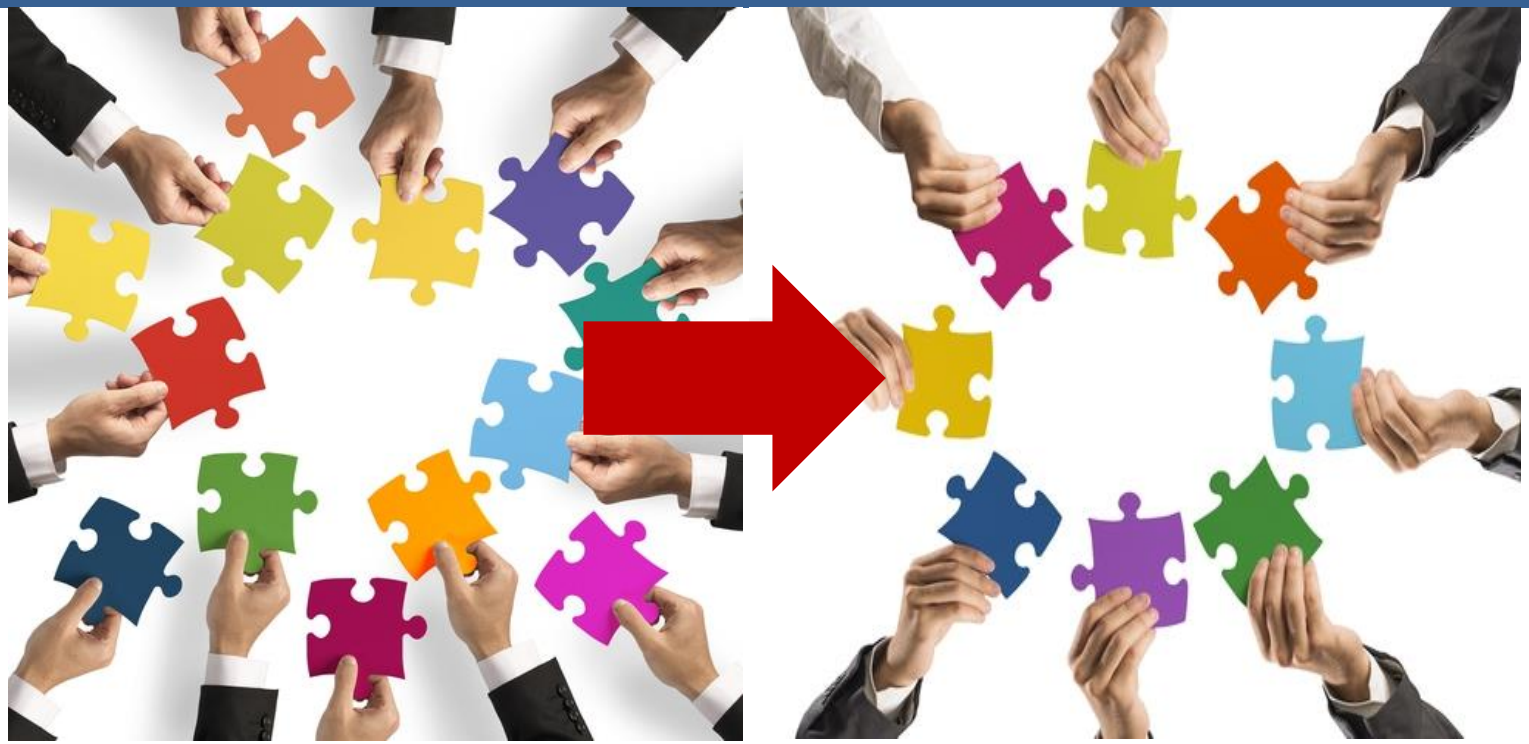
Ολοκληρωμένη φροντίδα.
Μετάβαση από ένα μη-σύστημα σε ένα σύστημα



Ευάγγελος Φραγκούλης, MD, MSc
Γενικός Οικογενειακός Ιατρός
MSc Διοίκηση Μονάδων Υγείας

Αν. Αρχίατρος ΕΔΟΕΑΠ
Γεν. Γραμματέας Ελληνικής Ένωσης Γενικής Ιατρικής
Μέλος Δ.Σ. ΕΛΕΓΕΙΑ

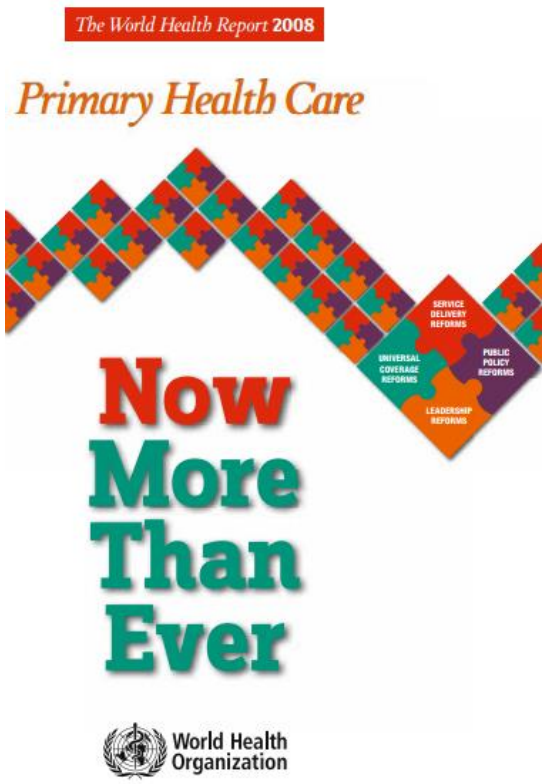
The Triple Aim: Care, Health, And Cost

The remaining barriers to integrated care are not technical; they are political.

by Donald M. Berwick, Thomas W. Nolan, and John Whittington

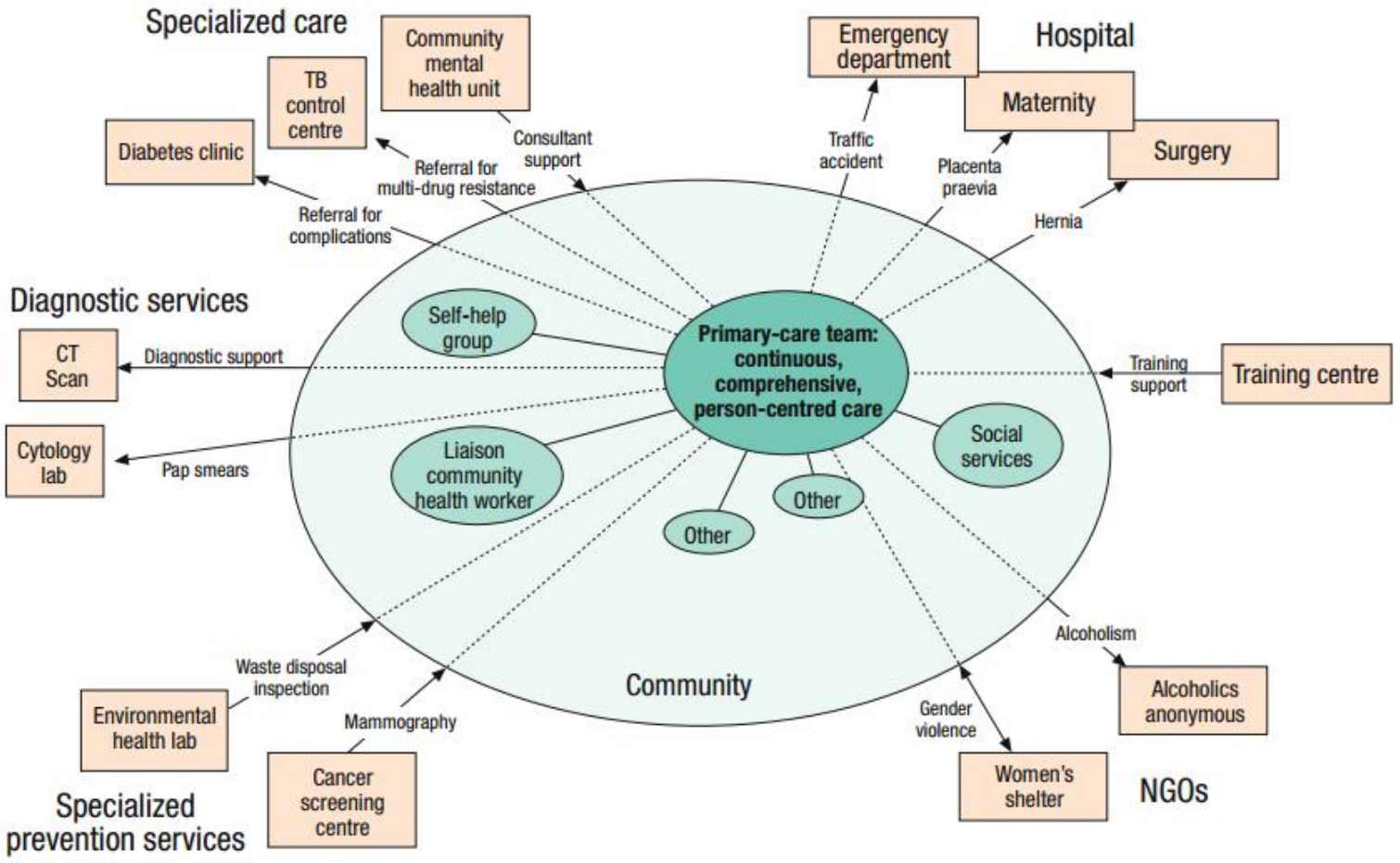
1. Improve the experience of care
2. Improve the health of the population
3. Reduce per capita costs of healthcare

