

Integrated care cases

Integrated care requires integrated supervision

Corry A.J. Ketelaars, PhD, Senior Inspector, Dutch Health Care Inspectorate, 's-Hertogenbosch, The Netherlands

Correspondence to: Corry A.J. Ketelaars, Health Care Inspectorate, PO Box 90137, 5200 MA, 's-Hertogenbosch, The Netherlands, Phone: +31 73 6207365, E-mail: ca.ketelaars@igz.nl

Abstract

Introduction: Given recent developments in integrated care, it is becoming increasingly important for the Dutch Health Care Inspectorate to direct its supervision in a way that may help speed up the implementation of integrated care.

Description of care practice: Since the implementation of integrated care for chronic patients is facing obstacles, alternative methods are required to ensure that the implementation process does not run into any delays. By applying a risk-based approach to integrated care providers, the Inspectorate can analyse the care providers' performance by means of quality indicators and rank them. In order to be effective, appropriated supervision arrangements will be applied to the care providers of integrated care.

Discussion: With a ranking model transparency will be improved and this may encourage integrated care providers to strive for greater quality due to the competition inherent in the system. Supervision based on advice and encouragement might be helpful in the implementation of integrated care.

Conclusion: Integrated care also requires integrated supervision, which means the Inspectorate may have to reconsider its working methods and the composition of its inspection teams.

Keywords

inspectorate, external supervision, integrated care

1. Introduction

Chronic illness has become the main cause of disability and death in the Netherlands. Despite recent advances, the Dutch health care delivery system is still highly fragmented, which has resulted in poorly integrated care [1]. The current Dutch system is focused on curing acute illness or individual medical conditions rather than managing patients with multiple chronic conditions. While it is now widely accepted that a strong primary health care system can help improve co-ordinated health care, the Dutch system has only recently begun to move in that direction. Since 2008, the Ministry of Health has introduced policy reforms and enabled new forms of integrated care in combination

with an integrated payment system. This programmatic approach is founded on health care standards in which the minimum requirements for good-quality health care for a particular condition are laid down from the patients' point of view. These standards are drawn up and adopted by patients' representatives, health care providers and health insurers. The standards consist of building blocks such as recognition at an early stage, prevention, education and self-management, diagnosis, treatment and supervision. Particular standards are linked to particular health care chain indicators in order to be able to measure health care outcomes. The various health care standards can be converted into individual treatment plans, depending on patients' individual health care needs. This also means that health

care can be tailored to the needs of patients with multiple chronic conditions.

Under the recently implemented Dutch integrated payment system, health care insurers pay not for a patient to see a certain care provider, but rather for whatever that care providers do for the patient (e.g., advice on how to quit smoking, application of self-management, physical examination). In cases where patients are suffering from diabetes, cardiovascular risk management or chronic obstructive pulmonary disease (COPD), and receive care in accordance with the relevant health care standards, multi-disciplinary care groups negotiate with health care insurers a certain total fee per patient per year for which they will receive all the care they require.

Such integrated care programmes with an integrated payment system for diabetes, cardiovascular risk management and COPD are currently being implemented throughout the country. However, there are still many obstacles to be overcome, such as applying theoretical health care standards in practice, converting health care standards into individualised treatment plans and addressing coordination of care and responsibility issues as care is delivered by multiple care providers.

1.1. Problem statement

Integrated care will not be supported adequately unless the monitoring by the health care inspectorate is similarly integrated. The introduction of integrated care in the Netherlands will change the way in which the Dutch Health Care Inspectorate externally monitors the health care system. At present there is no supervised integrated care for patients suffering from diseases such as COPD or diabetes. In addition, the fact that integrated care is provided through multi-disciplinary care groups means that hospitals, general practitioners and physiotherapists can no longer be supervised separately and on an individual basis. The Inspectorate will have to reconsider its methods and the constitution of its inspection teams in order to be able to stimulate the implementation of integrated care. This case study discusses how a regulator can best work with multi-disciplinary care groups providing integrated care.

