Coordination issues in the Dutch health care system

Issues in transferring older patients between different care units

Leyden Academy

ON VITALITY AND AGEING

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1. Information sharing in the Dutch health care system

1.1 Background

This report focuses on coordination issues regarding older clients in the Dutch health care system. The health care system itself will not be described. For more details on the Dutch health care system, please consult the previous report, entitled *The Dutch health care system – An overview of the three main laws, and potential policy reforms.* In this report, coordination is considered to relate to two concepts: (1) information-sharing, and (2) definition of roles and responsibilities. Through good coordination of care, the client is guided through the many difficult pathways in health care in an effective and timely manner, ensuring that the patient is kept informed and satisfied. Details on information-sharing and the definition on roles in the medical care, long-term care, and social support sector in Dutch health care system is provided in the next paragraphs. Details on coordination between these sectors is explained thereafter.

Overall, coordination of care in the Dutch health care system is hindered by bureaucracy, diffuse information collection (due to the existence of multiple information systems) and legislation.

- *Bureaucracy.* Because of the many organizations active in the Dutch health care market, and because of legislation to prevent misuse of health care, clients have to collect information, fill in forms, collect formal evidence, and wait for response when they apply for health care. This bureaucratic system makes health care time-consuming and more expensive. Box 1 (next page) offers an example of the bureaucratic nature of the Dutch health care system.
- *Diffuse information collection.* Many different information systems are used in the Dutch health care system. In the medical care sector, every health care provider collects its own information of clients. The AIS, HIS and ZIS stand for information system used by pharmacists, general practices and hospitals respectively. Only authorized personnel of a health care provider may log into the information system of the health care provider to track individual client data. In the long-term care sector, organizations share a common information system on client data, called AZR. In the social support sector, every municipality collects data in its own manner. Information-sharing between the different information systems is thwarted by legislation (next page) and competition. Also, because of the competitive nature of the semi-free market system of Dutch health care, providers are not inclined to easily share information with each other.
- *Legislation.* The use of information systems to obtain and sustain effective information-sharing between health care providers may not conflict with privacy rules and regulations. A famous

example of such a conflict is the failure to install a national electronic patient information-sharing platform (EPD) in the medical care sector. A proposed law that would make instant data-sharing between medical care providers possible in certain situations, was put to a halt by the senate in 2011, mainly because of privacy concerns.

