EAN DIGITAL SUMMIT

The Netherlands

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MALTA

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1. Current state of play

The Dutch vision on digitalization:

- Digital care is a main pillar of the ageing in place policy: If care is needed, the stepping stones are: informal care, digital care or hybrid care (70% end of 2025), and formal care for those people who need it the most

- It should lead to a reduced workload for caregivers, while retaining both the accessibility and quality of care.

Educational programs:

- Vocational training schools offer minor programs to enhance digital skills

→ Using technology in care

→ Working with electronic patient files

→ Supporting clients and informal caregivers in using technology.

2. Primary Use

- **Electronic patient files:**

→ Almost all small/medium/large care providers work with EHRs

→ An exception is formed by very small-scale healthcare providers.

- **Interoperability**?

→ E-overdracht (transmission) as a standard to exchange patient data between care professionals https://nictiz.nl/standaarden/overzicht-van-standaarden/eoverdracht/

- **Data accessibility for other care providers**

→ Patient is the owner of his own health data. Personal health environment for every citizen is being developed, also aimed for care professionals

→ Patient gives permission to share health data with other care providers. Others cannot access the care providers EHRs, since care providers works with different EHRS providers.

Is a personal health environment implemented?

→ Still work in progress: already started with small-scale implementation (currently more than 100,000 PHE users. They can retrieve all data from GP's and most hospitals/clinics).

→ A nationwide roll-out will probably only start in or after 2025.

3. Secondary Use

- **Patient data for secondary use:**

The Netherlands participates in:

→ Myhealth@eu: European network of national nodes for exchange of patient data for unplanned care

→ ERN: European network of rare disease expert centers that exchange patient records for support in treatment

→ International patient Summary Ips: global standard for x-border patient data exchange adopted by G7, G20, EU

- **Is it compulsory and useful?**

There is a large need for streamlining and simplification of the dataflow. In the national program KIK-V (Chain Informational Quality Nursing Home Care):

→ The aim is to streamline the exchange of quality information, to better coordinate new requests and to reuse information more.

→ Everything with a view to better information exchange in quality in nursing home care, and less administrative burden.

→ It is not compulsory yet. The healthcare providers participating in the program are positive because the program will ultimately save them a lot of work.

Exchange of patient data cross-border and if yes, how?

- The so called Border Region Project, coordinated by Nictiz (Nictiz support the Dutch healthcare sector in the use of IT to improve quality and efficiency within healthcare), promotes collaboration between healthcare organizations with Germany and Belgium to make cross-border exchange a reality

4. Technology and digital tools in LTC

- **Medication dispenser**

→ 16 years of use

→ (Still) a relatively low amount of users (16.000) considering the time due to various obstacles

- **Telemedicine or 'Screen to screen care'**

→ 10 years on market with around 10.000 users

→ Use has accelerated due to Covid

- **Personal alarm**

→ Has been upscaled

→ Right now research on the impact of it: the use of applications and data available

4. Technology and digital tools in LTC

Rising stars:

- **Bedsense**

→ Sensorplate beneath mattress

→ Provides data related to the clients posture and movement/safety during the night.

→ Data can also be used to improve the sleeping pattern from the client and increase the efficiency from caregiver visits to clients.

- **Helpsoq**

→ Small robot supports in putting on compression stockings

→ Creates self-autonomy and less physical workload for caregiver

→ https://helpsoq.com/helpsoq/

- **Voice activated reporting**

→ Really promising, reduces administrative burden efficiently.

→ It still however needs to be improved and developed to reach its full potential.

4. Technology and digital tools

- **Reimbursement schemes:**

→ Care homes:

- Care providers can spend the agreed daily rate. They can use a part of this rate for digital applications
- Care providers make agreements with the health insurers about a higher rate for the use of digital care.

→ Home care:

- Digital contact is reimbursed at the same hourly rate as physical contacts
- Reimbursement of a max. 6.5 hours per month per client for home care technology at the agreed rate for nursing, personal care or guidance. This also includes supervision of clients.

4. Technology and digital tools

- **Main obstacles:**

➔ Low adaptation of digital technology by healthcare professionals

➔ Application process asking too much of healthcare professionals

➔ Various reimbursement policies of health insurers

➔ Scaling of innovations is difficult for various reasons

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Thanks for your attention.

The Netherlands

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