

# Implementation of interprofessional collaboration in chronic care: What Switzerland could learn from other countries?

Jako Burgers

Symposium Bern, 27 November 2018

# My background

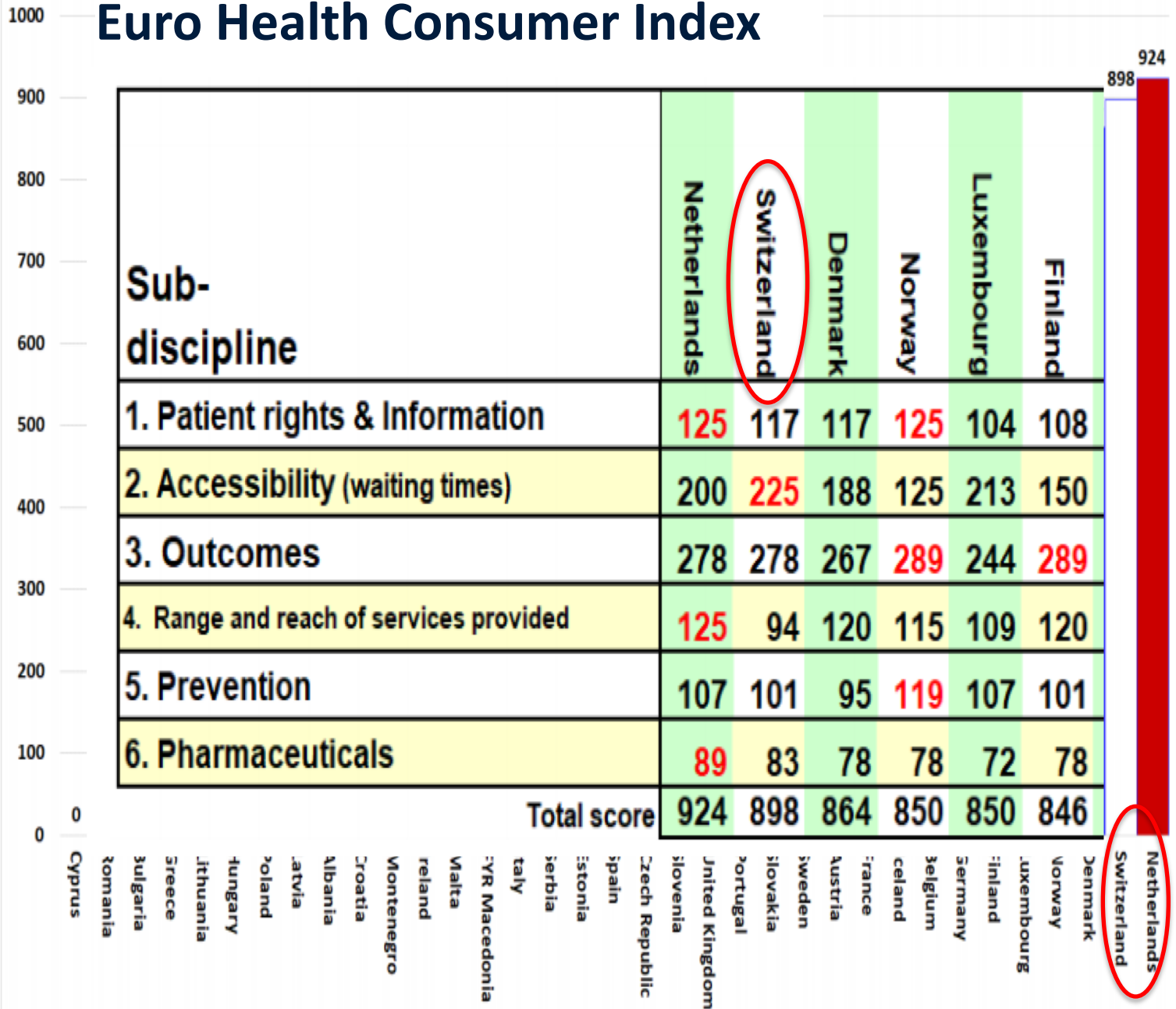
- General Practitioner, Gorinchem, Netherlands
- Senior Consultant, Dutch College of General Practitioners (NHG)
- Academic Chair 'Promoting Personalised Care in Clinical Practice Guidelines', Maastricht University
- Chair of G-I-N Multimorbidity working group



# Outline

- Background of collaboration in chronic care
- Practice example: chronic care in the Netherlands
- Pitfalls and challenges
- Recommendations for practice, research, and policy

