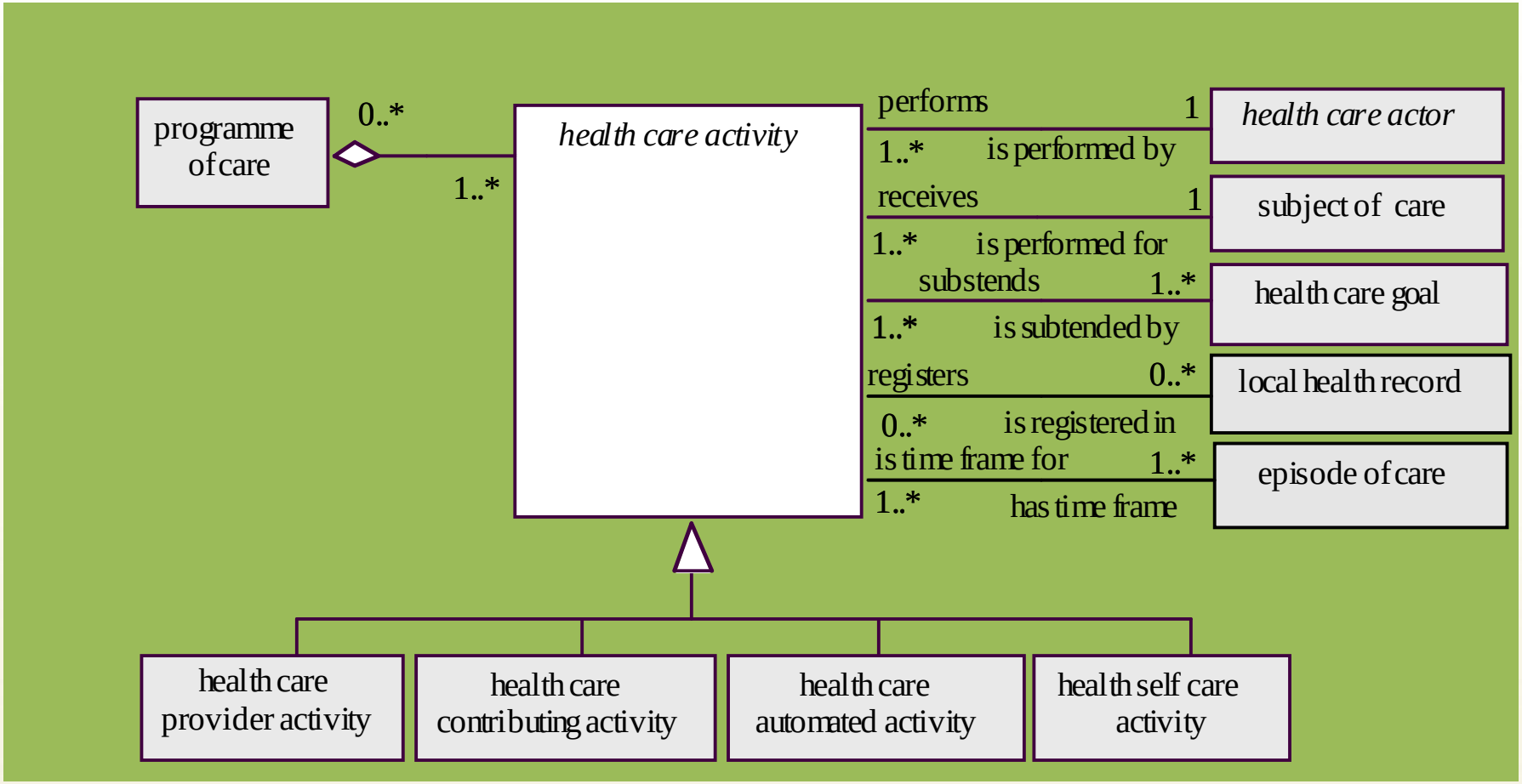
From messages to coordination



The Care Plan for Jan Jansen



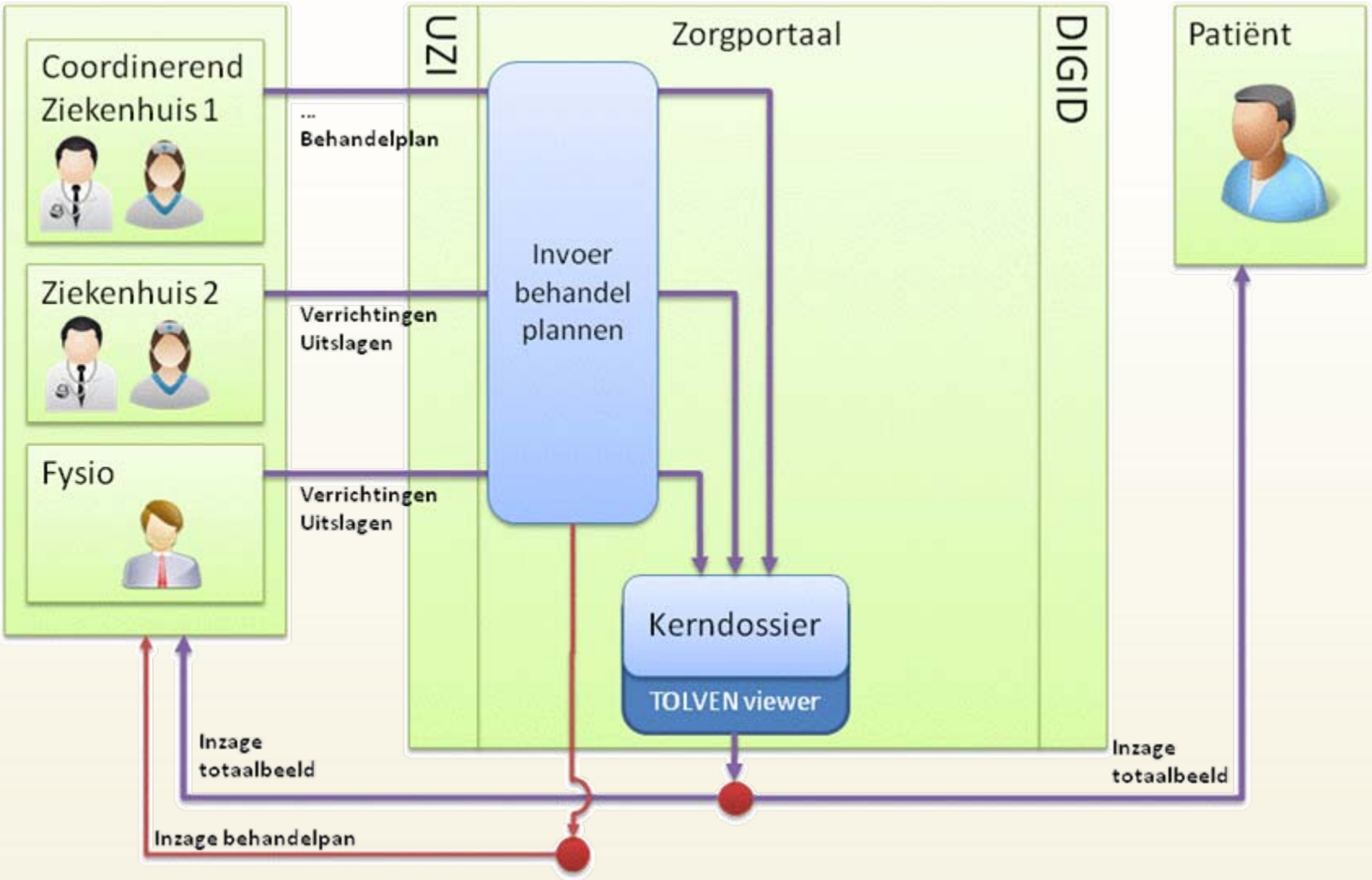
Contsys concepts available