ΠΦ- **Πρωταρχική** Φροντίδα



"Η παροχή φροντίδας
πρώτης επαφής,
εστιασμένης στο άτομο *και*
συνεχιζόμενης στο χρόνο,
που αντιμετωπίζει ***όλες τις σχετιζόμενες με την υγεία ανάγκες των ανθρώπων,***
παραπέμποντας μόνο αυτούς με αρκετά ασυνήθιστες ανάγκες *για να διατηρείται σε επίπεδο ΠΦΥ επάρκεια στην αντιμετώπιση τους,*
καθώς και ο ***συντονισμός της φροντίδας,*** *όταν οι άνθρωποι δέχονται υπηρεσίες σε άλλα επίπεδα του συστήματος"*

Primary care as a hub of coordination: networking within the community served and with outside partners



The World Health Report 2008. **Primary Health Care, Now More Than Ever.** WHO 2008

Integrated Care
A new idea?

- **fractures in systems and delivery** that allow **individuals to 'fall through the gaps' in care** – primary/secondary care, health/social care, mental/physical health care

- **Approaches to address fragmentation of care** are common across many health systems,
  and the need to do so is increasing as more **people live longer** and with **complex co-morbidities**

Fragmentation

*"**the breakdown in communication and collaboration** in providing services to an individual*

*which results in deficiencies in **timeliness, quality, safety, efficiency and patient-centredness**"*

Wagner, 2009

"Without integration at various levels [of health systems], all aspects of health care performance can suffer.

***Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes**."*

Kodner and Spreeuwenbur, 2002

Συνεργασία- Διασύνδεση- Συντονισμός Ομάδες Υγείας

Coordination -- we do NOT know how to play as a team

"We don't have a health care delivery system in this country. We have an expensive plethora of **uncoordinated,** unlinked, micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure and for individual patients." George Halvorson, from "*Healthcare Reform Now*"

International Journal of Integrated Care – Vol. 9, 30 July 2009 – ISSN 1568-4156 – http://www.ijic.org/

Policy

Special series: Integrated primary health care

Integrated primary health care in Greece, a missing issue in the current health policy agenda: a systematic review

***Christos Lionis**, MD, PhD, HonFRCGP, Associate Professor, Head of the Clinic of Social and Family Medicine, School of Medicine, University of Crete, 71003 Heraklion, Crete, Greece*

***Emmanouil K. Symvoulakis**, MD, PhD, Clinic of Social and Family Medicine, School of Medicine, University of Crete, 71003 Heraklion, Crete, Greece*

***Adelais Markaki**, RN, PhD, Clinical Specialist Community Health Nursing, Clinic of Social and Family Medicine, School of Medicine, University of Crete, 71003 Heraklion, Crete, Greece*

***Constantine Vardavas**, RN, MPH, Clinic of Social and Family Medicine, School of Medicine, University of Crete, 71003 Heraklion, Crete, Greece*

***Maria Papadakaki**, Social Worker, MPH, Clinic of Social and Family Medicine, School of Medicine, University of Crete, 71003 Heraklion, Crete, Greece*

***Natasa Daniilidou**, Scientific Collaborator, Health Economics Division, National School of Public Health, 196 Alexandras Avenue, 11521 Athens, Greece*

***Kyriakos Souliotis**, Scientific Collaborator, Health Economics Division, National School of Public Health, 196 Alexandras Avenue, 11521 Athens, Greece*

***Ioannis Kyriopoulos**, Professor of Health Economics, National School of Public Health, 196 Alexandras Avenue, 11521 Athens, Greece*

6 years later, still paving the way…

Results: Our systematic review identified 198 papers and 161 out of them were derived from electronic search. Fifty-three papers in total served the scope of this review and are shortly reported. A key finding is that the long-standing dominance of medical perspectives in Greek health policy has been paving the way towards vertical integration, pushing aside any discussions about horizontal or comprehensive integration of care.

Conclusion: Establishment of integrated PHC in Greece is still at its infancy, requiring major restructuring of the current national health system, as well as organizational culture changes. Moving towards a new policy-based model would bring this missing issue on the discussion table, facilitating further development.

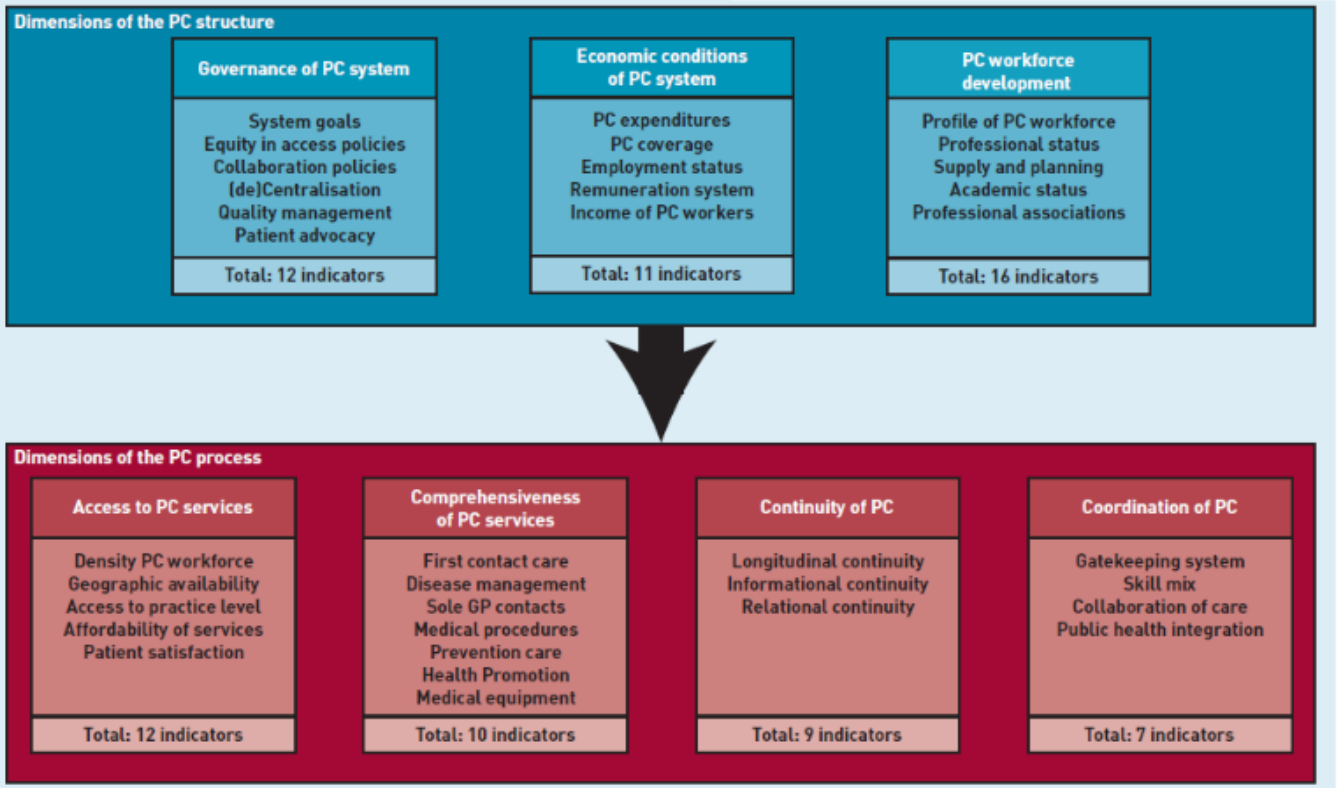
Research

Dionne Kringos, Wienke Boerma, Yann Bourgueil, Thomas Cartier, Toni Dedeu, Toralf Hasvold, Allen Hutchinson, Margus Lember, Marek Oleszczyk, Danica Rotar Pavlic, Igor Svab, Paolo Tedeschi, Stefan Wilm, Andrew Wilson, Adam Windak, Jouke Van der Zee and Peter Groenewegen