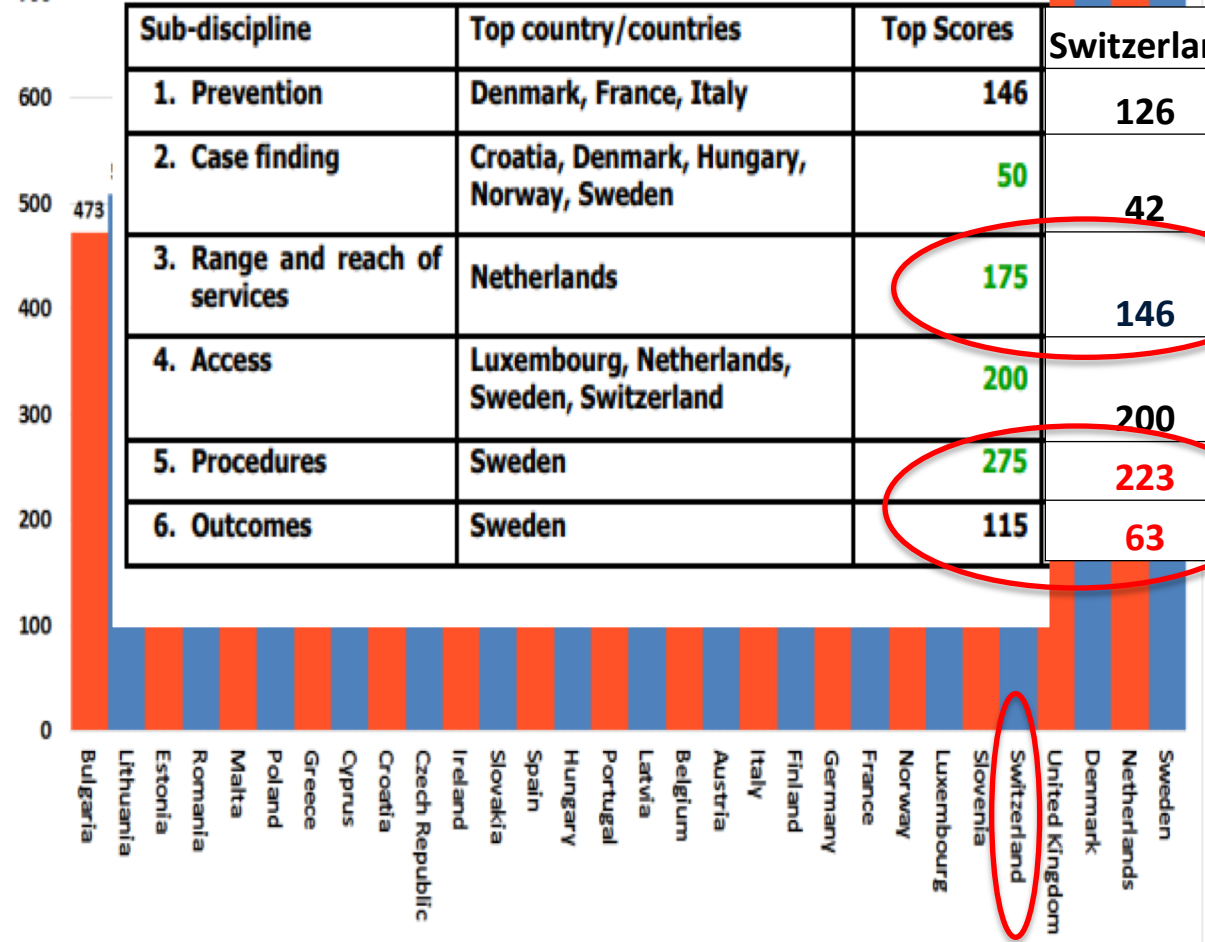
# Euro Health Consumer Index



Euro Diabetes Index 2014, Total Scores



| Sub-discipline                 | Top country/countries                        | Top Scores | Switzerland |
|--------------------------------|--|------------|-------------|
| 1. Prevention                  | Denmark, France, Italy                       | 146        | 126         |
| 2. Case finding                | Croatia, Denmark, Hungary, Norway, Sweden    | 50         | 42          |
| 3. Range and reach of services | Netherlands                                  | 175        | 146         |
| 4. Access                      | Luxembourg, Netherlands, Sweden, Switzerland | 200        | 200         |
| 5. Procedures                  | Sweden                                       | 275        | 223         |
| 6. Outcomes                    | Sweden                                       | 115        | 63          |



# Room for improvement

- Screening for co-morbidities, such as foot ulcer, diabetes retinopathy, and kidney function
- Uniformity in data collection from various cantons
- Coordination between federal and health levels needs to be strengthened

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# A brief history of medicine

| Time period | Movement                 | Leading actors or principles |
|-------------|--------------------------|------------------------------|
| Until 1990s | Authority-based medicine | Professional expertise       |
|             |                          |                              |
|             |                          |                              |
|             |                          |                              |
|             |                          |                              |
|             |                          |                              |



