To what extent do Local Multidisciplinary Networks in Belgium represent attributes of high quality integrated care for patients with chronic conditions: A cross-sectional analysis.

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Abstract

Introduction –The Belgian national government provided a funding for two care programs, diabetes and chronic renal failure, as well as Local Multidisciplinary Networks over a four-year period. This study wanted to investigate to what extent LMNs in the Dutch-speaking region of Belgium represent attributes of high quality integrated care for patients with chronic conditions after an implementation period of four years.

Methods – A questionnaire based on the Chronic Care Model was developed and validated by two experts who published extensively in the field of integrated care. All Care Program Promoters (CPPs) were contacted by phone to answer to the questionnaire. All data was summarized and analyzed quantitatively.

Results – Thirty-eight of the forty-tree contacted LMNs answered to the questionnaire. 79% of the LMNs stated to have clear explicit objectives. The majority of het CPPs stated to have adequate (clinical) leadership and 71% of the CPPs stated that, in their region, all disciplines needed in the care for patients with a CP were sufficiently available. Thirty of the CPPs stated that the caregivers in their network demonstrated the competences needed to address the complex needs of patients with diabetes and chronic renal failure. Thirty-seven CPPs stated to have a good overview of all disciplines involved in the care for patients with a CP. Half of the CPPs stated that their LMN had sufficiently clear shared care protocols. Fourteen LMNs relied on existing evidence-based care protocols without local adjustments, while fifteen LMNs reviewed their care protocols annually or more to fit the local needs of family physicians. All CPPs agreed that there was a sufficient amount of post-graduate training available for family physicians and other caregivers. All LMNs reported to have reminder systems for post-graduate training sessions and a range of other activities organized by the LMN. Only thirteen CPPs stated to have reminder systems concerning the clinical parameters. Ten CPPs reported to have an adequate reminder system for patients with a CP in order for patients to fulfill the conditions of their contract in time. Only two CPPs reported to have an adequate system for audit and feedback. More than half of the LMNs had no clear overview of the number of patients receiving education. Of the contacted CPPs, 50% agreed to have sufficient and adequate devices for supporting patients in their self-care. Sufficient attention to the education of informal caregivers was perceived in eighteen of the LMNs. Seven CPPs reported to have devices for electronic communication between the patient and the caregivers involved in the CP. Thirteen CPPs reported that their LMN adequately collected data on implementation of the CPs in view of research on, and evaluation of the working of the LMN.

Conclusion – Attributes on high quality integrated care are operationalized and implemented within the LMNs, but the data shows a high degree of diversity and level of maturity for all attributes related to the different dimensions of the Chronic Care Model.

Introduction

As premature death from acute illness has been reduced over the last fifty years, both the incidence and prevalence of chronic conditions is rising at a rapid speed (1,2). Most healthcare systems in Europe are still proving to be ill equipped to respond to the needs of patients with chronic conditions who require a combination of regular primary care support with both predictable and unpredictable specialist and social care.(3)

Many countries are experimenting with new methods of delivering care in ways that meet the complex needs of people with chronic conditions. (4) These so called 'integrated care initiatives' aim at "enhancing quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings". (5)

The way 'integrated care' is defined often depends on the perspective of the provider. This paper will use the definition of integrated care as it is defined by the World Health Organization (6), i.e.: *"The management and delivery of health services such as that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course."*

As with quality of care, high quality integrated care recognizes, anticipates and effectively addresses structural, organizational, provider and patient related barriers that impede the implementation of change. (7) Characteristics of high quality integrated care that are mentioned in literature are: patient-centeredness, effectiveness, efficiency, safety, acceptability, accessibility, equity, solidarity, relevance, appropriateness, respect, choice and sustainability. (8,9)

Care Programs and Local Multidisciplinary Networks

Multidisciplinary networks are considered an adequate response to the increasing complexity of patients' needs. In this context, the Belgium national government has provided the funding for the implementation of two care programs on type II diabetes and chronic renal failure. Local Multidisciplinary Networks (LMNs) also received funding in support of these care programs

A care program (CP) organizes and coordinates the approach, treatment and follow-up of a patient with a chronic disease. Care Programs reinforce the cooperation between the patient, family physician and the diabetes or renal specialist. All three parties are obliged to sign a "Care Program Contract (CPC)" in order for the patient to be granted a range of free services. The benefits of these CPs are considered two-sided. For professional caregivers they facilitate the cooperation with other caregivers and are supposed to improve the quality of care. For every CPC signed, both the family physician and the specialist receive an annually honorary of 80 euros. Benefits at the level of the

patient are: fully refunded, and thus free, consultations with their family physician and specialist, the development of a personal care plan and free access to specific tools and materials, consultations with a diabetes educator, dietician and podiatrists. A detailed overview of all available services in the context of these care programs is available upon request.

To support the aforementioned local multidisciplinary cooperation, Local Multidisciplinary Networks (LMNs) were established progressively since 2009 and for every LMN one or more Care Program Promoters (CPPs) were appointed. The goals of these LMNs were: 1. Collecting, updating and distributing information concerning the care of patients with a CPC and the organizations who cooperate with the CPs, 2. Supporting and facilitating local initiatives regarding education for caregivers and patients with a CPC, 3. Supporting and facilitating the communication, partnership and local consultation between caregivers involved in CPs, 4. Collecting information on the performance of the network based on parameters and following a method that permits evaluation of the performance of the network.
This study wanted to investigate to what extent LMNs in Belgium represent attributes of high quality integrated care for patients with chronic conditions, i.e. diabetes and chronic renal failure.