2. Case description

2.1. External supervision

While it is a matter of course that responsibility lies with the health care providers themselves to deliver high-quality and safe (internally monitored) care, health workers in the Netherlands also recognise the benefit and necessity of external supervision. The Dutch Health Care Inspectorate is an independent regulatory author-

ity which falls under the jurisdiction of the Ministry of Health. One hundred fifty inspectors monitor the national health care system and promote safe and high-quality health care. In addition, they make recommendations to the Minister of Health. The Inspectorate aims to discover good practices and use them as examples and benchmarks in order to eliminate any great disparities in the quality of care provided throughout the country.

Ngo, Breejen, Putters and Bal have studied the way in which the quality of health care is monitored in different countries, what kind of tasks the various inspectorates perform and what formal competences the inspectorates have [2]. They came to the conclusion that monitoring practices vary widely between countries and that monitoring systems are changing all the time due to ever-changing trends in health care. They also observed that the delivery of health care is becoming increasingly transparent in all markets analysed, and that the responsibility for health care is becoming increasingly decentralised, which means that inspectorates are facing changes in the way they deal with their tasks and responsibilities.

2.2. The Dutch Inspectorate's organisational structure, working methods and instruments

The Dutch Health Care Inspectorate is a decentralised organisation whose jurisdiction is divided into four separate regions. Each regional inspectorate carries out supervision programmes, focusing on such areas as handicapped care, mental health care, care for the elderly, curative care and primary health care, and monitors institutions such as nursing homes and hospitals, as well as individual health care professionals such as general practitioners. One important aspect of the Inspectorate's 2008–2011 policy plan [3] is a shift in focus from monitoring health care institutions (e.g., hospitals, nursing homes) to supervision of the care provided to certain groups of patients, e.g., chronically ill patients. Over the next few years, more Inspectorate's employees will be reassigned to the supervision of integrated care.

The Inspectorate currently employs four distinct working methods [2]. First, it employs theme-based regulation directed at specific care issues. The aim is to obtain an insight into the effects of government policy at the national level, or into specific bottlenecks in the delivery of care. Under this policy, the Inspectorate will randomly select health care institutions throughout the country and carry out in-depth studies of specific aspects of the care delivered at these institutions, e.g., intensive-care units, private clinics, drug safety, etc.

The second method used by the Inspectorate is incident monitoring in the event of serious problems or

calamities. If serious problems arise in the delivery of care, the Inspectorate will conduct an investigation into the cause of the problem, its consequences for the quality of care and ways to prevent recurrence of such problems in future.

Third, the Inspectorate audits health care organisations as a means of examining the safeguards which have been implemented to ensure that patients are receiving quality care. To ensure that such audits are effective, a risk-based three-stage method has been introduced in which each step along the supervision path acts as a filter to the next step. In Stage 1, health care organisations report on their own performance as assessed by a set of quality indicators. In Stage 2, health care organisations which show poor performance per these indicators are audited by the Inspectorate's officials. In Stage 3, the Inspectorate takes drastic (disciplinary) actions to ensure that steps are taken to restore the quality of care provided at the hospital or health care professional concerned.

Fourth, the Inspectorate advises the Minister of Health on important issues regarding health care, either upon the Minister's request or of its own accord.

The Inspectorate has several instruments at its disposal, both proactive (aimed at prevention) and reactive (sanction-based), all of which can have major or minor implications. Proactive instruments used by the Inspectorate include advice and encouragement aimed at improving the quality of the care provided. Furthermore, after investigating certain wrongs, the Inspectorate may make recommendations and urge organisations to draw up improvement plans or take appropriate measures. If these corrective measures are not effective, the Inspectorate may take action under administrative law, whose sanctions include fines, coercion enforced by law or forced closure of a ward or hospital. Finally, action may be taken in accordance with criminal or disciplinary law. The Inspectorate may lodge a complaint with the Disciplinary Committee, which is responsible for imposing disciplinary sanctions by striking a professional from the register or banning him temporarily from practising his profession. In practice, the Inspectorate's officials do not often exercise this power. Thanks to its independent status and widely acknowledged expertise, the Inspectorate wields a certain authority in the field, which means that its advice is usually acted upon and problems are generally solved without any need for legal procedures.