Box 1: An example of bureaucracy in the Dutch health care system

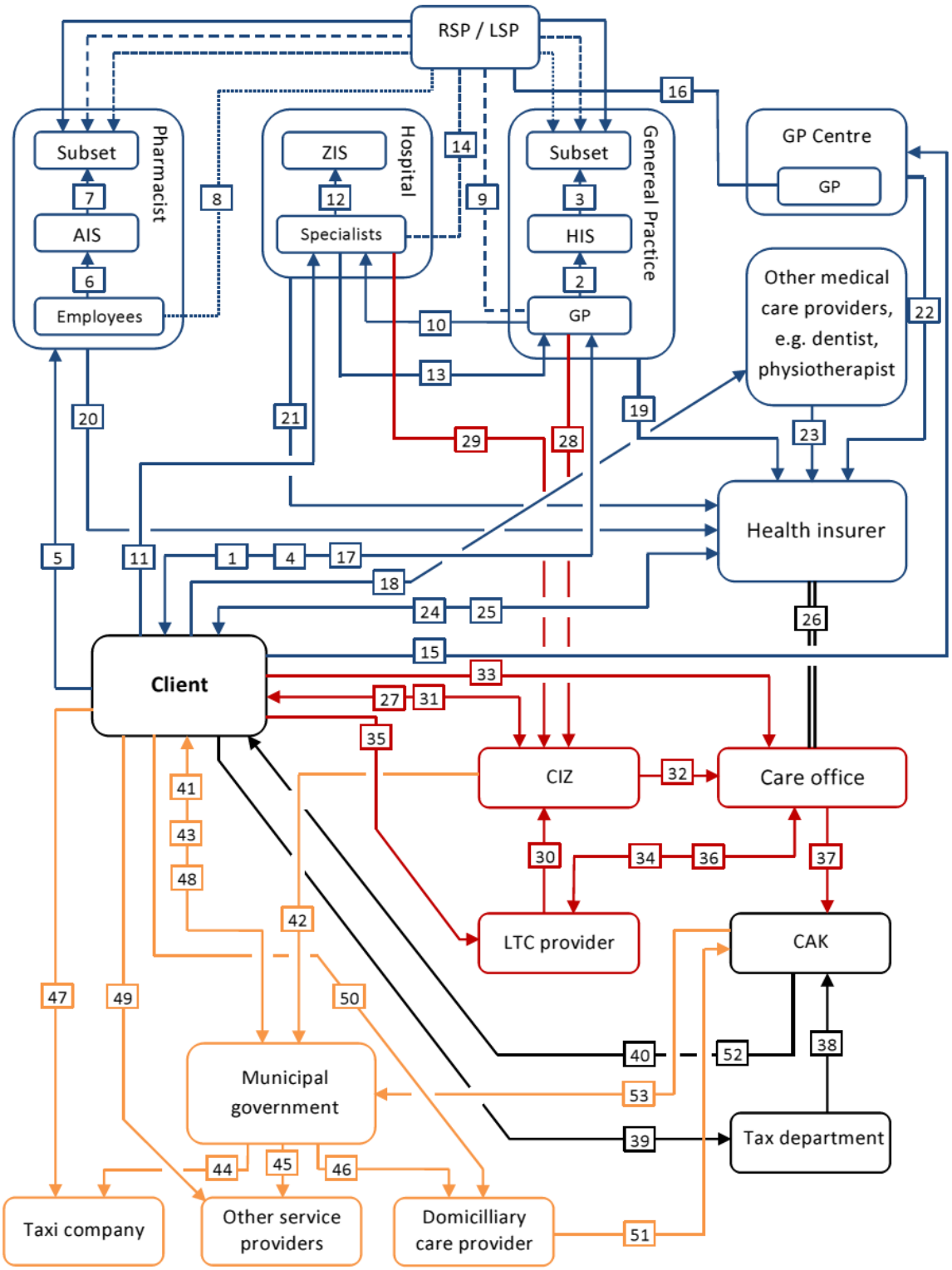
Mrs. X is terminally ill and receives domiciliary care and home care. She fell on Wednesday April 10, and had to wait for 2 hours before a family member coincidentally found her lying on the floor. Her children decide she needs an alarm that can be worn around the neck. After browsing the internet, they find that such an alarm is compensated by the health insurer. They apply for an alarm at a domiciliary care provider on the next day. The provider informs the children that they need a proof by letter from the acting physician. They call her GP, who sends the proof to the provider on Friday April 12. On Tuesday April 16, the provider calls and informs the children that it has no contract with the health insurer of Mrs. X. They need to pay for this alarm out of pocket, or apply at a different provider. They decide to apply at another provider, who has a contract with the health insurer. They have to ask the GP to send a new letter of proof, and finally receive the alarm on Monday April 22. Unfortunately, mrs. X passed away on that same day.

An oversight of information-sharing flows in the Dutch health care sector is given in figure 1.

1.2 Coordination issues in the medical care sector

Information exchange between the many different providers in the medical sector is relatively slow and incomplete in the Dutch health care system. This is mainly due to legislative and technological issues. Legislation basically stipulates that sharing information about personal data, health status and health care utilization is illegal, unless certain conditions apply. This is a consequence of the “duty of confidentiality” that every health care professional and institute has. The premise of this duty of confidentiality is that health care professionals and institutes cannot share private information of clients (in particular their health status), health related matters that have been discussed in the consultation room, as well as (medical) treatments that have been prescribed. However, the duty of confidentiality may be overruled, but only in certain situations.

Figure 1: All possible information-sharing flows between health care institutes and/or professionals in the Dutch health care system (Source: Leyden Academy).