# Authority-based medicine (until 1990s)



The Anatomy Lesson  
of Dr Nicolaes Tulp

Rembrandt van Rijn,  
1632

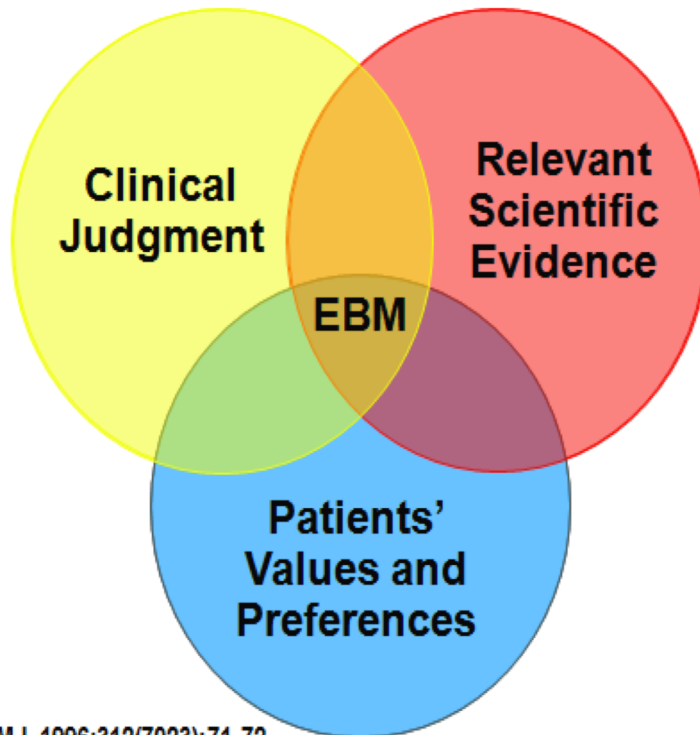
Mauritshuis museum,  
The Hague, the  
Netherlands

# A brief history of medicine

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| 1990s       | Evidence-based medicine  | Research findings and clinical guidelines |
|             |                          |   |
|             |                          |   |
|             |                          |   |

# Evidence-based medicine (1990s)

What Is Evidence-Based Medicine?



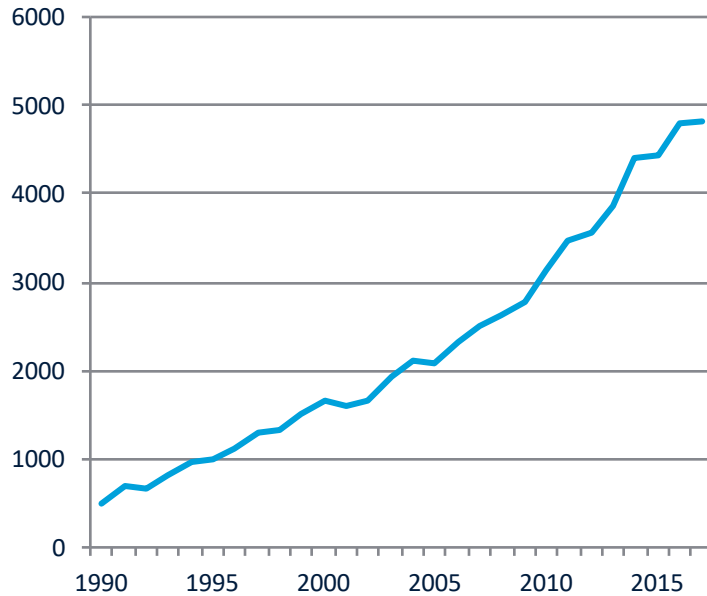
Sackett DL, et al. BMJ. 1996;312(7023):71-72.



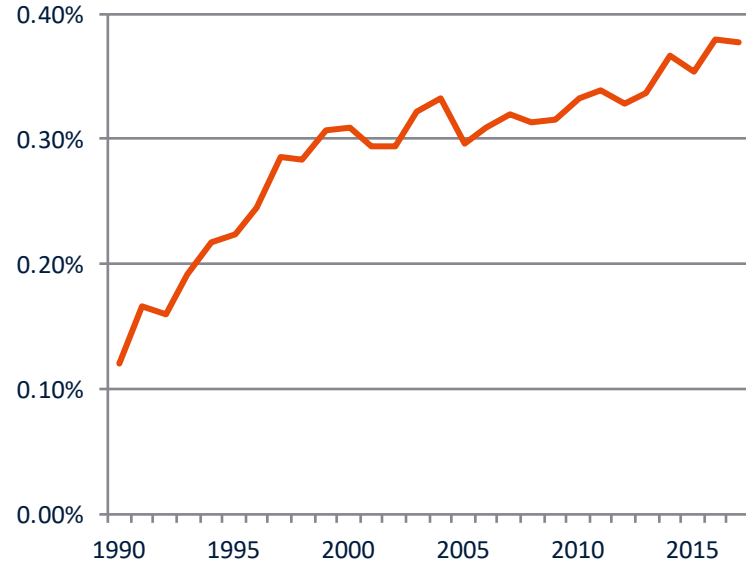
**FIGUUR** David Sackett en zijn 'evidence cart', een houten wagentje met een computer en cd-rom's met de inhoud van de belangrijkste medische vakbladen.<sup>5</sup>