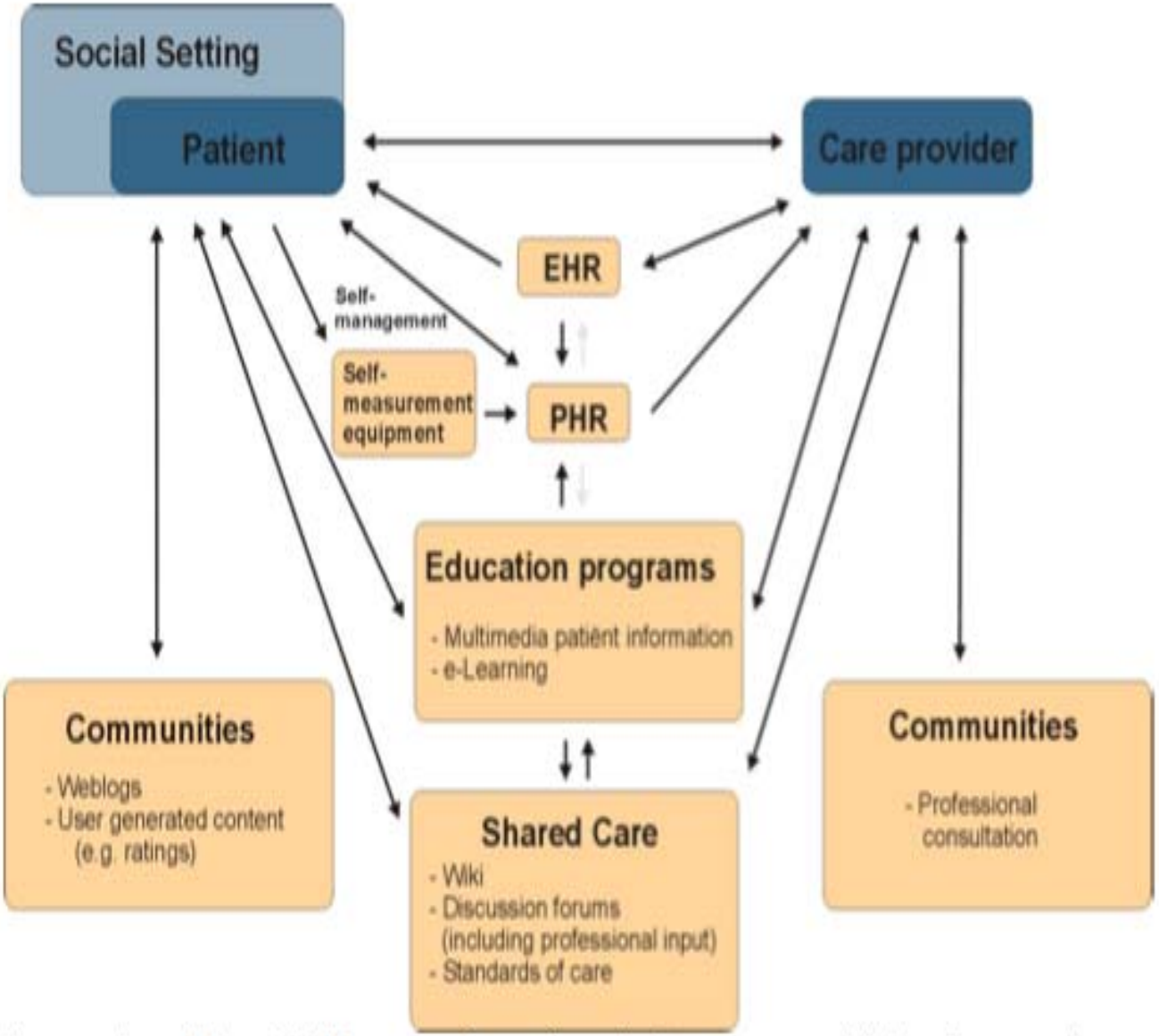
- Support system should cross silo's, link to operational systems
- Semantic Interoperability by the use of Clinical Building Blocks for Clinical Process and outcome data (Detailed Clinical Models)
- Linked to Care standards to harmonise and proliferate
    - Datasets, Performance indicators , eHealth specifications