1. The client visits the GP and shares information on his/her personal data, health and wellbeing.
2. New diagnoses and new treatments are stored in the HIS by the GP or assistant.
3. Important information about the client's diagnoses and treatments are stored in a separate subset of the HIS for the RSP/LSP.
4. If necessary, the GP can give the client a referral note for medication or other forms of medical care.
5. By purchasing medication and giving feedback on any side-effects, the client shares informa-tion with the pharmacist.
6. The pharmacist stores information on medica-tion use and potential side-effects in the AIS.
7. Important information about the client's medication use and side-effects is stored in a separate subset of the AIS for the RSP/LSP.
8. If necessary, the pharmacist can check important information from the GP on the client through the RSP/LSP.
9. If necessary, the GP can check basic and crucial information on medication use and side-effects from the pharmacist through the RSP/LSP.
10. If necessary, the GP can directly refer the client to a specialist.
11. The client visits the specialist and shares information on his health and wellbeing. The hospital collects his personal data.
12. Diagnoses, treatments, and scan and test results are stored in the ZIS.
13. After the consult, the specialist sends a letter to the GP, in which he summarizes the client's visit in terms of new diagnoses, medication, test and scan results, and others.
14. If necessary, the specialist can check important medical information of the client with the GP or pharmacist through the RSP/LSP.
15. In case of emergency, or when the client's GP is unavailable, the client can visit the GP center.
16. If necessary, the substituting GP from the GP center can check important information with the GP or pharmacist through the RSP/LSP.
17. If necessary, the GP can refer the client to an allied health professional (e.g. physiotherapist or psychotherapist). The client usually receives a referral letter for this.
18. The client visits the dentist or an allied health professional and shares information on his/her health and wellbeing.
19. The GP sends individual bills to the health insurer of the client.
20. The pharmacist sends individual bills to the health insurer of the client.
21. The hospital sends individual bills to the health insurer of the client in the form of coded DOTs.
22. The GP center sends individual bills to the health insurer of the client.
23. Other medical care providers sends individual bills to the health insurer of the client.
24. The client is enlisted with a health insurer. The insurer therefore has his/her personal data.
25. The health insurer may send copies of bills to the client, or charge the client with deductibles or client contributions.
26. The health insurer with the highest market share in an AWBZ region is obliged to act as the care office for this region. Legally, the health insurance branch of the company may not exchange client information with the care office branch, but this does happen in practice.
27. If the client requests an AWBZ indication, he/she shares personal data and information on his/her health, wellbeing and social surrounding with the CIZ.

28. If required for the indication, a CIZ employee can request information from the GP. The client first has to give explicit permission.
29. If required for the indication, a CIZ employee can request information from a specialist. The client first has to give explicit permission.
30. If required for the indication, a CIZ employee can request information from a current LTC provider of the client. The client first has to give explicit permission.
31. The CIZ sets an indication for AWBZ care and sends the indication decision the client.
32. The CIZ also sends the indication to the care office.
33. The client informs the care office on his/her LTC preferences and needs.
34. The care office checks if a LTC provider is able to provide the indicated care.
35. If so, the LTC provider commences with LTC provision, collecting information on the client's health, wellbeing and personal preferences to provide the best possible care.
36. The LTC provider sends messages to the care office, containing information on the start and end of LTC provision, and possible changes.
37. These messages on the start, end and changes in LTC are forwarded to the CAK.
38. The CAK receives information on the client's financial status from the tax department.
39. The client has already shared information on his/her financial situation with the tax department by filling in tax declarations.
40. The CAK gives feedback to the client on his/her LTC use, and charges a client contribution.
41. The client applies for WMO services by filling a form, and sending it to the municipal government.
42. The municipal government can second indication-setting to CIZ. In this case, the CIZ sends an official indication to the municipal government.
43. The client receives a letter about the indication decision for WMO support.
44. When the client is eligible for transportation services from the WMO, this is forwarded to the assigned taxi company.
45. When the client is eligible for other services from the WMO (such as instrumental aids), this is forwarded to the assigned service provider.
46. When the client is eligible for domiciliary care services from the WMO, this is forwarded to the assigned domiciliary care provider.
47. Some municipalities ask the assigned taxi company to collect information on the client's use of transportation services for billing purposes.
48. Some municipalities ask the client to collect information on his/her use of transportation services for billing purposes.
49. When the client receives other services from the WMO, he/she shares information on service needs with this service provider.
50. When the client receives domiciliary care services through the WMO, he/she shares information on service needs with the domiciliary care provider.
51. The domiciliary care provider is often asked by the municipal government to share information on the client's use of domiciliary care services with the CAK.
52. The CAK calculates the client contribution for domiciliary care services and charges the client.
53. The collected client contribution is forwarded to the municipal government.

These situations can be categorized into roughly four cases:

1. *Force majeur:* Other laws have priority over the duty of confidentiality.
2. The information that is shared is required by other health care professionals directly involved in the treatment relationship with the patient, such as colleagues, nurses, and assistants.
3. Patient consent to sharing information can be reasonably assumed (patient consent is implicit).
4. The patient has explicitly granted the health care professional or institute the authority to share information with specific other professionals or institutes.

