Between EBM and organizational structures: is there room in the black box to support prevention in primary care?

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1. BETWEEN EBM AND HEALTH STRUCTURES

To foster prevention in primary care we find policies focused on:

- EBM

- ORGANIZATIONAL STRUCTURES AND INCENTIVES

Is there additional managerial room, which may provide more effectiveness?

Definition

Operation and process management in health care.
Its about
- micro-management;
- Process assessment and redesign
- Professional roles and content planning
- Service models
- ICT for service support

To implement:
- **Integrated care**
- **Ongoing patient education and engagement**
- **Collecting and monitoring patient outcomes data**

2. DISEASE MANAGEMENT PROGRAMS

Several European countries are developing *Disease Management Programs* (DMPs) as a systematic secondary prevention embedded in primary care

Why?

Chronic conditions are having a growing **epidemiological** and **economic impact** throughout the world.
30% of the population in chronic conditions spend 70% of health care budget

Definition

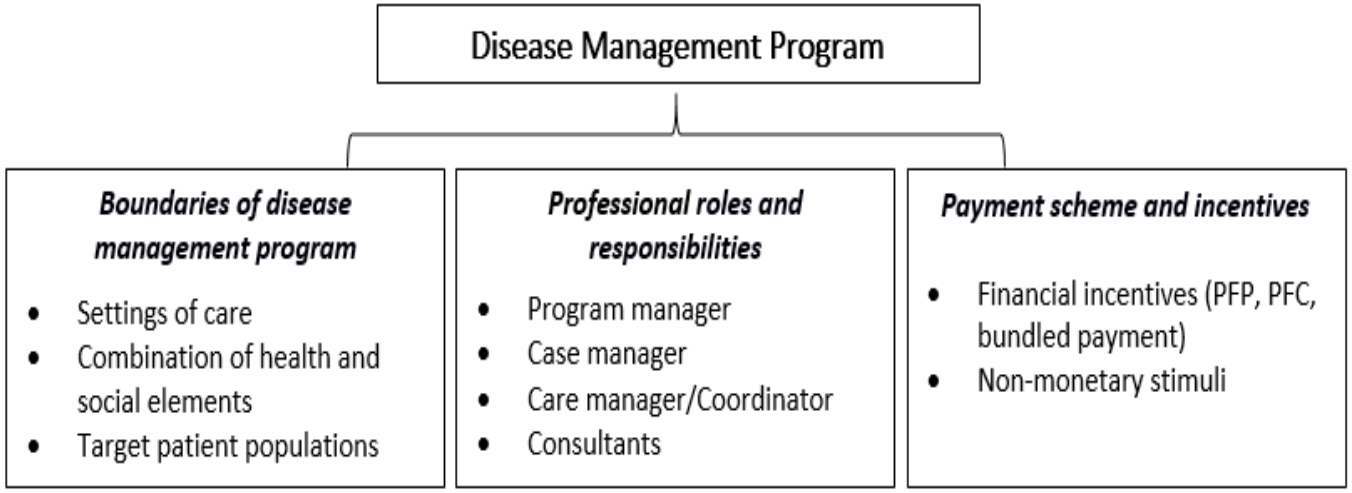
Disease management contents

- Proactive medicine
- Patient engagement and empowerment
- Case management to support patient compliance
- Multimorbidity approach
- Outcome oriented
- Systematic data sharing between patients, physicians, case managers

2. DISEASE MANAGEMENT PROGRAMS

✓ Assessing disease management programs as secondary prevention logics

A taxonomy that will be used to describe and compare the seven European DMPs selected for this study was developed.



2. DISEASE MANAGEMENT PROGRAMS

✓ Selection of countries

Six case studies were selected: the Netherlands, England, Germany, Sweden, Italy and France.

✓ Search strategy

A literature review in academic databases and search engines (Google Scholar, Pubmed and Scopus) was conducted.

✓ Country reports

This study provides an overview of the key features of the healthcare systems in each of the countries reviewed. Then, it highlights some of the main DMPs that have been implemented in the selected countries.