The strength of primary care in Europe:

an international comparative study

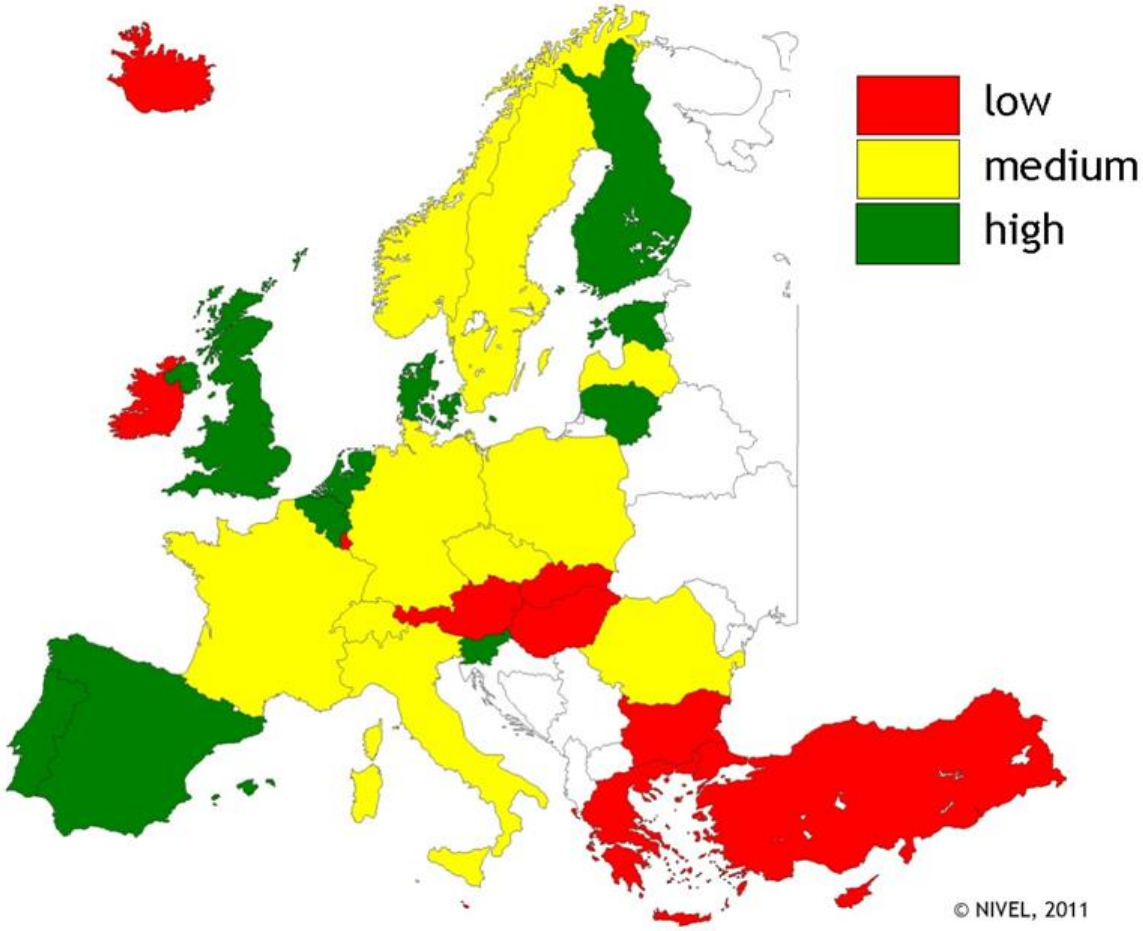
Figure 1. Primary care structure and process dimensions. PC = primary care.



Source: Kringos D. et al. British Journal of General Practice, November 2013

Primary Care in Greece- LOW strength

Strong primary care systems



Source: Kringos et al, 2012

Table 1. Availability of data on primary care indicators, by dimension and country

Country	Percentage of indicators (including subquestions with available data, by dimension and country)								
	Primary care governance (*n* = 16)	Economic conditions of primary care (*n* = 10)	Primary care workforce development (*n* = 17)	Mean %	Access to primary care (*n* = 19)	Continuity of primary care (*n* = 12)	Coordination of primary care (*n* = 9)	Comprehensiveness of primary care (*n* = 10)	Mean %
Austria	100	90	100	97	100	75	100	100	94
Belgium	100	100	100	100	100	100	100	90	98
Bulgaria	100	100	100	100	100	100	100	100	100
Cyprus	94	80	71	81	95	50	100	70	79
Czech Republic	100	100	100	100	95	75	100	100	92
Denmark	100	89	100	96	100	92	100	100	98
Estonia	100	100	100	100	100	92	100	100	98
Finland	100	89	94	94	95	92	100	100	97
France	100	100	100	100	100	92	100	100	98
Germany	100	90	100	97	100	100	100	100	100
Greece	50	70	94	71	89	67	56	70	70
Hungary	100	100	100	100	100	100	100	100	100
Iceland	75	80	100	85	84	75	78	100	84
Ireland	100	89	100	96	84	75	100	90	87
Italy	100	100	94	98	95	58	100	90	86
Latvia	100	100	100	100	95	100	100	100	99
Lithuania	100	100	100	100	100	100	100	100	100
Luxembourg	100	90	94	95	89	67	89	90	84
Malta	94	60	59	71	68	67	100	60	74
Netherlands	100	100	100	100	100	100	100	100	100
Norway	100	100	88	96	84	100	89	100	93
Poland	100	100	88	96	95	92	100	90	94
Portugal	100	89	100	96	100	100	100	100	100
Romania	100	80	100	93	95	100	89	80	91
Slovak Republic	100	100	100	100	100	100	100	100	100
Slovenia	100	100	76	92	89	100	89	100	95
Spain	100	100	94	98	89	100	100	100	97
Sweden	100	80	82	87	95	67	100	90	88
Switzerland	100	100	100	100	63	67	100	100	82
Turkey	100	60	100	87	100	100	100	90	98
UK	100	100	100	100	100	100	100	90	98
Mean %	97	91	95	—	94	87	96	94	—

Source: Kringos D. et al. British Journal of General Practice, November 2013

Continuity

- **Personal continuity** is a **problem** due to **the fragmented** health care system. Too many first contact points. Everyone can decide to visit whoever.

- **Referral letters are not common**.
- **No communication between specialists and GPs after the completion of an episode of treatment**.