After it is assessed that information-sharing is possible, the actual information exchange is hindered by technological issues. For example, some medical specialists send patient information (for example, feedback on consults or newly prescribed medication) to the GP by letter. GPs then sometimes receive this feedback on potentially new diagnoses, prescriptions and treatments after a delay. Currently, new possibilities are researched or followed through to effectuate improved information-sharing between medical care providers. For example, regional collaborations are initiated with a so-called Regional Switching Point (RSP). The RSP offers a web portal where a medical professional can find a patient's personal information. On the basis of this information, the professional can, with the use of an authorization card (called an UZI-card) and reader, look for basic medical information in another health care provider's information system. This will make medical care provision more efficient, also promoting timely health care and reducing mistakes due to lack of information. Important for older people in this context is the prevention of unnecessary polypharmacy.

1.3 Coordination issues in the long-term care sector

The AWBZ Care Registration system (AZR) is the information-sharing platform for the different institutions active in long-term care. The CIZ, the CVZ, the CAK, the different care offices, and long-term care providers have access to AZR. AZR is an information system that displays client-level information regarding AWBZ care, including previous and current indications and long-term care utilization. The AZR-system is updated regularly – in accordance with different health insurers (care offices), the CIZ, and the Ministry of Health, Welfare and Sports. Coordination issues in the long-term care sector mainly relate to indication-setting. Illnesses can progress fast and diagnoses can change. Also, indications can be set for a short period of time. Consequently, it is not uncommon that clients, or someone from the network of the client, has to continuously apply for new indications. This is problematic, considering that the procedure of indication-setting is a time-consuming administrative process.

1.4 Coordination issues in the social support sector

Municipalities are currently faced with issues in communication and information-sharing, mainly because of the quasi-market system:

- A single information-sharing platform with standardized messaging is missing. This means that, for example, a municipality receives batches of information from the client, an indication-setting organization, and the service providers. This leads to administrative hassle.
- Problems with the delivery and quality of WMO-services are not always known to the institutions involved in the WMO. This is most striking in the case of transportation services. Because of budgetary constraints, the taxi company with the lowest fares is often chosen as the proper candidate for transportation services. This can have detrimental effects on service quality: in some municipal regions, people who are dependent on the WMO for transportation sometimes have to wait hours before their taxi arrives. Municipalities or taxi companies are not always aware that clients are unhappy with service delivery, or discard this information.
- Through the quasi-market system municipalities try to achieve maximum efficiency. This can lead to restraints in information-sharing. Because different service providers compete with each other, they prefer not to share information about individual clients or about ways to improve quality and efficiency of service provision.

2. Coordination issues between sectors

2.1 The medical and long-term care sector

The medical and long-term care sector are fall under different legislative acts. The working of the medical sector is arranged through the Health Insurance Act (ZVW) and the long-term care sector is legislated by the Exceptional Medical Expenses Act (AWBZ). Coordination between ZVW institutions and AWBZ institutions mainly takes place during indication-setting. After an indication is set, and the client receives AWBZ care, no more information-sharing is usually necessary. For example, when an indication is set for intramural care, all health care is compensated through the AWBZ when the client enters the long-term care institution (including treatment by a nursing home specialist and medication).

The CIZ uses the funnel model to set an indication. The basis of the funnel model is that the CIZ gains knowledge of the specific illnesses and/or handicaps that the client is suffering from. For this

purpose, the CIZ usually contacts the client's GP or acting specialist to receive information on the diagnoses and/or prognoses. This can only be done after the client has given consent. When a new medical diagnoses is set, or an illness or handicap progresses, it is the responsibility of the client, or someone in the network of the client, to apply for a new indication.

In elderly care, there are instances that a transition of the client from a ZVW to an AWBZ institution takes place. This pertains to a transition from the hospital (or rehabilitation unit) to long-term care unit. When a specialist decides that a long-term care unit is more appropriate for a patient than staying in the hospital, a transfer nurse is usually involved (see paragraph 2.4) .

2.2 The medical and social support sector

A municipality may, just like the CIZ, ask for information about a client's medical status to be able to make an informed decision on an indication. The client has to give explicit permission for this. Some municipalities require all clients who request for a WMO-indication to give permission for medical information retrieval from a treating health care professional. In this case, clients have to sign for this permission in their application form. Transfer nurses may also assist clients with regard to WMO support.