Methods

For this investigation, a questionnaire based on the Chronic Care Model (CCM) (10,11) was developed. The CCM comprises 6 dimensions that are hypothesized to affect functional and clinical outcomes associated with disease management. (table 1) For the purpose of this study key attributes of high quality integrated care were linked to every individual dimension of the Chronic Care Model as outlined by the World Health Organization in their report on high quality integrated care. (12)
These attributes were translated into theorems where participants could answer according to five categories (totally disagree – disagree – neutral – agree – totally agree) (table 2) and a glossary was available to clarify the terms when necessary (available upon request). Two experts who published extensively in the field of integrated care validated the questionnaire.

After approval of the Ethic Committee, the questionnaire was sent to all Care Program Promoters (CPPs) of the Dutch-speaking Region of Belgium (see figure 1; n: 43) by mail together with an informative letter on the objectives of the project. Within a time frame of two months all CPPs where contacted by phone and received an interview that lasted on average 45 minutes. All answers were summarized in a Word-document and sent to the CPPs for validation and feedback.
All data was summarized and analyzed quantitatively. A detailed analysis of the data including all qualitative remarks given by the interviewees is available upon request.

Table 1: Dimensions of the Chronic Care Model	
Dimension	**Attributes of High Quality Integrated Care**
Health Care Organization	- Providing clear, explicit objectives/goals - Providing leadership for securing resources and removing barriers to change. - Providing clinical leadership in order to increase the changes for successful implementation - Assuring a sufficient number of health professionals involved in the care of patients with a CP - Providing an adequate workforce in terms of competences - Providing a clear, updated overview on the number of patients with a CP for every family physician
Community Resources	- Providing a good survey/overview of all disciplines involved in the care of patients with a CP
Delivery System Design	- Providing sufficiently clear shared-care protocols for the care of patients with a CP
Decision Support	- Providing evidence-based care protocols on diabetes and chronic renal failure for use in the general practice - Assuring a sufficient amount of post-graduate training sessions for caregivers involved in the care for patients with a CP - Providing sufficient reminder systems to support family physicians in the care for patients with a CP - Providing an adequate reminder system for patients with a CP in order to fulfill the conditions of their contract in time - Promoting and organizing quality control through audit and feedback for family physicians and other disciplines involved in the care for patients with a CP
Self-Management Support	- Providing sufficient attention to therapeutic diabetes education for patients with a CP - Providing sufficient and adequate devices for supporting patients with a CP in their self-care - Assuring sufficient attention to the education of informal caregivers - Providing an adequate device for electronic communication between the patient and the caregivers involved in the CP
Clinical Information Systems	- Assuring adequate data collection on the performance of the CPs

Results

Response rate

Of the Forty-three LMNs in the Flemish region of Belgium that were contacted, 90% agreed to participate in the study. In three cases, a person other than the CPP answered the survey.

Twenty-six LMNs employed one CPP on a full-time basis, five LMNs had two CPPs on a full-time basis and three LMNs had one CPP on a full-time basis and a second CPP on a half-time basis.

Two LMNs employed one joint CPP and one LMN hired two CPPs on a part-time basis. One LMN employed five CPPs. In six LMNs an additional assistant for administrative tasks was employed.

An overview of all responses to the theorems is given in table 2.

Table 4: Overview of all responses (part 1)					
Theorems	**Answers**				
	Totally disagree % (n)	**Disagree % (n)**	**Neutral % (n)**	**Agree % (n)**	**Totally agree % (n)**
Health Care Organization					
The LMN has clear, explicit objectives/goals (on annual basis or other) that are passed on to family physicians and other involved disciplines.	0 (0)	8 (3)	13 (5)	55 (21)	24 (9)
The necessary leadership for the development of the LMN or to realise the goals of the LMN, is present.	0 (0)	11 (4)	11 (4)	47 (18)	32 (12)
The necessary clinical leadership for the development of the LMN or to achieve the goals of the LMN, is present.	0 (0)	5 (2)	11 (4)	55 (21)	29 (11)
All disciplines involved in the care for patients with a Care Program Diabetes Mellitus type II or Chronic Renal Failure are sufficiently available (in terms of numbers and time available).	3 (1)	11 (4)	16 (6)	58 (22)	13 (5)
All disciplines involved in the care for patients wit a Care Program Diabetes Mellitus type II or Chronic Renal Failure demonstrate sufficient competences.	0 (0)	3 (1)	18 (7)	55 (21)	24 (9)
The LMN has a clear, updated overview of the number of patients with a Care Program for every family physician.	37 (14)	39 (15)	3 (1)	18 (7)	3 (1)
Community Resources					
The LMN has a good survey/overview of all disciplines involved in the care for patients with type II diabetes or chronic renal failure in the region the LMN operates.	0 (0)	3 (1)	0 (0)	34 (13)	63 (24)
Delivery System Design					
The LMN has sufficiently clear shared care protocols (with other disciplines involved) for the care of patients with a Care Program.	5 (2)	21 (8)	21 (8)	42 (16)	11 (4)

