D5.1 Readiness of European Regions for Integrated Care

Annex C: Self-assessment process in Flanders, Belgium

WP5 Maturity Assessment for Integrated Care

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Organisations responsible for conducting the self-assessment process in Flanders:

- Flanders Agency for Care and Health
- Flemish Institute of Primary Care

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With thanks to my colleagues from the Agency, VIVEL and all the organisations that participated.

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1 Introduction

The Agency for Care and Health (Flanders) is an agency of the Flemish government for the improvement and protection of the health and wellbeing of all inhabitants of Flanders. The Agency for Care and Health makes sure there are sufficient and high-quality provisions in Flanders for the elderly care, home care, general care and mental care. They also recognise individual healthcare professionals. The Agency helps Flemish residents to live a healthy life and to avoid health risks. The Agency is a part of the Department of Welfare, Public Health and Family.

1.1 Characteristics of healthcare system

Table 1 – Characteristics of the Flanders's Healthcare System

Item	Description
Region	Flanders region in Belgium
Geographical scale	
Geographical size and dispersion (km ^{2})	13.625 km2
Population size(thousands)	6.55 mil
Population density(inhabitants/km^2)	485/km2
Life expectancy (years)	82.4
Fertility rate (births/woman)	1.62/woman
Mortality rate (deaths/1,000 people)	9.55 for BE
Top three causes of death	Lung cancer; suicide; cerebrovascular conditions
Organisation and governance of healthcare services	The Belgian health care system is founded on the principles of • equal access and freedom of choice; • a compulsory public health insurance system covering the whole population with a broad benefits package. The compulsory health care insurance covers almost 75% of all health care expenses. The Belgium healthcare system covers public and private sectors, with fees payable in both, funded by a combination of social security contributions and health insurance funds. With mandatory health insurance, patients are free to choose their medical professionals and places of treatment. The healthcare system includes: • a reimbursement system for ambulatory care (patient pays fee to provider and is then partly refunded).

	• a third-party payer system for inpatient care and pharmaceuticals (the health insurance fund directly pays the provider; the patient only pays the non-refundable part). Flanders adds a Flemish Social Protection layer (FSP) organised separately from, and parallel to, the health insurance system, covering non-medical care expenses by providing material and/or financial support according to people's needs. 2019 FSP budget was 923.937.000,00 €, covering care budgets for the severely care-dependent disabled and elderly as well as mobility aids. The budget will increase as Flanders moves towards a 'person-linked' funding including care in centres for mental health, homes for psychiatric care, sheltered accommodation schemes and physical rehabilitation centres. (FSP budget is 18,20 % of the total 2019 budget of the Flemish Agency for Care and Health, being 5.076.654.631 euro.)			
Healthcare spending (% of GDP)	10%GDP			
Healthcare expenditure (thousands)	3.745€			
Distribution of spending	Budgets are managed by different authorities (federal, regional). Health care reimbursement is managed by the federal – national level: 33% fees physicians; 23% hospital stay; 17% pharmaceuticals; 27% other. Flanders Agency for Care and Health budget for social services: 53.48% residential care; 5.77% rehabilitation; 14% home care; 18.20% Flemish Social Protection			
Size of the workforce (thousands) and its distribution (%)	**In practice**	**In training**	**Belgium**	**Density (per 1.000 inhabitants)**
GP	8.982	661	15.989	14,6
Pediatricians	972		1.975	1,6
Gynecologists	835		1.703	1,3
Psychiatrists	269		977	0,4
Medical specialists	15.401	2.736	28.545	25
Professional carers	77.854		127.513	126,5
Pharmacists	12.028		20.238	19,5

Dentists	5.534	124	9.420	8,9
Nurses & midwives	132.478		191.460	215,4
Physiotherapists	19.130		34.713	31,1
Paramedic professions	35.500		59.917	57,7
Healthcare policies in the country	Primary Care Reform – Integrated care; Hospital of the Future: hospital reform; Mental health care reform: patient centred and involvement of the surroundings of the patient			

1.2 Integrated care in Flanders region

Since the last Belgian State Reform in 2014, Flanders has been engaged in the reform of primary care (integrating health and social care), mental health care, hospital care (strategic care planning) and rehabilitation.