Coordination

- **No referral system.**
- **No information about actual coordination.**

ΕΛΛΗΝΙΚΗ ΕΝΩΣΗ ΓΕΝΙΚΗΣ/ ΟΙΚΟΓΕΝΕΙΑΚΗΣ ΙΑΤΡΙΚΗΣ
GREEK UNION OF GENERAL PRACTITIONERS
Βίαντος 18, 17122 Νέα Σμύρνη • Τηλ.:210 9320015
18 Viantos str. 17122 Nea Smyrni, Greece • Tel.: +30 210 9320015
www.enosigi.gr • contact@enosigi.gr

Προς

Πρόεδρο ΕΟΠΥΥ κ. Κοντό

Αντιπρόεδρο ΕΟΠΥΥ κ. Μπραβάκο

Κοινοποίηση

Υπουργό Υγείας Μ. Βορίδη

Αξιότιμοι κύριοι,

Έκπληξη και δυσαρέσκεια μας προκάλεσε η γνωστοποίησ
παροχή γραπτών εξηγήσεων από τον Αντιπρόεδρο τ
συναδέλφου Γενικής Ιατρού Α.Χ. από την Δωδεκάνησο (Α.Π.
2014), με κύριο διαπιστωμένο παράπτωμα την **«αναγραφή**
ειδικότητας, χωρίς να υπάρχει ένδειξη ιατρού ειδικότητ
σχεδόν αποκλειστικά αφορούσαν φαρμακευτικά
χορηγήθηκαν σε ασθενείς με Χρόνια Αποφρακτική
Θεωρούμε, βασισμένοι σε ακράδαντα επιστημονικά στοιχεί
σας παραθέσουμε, πως ο Γενικός/ Οικογενειακός Ιατρός είν
ιατρός για τη διαχείριση της Χρόνιας Αποφρακτικής Πνευμονο

Αποτελεί η ΧΑΠ αντικείμενο εκπαίδευσης στη Γενική Ιατ

Η Χρόνια Αποφρακτική Πνευμονοπάθεια (ΧΑΠ) αποτελεί μια
χρόνιες παθήσεις και μια σημαντική πρόκληση για τη δημό
δυνατόν τόσο να προληφθεί, όσο και να θεραπευτεί. Η ΧΑΠ
χρόνιας νοσηρότητας και θνησιμότητας (4η αιτία θανάτων
άνθρωποι πάσχουν από τη νόσο για πολλά χρόνια και τελικ
από αυτή και τις επιπλοκές της. Στα αντικείμενα της εκπ
Ιατρική είναι η διαχείριση των συνήθων χρόνιων νοσημάτων
ΧΑΠ σαφέστατα είναι ένα από αυτά. Ο πρόσφατος άλλωστ
Π.Ε.Δ.Υ. ΝΟΜΟΣ ΥΠ' ΑΡΙΘ. 4238 «Πρωτοβάθμιο Ε
(Π.Ε.Δ.Υ.), αλλαγή σκοπού Ε.Ο.Π.Υ.Υ. και λοιπές διατάξει
το Γενικό Ιατρό θεμέλιο στο Εθνικό Σύστημα Υγείας
Οικογενειακοί Ιατροί παρέχουν δέσμη υπηρεσιών υγείας
τη διαχείριση των πλέον συχνών χρόνιων νοσημάτω
στην κοινότητα.

ΕΛΛΗΝΙΚΗ ΕΝΩΣΗ ΓΕΝΙΚΗΣ/ ΟΙΚΟΓΕΝΕΙΑΚΗΣ ΙΑΤΡΙΚΗΣ
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www.enosigi.gr • contact@enosigi.gr

Αθήνα, 16/11/2014

Προς:

- **Πρόεδρο Συλλόγου Διαβητικών του Ν. Δράμας,**

Κοινοποίηση προς:

- **Υπουργό Υγείας**
- **Πρόεδρο του Πανελλήνιου Ιατρικού Συλλόγου**
- **Πρόεδρο του Πανελλήνιου Συλλόγου Διαβητικών**
- **Πρόεδρο του Ιατρικού Συλλόγου Δράμας**

Η Ελληνική Ένωση Γενικής Ιατρικής αποτελεί τον επίσημο φορέα που εκπροσωπεί και προασπίζει τα επαγγελματικά δικαιώματα των Γενικών Ιατρών στην Ελλάδα. Η Γενική/ Οικογενειακή Ιατρική αποτελεί μια μοναδική ιατρική ειδικότητα και η μοναδικότητα της έγκειται κύρια στη εντελώς διαφορετική, με όλες τις άλλες ειδικότητες, σχέση που αναπτύσσει ο Γενικός Ιατρός με τον ασθενή του. Μια διαχρονική σχέση, «από την κούνια έως το τάφο» **συμμάχου-συνεταίρου (partner)** με κοινό στόχο την επίτευξη και τη διατήρηση της καλής υγείας του ασθενούς, των μελών της οικογένειας του και της κοινότητας μέσα στην οποία αυτός διαβιεί! Εστιάζει, αντί στην νόσο στην υγεία, αντί στην θεραπεία της νόσου στην πρόληψη της, αντί στην αντιμετώπιση της ασθένειας στην προαγωγή της υγείας. Περνά από τα μεμονωμένα προβλήματα στην ολιστική προσέγγιση του ασθενούς και από την περιστασιακή αποσπασματική φροντίδα στην συνεχή. Ο οικογενειακός γιατρός αποτελεί την **πυξίδα (navigator)** του ασθενούς μέσα στο πολυδαίδαλο σύστημα υγείας, συντονίζει σαν μαέστρος την φροντίδα του, όταν σε αυτή πρέπει να εμπλακούν και άλλοι επαγγελματίες υγείας και δρα συχνά σαν **συνήγορος (advocate)**, αλλά και σαν **προστάτης** αυτού από την υπερδιάγνωση και την υπερθεραπεία, που πολλές φορές εγκυμονεί η φροντίδα από υπερεξειδικευμένους ιατρούς- η **έννοια της τεταρτογενούς πρόληψης**. Ο ασθενής δεν είναι για τον οικογενειακό γιατρό του άλλη μια χολή, ένα έντερο, ούτε μια σκλήρυνση κλπ, αλλά ο Μιχάλης, η κυρία Μαρία κλπ. Δεν είναι τυχαίο πως ο ένας, από τους δυο μόνο, καθηγητές ιατρικής στην οργανωτική επιτροπή του "3ου *Πανελλήνιου Συνεδρίου Ασθενών. Patients in power. Στρατηγική υγείας: σχεδιάζοντας μαζί με τους ασθενείς*", ήταν ο μοναδικός, δυστυχώς, στην Ελλάδα Καθηγητής Γενικής Ιατρικής & Πρωτοβάθμιας Φροντίδας Υγείας, ο κ. Χρήστος Λιονής.

From Non-System to System

Κατεστραμμένο, αναποτελεσματικό σύστημα

Κατακερματισμένη, επεισοδιακή, χαοτική μη συντονισμένη φροντίδα

Πάροχοι απομονωμένοι

Μοντέλο οικιακής βιοτεχνίας

Πολλαπλά σημεία εισόδου

Πολλαπλά μονοπάτια φροντίδας

Διαφορές σε αποτελέσματα

Αδυναμία σύναψης μακρόχρονης σχέσης, Διάχυση ευθύνης

Αποζημίωση για την όγκο-ποσότητα υπηρεσιών

Ολιστική, συντονισμένη φροντίδα

Συνέχεια φροντίδας- μακρόχρονη σχέση συνεργασίας με ασθενή

Συνεργασία- διασύνδεση ιατρών, επαγγελματιών υγείας, υπηρεσιών, δομών

Κοινός στόχος η βελτίωση της υγείας του ασθενούς και του πληθυσμού

Ευθυγράμμιση των κινήτρων των παικτών- αποζημίωση παρόχων βάση της αξίας που παράγουν

Μέτρηση- καταγραφή-δημοσιοποίηση αποτελεσμάτων υγείας και κόστους για κάθε ασθενή

Ενσωμάτωση υψηλής τεχνολογίας

Διαφάνεια των αποτελεσμάτων

Swenson, Stephen MD, et al. **Cottage Industry to Postindustrial Care – The Revolution in Healthcare Delivery**. NEJM, January 20, 2010

What does good integrated care mean to you?