Table 4: Overview of all responses (part 2)					
Theorems	**Answers**				
	Totally disagree % (n)	**Disagree % (n)**	**Neutral % (n)**	**Agree % (n)**	**Totally agree % (n)**
Decision Support					
The LMN has evidence-based care protocols on diabetes and chronic renal failure for use in general practice.	0 (0)	3 (1)	18 (7)	55 (21)	24 (9)
There is a sufficient amount of continuing professional trainings available for family physicians and other caregivers involved in the care for patients with a Care Program.	0 (0)	0 (0)	0 (0)	63 (24)	37 (14)
Within the LMN there are sufficient reminder systems to support family physicians in the care for patients with a Care Program.	16 (6)	21 (8)	29 (11)	32 (12)	3 (1)
The LMN has an adequate reminder system for patients with a Care Program in order for patients to fulfil the conditions of their contract in time.	45 (17)	24 (9)	5 (2)	24 (9)	3 (1)
There are adequate systems for audit and feedback for family physicians and other disciplines involved in the care for patients with a Care Program.	42 (16)	24 (9)	29 (11)	3 (1)	3 (1)
Self Management Support					
Within the LMN, sufficient attention is paid to therapeutic diabetes education for patients with a Care Program.	0 (0)	11 (4)	29 (11)	32 (12)	29 (11)
The LMN has sufficient and adequate devices for supporting patients with a Care Program in their self-care.	3 (1)	13 (5)	13 (5)	50 (19)	21 (8)
Within the LMN, sufficient attention is going to education of informal caregivers	3 (1)	26 (10)	24 (9)	39 (15)	8 (3)
Within the LMN there are adequate devices for electronic communication between the patient and the caregivers involved in the Care Program.	50 (19)	29 (11)	3 (1)	13 (5)	5 (2)
Clinical Information Systems					
The LMN adequately collects data on performance of the Care Programs in addition to the mandatory data collection requested by the Belgian national government.	32 (12)	24 (9)	11 (4)	21 (8)	13 (5)

Dimensions of the Chronic Care Model and related attributes of high quality integrated care

Health Care Organization

Providing clear, explicit objectives/goals

The majority of the LMNs (30/38; 79%) stated to have clear explicit objectives/goals that were passed on to family physicians and all other disciplines involved. These objectives/goals were in 26% (10/38; 26%) not passed on to caregivers other than the steering Committee. Five LMNs reported that only family physicians had insight in the objectives/goals of the LMN. The channels used for communication of the objectives/goals were e-mail, electronic newsletters and websites (13/38; 34%) and meetings organized by the LMN for its professional members (13/38; 34%).

Providing leadership for securing resources and removing barriers to change

While the majority of het CPPs stated their LMN to have adequate leadership for the development of the LMN or to achieve the goals of the LMN (30/38; 79%), four CPPs (4/38; 11%) reported not to have the needed adequate leadership. The presence of adequate leadership was reflected in competencies of the CPPs alongside the leadership competencies of the president of the LMN, mostly a physician.

Providing clinical leadership in order to increase the changes for successful implementation

Thirty-two CPPs stated to have the necessary clinical leadership for the development of the LMN or to achieve the goals of the LMN (32/38; 84%). In 15 (15/38; 39%) of the interviewed LMNs, family physicians were considered to display professional behavior identified as being part of what is considered clinical leadership. Only one CPP reported a specialist within the LMN to display behavior that was recognized as clinical leadership (1/38; 3%).

Assuring a sufficient number of health professionals involved in the care of patients with a CP

While 27 LMNs (27/38; 71%) stated that in their region all disciplines needed in the care for patients with a CP were sufficiently available, 5 LMNs (5/38; 13%) reported this was not the case for their LMN.

Four CPPs reported a lack of dieticians, especially dieticians specialized in chronic renal failure (4/38; 11%).

Providing an adequate workforce in terms of competences

Thirty of the CPPs (30/38; 79%) stated that the caregivers in their network demonstrated sufficient competences, but only eleven of the CPPs (11/38; 29%) reported that they had a quality profile for caregivers to be included in the LMN. Most LMNs relied on diploma and registration of the

professionals with the Belgian national government (29/38; 76%). One LMN had developed specific quality directives for dieticians and educators in their network and one other LMN organized post-graduate training courses on regular basis on chronic renal failure for dieticians with a certificate paired to this. Only two CPPs (2/38; 5%) stated that there was an evaluation system available for the caregivers involved in the care of patients with a CP. One of these evaluation systems was based on peer review (annually presenting results to colleagues). Ten CPPs stated they did not consider evaluating the competences of caregivers in their LMN to be their task (10/38; 26%).

Providing a clear, updated overview of the number of patients with a CP for every family physician

Only eight LMNs (8/38; 21%) stated to have a clear and updated overview of the number of patients with type 2 diabetes and renal failure with a CP for every individual family physician.