Flanders opts for a comprehensive approach to the reform of health and social care, characterised by a bottom-up approach and focus on multi-disciplinary cooperation and access (for the person with a care need) to specialised care according to his / her personal wishes and priorities. The Primary Care Boards are closest to citizens with care needs and are supported by their Regional Care Platform and the Flemish Institute of Primary Care, according to the needs of their primary care zones. Research and innovation are expected to bring novel digital and technological solutions. In this respect, a Digital Care and Support Plan (DZOP) for a person with a care need will be instrumental while partnering with industry. Other policy measures include: a Flemish Social Protection Plan covering the non-medical costs; an integration of primary, secondary and specialised care; home and informal care; and last but not least, a continued focus on prevention and public health.

2 Self-assessment process in the Region of Flanders

2.1 Identification process of the local stakeholders

The Flanders Institute for Primary Care, VIVEL, was established in May 2019. Its role is to support, facilitate and coach the Regional Care Platforms and the 60 Primary Care (PC) Boards, the latter representing 75.000 up to 125.000 inhabitants. It is expected to have the Boards' fully operational in the second half of 2021. Their role is to strengthen collaboration and coordination between local authorities, primary (health and wellbeing) care professionals, associations of people with a need of care and support, associations of informal carers and volunteers.

The goal is to implement, gradually and on a voluntary basis, the SCIROCCO Maturity Assessment Tool within every PC Board. The results of their self-assessments should give the different Boards a means to compare and learn from another Board. VIVEL and the Agency for Care and Health can use the results for better policy development and planning. The international knowledge sharing will assist and enhance new opportunities.

The first step was to test the self-assessment within the Governing Board of Directors of VIVEL. The Board is composed of 15 members, 12 members participated in the self-assessment. Some participated as an individual, others with their team / other disciplines within their organisation. The organisations participating were:

- Domus Medica (GPs),
- Steunpunt Mantelzorg (Carers (family and friends),
- Ergotherapie Vlaanderen (Occupational Therapy),
- Huis voor Gezondheid (Brussels support for primary health care providers),
- VZW Zorggezind (Home care network for family services),
- Prof Emeritus – University of Ghent,
- Vlaams Patiëntenplatform (Patient Organisation),
- Centrum voor Algemeen Welzijnswerk (Centre for General Wellbeing),
- Zorgnet Icuro (General Hospitals, mental health, elderly care),
- Vlaams Apothekersnetwerk (Pharmacists),
- Wit-Geel Kruis (Home care and nursing),
- Christelijke Mutualiteit (Insurance Company),
- VIVEL (Flanders Primary Care Institute).

2.2 Self-assessment survey

The Maturity Model and the SCIROCCO Exchange Tool were presented and discussed at the end of November 2019 in the Board of VIVEL. On 17 December 2019, the coordinating team (from the Agency and VIVEL) made a first overview. It was then decided to extend the deadline until after the Christmas break to give some respondents extra time. On January 10th 2020, a final overview was made from 12 respondents.

2.2.1 Outcomes of self-assessment survey

The 12 stakeholders filled the online survey, and all of them provided justifications for their ratings, using the Dutch version of the SCIROCCO Exchange online self-assessment tool. The following spider diagrams reflect the diversity of the stakeholders' perceptions on the maturity of integrated care in the Flanders region.