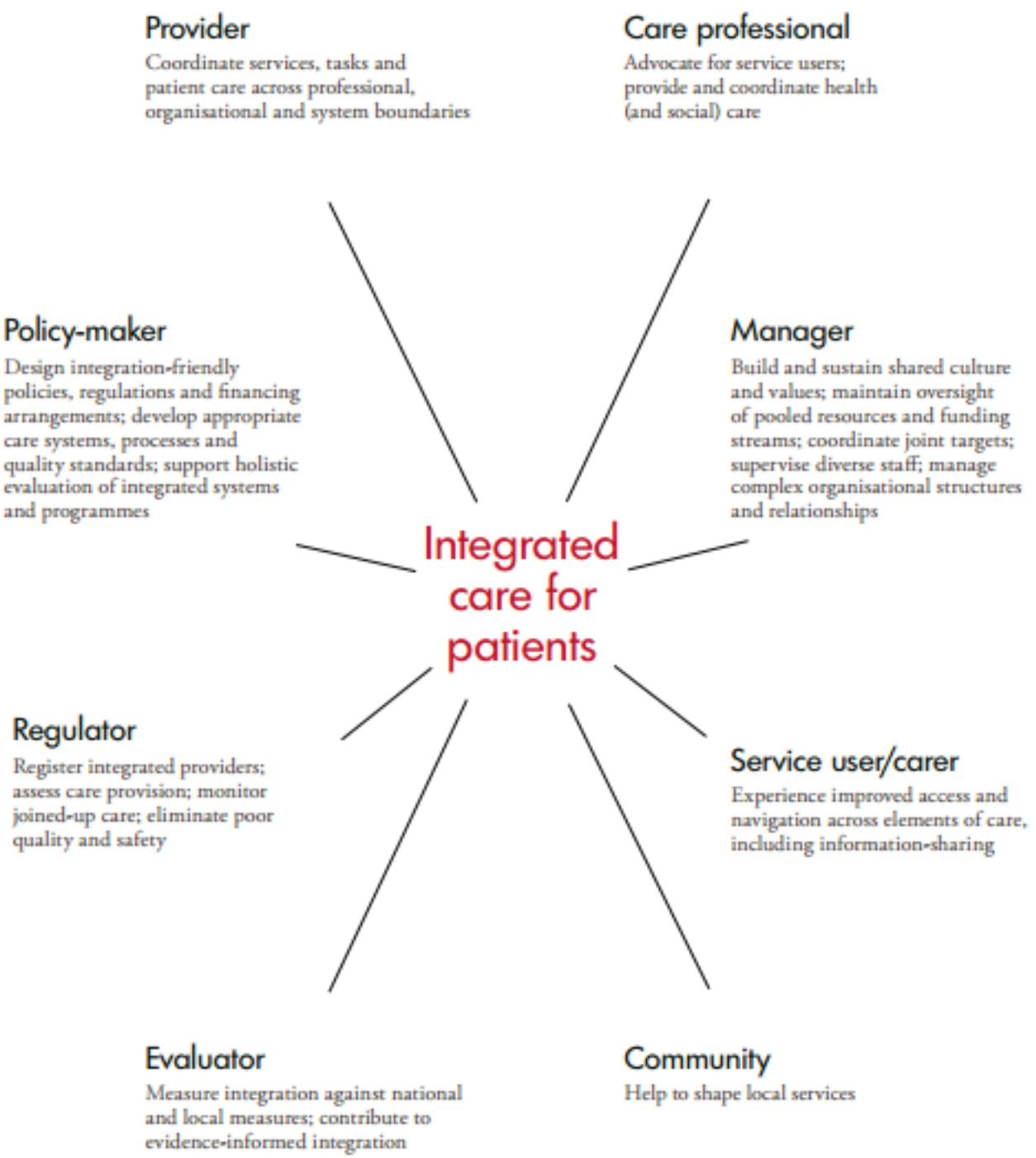
http://www.kingsfund.org.uk/topics/integrated-care/what-does-good-integrated-care-mean-you

Integrated care is centered around the needs of users

‘The patient’s perspective is at the heart of any discussion about integrated care.

Achieving integrated care requires those involved with planning and providing services to **impose the patient’s perspective as the organizing principle of service delivery’**

Shaw et al 2011, Lloyd and Wait 2005



Perspectives Shaping Integrated Care

patient's perspective at the heart

What is integration?

a coherent set of **methods and models** on the **funding, administrative, organisational, service delivery** and **clinical** levels

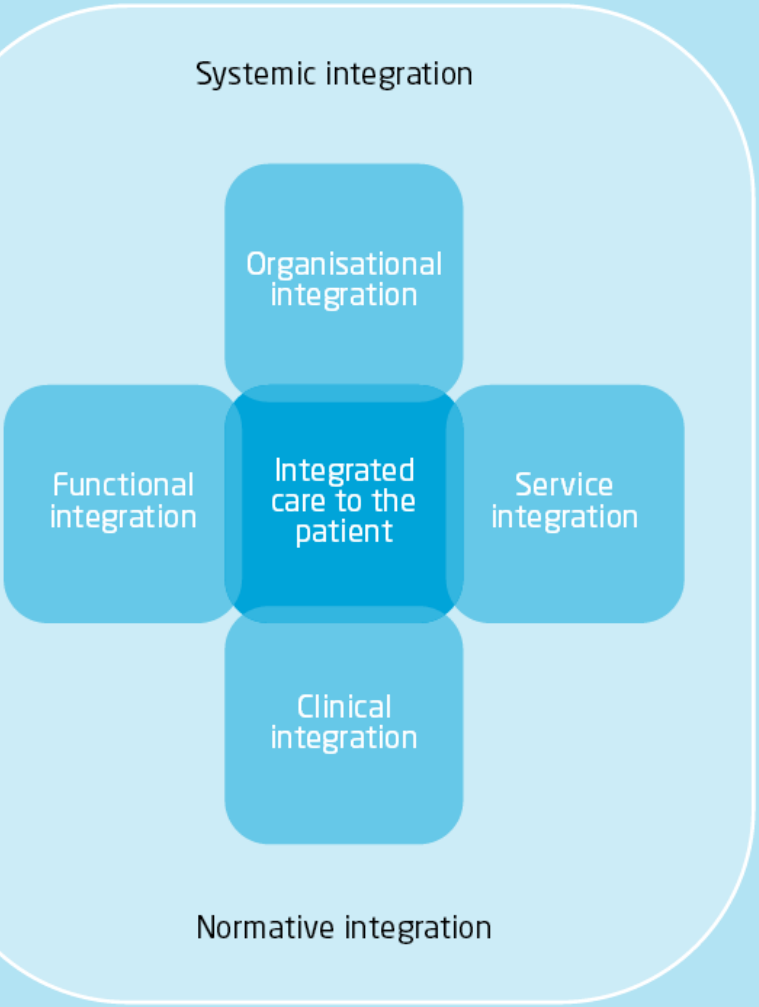
designed to create **connectivity, alignment and collaboration** within and between the cure and care sectors.

The goal of these methods and models is **to enhance quality of care and quality of life, consumer satisfaction and system efficiency** for patients with **complex, long term problems** cutting across multiple services, providers and settings.

The result of such multipronged efforts to promote integration for the benefit of these special patient groups is called **'integrated care'**.