Other health care professionals may also assist the client with requesting a WMO indication. Experiments have been done whereby GPs act as indication-setters for WMO support, but these experiments were deemed unsuccessful. The main reason for abandoning the experiments is a conflict of interest: a general practitioner might benefit from a WMO-indication. A WMO indication can divert some expenditure for the GP to the municipality. Currently, the GP does inform his patients when a service is not compensated through the ZVW, but when they can benefit from social support.

2.3 The long-term care and social support sector

Currently, there is no client-level information-sharing between institutions active in the AWBZ and WMO. This has three major consequences:

1. Clients with multiple care and support needs, often have to tell the same story about their physical and personal circumstances to different institutions. Also, if a client moves from one municipal region to another, the process of requesting WMO support, setting indications and arranging support services starts all over again. If municipalities, care offices, long-term care providers, and social support providers could gain access to one database, where the CIZ reports

indication decisions and the client's care and support needs, the client would only have to tell his/her story once to the CIZ.

2. Some service providers deal with multiple municipalities and care offices. This means that these providers have to deal with different ways in which indications are communicated and compensated. Because communication and billing procedures are unstandardized, service providers suffer from administrative hassle.
3. Every municipality sets its own client contribution fees. The CAK deals with many different contribution fees and arrangements, and communication between municipalities and the CAK doesn't always occur smoothly. Some clients receive numerous recalculations of the CAK because of these reasons, leading to administrative hassles to both the CAK and the clients.

A common information-sharing platform with standardized messaging is needed within the WMO. Further still, developing such a common platform for both the WMO and AWBZ could greatly reduce administrative hassles for different parties in the long-term care and social support market.

2.4 Specific roles in improved care and care coordination

Some health care professionals in the Netherlands specifically fill the role of coordinator. There are basically three of these professionals – each with their different function – and they are described below. First, some medical care providers offer the assistance of a *transfer nurse*. By her knowledge and expertise, this health care professional is able to inform the client of all possible provisions he or she may receive, as well as the processes that are involved in applying for these provisions. The transfer nurse has different responsibilities:

- Requesting an indication from the CIZ..
- Informing the patient and relatives on the progress in requesting admission to a long-term care unit, as well as legal and financial matters that are important.
- Contacting the long-term care provider after an indication is approved.
- After the patient is admitted in a long-term care unit, the transfer nurse stays in contact with the care unit to stay informed about the patient's state.

The role and responsibilities of the transfer nurse are clear, and her expertise can greatly benefit the timeliness and quality of care for patients. Besides the GP, the transfer nurse is the only health care professional who can apply for an AWBZ indication with urgency. The transfer nurse is employed by a hospitals or rehabilitation units.

Second, the *case manager* helps clients who are no longer independent and have complex care needs. The role of case manager is in a developmental stage and case managers are currently only installed to aid elderly who are suspected of dementia. The case manager has a more broader focus than the transfer nurse, and can assist clients with (suspected) dementia in the following ways:

- Counseling before or after the diagnosis.
- Mapping the care needs of the client.
- Providing information and advise on the diagnosis, prognosis and consequences.
- Coordinating care by offering information on possible provisions and on administrative requirements and processes for these provisions.
- Stimulating elderly who avoid care to accept some care provisions.
- Emotional and practical support to the client and informal care-givers.

Case managers are employed by long-term care providers, and are therefore paid through the AWBZ Research shows that clients are very satisfied with the help from case managers, and it is forecasted that installing case managers nation-wide could reduce admission rates to care homes and nursing homes. Consequently, investments in case managers are expected to be cost-effective due to a reduction in AWBZ expenditure.[1]

Third, the role of the *neighbourhood nurse* is also to prevent early admission to care homes or nursing homes. But where the case manager provides assistance and information, the neighbourhood nurse offers basic nursing activities, such as preparing and giving medication, dressing wounds, performing injections, providing intravenous therapy, inserting catheters, and so on. The neighbourhood nurse also fills a social role, making conversation, advising the patient on self-care issues or (psychological or social problems) and by keeping a close eye on the patient. She provides feedback to family members or the GP when the client's illness progresses or when situations change. Currently, the municipalities employ neigbourhood nurses, but from 2015, health insurers will become responsible for providing these services. Research has shown that neighbourhood nurses can prove to be cost-effective, as they realize cost savings (€18,000 per nurse per year) in other health care services.[2]