# From EBM to guideline movement

## Number of guidelines in Pubmed



## Guidelines as percentage of total number of publications in Pubmed



Search term guideline\* limited to title and year

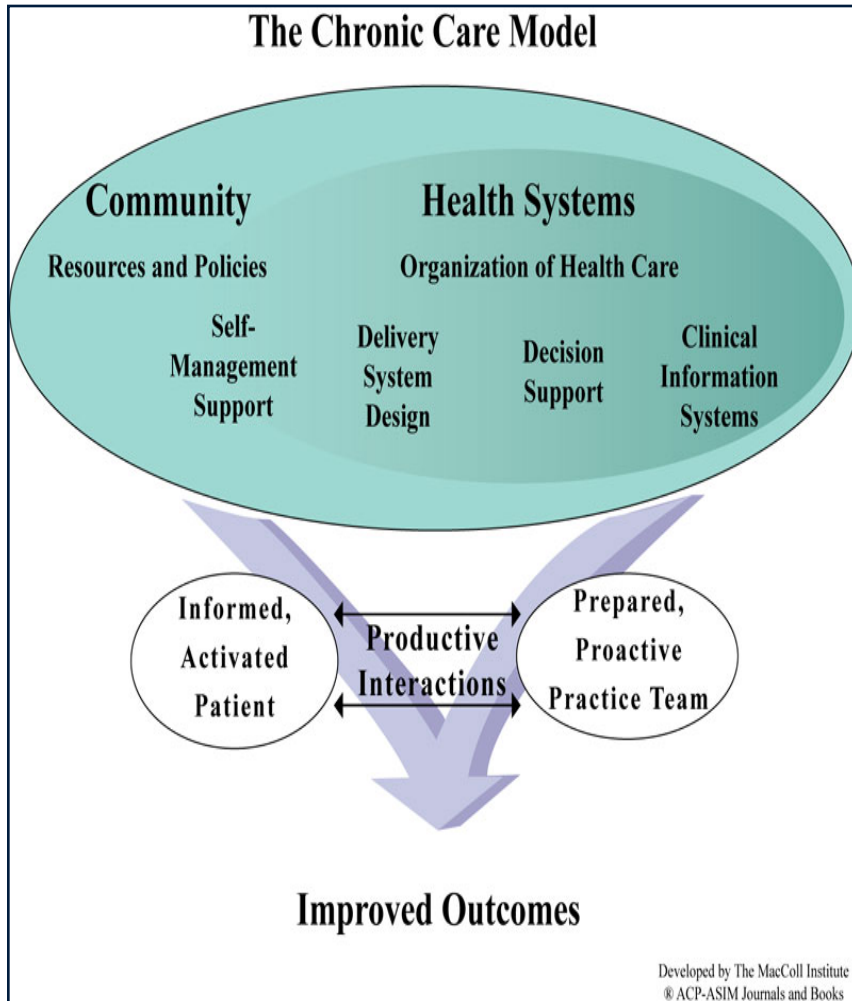
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| 2000s       | Disease management       | Quality and safety standards              |
|             |                          |   |
|             |                          |   |

# Research evidence on disease management

- Renders et al. Interventions to improve the management of **diabetes mellitus** in primary care. Cochrane review, 2000.
  - Regular prompted recall using central computerised tracking systems and nurses who regularly contact the patient, improve diabetes outcomes
  - Effects on process outcomes (e.g. HbA1c) are more convincing than effects on patient outcomes (quality of life)
  - No effect on mortality

# Chronic Care Model



- Mobilize community **resources** to meet needs of patients
- Empower and **prepare patients** to manage their health and health care
- Create a **culture**, organization and mechanisms that promote safe, high quality care
- Assure the delivery of **effective, efficient** clinical care and self-management support
- Promote clinical care that is consistent with scientific evidence and **patient preferences**
- Organize patient and population **data** to facilitate efficient and effective care

[www.improvingchroniccare.org](http://www.improvingchroniccare.org)

Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. *Managed Care Quarterly* 1996;2:12-25

Coleman K, Austin BT, Brach C, Wagner EH. **Evidence** on the Chronic Care Model in the new millennium. *Health Aff (Millwood)*. 2009;28:75-85.

# Selected chronic diseases and conditions

- Diabetes mellitus
- Cardiovascular diseases (CVD)
- High (CVD) risk (hypertension, hyperlipid)
- COPD
- Asthma
- Heart fail
- Depression
- (Frail) elderly
- **Combination of diseases/conditions (multimorbidity)**