Figure 1- Outcomes of the individual self-assessments

CM – Insurance Company

CAW – Centres for General Wellbeing

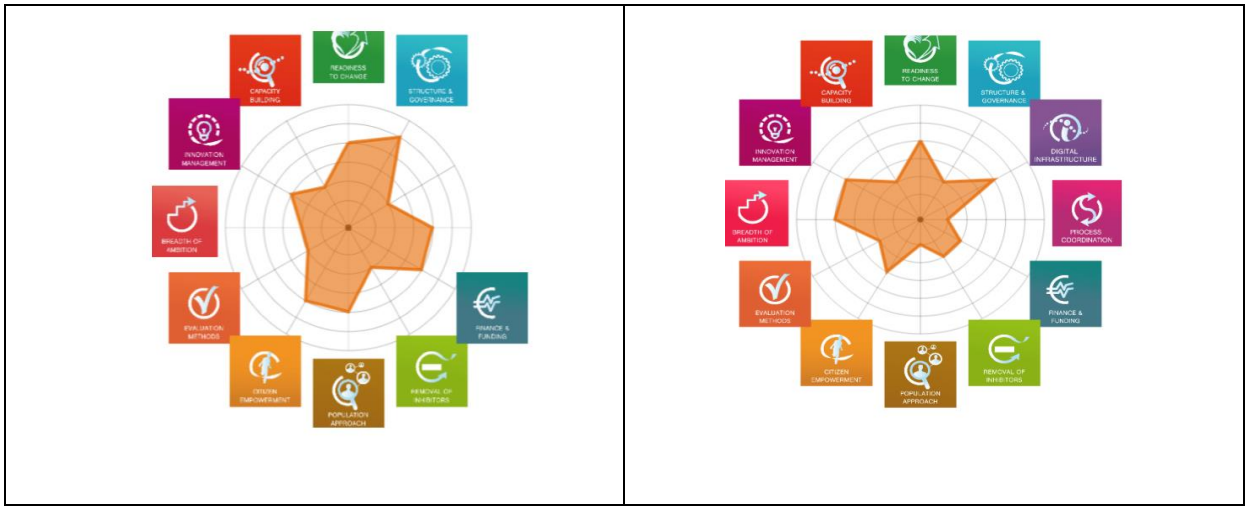
Huis voor Gezondheid - Brussels support for primary health care providers

VIVEL

Vlaams Apothekersnetwerk (Pharmacists)

Domus Medica – GPs

Zorgnet Icuro - General Hospitals, mental health, elderly care	Wit-Geel Kruis (Home care and nursing)
	
VPP – Flemish Patient Platform	University of Ghent – Primary Care
	
Steunpunt Mantelzorg – Carers	Ergotherapie Vlaanderen (Occupational Therapy)



All participants agreed that the individual assessment is more influenced by the context of the moment: e.g. some were concerned about the current savings of the Flanders Government. Due to the complicated state structure of Belgium, the assessments showed more positive or negative outcomes when an organisation only depends on Flanders; or if the organisation has a work field covering Flanders and Brussels; or if the organisation depends on both Flanders and Federal rules and financing.

The scores were often a point of concern, as not every description of the Tool's dimensions fitted the situation of the care professionals. Choices were often made for the score that is closest to the assessor's situation; maybe a score between 1 and 10 might give more room for nuance.

2.3 Stakeholder workshop

Twelve respondents participated in the workshop on 16 January 2020. It was decided to have the workshop from 9.30 till 12.30. The discussion was organised and facilitated around the 8 dimensions where the scores had the largest diversions. Since we aimed for a dynamic workshop in a maximum of 4 hours (half a day), we decided to discuss only 8 dimensions. The workshop agenda included discussion on:

- the use of the Tool and participants' experiences when using the Tool;
- if the assessment was conducted by one person / team or several different disciplines; levels in the organisation; and if the assessment was done from an individual's own perspective; and if the perspective of the organisation considered the Flanders or the Belgium context.
- the consensus building.
- finally, and rather importantly for Flanders, the local implementation by the Primary Care Boards.

2.3.1 Negotiation and consensus building

Figure 2 – Flanders's consensus diagram

The consensus workshop was an interactive and intensive discussion about 8 of the dimensions of the SCIROCCO Exchange Tool where the spread of participants' scores was the largest. We remained in one group and engaged in dialogue together. The respondents with the most divergent scores started by presenting and explaining their rationale for their scores. Together with the more 'moderate' opinions, a consensus was built on which path should/can be taken.

Two facilitators supported the discussion, the discussion was very active and intense in the sense that participants had to move physically according to their scores. After the introduction and the first discussion, the facilitators started the consensus as follows:

'How do we look today at integration of care in Flanders: only from the Flemish policy level? Is this possible or what conflict do we notice with federal level? What are our doubts looking at the description of the scores and why? All these nuances were part of the dialogue and of the consensus".

It was good to have this discussion first before entering into the detail of the consensus because it gave people the opportunity to air some concerns about the description of the different dimensions. Whilst during the individual assessments, the participants were focused on the wording of the score description, but this became less important during the consensus discussion.

The two most divergent scores were observed in the dimensions of "Structure and Governance and "Breadth of Ambition":

Structure and Governance scored between 0 and 4:
Score 0: readiness to change exists, many projects, processes in the primary care reform are set. However, it is unclear what the vision of the new Flanders Government will be. And not only the vision but what the practical approach will be, such as a financial programme and plan.
Score 4: this has been a process of 20 years. Managing to bring the health and wellbeing professionals together is a merit. There is a Roadmap, a consensus, VIVEL – the Primary Care Institute exists, the Care boards are there and in development. Formal working groups have started. Parliamentary Decrees need to be amended and the financial plan should follow.