Community Resources

Providing a good survey/overview of all disciplines involved in the care of patients with a CP

Thirty-seven CPPs (37/38; 97%) stated to have a good overview on all disciplines involved in the care for patients with a CP. The social map/referral map was available in most LMNs on their website (33/38; 87%) and/or communicated by means of email (23/38; 61%). Twenty-four (24/38; 63%) LMNs reported the social map to be updated when a new caregiver signed up or when contact details were changed. Nineteen (19/38 or 50%) of the LMNs screened their social map annually or more frequently and four LMNs (4/38; 11%) wanted to implement a type of screening of their social map in their future objectives

Delivery System Design

Providing sufficiently clear shared care protocols for the care of patients with a CP

Half of the CPPs (20/38; 53%) stated that their LMN had sufficiently clear shared-care protocols. Regarding the CP Diabetes, the CPPs stated that clear shared-care protocols between family physicians and specialists were present in 84% (32/38; 84%), between family physicians and diabetes educators in 82% (31/38; 82%), between family physicians and dieticians in 68% (26/38; 68%), between family physicians and pharmacists in 61% (23/38; 61%) and between family physicians and podiatrists in 55% (21/38; 55%). Regarding the CP chronic renal failure, shared care protocols between family physicians and specialists were present in 76% (29/38; 76%), between family physicians and dieticians in 63% (24/38; 63%) and between family physicians and pharmacists in 55% (21/38; 55%).

Twenty-one CPPs (21/38; 55%) described complaints expressed by family physicians on other caregivers. These complaints were mostly related to communication (11/38; 29%) and long waiting lists for consultation with specialists and diabetes educators (9/38; 24%).

Of all CPPs, 32 (32/38; 84%) reported on other caregivers expressing complaints about family physicians. These complaints dealt with not willing to start a CP (8/38; 21%), administrative errors (10/38; 26%), insufficient referring to other caregivers, especially educators, dieticians and podiatrists (24/38; 63%), not providing sufficient information upon referral of a patient to specialists or other caregivers (17/38; 45%), providing insufficient or wrong information regarding CPs (6/38; 16%) and no follow-up of the CPs (9/38; 24%). Eleven CPPs (11/38; 29%) reported on complaints from patients, while 21 of them (21/38; 55%) did not record complaints from patients. Those LMNS who collected complaints from patients described patients who were dissatisfied about their physician not willing to start a CP (3/38; 8%), the complexity of CPs (3/38; 8%) and sickness funds that canceled CPs without warning (2/38; 5%).

Decision Support

Providing evidence-based care protocols on diabetes and chronic renal failure for use in the general practice

While fourteen LMNs relied on available evidence-based care protocols without local adjustments (14/38; 37%), fifteen LMNs reviewed their care protocols annually or more to fit local needs (15/38; 39%). The Care Protocols were available on websites (22/38; 58%), circulated by mail (20/38; 53%) and presented during professional trainings or meetings (14/38; 37%). Four LMNs had included the Care Protocols in an informative map for the caregivers (4/38; 11%) and five CPPs visited the family physicians to inform them about the Care Protocols (5/38; 13%).

Assuring a sufficient amount of post-graduate training sessions for caregivers involved in the care for patients with a CP

All CPPs agreed that there was a sufficient amount of post-graduate training sessions for family physicians and other caregivers involved in the care for patients with a Care Program. Caregivers were mostly invited to these trainings by means of electronic communication (36/38; 95%) and an overview of the trainings was available on the website in twenty-three cases (23/38; 61%).

Providing sufficient reminder systems to support family physicians in the care for patients with a CP

Concerning reminder systems for follow-up of clinical parameters, twenty-six LMNs stated not to be involved in the clinical follow-up of the patients (26/38; 68%). Twelve of them referred to the electronic medical records for follow-up of clinical parameters (12/38; 32%). Of the LMNs who stated

to have reminder systems for follow-up of clinical parameters (13/38; 34%), seven (7/38; 18%) stated they worked with general reminders in their newsletters and two referred to their care protocol (2/38; 5%). All LMNs reported to have reminder systems for professional trainings and other activities organized by the LMN, mostly through electronic communication tools (email, website, newsletter) (35/38; 92%)

Providing an adequate reminder system for patients with a CP in order to fulfill the conditions of their contract in time

Ten CPPs reported to have a adequate reminder system for patients with a CP in order for patients to fulfill the conditions of their contract in time (10/38; 26%). These reminders where regarding visits to the family physicians and specialists (7/38; 18%). Nine of the CPPs who reported to have an adequate system, worked with a diary or roadmap for patients (9/38; 24%). One CPP stated patients were reminded by a phone call of their educator or CPP. Of the CPPs who disagreed on the theorem, five stated this was the job of other professional caregivers (5/38; 13%) and four stated this was a responsibility of the patients themselves (4/38; 11%).

Promoting and organizing quality control through audit and feedback for family physicians and other disciplines involved in the care for patients with a CP

Only two CPPs (2/38; 5%) reported to have an adequate system for audit and feedback. Twelve of the CPPs (12/38; 32%) referred to a system provided by the Belgian national government, although this system didn't work fluently: the program was not considered to be user-friendly (11/38; 29%) and feedback was perceived as 'not in time' (5/38; 13%)

Self-Management Support

Providing sufficient attention to therapeutic diabetes education for patients with a CP

More than half of the LMNs had no clear overview of the number of patients receiving education (27/38; 71%) and the available data mostly came from primary care centers (8/38; 21%). The government provided data on this subject, but the information was perceived to arrive too late and the district borders used by the government did not correspond to the borders of the LMNs.