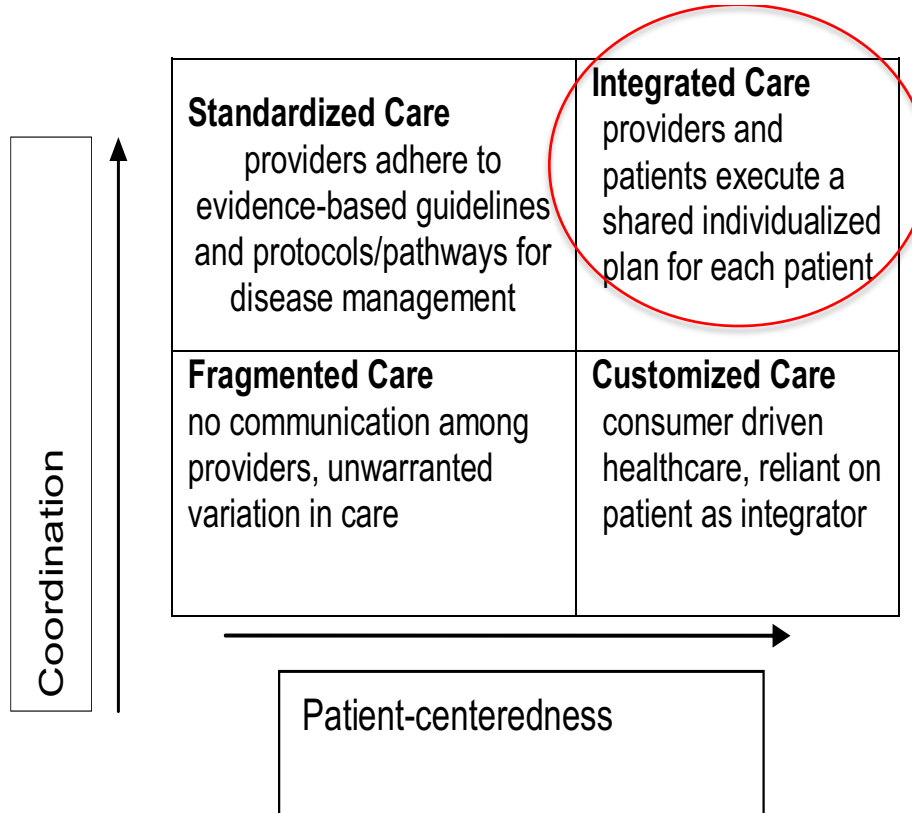
10-30% of total patient population



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| 2010s       | Integrated patient care  | Collaborative team and patient involvement |
|             |                          |  |

# Towards integrated patient care



Singer SJ, Burgers J, Friedberg M, Rosenthal MB, Leape L, Schneider E. Defining and measuring integrated patient care: promoting the next frontier in health care delivery. *Med Care Res Rev.* 2011 Feb;68(1):112-27.

# Outline

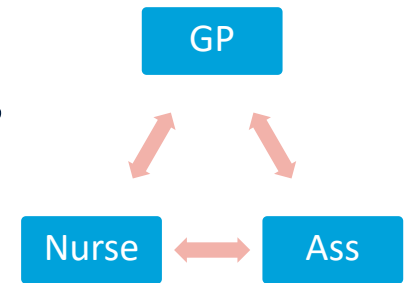
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# Characteristics of Dutch Health Care System

- Complete coverage for all residents (< 1% uninsured)
- All patients are registered in one general practice
- General practitioner is gatekeeper to hospital and specialist care
- Strong national organization of healthcare professionals, responsible for quality of care
- Balance between external, governmental systems and internal, professionally led systems for quality improvement

# Primary care in Netherlands: basic characteristics

- 11,000 general practitioners (GPs)
- 5,000 practices: 50% solo, 35% duo, 15%  $\geq 3$  GPs
- 85% of GPs work part time
- 100% has practice assistance, 90% practical nurse
- 100% has electronic healthcare record system
- 85% of GPs is member of Dutch College of GPs, producer of 130 evidence-based guidelines and public website with health information (Thuisarts.nl)
- 50% of income is capitation fee, 30% fee-for-service, 15% chronic care, 4% after-hours care, 1% pay for performance



# Organisation of chronic care in the Netherlands

- 115 primary care groups/collaboratives (covering 50,000 – 200,000 citizens) coordinate care of patients with diabetes type 2, (high risk of) cardiovascular disease, asthma or COPD
- GPs are paid through bundled payments with care groups negotiated with health insurers (€ 100-200 per patient per year)
- Collaboration with other disciplines is also contracted (dietician, foot care, eye care, internist, lung specialist)
- Care groups send invitations to patient for annual follow up and laboratory tests
- Practice nurse provide care in general practice according to national guidelines (2 days/wk per practice of 2,000 patients)
- Data are registred in special electronic health record, enabling feedback on performance indicators