Kodner and Spreeuwenberg 2002

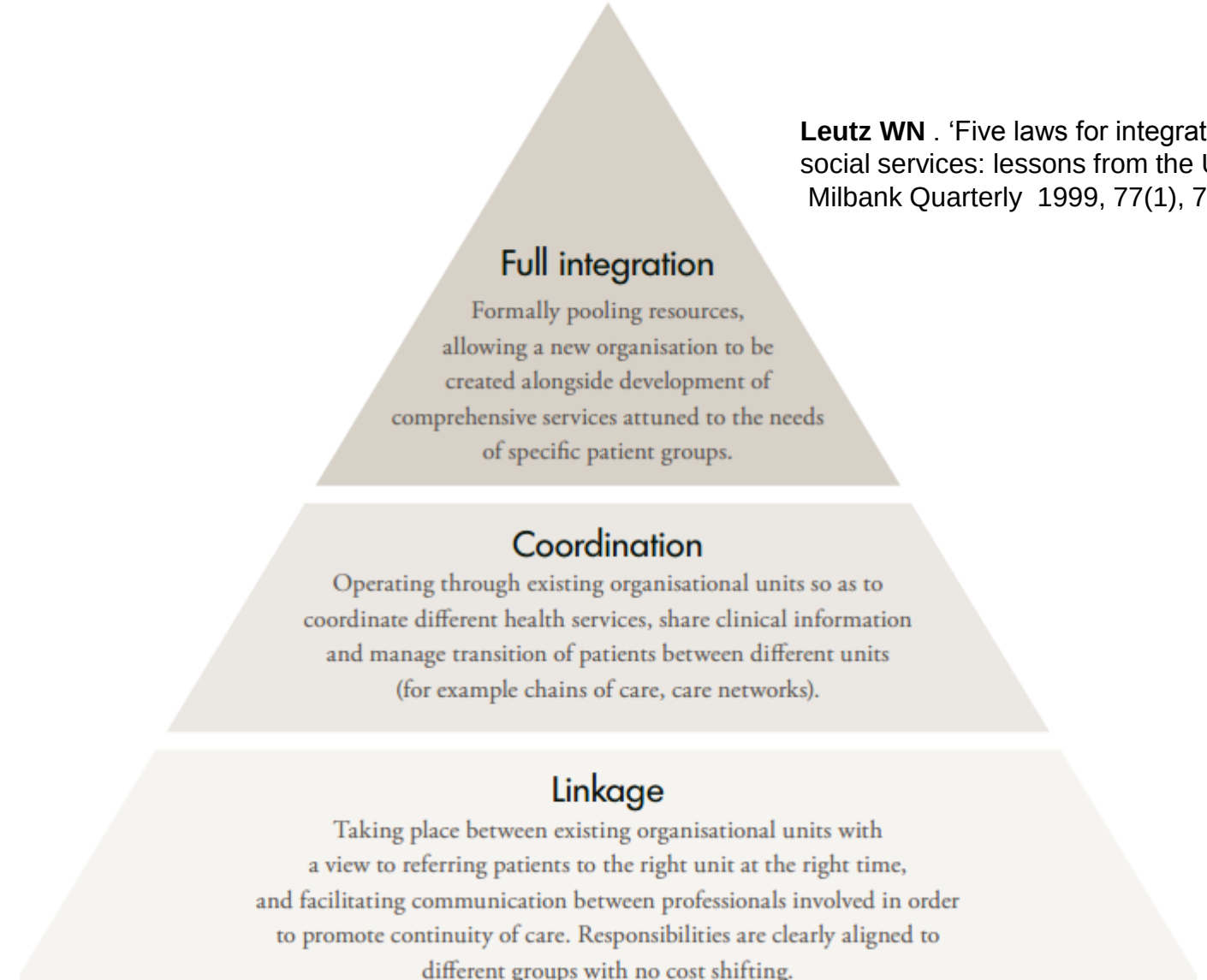
Types of integration



- Organisational integration, where organisations are brought together formally by mergers or through 'collectives' and/or virtually through co-ordinated provider networks or via contracts between separate organisations brokered by a purchaser.
- Functional integration, where non-clinical support and back-office functions are integrated, such as electronic patient records.
- Service integration, where different clinical services provided are integrated at an organisational level, such as through teams of multidisciplinary professionals.
- Clinical integration, where care by professionals and providers to patients is integrated into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols.
- Normative integration, where an ethos of shared values and commitment to co-ordinating work enables trust and collaboration in delivering health care.
- Systemic integration, where there is coherence of rules and policies at all organisational levels. This is sometimes termed an 'integrated delivery system'.

Source: Adapted from Fulop *et al* (2005)

Intensity of integration



Leutz WN . 'Five laws for integrating medical and social services: lessons from the US and the UK, Milbank Quarterly 1999, 77(1), 77–110

Many approaches to integration

Integration can be undertaken between organisations, or between different clinical or service departments within and between organisations

Integration may focus on joining up primary, community and hospital services ('vertical' integration) or involve multi-disciplinary teamwork between health and social care professionals ('horizontal' integration)

Integration may be 'real' (ie, into a single new organisation) or 'virtual' (ie, a network of separate providers, often linked contractually).

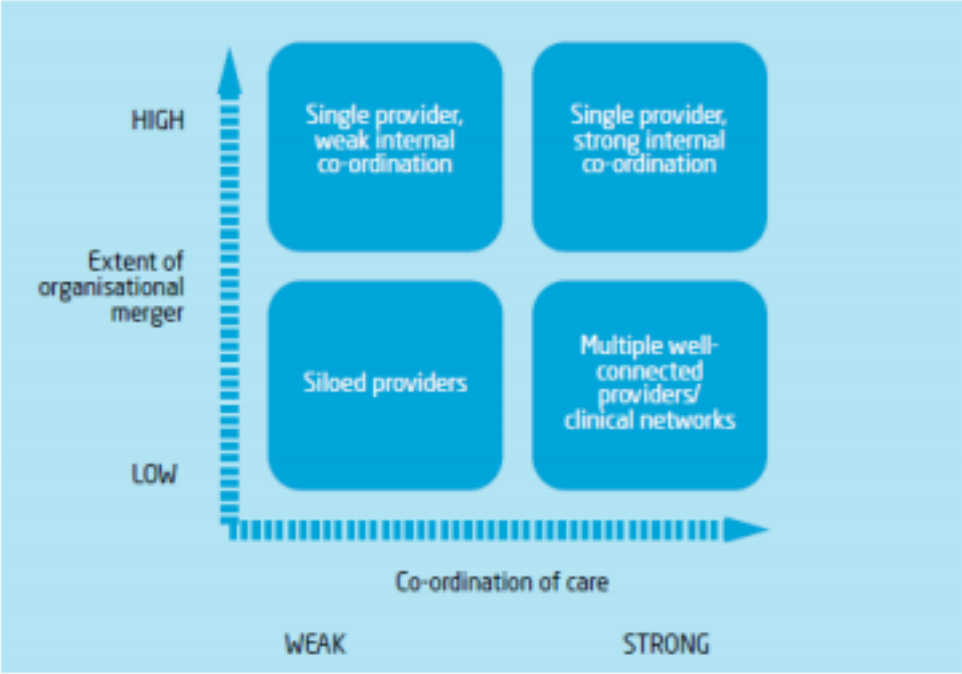
Integration may involve providers collaborating, but it may also entail integration between commissioners, as when budgets are pooled.

Integration can also bring together responsibility for commissioning and provision. When this happens, clinicians and managers are able to use budgets either to provide more services directly or to commission these services from others: so-called 'make or buy' decisions.

(Curry and Ham 2010)

Integration without care co-ordination cannot lead to integrated care

Effective care co-ordination can be achieved without the need for the formal ('real') integration of organisations. Within single providers, integrated care can often be weak unless internal silos have been addressed. **Clinical and service integration matters most**.



The King's Fund
Ideas that change health care

nuffield trust
evidence for better health care

The Mrs Smith test...