Providing sufficient and adequate devices for supporting patients with a CP in their self-care

To the theorem that the LMN had sufficient and adequate devices for supporting patients in their self-care, 50% (19/38; 50%) of the CPPs agreed and 21% (8/38; 21%) even strongly agreed. The devices named were: informative leaflets (29/38; 76%), self-care maps (15/38; 39%), informative sessions and/or workshops for patients (13/38; 34%) and demo materials (12/38; 32%).

The CPPs who disagreed (6/38; 16%), reported that the LMN had no material on their own, but referred to the educators and reported to have a supporting role between educators and companies who provided the devices.

Assuring sufficient attention to the education of informal caregivers

To the theorem whether the LMN paid sufficient attention to education of the family caregivers, the answers were divided. Reported ways to involve the family caregivers were: open informative sessions (22/38; 58%), health fairs (5/38; 13%) and active invitation of the family caregivers to educational sessions (7/38; 18%). Of the eleven CPPs who disagreed, five stated that this was not their job and referred to the educators to fulfill this role (5/38; 13%) and four reported involvement of family caregivers to be a strategy to develop in the future (4/38; 11%).

Providing an adequate device for electronic communication between the patient and the caregivers involved in the CP

Seven CPPs reported to have an adequate device for electronic communication between the patient and the caregivers involved in the CP (7/38; 18%). Remarks of the CPPs who disagreed were that a lot of patients did not know how to work with computers (2/38; 5%) and that there was no adequate, safe program for this type of communication available (12/38; 32%).

Clinical Information Systems

Assuring adequate data collection on the performance of the CPs

Thirteen CPPs (13/38; 34%) reported their LMN to adequately collect data on the performance of the CPs in view of research objectives and evaluation of the performance of the LMN. Data was collected by means of questionnaires (11/38; 29%), contributions of student researchers (1/38; 3%) and external companies (2/38; 5%). Four CPPs considered data collection for the purpose of research and performance objectives not to be their responsibility (4/38; 11%).

Discussion

Health Care Organization

Providing clear, explicit objectives/goals

Although 79% of the LMNs stated to have clear explicit objectives/goals, 26% did not pass these objectives/goals on to all caregivers of the LMN. However, to operate well as a network, the network needs to have clear objectives/goals that are forwarded to all members. (13)

Providing leadership and clinical leadership

Other attributes of high quality integrated care are adequate leadership and adequate clinical leadership (14,15), which the majority of the CPPs stated to have.

Assuring a sufficient number of health professionals involved in the care of patients with a CP

71% of the CPPs stated that, in their region, all disciplines needed in the care for patients with a CP were sufficiently available. Disciplines that were considered insufficient in numbers were diabetes educators and podiatrists, similar to a previous study (16).

Providing an adequate workforce in terms of competences

Almost 80% of the CPPs stated that the caregivers in their network demonstrated sufficient competences, but most of them only relied on diploma and registration by the Belgian national government. Only one LMN organised a course on chronic renal failure for dieticians despite the reported lack of dieticians with experience in chronic renal failure, which was perceived as a major problem.

Although peer review is an effective way to accelerate learning and improvement of care, only one LMN used this method to evaluate and improve the competences of the caregivers involved. (17,18)

Providing a clear, updated overview of the number of patients with a CP for every family physician

Although 76% of the LMNs had no clear updated overview on the number of patients with a CP for every family physician, fifteen CPPs stated that such overviews could be helpful to evaluate the performance of the LMN and to support family physicians in their management of CPs.

Community Resources

Providing a good survey/overview of all disciplines involved in the care of patients with a CP

For an LMN to be efficient, to provide an accessible health care and to give patients the choice between caregivers, an adequate workforce in terms of numbers, competences and distribution is required. (12) As previous studies highlighted the need for a good social map/referral map with correct, up-to-date contacts and possible sub-specializations of these different caregivers, (16,19) this study showed that LMNs paid attention to this need by providing an up-to-date social map/referral map on their website and/or through e-mail.

Delivery System Design

Providing sufficiently clear shared care protocols for the care of patients with a CP

To sustain the relationships and commitments among the caregivers involved in a network, clear shared-care protocols are needed (16). Our study revealed that only half of the LMNs had sufficiently clear shared care protocols and 45% of the LMNs didn't have clear shared care protocols with pharmacists. However, as provider of medicines, pharmacists have an important role in informing patients about correct use and side effects of drugs and in alerting family physicians when interactions between different drugs can occur.

Of all CPPs, 84% reported to receive complaints of other caregivers regarding the multidisciplinary cooperation of the family physician and half of them also reported to receive complaints from family physicians about other caregivers. These reported problems are similar to previous research in this domain. (16,20–23)

Decision Support

Providing evidence-based care protocols and assuring a sufficient amount of continuing professional trainings

Providing evidence-based care protocols and assuring a sufficient amount of continuing professional trainings for caregivers involved in the care for patients with a CP are two essential attributes of high quality integrated care with the purpose to support caregivers in their decision-making. Our study did not reveal any problems within LMNs regarding these attributes. It must be noted that only 15 LMNs reviewed their care protocols on an annual basis to fit the local needs.