# Feedback on performance

|   | Target 2018 | Mean Care Group | Your score |          |          |
|---|-------------|-----------------|------------|----------|----------|
|   |             | 1-9-2018        | 1.2.2018   | 1.5.2018 | 1.9.2018 |
| <b>DM</b>                                   |             |                 |            |          |          |
| Individual care plan                        | 80%         | 95%             | 98%        | 98%      | 100%     |
| eGFR (kidney function)                      | 90%         | 92%             | 85%        | 91%      | 96%      |
| Foot examination                            | 80%         | 84%             | 90%        | 89%      | 89%      |
| Fundus                                      | 80%         | 84%             | 92%        | 87%      | 94%      |
| Smoking status                              | 80%         | 97%             | 98%        | 98%      | 100%     |
| Number of smokers                           |             | 12%             | 20%        | 15%      | 16%      |
| <b>Cardiovascular disease</b>               |             |                 |            |          |          |
| Individual care plan                        | 80%         | 84%             | 100%       | 96%      | 96%      |
| Smoking status                              | 80%         | 88%             | 96%        | 96%      | 96%      |
| Number of smokers                           |             | 13%             | 24%        | 20%      | 24%      |
| Systolic blood pressure<br>140mmHg (<70 yr) |             | 80%             | 56%        | 81%      | 77%      |
| <b>Cardiovascular risk</b>                  |             |                 |            |          |          |
| Individual care plan                        | 80%         | 80%             | 87%        | 91%      | 91%      |
| Smoking status                              | 80%         | 90%             | 75%        | 79%      | 85%      |
| Number of smokers                           |             | 11%             | 11%        | 12%      | 10%      |
| Blood pressure measured                     | 80%         | 87%             | 91%        | 95%      | 95%      |

# Outline

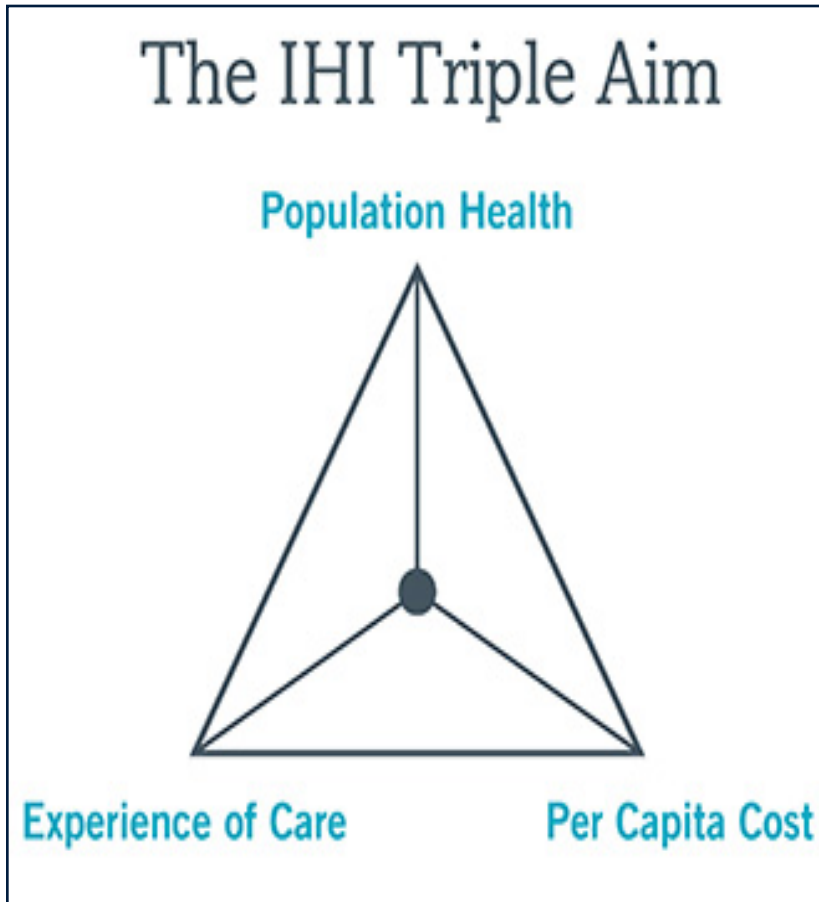
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# Is everybody happy?

- Are patients happy with chronic disease management?
- Are doctors happy with chronic disease management?

# The Triple Aim



1. Improving the health of populations
2. Reducing the per capita cost of health care
3. Improving the patient experience of care, including quality and satisfaction

IHI = Institute for Healthcare Improvement, Boston, USA

# Case in general practice: Mrs Schöl, age 84

- Multiple conditions: hypertension, nocturnal restless legs, osteoporosis, renal dysfunction, thyroid disease
- Use 8 different drugs daily
- Lives independently in senior apartment
- Good contact with children and grandchildren in neighborhood



*This case study is fictitious for privacy reasons.*

# Case in general practice: Mrs Schöl, age 84

- Multiple conditions: hypertension, nocturnal restless legs, osteoporosis, renal dysfunction, thyroid disease
- Use 8 different drugs daily
- Lives independently in senior apartment
- Good contact with children and grandchildren in neighborhood
- 2010: stroke with left-sided paraesthesias and strongly rising blood pressure



*This case study is fictitious for privacy reasons.*

# Problems with disease management

- Use of targets as quality measure in chronic disease programs
- Difficult to reach target values (SBP < 140 mmHg, LDL < 2,5 mmol/l)
- Increasing burden of treatment due to multimorbidity and polypharmacy
- Not person centered



# Pitfalls and challenges

- Are patients happy with chronic disease management?
- Are doctors happy with chronic disease management?

