International Journal of Integrated Care

Goderis, Geert et al 2016 Barriers and Facilitators towards an Integrated Chronic Care Model as experienced by primary care health providers. *International Journal of Integrated Care*, 16(6):A78, pp. 1-8, DOI: http://doi.org/10.5334/ijic.2626

CONFERENCE ABSTRACT

Barriers and Facilitators towards an Integrated Chronic Care Model as experienced by primary care health providers

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

Geert Goderis[1], Gunther D'hanis[2], Gert Merckx[2], Wim Verhoevven[2], Pierre Sijbers[2], Dimitri Gaethofs[3], Areski Boumendil[2], Peter Hoffman[2], Jan Palsterman[4], Jo Borloo[3], Bruno Mettepenningen[5], Anne-Cathérine Poelmans[4], Dieter Deplancke[5], Dirk Put[6]

1: KU Leuven, Belgium;
2: Domus Medica, United Kingdom;
3: Lokaal Multidisciplinair Netwerk, Belgium;
4: Samenwerking Eerste Lijn, Belgium;
5: Loco-regionaal gezondheidsoverleg en -organisatie, Belgium;
6: Change With Impact, Belgium.

Background: The highly increased prevalence of chronic conditions challenges the actual health care systems. The Flemish governments has adopted the Chronic Care Model as the mainframe for health policy changes. However until now, there was no major practice change in the way how health care is provided in primary care. Most providers continue to work in the classic way on their own with few multidisciplinary contacts, presence of silos between primary and secondary care, lack of planned population management, little use of existing guidelines... Therefore, the Flemish government ordered Domus Medica, the Flemish General Practice professional organisation, to develop an action research project. The aim of the project was 1. To promote and spread the chronic care model amongst Flemish health care workers; 2. To evaluate both barriers and facilitators towards its implementation.

Method: Domus Medica organised a large survey in 16 Flemish regions. Therefore it put up 1 national and 16 regional steering committees. Each regional steering had to involve as many health care workers in the process as possible. Each committee was free to use its own methods. In total, six different methods were used: electronic survey, survey on paper, face to face interviews, workshops, seminars and 'world cafes'. Most regions used a 'mixed method' approach. Each region had to write down the results into a report. The collected reports were analysed. Barriers and facilitators were listed for each region and then brought together. This 'long' list was analysed by an expert who used the 'Implementation model' (Grol, Wensing) to filter the most relevant items. These results were fed back for validation towards the involved stakeholders: respondents had to mark their agreement on a Likert scale from 1 (strongly disagree) to 4 (strongly agree). Only those items that obtained a score of 3 or 4 by more than 70% of all respondents were selected. This lead to a 'short list' summed up according to the

pillars of the Chronic Care Model. Finally the results were thoroughly discussed leading to a report with recommendations.

Results: 598 people responded to the written surveys and interviews and 943 people participated to the workshops, seminars and world cafes. There was some overlap but in total, more than 1300 different persons participated including about 400 General Practitioners and nurses and 200 physiotherapists and pharmacists. 166 people participated in the validation process. The 'long list' contained 349 barriers and 167 facilitators and the short 'short list' 63 barriers and 39 facilitators. The report for the Flemish Minister of health contained 17 core recommendations. Main barriers remain the concept of patient empowerment and health promotion, multidisciplinary teamwork, integration and continuity between hospital and primary care and between health care and social welfare. Evidence Based Medicine is inadequately acquired, especially by non-physicians. ICT is experienced as thé necessary tool for integration and communication. However in practice it is a source of major concern because systems are often unstable, necessary knowledge to use the systems and to resolve technical problems are lacking and ICT investment is both expensive and time consuming. Two major structural barriers that hamper all evolution towards integrated chronic care were put forward: the payment system that enables a comfortable revenue by fee for service and unfitted organisational structures in primary care, both at micro level (too small business units) as at meso-level (a patchwork of different organisations with overlapping competences). Finally, health care providers would like to be more involved in government initiatives and campaigns. Major facilitators put forward were the existing and well developed health services as well as the recent initiatives to promote chronic care and spread ICT. As such, the existing structures and initiatives must be considered as the basement of future change. The professional commitment of the providers towards their patients and the open mind towards the upcoming change were also put forward as essential facilitators. Finally, providers experience the patients' tendencies to more empowerment and independence as a positive evolution.

Discussion: The strength of this project is the involvement of a large number of Flemish primary care providers into a movement for better chronic care. It also listed essential barriers towards its implementation as well as key facilitators. Its major weakness is its scope, only based on the experience of primary health care providers without involvement of neither social workers, nor secondary care and expert opinion. However, the project enabled a landmark report for the Ministry of Health with key recommendations to successful future nation-wide implementation of chronic care.

Keywords: barriers; facilitators; implementation; chronic care