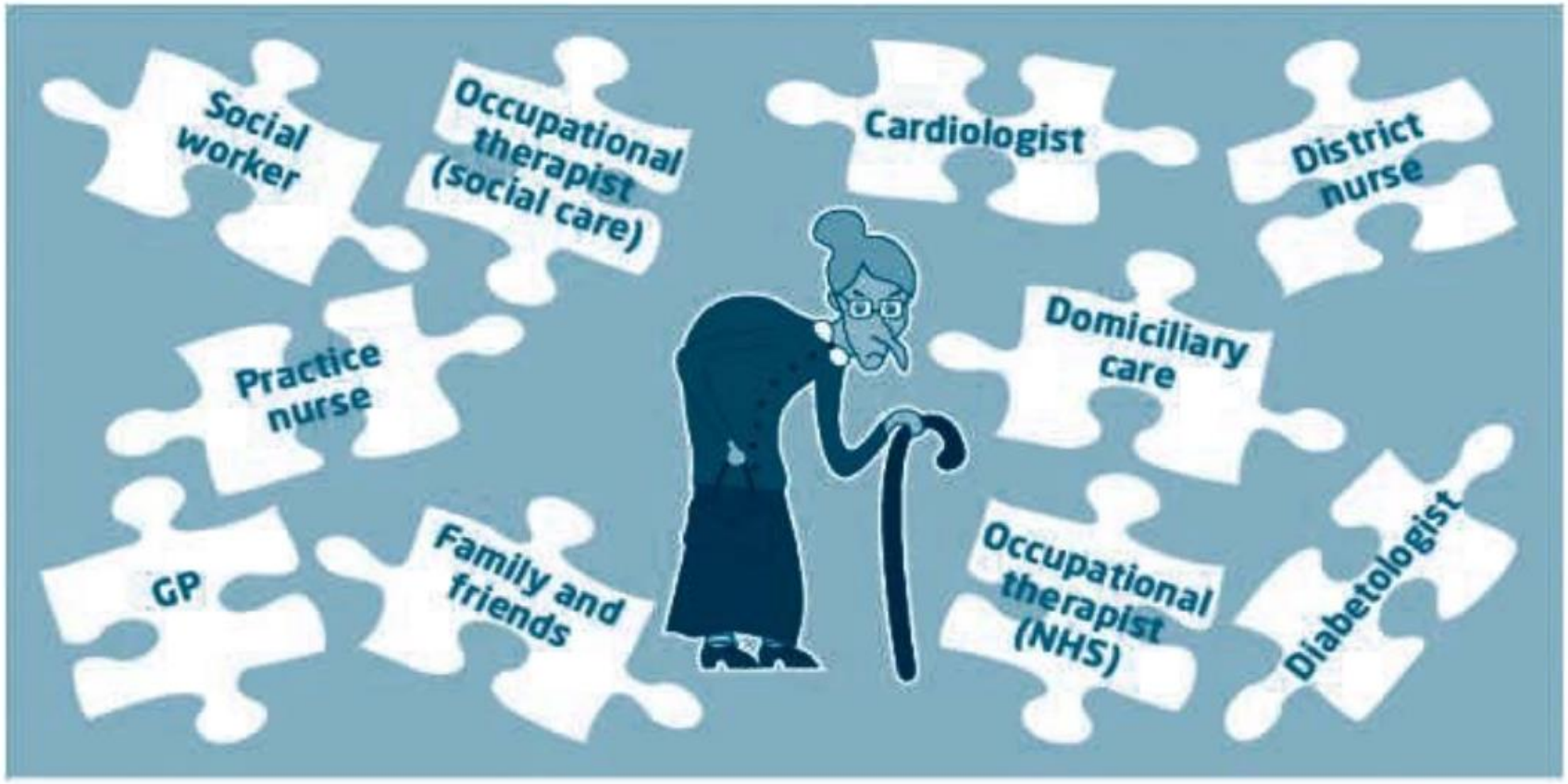
Many people with mental, physical and/or medical conditions are at risk of long hospital stays and/or commitment to long-term care in a nursing home.

Mrs Smith is a fictitious women in her 80s with a range of long-term health and social care problems for which she needs care and support.

Mrs Smith encounters daily difficulties and frustrations in navigating the health and social care system.

Problems include her many separate assessments, having to repeat her story to many people, delays in care due to the poor transmission of information, and bewilderment at the sheer complexity of the system.

From a fragmented set of health and social care services …



The Kings Fund

Ideas that change health care

nuffield trust

evidence for better health care

… to a co-ordinated service that meets her needs

The Kings Fund

Ideas that change health care

nuffield trust

evidence for better health care

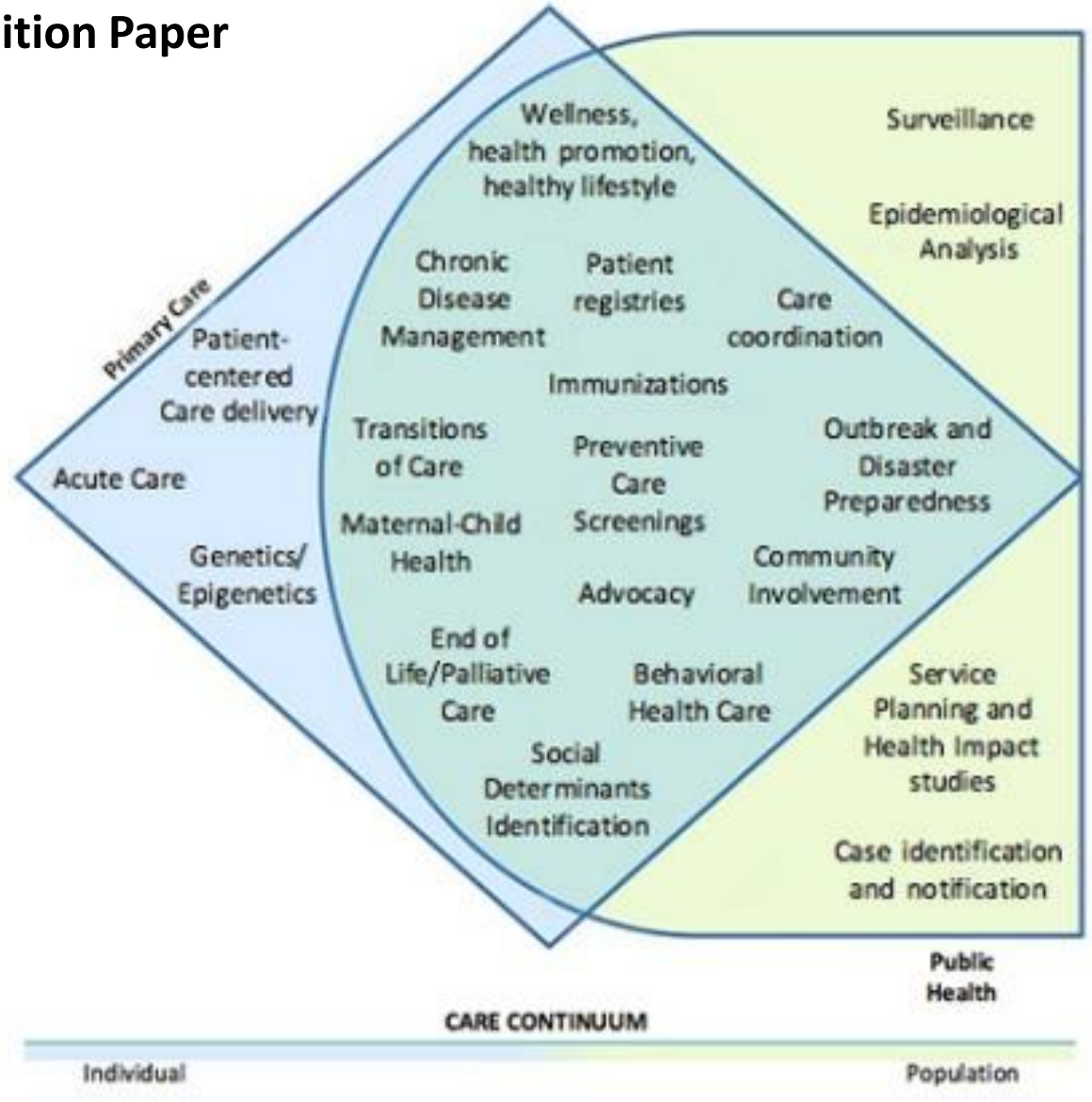
Key forms of integrated care

- Integrated care between health services, social services and other care providers (horizontal integration)
- Integrated care across primary, community, hospital and tertiary care services (vertical integration)
- Integrated care within one sector (eg, within mental health services through multi-professional teams or networks)
- Integrated care between preventive and curative services
- Integrated care between providers and patients to support shared decision-making and self-management
- Integrated care between public health, population-based and patient-centred approaches to health care
  - This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just to care groups or diseases

Source: adapted from *International Journal of Integrated Care*

Integration of Primary Care and Public Health

AAFP Position Paper



Key organisational and management barriers

- Bringing together primary medical services and community health providers around the needs of individual patients
- Addressing an unsustainable acute sector
- Developing capacity in primary care to take on new services
- Managing demand and developing new care models
- Establishing effective clinical leadership for change
- Overcoming professional tribalism and turf wars
- Addressing the lack of good data and IT to drive integration, eg, in targeting the right people to receive it
- Involving the public and creating a narrative about new models of care
- Establishing new forms of organisation and governance (where these are needed)
- Learning from elsewhere in the UK and overseas

(Ham and Smith, 2010; Goodwin 2011)

Key issues in creating an enabling policy environment for integrated care

- Have a **regulatory framework** that encourages integration and integrated care
- Have a **financial framework** that encourages integrated care
- Provide support to **innovative approaches to commissioning** integrated services
- Apply **national outcome measures** that encourage integrated service provision
- Invest in **continuous quality improvement** including publishing the use of outcome data for peer review and public scrutiny

Goodwin et al 2011; Rosen et al 2011

The core components of a successful integrated care strategy (I)

- **Defined populations** that enable health care teams to develop a **relationship over time** with a 'registered' population or local community,

  and so to **target individuals who would most benefit** from more co-ordinated approach to the management of their care