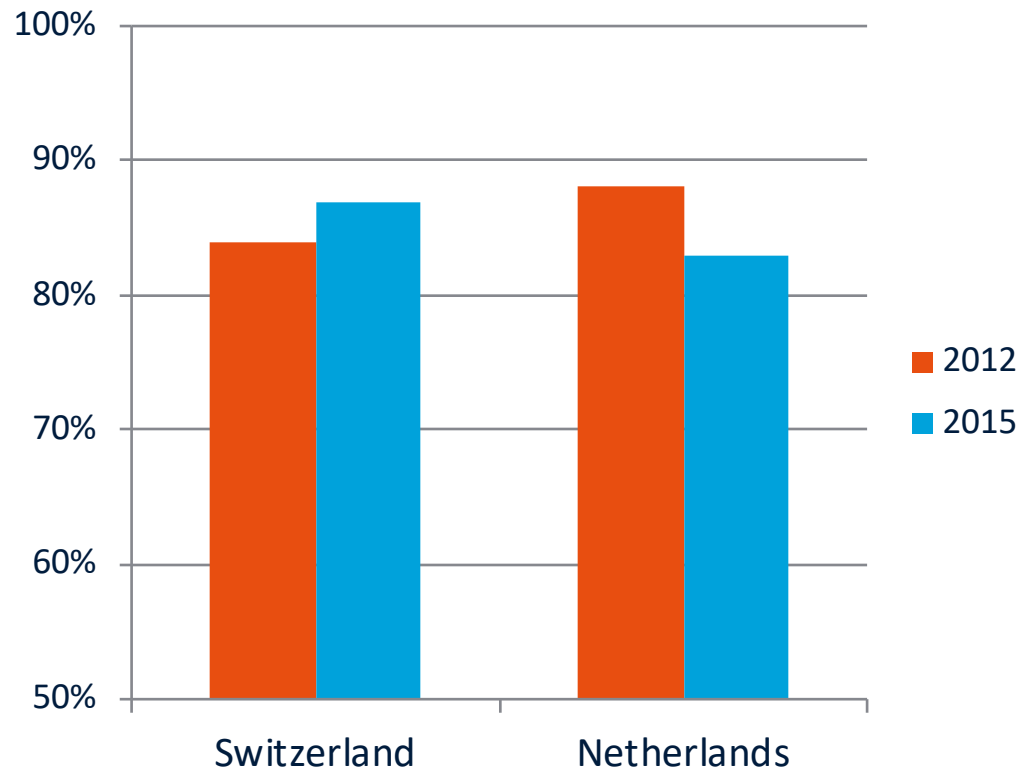
# Moving from triple aim to quadruple aim

## The Missing Aim



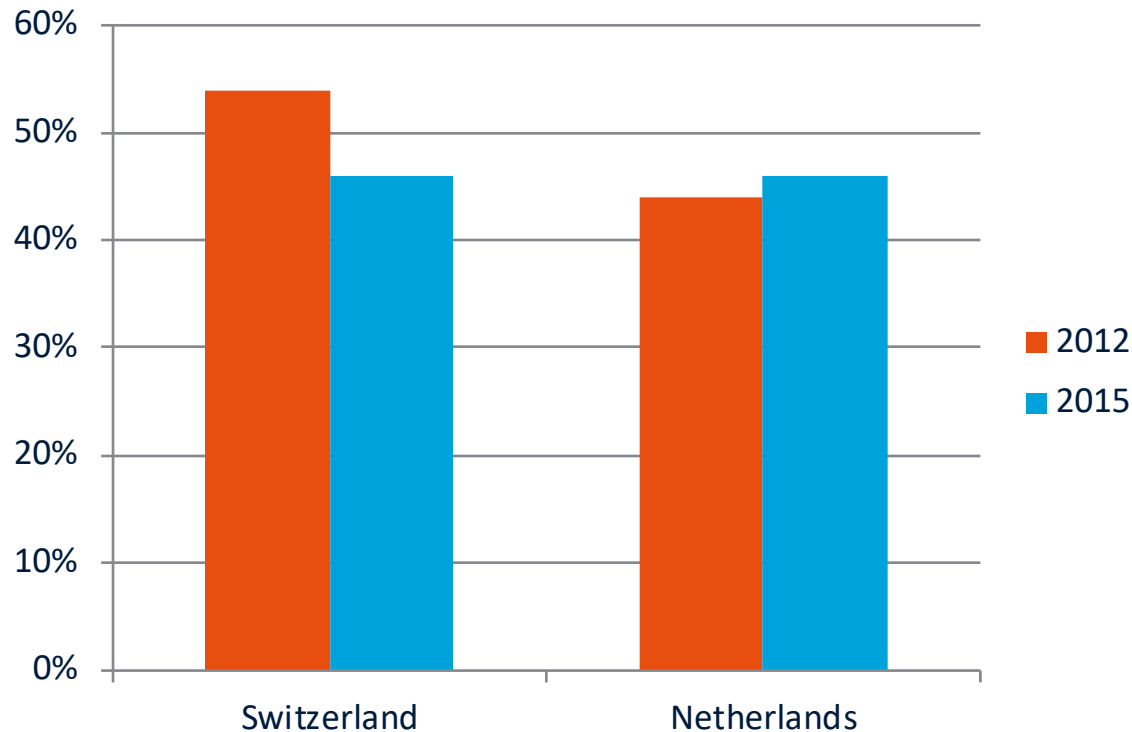
Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014 Nov-Dec;12(6):573-6