Breadth of ambition scored 0 and 4:
Score 0: score 0 is not less than 1. The citizen is left to his own devices. There are many initiatives to make integrated care a reality but the integration at local level, by the professional carers, is fragmented. The carer (informal) or the person with a care need are not well supported.
Score 4: there is a lot of ambition in the Primary Care Zones and their Boards. Ambition means the direction we want to move towards. The answers by the respondents were often about the current situation.

2.3.2 Final consensus

Figure 2 – Flanders's final consensus diagram

Table 1: Scores, Justifications and Reflections assigned to each of the dimensions

Dimension	Scoring	Justifications & Reflections
Readiness to Change	Not discussed	Only 8 dimensions where the opinions were most divergent were discussed during the consensus-building.
Structure & Governance	3	There is change on the field. Some were still in favor of score 2, because it is not so clear if the current governance is/can provide the right support. Communication between different levels of governance and between the Belgium' regions could improve. Local social governance needs to be better tuned. Keep on engaging in a dialogue with the work field and continue bottom-up participation. In conclusion: Ensure continuity of the governance and support change management.
Digital Infrastructure	Not discussed	Only 8 dimensions where the opinions were most divergent were discussed during the consensus-building.
Process Coordination	1	Here the influence of the divided competences in Belgium is high. Still the coordination remains medical / disease specific. Process coordination is largely based on care process and not on social processes. The latter was the reason to move the score towards 1. Agreements however exist between some organisations such as the guidelines on intra-family violence, for GPs and social carers.
Funding	1	For the primary care actors, elements like financing and exceptions on regulatory obligations are necessary in the testing phase. If in a later stage, financing cannot be optimal, at least the authorities should work towards additional incentives, such as recognition of the tasks of primary care actors who spend their time and energy in the Primary Care Boards in Flanders (interdisciplinary governance body - 60 boards). The level of financing should be high enough to avoid having to rely too much on volunteers. The Primary Care Boards are expecting a balanced choice and motivation of the financing decision. Informal care (family and friends) and patient participation remains crucial
Removal of inhibitors	Not discussed	Only 8 dimensions where the opinions were most divergent were discussed during the consensus-building.
Population Approach	2	Although we settle on score 2, this approach has still a too much experimental nature. Although the Primary care Zones focus on specific groups, it is not yet supported by a sustainable structured policy. A population-oriented approach is subject to the fragmentation of competences in Belgium. Once the approach involves the local level, it should be clear that it is not an administrative burden and should be patient outcome oriented rather than a financially driven result. Small listing: the Care Atlas is a start towards this approach; although it is true that the process runs less smoothly since various competent authorities are involved.
Citizen Empowerment	2	Until now, not enough policy making; fragmentated initiatives; Increasing the health literacy of people is one part, but the same effort should exist for the care providers that there is a need for self-care and not only curative care.

Dimension	Scoring	Justifications & Reflections
Evaluation Methods	1	Score 1, although the tools and procedures are not yet systematically planned. We look positively to the future with the Flemish Institute for Quality of Care. The Care Atlas (Agency for Care and Health) will provide as of half 2020 data to citizens and local authorities. The comment was made that there is a need to harmonise the threshold values. A good example in Flanders is the evaluation method used for Falls Prevention. Evaluation methods should be user friendly, practical and should be included from the start in projects on integrating care.
Breadth of Ambition	2	The integration between secondary and tertiary care is not structured. No real link exists between primary and secondary care. Some care organisations are linking up but that is on an individual basis. Need for a vision on a common ambition to work together. Should be the task of the authorities to enhance this ambition at every level of integration: horizontally (between and amongst organisations); vertically between the different levels of governance: local, regional, national (when required).
Innovation Management	Not discussed	Only 8 dimensions where the opinions were most divergent were discussed during the consensus-building.
Capacity Building	2	Coordination of integrated care needs to be done on the field. Different approaches are necessary: younger generation is more and more trained for multidisciplinary environments (although university curricula should include it); other generations of carers may have a need of other methods. Lifelong learning is important together with the creation of a 'learning network'. A discussion on capacity building requires the expertise of those involved in change trajectories.

