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POSTER ABSTRACT

Integrated neighborhood teams in the chronic care project 'Leuven Cares' (Zorgzaam Leuven)

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Renilde Alaerts[1]

1: University Hospitals Leuven, Leuven, Belgiium

In the city of Leuven, 'integrated neighborhood teams', as the smallest building blocks of primary care networks, work together facilitated by 'Leuven Cares' and driven by population health management and clinical guidelines for the most common chronic diseases.

Primary caregivers from different professional backgrounds and working in the same neighborhood cooperate to provide structured and coordinated care.

The targeted patient groups are their shared most vulnerable population with complex needs.

In 2018 Leuven Cares started founding neighborhood teams. Via a bottom up approach, primary care providers were stimulated to unite in neighborhood oriented networks. Frameworks and local actions for integrated care are elaborated by the neighborhood teams, who act on the level of the neighborhood, while individual teams at patient level do apply them. To start with, risk stratification based on queries in the electronic records helps the teams to indicate what population(s) to focus most on. Than agreements are made for disease management in patients with chronic diseases and care protocols for patients with increased care needs. Stratification helps to see parallelism and complementarity in existing interventions and actions. It also points out where gaps exist that are not covered with usual care. Proactive care, profound coordination of care for complex needs, care planning, empowerment of patients to control their own care process are items that are focused on in the local teams.

More specific, those frameworks make sure that every patient has access to a care plan that is spoken trough and clear. Items of this care plan are medical follow up and coordination of care, medication coordination, healthy lifestyle, mental wellbeing, prevention etc…

An individual care plan structures the fragmented care and supports communication between the individual caregivers. An even more important goal of this plan is the possibility for the individual patient to take control over his own care process. For people who are not capable to coordinate their own care, support can be given by the local network. One team member, with a specific focus takes on a coaching role in care coordination This team member can supervise the individual care process for those who cannot do it alone, or can even take over coordination if needed.

General team processes are supported by the team coach, acting as an operational manager, who assists the team in focusing on the long-term vision, in the implementation of the framework, in gathering data of what happens in the local actions etc.

This results in eight multidisciplinary primary care teams that are progressively engaged to provide integrated care to their shared, most vulnerable population. In these teams up to 60% of the primary caregivers are involved to support the needs of 4000 included patients (October 2022).

Leuven has been our testing ground to develop these co-acting teams. The overall population of this city is already very divers. On the other hand, our model is not tested for smaller less divers cities, and more rural neighborhoods.

Next steps are to find out whether our model is implacable for other environments.

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