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CONFERENCE ABSTRACT

Towards more goal-oriented care through care coordination and care planning.

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The increasing aging of our society is putting increasing pressure on the current organization of care and support. This moved the Flemish government to a thorough reform of primary care in Flanders. This was started in 2017. The reform involves changes in terms of content, structural support and instrumental support. All these changes should lead to care and support that can be organized using the principles of integrated care and goal-oriented care. The major challenges are:

- bring about a change in mentality among care providers toward these principles of integrated care and goal-oriented care;

- make a connection between health care and welfare care, as well as between primary care and more specialized care, and align the processes of care and support.

In addition, it is necessary to translate the principles of goal-oriented care into practical tools and accelerate methodology development. We are working together with several partners in Flanders for this purpose.

In goal-oriented care, an important role is reserved for the care coordinator. The care coordinator is the focal point of the care team who, as a member of the care team, takes on the task of:

- maintain an overview of the care process;

- ensure that all care and support, determined on the basis of the person's care or support needs and translated into life goals and care and support goals, is coordinated, monitored and evaluated.

Care coordination in a care process maintains a focus on goals, both the person's own life goals and the care and support goals of the care team.

For implementing qualitative care coordination, the care and support plan is an indispensable tool within the Flemish reform. This care and support plan must:

- allow an overview of the sometimes multitude of care and support goals;

- be a means of communication between the members of the care team (including the person himself and his informal care);

- reflect the extent to which care agreements are met;

- allow the care process to be monitored, evaluated and adjusted if necessary.

In the near future we want to design this care and support plan in a digital way.

The care coordinator must have a wide range of competencies in order to coordinate the care process in a quality manner, including:

- mastering to perfection the methodology of goal-oriented care, interview techniques, conflict management, process guidance, process analysis, coordination and organization skills;

- being the point of contact for the person with a care and support need;

- be able to play the bridge between the person, informal care and professional care providers.

In this presentation, we focus on the role of the care coordinator throughout the care process and the planning aspect. We propose how the Flemish government want to develop this role in the future. We also reflect on the preconditions that are necessary to achieve a solid implementation of this role, and indicate what opportunities we see to promote and accelerate the change in mentality in this regard.