3 Analysis of the outcomes

1. The extent to which the outcomes of the self-assessment reflect the actual maturity of Flanders' healthcare system very much depends on the organisation that performs the self-assessment. Moreover, some organisations are only depending on the Flanders region, others have to combine the Brussels and the Flanders region and some of them are also dependent on the policy making of the Federal level. Most of participants agreed that they were filling in the assessment in the context of that moment. It highlights, however, that the more local you go; the less confidence there is about structural arrangements, while at the regional level confidence is higher. Many organisations take individual initiatives to work together.
2. At the level of the organisations: many of them are moving into working together (health and social care). It definitely shows that ownership gradually comes from the field organisations. The level of enthusiasm of the participants in the discussion was surprising, as was their eagerness to combine both health and social care. What was less surprising was that the awareness of the local health and social care professionals still has a long way to go. The role of umbrella organisations, and the recently started Primary Care Boards, will be necessary to support this process.

3. There are some connections/grouping of specific dimensions which can be observed namely:
    - Digital infrastructure and Structure and Governance: digitalisation is strongly represented.
    - Process coordination and Population management into 'Goal orientated care'?
    - The wellbeing component and social cohesion are less visible? (e.g. healhcare systems could be Care systems or Integrated Care systems)

4. Looking at the overall consensus diagram, there are not many dimensions which one would consider as strengths for the Flanders' region. None of the dimensions scored very high. The dimensions of "Readiness to Change", "Innovation Management" and "Structure and Governance" (after consensus) reached the best scores. There are no dimensions where the maturity was already reached and there is definitely a need for further improvement in them all.
5. There are a number of other specific factors which may have affected the assessment outcomes. These include:
    - Change management is hard to comply with and to change from working in silo's to integration of care;
    - The health care system is still oriented to disease approaches.
    - The Belgian state structure - two levels (regional and federal) both have competences in the way integrated care can be organised. The policy on integrated care for Flanders also needs to be adopted in the Brussels region.

4 Key messages

Some lessons learned can be summarised on the basis of Flander's experience for those interested in organising the maturity assessments process:

- Consider that people will focus on the assessment scales, which may be subject to different interpretation at the stage of the individual assessments. However, the wording of the assessment scales became less important during the consensus discussion.
- Clarify at an early point in the process whether the self-assessment should consider the whole care system (Flanders) or should assess from the point of view of the area of expertise and the zone of the assessor.
- The online Tool was not for practical for everyone to use: be prepared to intercept and pro-actively assist. If not, people may get bored using the Tool.

On reflecting about the SCIROCCO Exchange Tool, the process and the continuation of the Tool: the question was will it be a Tool only for the regional level – meaning the Flanders Primary Care Institute or can it be used by the Primary Care Boards?

Feedback from the participants about the maturity assessment process:

The Tool and the process are inspiring to:

- learn to get to know each other;
- bring in the different contexts, disciplines;
- get out of the individual level or the familiar sector;
- note how during the consensus-building workshop the scores moved towards an average.

The Tool can be used as a means for a future task division or to unfold 'blind spots' to:

- get a comprehensive view of which elements of integrated care are still missing in Flanders's region;
- provide an inspiration for the policy plan of VIVEL;
- provide a means for the different organisations to identify where they can improve the reform process towards person centered care;
- provide a basis for VIVEL to exchange good practices with other countries and regions, as well as internally within Flanders and Belgium;
- provide an opportunity to assist in capacity building at regional level to get people motivated.

5 Conclusions and next steps

In conclusion, Flanders will move on with the use of the Scirocco Exchange Maturity Assessment Tool towards the local level.

1. Within a year or so, VIVEL will use the Tool again;
2. On 31/01/2020, Flanders organised a small workshop with the research community which was very inspiring. Those that participated came from the VUB (University of Brussels), the Ugent (University of Ghent), the King Baudouin Foundation (KBS), the Flemish Institute on Quality in the Care - VIKZ – VIVEL – Chronic Care projects from the Federal level. We agreed to move on and to test (within the research communities and partner organisations) how to amend the SCIROCCO Exchange Tool for the Flanders Primary Care Boards. There was a strong voice to include the Patient Organisations in order to lower the threshold of the text of the dimensions.
3. Next step for the Scirocco Exchange Tool: the development of a business model to use the Tool after the project.