- **Aligned financial incentives** that support providers **to work collaboratively** by avoiding any perverse effects of activity-based payments;

  promote joint responsibility for the prudent management of financial resources;

  and **encourage the management of ill-health in primary care settings** that help prevent admissions and length of stay in hospitals and nursing homes

The core components of a successful integrated care strategy (II)

- **shared accountability** for performance through the **use of data** to improve quality and account to stakeholders through **public reporting**

- **information technology** that supports the delivery of integrated care, especially via the **electronic medical record** and the use of **clinical decision support systems**, and through the ability to **identify and target 'at risk' patients**

- **the use of guidelines** to **promote best practice**, **support care co-ordination** across care pathways, and **reduce unwarranted variations** or gaps in care

The core components of a successful integrated care strategy (III)

- A **physician–management partnership** that links the clinical skills of health care professionals with the organisational skills of executives, sometimes bringing together the skills of purchasers and providers ‘under one roof’

- **Effective leadership** at all levels with a focus on continuous quality improvement

- A **collaborative culture** that emphasises **team working** and the delivery of highly **co-ordinated** and **patient-centred** care

The core components of a successful integrated care strategy (IV)

- **Multispecialty groups** of health and social care professionals in which, for example, generalists work alongside specialists to deliver integrated care

- **Patient and carer engagement** in taking decisions about their own care and support in enabling them to self-care – **'no decision about me without me'**

Disease management in Germany

- **use of evidence-based guidelines**
- **patient involvement and self-management**
- **intersectoral care with treatment in specialised institutions**
- **quality assurance measures**

- **Patients must first choose a physician** (usually the family physician) who co-ordinates their treatment.
- **how and when specialists should be involved in** the patient's care
- **Disease-specific objectives, defined treatment goals and specific criteria for referral to secondary care.** Deviation from the framework is discouraged and physicians are expected to justify any variation.
- **Patient involvement is emphasized** and **patient education** and **self-management** are key elements. If a patient fails to participate, his or her registration with the programme can be cancelled by the health insurance fund.
- **Active participation among patients and physicians is rewarded through financial incentives** (providers receive reimbursement for disease-specific education programmes, patients may be exempted from the quarterly practice fee)

Nolte et al 2008

Integrated systems in US
(Kaiser Permanente, Geisinger Health System etc).

- **multispecialty medical groups** in which generalists work alongside specialists to deliver integrated care
- **aligned financial incentives** that avoid the perverse effects of fee-for-service reimbursement- prudent use of resources and promoting quality improvement
- **Information Technology** that supports the delivery of integrated care- Electronic Medical Record, clinical decision support systems
- **guidelines**: promote best practice, reduce unwarranted variations in care
- **accountability for performance**: use of data to improve quality and account to stakeholders through public reporting
- **defined populations**: doctors and the wider health care team to develop a relationship over time with a 'registered' population
- **a physician–management partnership**: links clinical skills of health care professionals and organisational skills of executives
- **effective leadership** at all levels, focus on continuous quality improvement
- **collaborative culture:** team working and patient-centred care.

Shortell and Schmittdiel 2004

Integrating Specialty Care

- The **ideal combination of primary and specialty care will vary** by patients' subgroup/ medical condition/ individual patients across time.
- **A joint team, organized around meeting the needs of patients**. **Shared goal of improving outcomes and efficiency for their common patien**t.
- **Systematic efforts to share protocols, define handoffs, and build personal relationships**.
- **Access to the same clinical information system**, **consistent outcomes data routinely collected and shared**.
- **Bundled payment systems that reimburse primary care and specialty clinicians as a group for a given patient** increases the likelihood that they will collaborate.

Porter et al. **Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs** . *Health Affairs, 32, no.3 (2013):516-525*

Four Levels of Provider System Integration

1. **Define the scope of services** for each facility, and for the organization as a whole, based on **value**

2. **Concentrate volume by condition** in fewer locations

3. Choose the **right location for each service** based on medical condition, acuity level, resource intensity, cost level and need for convenience

   E.g., shift routine surgeries out of tertiary hospitals to smaller, more specialized facilities

4. Integrate care **across appropriate locations** through IPUs

Creating a Value-Based Health Care Delivery System

The Strategic Agenda

1. Organize Care into Integrated Practice Units (IPUs) around Patient Medical Conditions
   - For primary and preventive care, organize to serve distinct patient segments
2. Measure Outcomes and Costs for Every Patient
3. Move to Bundled Payments for Care Cycles
4. Integrate Care Delivery Systems
5. Expand Geographic Reach
6. Build an Enabling Information Technology Platform

What is a Medical Condition?

Specialty Care

- A medical condition is **an interrelated set of patient medical circumstances best addressed in an integrated way**
  - Defined from the **patient's** perspective
  - Involving **multiple** specialties and services
  - **Including** common co-occurring conditions and complications

  Examples: diabetes, breast cancer, knee osteoarthritis

Primary/Preventive Care

- In primary / preventive care, the unit of value creation is **defined patient segments** with similar preventive, diagnostic, and primary treatment needs (e.g. healthy adults, patients with complex chronic conditions, and frail elderly)

- The medical condition / patient segment is the proper **unit of value creation and value measurement** in health care delivery

Source: Porter, Michael E. with Thomas H. Lee and Erika A. Pabo. "Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs," *Health Affairs*, Mar, 2013

Attributes of an Integrated Practice Unit (IPU)

1. Organized around a **medical condition** or set of **closely related conditions** (or around defined patient segments for primary care)
2. Care is delivered by a **dedicated**, **multidisciplinary team** who devote a significant portion of their time to the medical condition
3. Providers on the team see themselves as part of a **common organizational unit**
4. The team takes **responsibility** for the **full cycle of care** for the condition
   - Encompassing **outpatient**, **inpatient**, and **rehabilitative** care, as well as **supporting services** (such as nutrition, social work, and behavioral health)
5. Patient education, engagement, follow-up, and secondary prevention **are Integrated into care**
6. The IPU has a **single administrative** and **scheduling structure**
7. Much of care **is co-located** in one or more **dedicated sites**
8. A **physician team captain** or a **clinical care manager** (or both) oversees each patient's care process
9. The **team measures** outcomes, costs, and processes for each patient using a **common measurement platform**
10. The providers on the team meet **formally and informally** on a regular basis to discuss patients, processes, and results
11. **Joint accountability** is accepted for outcomes and costs

Reimbursing through Bundled Prices for Care Cycles

Aligning reimbursement with value in this way rewards providers for efficiency in achieving good outcomes, while creating accountability for substandard care

Bundled Price

- A single price covering the **full care cycle for an acute medical condition**
- Time-based reimbursement for overall care of a **chronic condition**
- Time-based reimbursement for **primary/preventive care** for a **defined patient segment**

From Non-System to System

Κατεστραμμένο, αναποτελεσματικό σύστημα

Κατακερματισμένη, επεισοδιακή, χαοτική μη συντονισμένη φροντίδα

Πάροχοι απομονωμένοι

Μοντέλο οικιακής βιοτεχνίας

Πολλαπλά σημεία εισόδου

Πολλαπλά μονοπάτια φροντίδας

Διαφορές σε αποτελέσματα

Αδυναμία σύναψης μακρόχρονης σχέσης, Διάχυση ευθύνης

Αποζημίωση για την όγκο-ποσότητα υπηρεσιών

Ολιστική, συντονισμένη φροντίδα

Συνέχεια φροντίδας- μακρόχρονη σχέση συνεργασίας με ασθενή

Συνεργασία- διασύνδεση ιατρών, επαγγελματιών υγείας, υπηρεσιών, δομών

Κοινός στόχος η βελτίωση της υγείας του ασθενούς και του πληθυσμού

Ευθυγράμμιση των κινήτρων των παικτών- αποζημίωση παρόχων βάση της αξίας που παράγουν

Μέτρηση- καταγραφή-δημοσιοποίηση αποτελεσμάτων υγείας και κόστους για κάθε ασθενή

Ενσωμάτωση υψηλής τεχνολογίας

Διαφάνεια των αποτελεσμάτων

Swenson, Stephen MD, et al. **Cottage Industry to Postindustrial Care – The Revolution in Healthcare Delivery**. NEJM, January 20, 2010