[1] http://www.nivel.nl/sites/default/files/bestanden/Rapport-casemanagement-dementie.pdf
[2] http://www.bmc.nl/expertisegebieden/bedrijfsvoering-in-het-sociale-domein/mediatheek/rapport-de-zichtbare-schakel-wijkverpleegkundige-een-hele-zorg-minder/

3. Improving coordination in the Dutch health care system

Figure 1 shows that the Dutch health care system has a highly bureaucratic structure. An important reason for this bureaucracy is that information-sharing is regarded as an exception, rather than a standard way of working. This means that many forms of information-sharing may not take place at all. For example, CIZ-employees would greatly benefit from access to information systems of medical care providers. This way, a CIZ-employee can quickly get a complete picture of a client's health status. For privacy reasons, access to these systems is heavily restricted by law.

When information-sharing does take place, laws, regulations and protocols are in place to ensure that it occurs in a secure setting and all precautions have been taken. Medical care professionals need authorization, an authorization card and a password, to access just a subset of another information system. Ways to improve efficiency of information-sharing without sacrificing the privacy of clients are discussed by policy-makers and academics in the Netherlands. The most important (possible) developments to diminish bureaucratic problems can roughly be divided in three categories, explained below:

1. *A more central role for the client, and more financial transparency for the client.* Letting the client arrange many of his/her own required services is a way to decrease information-sharing "backstage" and diminish overhead costs. In the AWBZ and WMO policies can become more oriented towards personal budgets. This way, municipalities and care offices are only concerned with paying out personal budgets and monitoring the use of personal budgets, rather than arranging all the long-term care or social support for the client. However, the frail elderly and elderly with a cognitive disability or psychogeriatric illness are usually not able to make effective use of personal budget due to their lack of independence. A care manager or family member can then play a role.
2. *Improved system of information-sharing within the ZVW.* The introduction of regional or even national collaborations between medical care providers (mainly GP, substituting GP, pharmacist, and hospitals) can reduce administrative hassles and delays in information-sharing between them.
3. *Improved system of information-sharing within the AWBZ and WMO, and between the AWBZ and WMO.* In the beginning of 2012, a discussion and innovation platform, called Platform IZO has been initiated by the Ministry of VWS. Besides the ministry, different organizations are involved in this project, namely: Actiz, the CAK, the CIZ, the CVZ, Federatie Opvang, the GGZ, the VGN, the VNG, and ZN. The aim of Platform IZO is to find the most important bottlenecks in

information-sharing regarding the ZVW, AWBZ and WMO, and to define a common goal to improve information-sharing in the long-term. Part of Platform IZO are the following initiatives:

- A “think tank” called iAWBZ. In iAWBZ, health care professionals are asked to define the most important bottlenecks in the administrative burden of the AWBZ and come up with solutions. The iAWBZ has led to an update from AZR 3.0 to 3.1, in which “quick wins” were gained: messages can be simplified and may be sent less often, changing personal data from clients is simplified, LTC providers can view the initial indication-decision from the CIZ, and so on.
- Since October 2012 different organizations in the health care sector are working on an information-sharing platform for both the AWBZ and WMO. The project is called GuWA (Data exchange WMO-AWBZ), and is now in the first phase. Flows of existing platforms and flows of information- and data-sharing are now thoroughly analyzed. Possible scenarios to improve information-sharing are researched, as well as any legal restraints. As of yet, it remains unclear what form an information-sharing platform for the AWBZ and WMO will look like. A new system of standardized and coded messages could be developed, but it could also be possible that municipalities will be included in the AZR.
- The long-term goal from Platform IZO currently entails three ambitions for 2016: (1) more simplicity for the client, (2) less administrative burden for organizations in health care and social support, and (3) modernization of data management. They hope to achieve these ambitions by developing an information system with standardized messaging, that can be used by many organizations, while preventing misuse of this system. This way, the CIZ, the CAK, municipalities, care offices, long-term care providers, other service providers, etc. can quickly gain access to clear information for which they are authorized.

Through these measures, the different institutions and organizations hope to make gains in efficiency by reducing:

- overhead costs;
- delays in information exchange;
- hours spent on administrative tasks by health care professionals;
- frequency of uninformed decisions by doctors;
- occurrence of overlapping, similar activities done by different professionals (for example, indication-setting by the municipalities and the CIZ).