Approach to IT issues integrated care

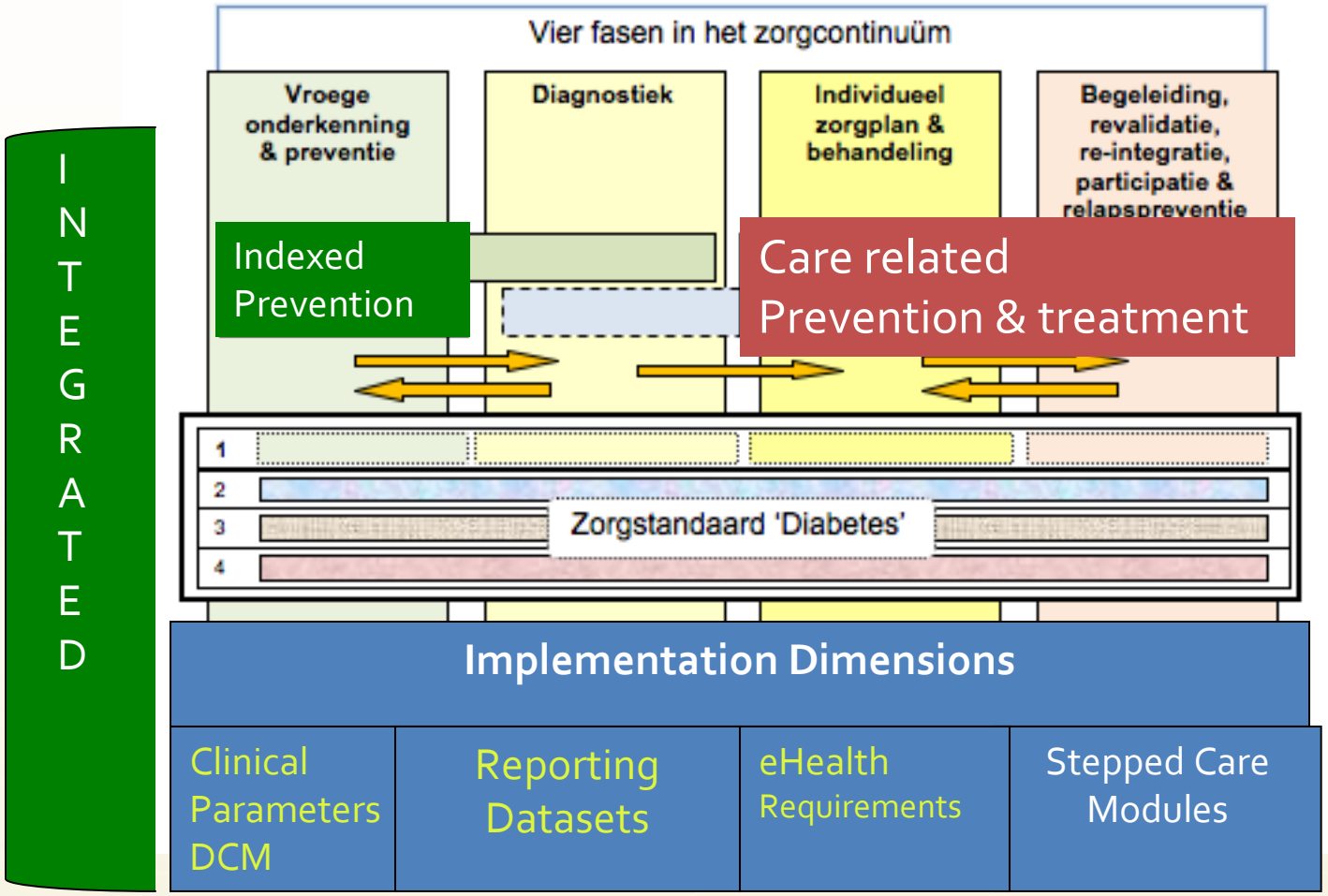
Implementation in careportal



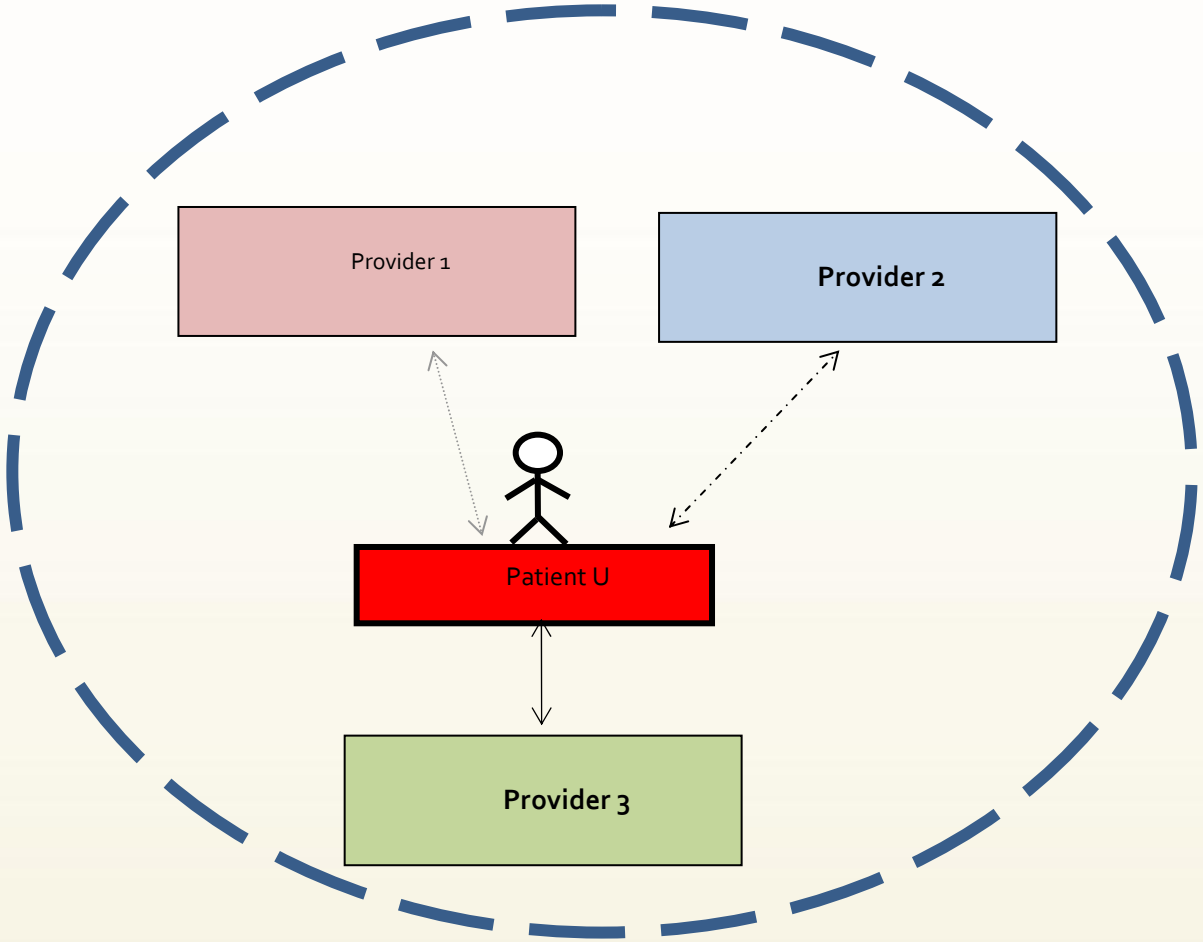
Health 2.0 management scene



Care standard links to eHealth



the Holistic Client-Centric View