2.3. Implementation of integrated care

In 2008, the increasing prevalence of chronic illness, the problems inherent in an ageing society and the realisation that the existing health care system was

inadequate for patients suffering from chronic illness prompted the Dutch Ministry of Health to launch an integrated-care policy with a programmatic approach for the chronically ill [1]. The keywords of the new policy are patient-oriented and fully integrated care, encompassing early recognition, prevention, self-management and adequate multi-disciplinary care, and a transparent system indicating quality of care. Cost efficiency is achieved by competition between the various health insurers and health care providers, and through the introduction of an integrated payment system based on so-called 'chain care diagnosis-based cost calculation' (chain care DBC). The implementation of integrated care with integrated fee payment for diabetes, COPD and cardiovascular risk management commenced in 2010. More and more care groups are being established throughout the country. Such care groups are multi-disciplinary collaborative network ventures. By 2009, 90% of all Dutch general practitioners were involved in a care group.

It is worth pointing out that the Dutch Ministry of Health never intended to lay down clear organisational regulations for integrated care. The way in which health care is delivered may differ from place to place, depending on the local situation. However, each care group providing integrated care must meet the requirements laid down in the health care standards, and the way in which the system is financed provides an incentive to provide co-ordinated care. As for government involvement in the health care system, the Dutch system can be positioned, on an international scale, somewhere between countries with a national health service, such as the United Kingdom, and countries where the market approach in organising and financing health care is dominant, such as the USA [4].

3. Discussion

3.1. Obstacles to the effective implementation of integrated care

The recent health care reforms may be seen as the first careful steps towards a more fully integrated health care system in the Netherlands. However, several authors have voiced concerns about the integrated-care approach [5–7], stating that bringing professionals together in care groups does not necessarily lead to integrated care. For instance, integration can be improved by sharing electronic patient medical records between various hospitals, general practices, etc. which as yet is not standard practice. Second, the integration of primary and secondary care in care groups does not yet imply that the care provided by such groups is well-attuned to home care and com-

munity services, since services in these sectors tend to be financed by different funding streams and insurance regimes. Third, the existence of care groups with contracted primary care workers and hospital specialists may undermine the patient's freedom to choose his or her own health care provider, which may in turn affect the patient's self-management. The freedom to choose one's own care provider is considered a fundamental patient's right in the Netherlands.

The market of health care providers poses another problem. Ideally, care groups should look after the interests of patients suffering from different types of chronic illness, because of the likelihood of comorbidity and multi-morbidity. However, competition between care providers results in all kinds of initiatives, causing some care groups to focus exclusively on one specific medical condition (e.g., diabetes). At present, it is unclear whether care groups will treat all major chronic conditions, and whether they will be able to tackle any co-ordination issues which might arise from their treating multiple conditions.

Recently, Dutch policy reforms have been met with considerable resistance, predominantly because it is difficult to change long-established traditions, providers' and patients' expectations and practical habits. Doctors feel threatened by the structural changes initiated by policy-makers. Many doctors complain about the increased reporting and documentation duties that come with the newly instituted quality indicators. Transparency and bench-marketing tools are seen by some doctors as an attack on their independence and professionalism, as is the introduction of case managers and nurse practitioners in the primary care setting.

3.2. Supervision of integrated care using a ranking model

Since the implementation of integrated care is facing such resistance and obstacles, alternative methods are required to ensure that the implementation process does not run into any delays. The Dutch Health Care Inspectorate may serve as one such driving force behind the rapid implementation of integrated care. As mentioned above, one of the Inspectorate's working methods is a risk-based three-stage method. By applying this risk-based approach to integrated care providers for chronically ill patients, the Inspectorate can in Stage 1 analyse the care providers' performance by means of quality indicators. As stated above, Dutch patients are supposed to receive diabetic, COPD and cardiovascular care in accordance with certain care standards, which in turn feature quality indicators. The Inspectorate distinguishes two kinds of quality indicators. First, there are indicators measuring the outcome of

care at the patients' level, e.g., the percentage of diabetic patients with HbA1c >53 mmol, the percentage of diabetic patients with retinopathy, the percentage of smokers among patients with COPD, or the percentage of patients with a body mass index (BMI) >25. Second, there are indicators measuring the quality of the integrated care organisation, e.g., the percentage of patients with an individual treatment plan, the percentage of patients with (electronic) multidisciplinary record, the percentage of patients with a care co-ordinator or case manager, etc. As health care organisations in the Netherlands are required by law to report annually on their own performance, the Inspectorate is able to obtain a clear picture of how well integrated care groups are performing. The Inspectorate can then use the information obtained from these quality indicators to rank the various integrated care groups for her risk-based three-stage ranking method. Class-1 integrated-care providers are care providers who have been shown to perform well or very well; class-2 providers have shown average performance; and class-3 providers have displayed below-average performance.