Providing sufficient reminder systems to support family physicians in the care for patients with a CP

Concerning reminder systems for clinicians, all LMNs reported to have sufficient reminder systems for professional trainings and other activities organized by the LMN. However, there was a perceived lack of reminders for clinical parameters, although there is evidence that reminder systems can be effective in changing routine behaviors amongst clinicians, as well as improving quality of care provided. (24–26)

Providing an adequate reminder system for patients with a CP in order to fulfill the conditions of their contract in time

Through the contract, patients are partially responsible for their own health. If the conditions of the contract are not fulfilled in time, the contract will not be prolonged and patients will lose the CP-related benefits. An effective way to support patients in fulfilling these conditions in a timely way is to provide an adequate reminder system. (27) However, according to our study, most of the LMNs

didn't have an adequate reminder system, most of the LMNs even admitted to have no reminder system at all. Only one CPP stated patients were reminded by a phone call of the educator or CPP.

Promoting and organizing quality control through audit and feedback for family physicians and other disciplines involved in the care for patients with a CP

Although audit and feedback have proven their effectiveness on outcomes of care (28), only two LMNs reported to have an adequate system for audit and feedback. One third of the CPPs referred to a system provided by the Belgian national government, but reported problems as "not being user friendly" and "feedback and results of the study came too late". One of the important conclusions of this study was the need for a good audit and feedback system equally for the LMNs as an entity as for the individual caregivers. (23)

Self-Management Support

Providing sufficient attention to therapeutic diabetes education and sufficient and adequate devices for supporting patients with a CP in their self-care

According to our study, within the LMNs, self-management support is sufficiently present, mainly through education and devices for supporting self-care (informative leaflets, self-care maps, informative sessions and/or workshops for patients and demo materials).

Assuring sufficient attention to the education of informal/family caregivers

In half of the LMNs informal/family caregivers were invited to attend educational and informative sessions together with the patients. This finding is important since informal caregivers play an important role in maintaining the health and independence of chronically ill patients and education of these informal caregivers can lead to a reduction in depression and anxiety, increase the knowledge of the chronic conditions and change the way patients and their caregivers respond to caregiving situations. (29,30)

Providing an adequate device for electronic communication between the patient and the caregivers involved in the CP

Although most of the communication within the LMN occurred through electronic communication tools, 79% of the CPPs reported that within their LMN there was no adequate device for electronic communication between patients and caregivers. Previous research demonstrated the need for solid communication tools (16)

Clinical Information Systems

Assuring adequate data collection on the performance of the CPs

Although one of the goals of the LMNs was collecting information about the performance of the network, based on parameters and following a method, which permits evaluation of the performance of the network, less than half of the LMNs reported to do so.

General remarks

One of the general remarks of the CPPs was that they found CPs too narrow. This was confirmed by other researches: Many programs for chronic care are written from a professional perspective for groups of patients with only one disease. The perspective of the patient is often underexposed, differences between and different needs of patients are not addressed in these programs and the fact that elderly patients often have more than one chronic disease is not taken into account. (31,32) With this in mind, the Belgian national government is currently thinking about restructuring the system of CPs and introducing a "chronic care nurse". (23)

As reported in a previous study, the function of CPPs was operationalized in many different ways in the different LMNs. One of the remarks of CPPs and of this previous study, was that a clear framework needs to be considered with specific expectations concerning integrated care, roles and tasks of the steering committee and the CPPs. (23)

An important attribute for the successful development of high quality integrated care is the availability of an adequate financing system linked with quality improvement. This was not included in our questionnaire since this is a task of the Belgian national government and not of the LMNs. However, a lot of CPPs reported that the current financing system was inadequate. An appropriate financing system should stimulate structural and collaborative efforts between health care providers, should be outcome-oriented and should promote the use of evidence-based guidelines and self-management. (33)

Limits/strengths of the study

This is, to our knowledge, the first study in Belgium to provide a comprehensive overview of essential attributes of integrated care as provided by Local Multidisciplinary Networks using the Chronic Care Model as a conceptual backbone to the study. The response rate to this study was very high (38/43; 88%). Previous studies focused on one or more aspects of high quality integrated care in one LMN (16,21,22). With a response rate of 90% the results highly represent the LMNs in the Dutch-speaking region of Belgium. However, results cannot be generalized for Belgium as a whole, since the French-

speaking region of Belgium was not included. This might have provided additional insights in the diversity of how attributes of high quality integrated care are operationalized and implemented. Opinions presented in this study are the opinions of a single person within the network, and although the CCPs hold a key position within the LMN, there is still an important component of subjectivity that must be acknowledged.

Conclusion

Attributes on high quality integrated care are operationalized and implemented within the LMNs, but data shows a high degree of diversity and level of maturity for all attributes related to the different dimensions of the Chronic Care Model.

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Figure 1: LMNs in the Dutch Speaking Region of Belgium

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Appendices

1. Questionnaire (in Dutch)
2. Informative letter to the CPPs (in Dutch)

Appendix 1: Questionnair (in Dutch)



Vragenlijst naar attributen van hoog-kwalitatieve geïntegreerde zorg in de LMN's in Vlaanderen

Goeiedag, mijn naam is … (naam van de beller) en ik bel u op in verband met een vragenlijst rond attributen van hoog-kwalitatieve geïntegreerde zorg in het kader van een masterthesis huisartsgeneeskunde binnen het project 'Integrated Care' aan de VUB.