The care plan brings structure , but

the poor patient in the centre of even more

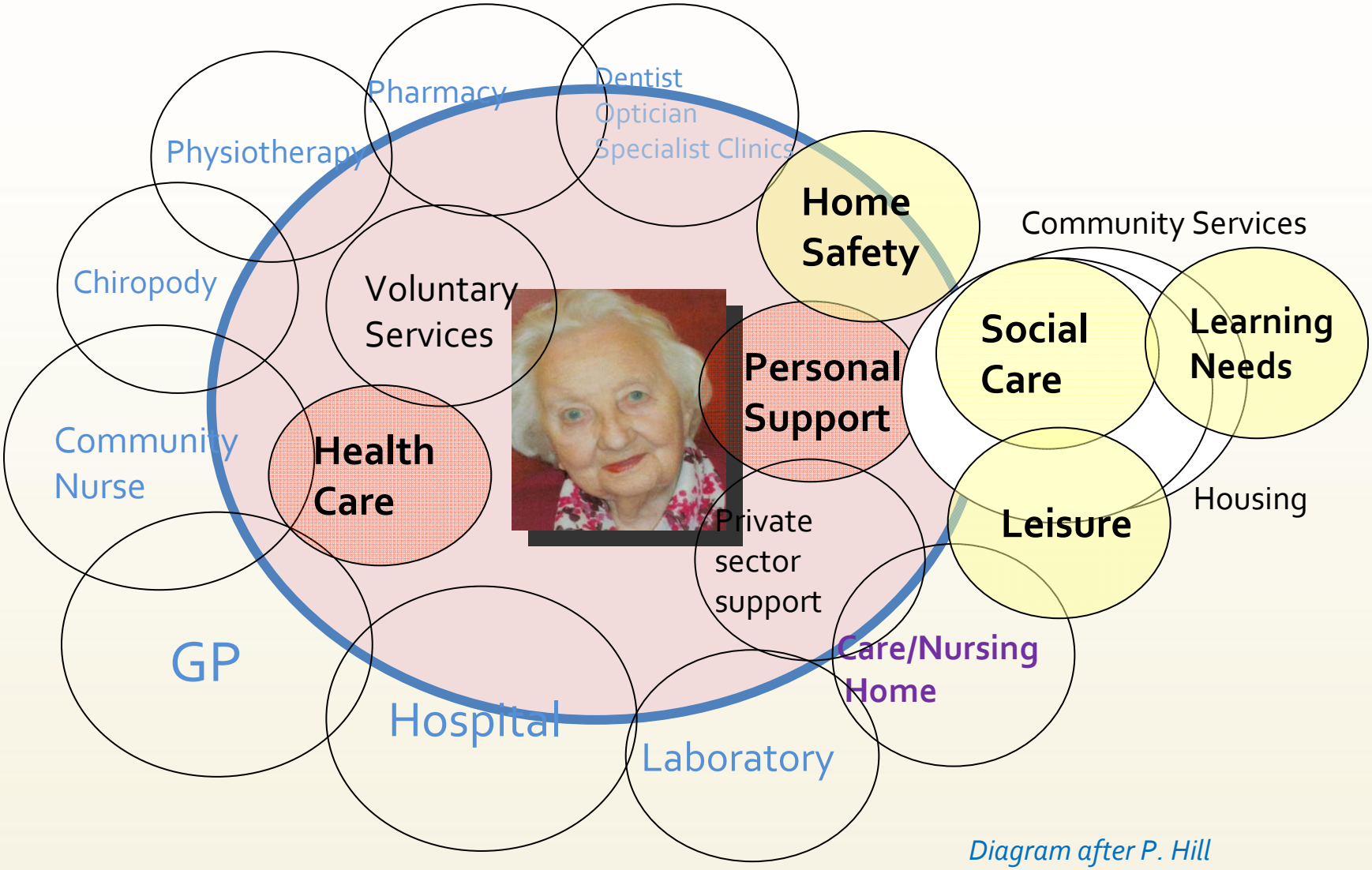
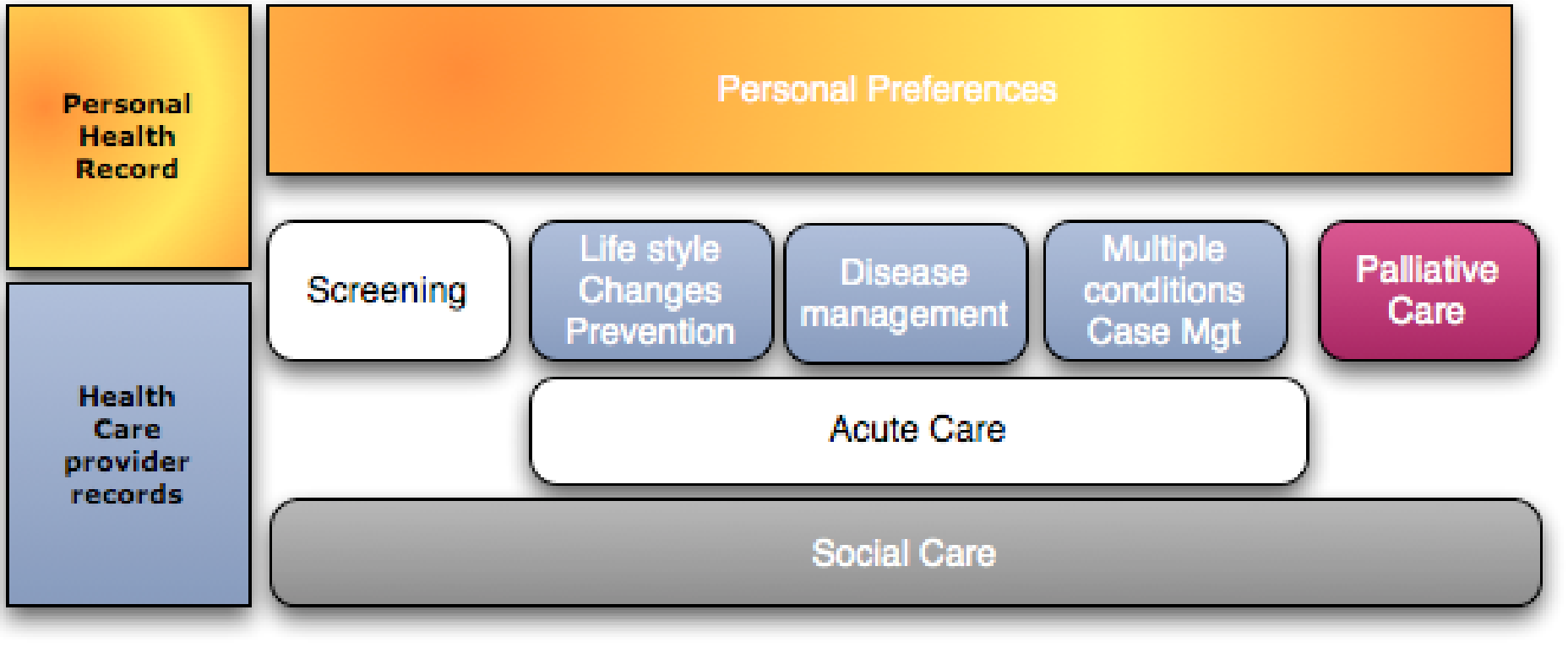


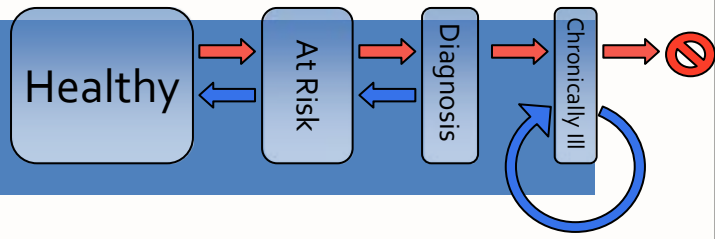
Diagram after P. Hill

The point on the horizon



So silo's will break,

The Free Message



- Focus on the Patient means
- Individual treatment plan based on
  - Care standard base for eHealth standards
  - IT supporting Collaborative working
  - Citizen / Patient active in 2.0 control
  - Involve social care as well
- Try to prevent citizens to get in the system so focus on health
- We all need to find the motivation to CHANGE

Is this a good reason ! A sustainable system for my grandson Mick and yours

The trip has started Join us in

MIE 2012