By ranking integrated care providers, the Inspectorate obtains a picture encompassing a small group of leaders, a majority of average care groups and a small group of stragglers in the field. The Inspectorate will then reward the first group with a special distinction, e.g., by promoting them as 'best practice'. The second group will be guided and encouraged to write improvement plans and implement improvements themselves. The third group will be visited by the Health Care Inspectorate, which will then draw up inspection reports. Following each visit, the Inspectorate decides whether the care group concerned must be required to make improvements and, if so, how much time it will be allowed to make the said improvements. If the care provider fails to take appropriate action, the Inspectorate may impose a regime of 'enhanced supervision' which may include additional inspection visits or intensive follow-up activities, among other things. Measures under administrative and disciplinary law may be taken if this is felt to be necessary. However, legal sanctions are not considered an appropriate tool at this stage of integrated-care development, for one reason because it is not yet clear at the time of writing to which extent the quality indicators are valid and reliable (more research has to be done in this area), and for another reason, because some care groups have only just begun implementing the care standards and may need more time to consolidate this process.

The information obtained from the quality indicators and the ranking model will improve transparency and may encourage integrated care providers to strive for greater quality due to the competition inherent in the system. In this way, the ranking model may encourage

care groups to make major improvements. After all, every organisation wishes to be the best in their field. Moreover, the Dutch Health Care Inspectorate publishes its findings on care providers on the Internet as a matter of policy. By providing such transparency on the quality of the nation's care providers, the Inspectorate may contribute to improved care. However, the Inspectorate is mindful of the fact that inspecting the quality of health care is not just about assessing organisations and steering them towards quantifiable results. It is also about creating trust, improving organisational learning and balancing public, private and professional responsibilities with an eye to improving quality and safety. Supervisory arrangements will have to address these issues in order to be effective and legitimate.

3.3. Changing the Inspectorate's methods and the constitution of its inspection teams

In addition to current methods such as the ones described above, the Inspectorate has gained a better insight into how to measure the quality of integrated care by carrying out studies aimed at identifying indicators which in turn might provide an insight into the performance of chains as a whole, by means of a clinical logic model [8].

On the other hand, the Inspectorate's current programmatic organisational structure could benefit from a degree of rethinking. Some of the Inspectorate's programmes function more or less like vertical silos, in that they operate with little interaction between them. As a result, some inspectors perceive a distance between the various programmes, which prevents a unified approach in which knowledge gained in multiple settings is combined and utilised. A unified approach would be beneficial in that it stimulates the exchange of knowledge between inspectors working in different areas of the health care system, an increasingly important factor in the development of integrated care. Integrated care

thus requires multi-disciplinary inspection teams consisting of inspectors from various programmes, e.g., preventive care, mental care, pharmaceuticals, curative care and primary care. That said, inspections carried out by multi-disciplinary inspection teams inevitably present many challenges, not least in shaping the various professional approaches, values, cultures and leadership and management skills into a workable whole.

4. Conclusion

The implementation of integrated care is facing an interesting challenge in the Netherlands. The Dutch Health Care Inspectorate may help health care providers implement more fully integrated care by using effective supervision methods such as advice and encouragement. Publishing inspection results may also contribute to a speedier implementation process.

Since integrated care requires integrated supervision, the Inspectorate itself will have to undergo some changes. In addition to current methods, the Inspectorate hopes to gain a better insight into how to assess the quality of integrated care. Therefore, the Inspectorate is considering establishing new multi-disciplinary inspection teams assigned with monitoring integrated care for patients suffering from chronic illness.

5. Reviewers

J. van der Zee, PhD, Professor, Chair of Primary Health Care Research at the Department of International Health, Faculty of Health, Medicine and Life Sciences, Maastricht University, The Netherlands

H.J.M (Bert) Vrijhoef, PhD, Professor Chronic Care, Maastricht University Medical Center, Tilburg University, Department of Integrated Care, TRANZO, The Netherlands

Nick Goodwin, PhD, Senior Fellow, Policy, The King's Fund, London, UK

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