Conditions to make the local implementation successful:

1. A discussion with the partners about whether an extra Dimension on Goal Orientated Care is feasible and desirable to be added in the current structure of SCIROCCO Exchange tool.
2. The Consensus workshop agreed that it would be interesting to offer the SCIROCCO Exchange Tool to the Care Boards. It will help them to structure the dialogue in a uniform

and standardised way which will allow them to discuss the results with other Care Boards. Before reaching this stage, the following should be checked / be allowed to modify:

a. It remains an abstract exercise, so it should be linked to something practical/concrete; some ideas from Flanders:
    i. Use the Tool as the basis of a 'learning network for Primary Care Boards. The first five best Primary Care Boards share information with other Care Boards.
    ii. Use the Tool within the context of a Knowledge Platform.
b. Clarify the questions about the content and structure of the SCIROCCO Exchange Tool and discuss with the project partners if the following can be considered:
    i. Social Cohesion and Welfare – wellbeing should be a clearer focus in the Scirocco Tool. Current focus is on the 'Health Care Systems'.
    ii. Carefully look at the description of the dimensions and see if digitalisation is not dominant. (e.g. Dimension 2)
    iii. Although the 12 Dimensions were considered relevant, participants observed that the financial and regulatory elements were understandable from a regional point of view but less so from a local level. We are looking forward to hearing about the experience of the regions where the local levels have used the Tool.
c. Tailor the text to the users in the Flanders Primary Care Zones (together with Research Community, Patient Organisations):
    i. The translation of Population Based Approach is not "Public Health Approach" (Volksgezondheidsbenadering)
    ii. The meaning of Risk Stratification is not adapted to the Flanders context.
    iii. Use process facilitators and foresee them also facilitating the process for the local Care Boards.

Annex 1 - Self-Assessment Workshop in Flanders Region – Agenda

Donderdag 16 Januari 2020

Herman Teirlinck gebouw – 01.16 Rik Wouters, Havenlaan 88, 1000 Brussel.

8.30 – 9.00 Welkom
9.00 – 9.40
Inleiding en bespreking toepassing Assessment Tool door Caroline Verlinde - VIVEL
Vooraf een korte reflectie door iedereen die de Assessment invulde over de context en de invalshoek van zijn/haar 'individuele' assessment, zoals: eigen invalshoek ; invalshoek van de organisatie; rekening houdend met Vlaamse en / of Belgische context.
9.40 – 12.15:
Bespreking van de scores – dialoog - consensus
Thomas Boeckx en Anneleen Craps (Z&G) faciliteren de discussie. Sol Wallyn en Elke Verbesselt (Z&G) nemen nota. We proberen kort terug te koppelen na iedere bespreking.
De dimensies die worden voorgelegd: 1. Dimensies waar de scores het verst uiteen liggen: a. Structuur en goed bestuur (0-4) b. Omvang van de ambitie (0-4) 2. Dimensies met een verschil van 0 – 3 of 1 -4: a. Mondig maken ('empowerment') van de burgers (1-4) b. Procescoördinatie c. Evaluatiemethoden d. Capaciteitsopbouw e. Volksgezondheidsbenadering f. Financiering
Hoe: We blijven in één groep en gaan met elkaar de dialoog aan. De dialoog gebeurt in de eerste plaats door de uitersten in de opinies voor te leggen en uit te leggen. De individuele assessments in pdf liggen geprint klaar voor hen die deze vergat. De facilitatoren (Thomas – Anneleen) leiden de dimensie in, en vragen aan de 'uitersten' om zich te positioneren en hun argumenten naar voren te brengen. Samen met de meer 'gematigde' opinies hopen we dan tot een consensus te komen en te verduidelijken welke weg moet / kan worden ingeslagen en wat nodig is.
Een inschatting van de tijd: 20 minuten per dimensie.
Koffie / thee zijn beschikbaar tijdens de besprekingen.
12.15 – 12.45
Wat nu verder met de Maturity Matrix Tool? – Sol Wallyn
De finaliteit van onze oefening is om in te schatten of deze tool in Vlaanderen kan gebruikt worden en onder welke voorwaarden: - Voor de Vlaamse beleidscontext? - Voor de Eerstelijnszones?
Sandwiches voorzien vanaf 12.30