Zoals u weet zijn in België de Lokale Multidisciplinaire Netwerken of LMN's sinds een viertal jaar operationeel. Met de vragenlijst die ik zo dadelijk aan u zou willen voorleggen, willen we nagaan of alle attributen voor de hoog-kwalitatieve geïntegreerde zorg in voldoende mate aanwezig zijn voor de doelen die we nastreven met de LMN's en zorgtrajecten. Het gaat om een 20-tal stellingen waarbij u kunt antwoorden met de antwoordcategorieën helemaal niet akkoord – eerder niet akkoord – neutraal – eerder wel akkoord – helemaal akkoord. Aan de hand van uw antwoord worden er enkele bijkomende vragen gesteld. Daarenboven kunt u bij elke vraag een opmerking formuleren indien gewenst. Indien u de vraag niet volledig begrepen hebt, kunt u steeds vragen of we deze willen verduidelijken. De antwoorden worden nadien samengevat en in een documentje aan uw LMN terugbezorgd. Het LMN bepaalt zelf of er hier iets mee gebeurt. Bent u akkoord om deel te nemen?

Wat is uw naam?
Binnen welk LMN bent u werkzaam?
Wat is uw functie?
Hoeveel zorgtrajectpromotoren zijn er werkzaam binnen het LMN?
Op welk emailadres mogen we de samenvatting van dit interview toesturen?

1. **Het LMN heeft duidelijk geëxpliciteerde doelstellingen (OP JAARBASIS OF ANDERS) die kenbaar zijn gemaakt aan de huisartsen en andere betrokken disciplines**

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Zijn deze doelstellingen neergeschreven in een beleidsplan? Ja – nee
   Indien ja:
   - Is dit beleidsplan kenbaar gemaakt aan de huisartsen en andere betrokken disciplines? Ja – nee
   - Op welke manier?

b. Waarover gaan de doelstellingen?
c. Zijn er meetbare indicatoren gekoppeld aan deze doelstellingen en zo ja, welke?
d. Indien nee: op welke manier wordt geëvalueerd of de doelstellingen behaald worden?

Opmerkingen:

2. **Het noodzakelijke leiderschap voor de uitbouw van het LMN OF om de doelstellingen van het LMN te realiseren, is aanwezig**

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. In hoofde van wie komt dit leiderschap het meest tot uiting: de voorzitter van de stuurgroep, de ganse stuurgroep, de zorgtrajectpromotor of nog iemand anders?
b. Hoe uit dit leiderschap zich?

Opmerkingen:

3. Het noodzakelijk klinisch leiderschap (in hoofde van huisartsen en specialisten) is aanwezig voor de uitbouw van het LMN of de doelstellingen van het LMN te realiseren

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. In hoofde van wie komt dit leiderschap het meest tot uiting (huisarts of specialist, welke discipline?)
b. Hoe uit dit leiderschap zich?

Opmerkingen:

4. Het LMN heeft een goed overzicht over alle disciplines en instanties die betrokken zijn bij de zorg voor patiënten met diabetes of chronische nierinsufficiëntie

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Bestaat er binnen het LMN een overzichtelijke, complete en geüpdate sociale kaart waarop alle betrokken zorgverleners met contactgegevens te vinden zijn? Ja – nee
b. Is deze sociale kaart kenbaar gemaakt aan alle betrokken zorgverleners en zo ja, op welke manier?
c. Hoe vaak wordt deze sociale kaart geüpdate?

Opmerkingen:

5. Alle disciplines betrokken bij de zorg voor patiënten met een zorgtraject diabetes of CNI zijn voldoende beschikbaar

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Zijn er wel eens klachten van de huisartsen over de bereikbaarheid of beschikbaarheid van bepaalde zorgverleners?
b. Over welke disciplines gaan deze klachten meestal en wat is het grootste probleem?
c. Zijn er bij de zorgverleners wel eens klachten over de huisartsen?
d. Wat is hier het grootste probleem
e. Komen er soms klachten binnen van de patiënten zelf? Zo ja, welke soort klachten betreft het dan?

Opmerkingen:

6. Alle disciplines betrokken bij de zorg voor patiënten met een zorgtraject diabetes of CNI beschikken over voldoende competenties

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Is er een profiel beschikbaar waaraan de zorgverleners betrokken bij de zorg voor patiënten met een zorgtraject moeten voldoen om opgenomen te worden in het netwerk?
b. Hoe wordt bepaald of de juiste competenties aanwezig zijn?
c. Bestaat er een evaluatie-systeem van de verschillende zorgverleners betrokken bij de zorg voor patiënten met een zorgtraject die nagaat of deze over voldoende competenties beschikken en zo ja, hoe werkt dit systeem?

Opmerkingen:

7. Het LMN beschikt over geactualiseerde zorgprotocols voor huisartsen rond diabetes en CNI.

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Werden deze zorgprotocols kenbaar gemaakt aan de huisartsen en zo ja, op welke manier?
b. Wie staat in voor de actualisatie van deze zorgprotocol?
c. Op welke termijn worden deze zorgprotocols herzien en zo nodig aangepast?

Opmerkingen:

8. Er zijn voldoende navormingen voor huisartsen en andere zorgverleners betrokken bij het zorgproces voor patiënten met een zorgtraject

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Bestaat er een overzicht van navormingen voor de betrokken disciplines?
b. Waar is dit overzicht consulteerbaar voor de verschillende zorgverleners?
c. Hoe worden de zorgverleners uitgenodigd voor deze navormingen?