# How satisfied are you with practicing medicine? (% very satisfied/satisfied)





# What is your overall view on the health care system in your country? (% fundamental changes are needed)





HET ROER MOET OM

# Unhappy doctors in The Netherlands: 'it must change!'

2015

## Manifest van de Bezorgde Huisarts

Het roer moet om!

Teken het Manifest

Aantal steunbetuigingen per dinsdag 10 januari om 21.09

Al gesteund door **7,928** huisartsen en **18,948** sympathisanten



In totaal zijn er **11.345** huisartsen in Nederland



HET ROER MOET OM

# Unhappy doctors in The Netherlands: 'it must change!'

- Dutch GP's are not happy with:
  1. Law that hinders collaboration (and promotes competition)
  2. Administrative burden
  3. System of control (using invalid data) instead of trust
- 70% of the GPs signed the manifesto in 2 weeks
- Government, insurance companies and other stakeholders supported the movement
- Working groups were installed to implement change

# A global movement?

## Don Berwicks Era in Medicine and Health Care

Era 1: Professional Autonomy

Era 2: External Accountability

Era 3: 'The Moral Era'

1. Reduce Mandatory Measurement
2. Stop Complex Individual Incentives
3. Shift the Business Strategy from Revenue to Quality
4. Give Up Professional Prerogative When It Hurts the Whole
  
5. Use Improvement Science
6. Ensure Complete Transparency
7. Protect Civility
8. Hear the Voices of the People Served
9. Reject Greed

Berwick MD. Era 3 for Medicine and Health  
Care.

JAMA. 2016 Apr 5;315(13):1329-30.

# Effects of 'It must change' in the Netherlands

## 1. Collaboration: 11 agreements

(e.g. 2 year contract, more flexible negotiation options)

## 2. Administrative burden: 16 agreements

(e.g. less burden with drug prescribing, referrals, process of declaration, digital contracting)

## 3. Quality system: in progress

(e.g. less performance indicators, improving audit and feedback, patient surveys, more information on services)

# Case. Mrs Schöl (epilogue)

Consultation nephrologist

- *‘Our patient always gets side effects with new antihypertensive drugs. That is why **we** decided to keep it with enalapril and no longer measure blood pressure ’*



Mrs. Schöl, one week later

- *‘I am so happy that my blood pressure no longer needs to be measured. I now feel much more relaxed’*
- *‘I prefer a higher risk of dying rather than feeling bad from additional medication’*



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# Promote dialogue between doctor and patient

- The guideline does not define good care, but doctor and patient do in practice
- The doctor prepares her/himself by knowing the guideline
- The patient prepares her/himself by asking the right questions
  1. What are my options?
  2. What are the possible benefits and risks of those options?
  3. How likely are the possible benefits and risks of each option to occur?



Shepherd H, Barratt A, Trevena L, et al. Three simple questions to increase information about treatment options and patient involvement in healthcare consultations. *Patient Education and Counseling*. 2011;84:379–85



# Promote accountable personalised care



- Educate patients and doctors (and policy makers) about use of guidelines and health information
- Promote and teach shared decision making
- Provide tools such as decision aids and option grids
- Encourage use of individual healthcare plans with goal setting

# Recommendations for research

- Do not consider RCT as best design for all questions
- Use mix of qualitative and quantitative methods
- Involve healthcare professionals and patients
- Ensure systematic data collection in practice
- Consider small steps versus breakthrough\*
- Define determinants of successful collaboration (e.g. concerning culture, leadership, attitude, communication)
- Value studies with negative health outcomes

# Recommendations for research: think PICO!

- P: patient population
  - Often heterogeneous, multimorbid
- I: intervention
  - Often complex and multifaceted
  - Long term care instead of short term cure
- C: controle
  - Often usual care
  - ‘Contamination’
- O: outcome
  - Focus on health outcomes that matter most to patients\*
  - Individual goal setting

# Recommendations for policy

- National government supports primary healthcare
- Payment system supports collaboration and coordination of care
- National professional organization produces well-accepted guidelines and guidance
- National patient organization is partner in healthcare policy and system design
- Regions/cantons produce and promote best practices
- Ensure coordination and communication between federal and regional health policy

# A brief future of medicine

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| 2000s       | Disease management       | Quality and safety standards               |
| 2010s       | Integrated patient care  | Collaborative team and patient involvement |
| 2020s       | 'Personalized care'      | Big data and algorithms                    |

Thank you!