Opmerkingen:

9. Binnen het LMN wordt er voldoende aandacht besteed aan educatie voor patiënten met een zorgtraject

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Heeft het LMN zicht op hoeveel patiënten educatie ontvangen en bij wie? Verklaar.
b. Kan de patiënt feedback geven over inhoud en frequentie van de educatie? Zo ja, hoe gebeurt dit dan?

Opmerkingen:

10. Het LMN heeft een duidelijk, geactualiseerd overzicht van het aantal patiënten met een zorgtraject per huisarts

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a) Zorgtraject diabetes

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

b) Zorgtraject CNI

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

Opmerkingen:

11. Het LMN beschikt over voldoende duidelijke samenwerkingsprotocols met andere disciplines betrokken bij de zorg voor patiënten met een zorgtraject

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a) Zorgtraject Diabetes
   - Diabetologen/endocrinologen
   - Dietisten
   - Educatoren
   - Podologen
   - Apothekers

b) Zorgtraject CNI
   - Nefrologen
   - Dietisten
   - Apothekers

Opmerkingen:

12. Binnen het LMN bestaan er voldoende 'reminder'systemen om huisartsen te ondersteunen in de zorg voor patiënten met een zorgtraject

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Zijn er remindersystemen m.b.t de opvolging van klinische parameters en zo ja, welke?
b. Zijn er remindersystemen voor de navormingen en zo ja, welke?
c. Zijn er reminder systemen voor andere door het LMN georganiseerde activiteiten (bv. Symposia,…) en zo ja, welke?

Opmerkingen:

13. Er bestaan adequate systemen voor audit en feedback naar huisartsen en andere disciplines betrokken bij de zorg voor patiënten met een zorgtraject

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Op welke manier wordt deze audit uitgevoerd?
b. Op welke manier wordt er feedback gegeven aan de verschillende zorgverleners?

Opmerkingen:

14. Het LMN beschikt over voldoende en adequate hulpmiddelen om patiënten met een zorgtraject te ondersteunen bij hun zelfzorg

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Over welke hulpmiddelen beschikt het LMN?

Opmerkingen:

15. Er wordt binnen het LMN ook voldoende aandacht besteed aan educatie van omgeving (=familie) van patiënten met een zorgtraject.

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Hoe wordt dit gedaan?

Opmerkingen:

16. Het LMN beschikt over een adequaat 'reminder'systeem voor patiënten met een zorgtraject opdat zij alle voorwaarden van het contract tijdig nakomen.

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Met betrekking tot welke voorwaarden van het contract bestaan deze reminders?
b. Hoe wordt dit georganiseerd?

Opmerkingen:

17. Binnen het LMN bestaan er elektronische en adequate hulpmiddelen voor elektronische communicatie tussen patiënt en zorgverleners betrokken bij het zorgtraject.

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Zo ja, hoe wordt dit georganiseerd?

Opmerkingen:

18. Het LMN verzamelt op adequate wijze data rond zorgtrajecten buiten de verplichte dataverzameling voor het RIZIV, met het oog op onderzoek naar en evaluatie van de werking van het LMN zelf.

Helemaal niet akkoord	Eerder niet akkoord	Neutraal	Eerder wel akkoord	Helemaal akkoord

a. Welke data worden verzameld?
b. Hoe worden deze data verzameld?
c. Welk doel heeft deze dataverzameling?

Opmerkingen:

Appendix 2: Informative letter to the CPPs (in Dutch)

Geachte zorgtrajectpromotor,

Mijn naam is Karen Sinnesael, huisarts in opleiding en in het kader van mijn masterproef voer ik een onderzoek naar de werking van de Lokale Multidisciplinaire Netwerken (LMN's) en in het bijzonder de aanwezigheid van de attributen voor hoog-kwalitatieve zorg binnen de LMN's. Hiervoor vraag ik graag uw medewerking. Een kleine toelichting bij dit onderzoek vindt u in onderstaande e-mail.

Voor dit onderzoek is een vragenlijst samengesteld op basis van attributen van hoog-kwalitatieve zorg voorgesteld door de WHO (World Health Organisation) en PAHO (Pan American Health Organisation). Deze vragenlijst zal voorgelegd worden aan de zorgtrajectpromotoren van alle Vlaamse LMN's door middel van telefonisch contact.
De vragenlijst bestaat uit een twintigtal stellingen met telkens vijf antwoordcategorieën. Bij elke stelling is er tevens de mogelijkheid om opmerkingen te formuleren en bij onduidelijkheid kan er steeds toelichting gevraagd worden. Nadien worden de antwoorden en opmerkingen uitgetypt en ontvangt de zorgtrajectpromotor hier een kopie van en zal er nog wat bijkomende beschrijvende informatie van het LMN gevraagd worden. De zorgtrajectpromotoren kunnen zelf beslissen wat ze met de antwoorden en opmerkingen binnen hun LMN zullen doen.
Wanneer alle Vlaamse LMN's gecontacteerd zijn, worden de antwoorden samengevat en verwerkt om na te gaan in welke mate de attributen van hoog-kwalitatieve zorg geïmplementeerd zijn in de Vlaamse LMN's.

Alvast bedankt voor uw medewerking
Met vriendelijke groeten

Karen Sinnesael
Huisarts in Opleiding