Primary care group ZIO (Maastricht–Heuvelland)


Integrated Care Pilots


Gesundes Kinzigtal


Esther model

CReG Model

Case della Salute


Sophia diabetes care programme

2. DISEASE MANAGEMENT PROGRAMS

Findings

Within which boundaries are broad programs for chronic conditions developed in Europe?

	Target population	Multimorbidity	Integration between health and social care	Settings
	Disease-specific	✗	✗	From prevention to LTC nursing
	Mixed	✓	✓	Complete care program
	Generalist	✓	✗	Complete healthcare program
	Elderly people	✗	✓	Complete care program (without prevention)
	Panel of conditions	✓	✗	Primary care-centered model
	Panel of conditions	✗	✓	Program without acute and sub-acute care
	Disease-specific	✗	✗	From prevention to LTC nursing

Table 1

2. DISEASE MANAGEMENT PROGRAMS

Findings

How are roles and functions defined and allocated within different DMPs?

	Program manager	Case manager	Care manager	Consultant	Clear indication of professional roles
	Regional GP Care Association	GPs	Nurses	Hospital specialists	★★★
	An appointed health care organization	Trained nurses	Mixed	Specialists, physiotherapists, dieticians and psychologists	★
	Gesundes Kinzigtal GmbH	Varied	Physicians or psychotherapist	Specialists, physiotherapists and psychologists	★★
	Qulturum	GPs	Mixed	Team specialists	★★
	Regione Lombardia, ASLs	GPs	Physician	Hospital specialists	★
	ASLs	Nurses	Nurses	Specialists	★★
	Government	Trained nurses	GPs	Specialists	★★★

Table 3

Note: ★=No clear indication (case-by-case approach); ★★=Standardized and rigid indication; ★★★=Tailored indication

2. DISEASE MANAGEMENT PROGRAMS

How are roles and functions defined and allocated within different DMPs?

Comments

- ✓ In nearly all analyzed DMPs, **nurses** generally play a **key role** in care coordination or case management.
- ✓ The **tasks and responsibilities** of nurses employed in selected DMPs **vary greatly**, from nurses forming an integral part of primary care (the Netherlands, England), to a limited involvement in defined areas of care delivery (Germany).
- ✓ The **allocation of roles** within European DMPs **is not always clearly defined** (e.g. by law, protocols or guidelines) but sometimes follows a *case-by-case approach*.

	Clear aim	***Detailed planning document***	***Case-by-case approach***	**Clear professional roles indication**		***Indication of professional roles***
				Standardized and rigid indications of roles	*Tailored according to disease stage or complexity of patient needs*	
	✓	✓			✓	★★★
	✓	✓	✓			★
	✓	✓		✓		★★
	✓	✓		✓		★★
 1	✓	✓	✓			★
 2	✓	✓		✓		★★
	✓	✓			✓	★★★

Table 4

2. DISEASE MANAGEMENT PROGRAMS

Findings

How are reward and compensation systems designed in European DMPs?

	INCENTIVES	Financial incentives					Non-monetary stimuli
		Lump sum	Capitation	PFP elements	PFC elements	Bundled payment scheme elements	
	**Both financial and nonmonetary**			✓		✓	✓
	**Both financial and nonmonetary**	✓					✓
	**Both financial and nonmonetary**		✓	✓	✓		✓
	**Only nonmonetary stimuli**						✓
 1	**Both financial and nonmonetary**			✓		✓	✓
 2	**Only financial**			✓			
	**Both financial and nonmonetary**		✓				✓

Table 5

2. DISEASE MANAGEMENT PROGRAMS

How are reward and compensation systems designed in European DMPs?

- ✓ Several programs involve **pay-for-performance elements**: usually, an additional reimbursement against the completion of defined tasks (Germany*)* and/or the accomplishment of measurable goals (Netherlands, Italy*)*.
- ✓ Nearly all selected disease management programs involve **non-monetary stimuli.**
- ✓ **Different actors** (program managers, providers and patients) receive financial and non-monetary incentives in the DMPs analyzed.

	Financial incentives (Lump sum, Capitation, Pay-for-performance elements, Pay-for coordination elements, Bundled payment scheme elements, Copayment reduction)	**Non-monetary stimuli**
Program manager		
Provider Organization		
Professionals		
Patients		

Table 6

2. DISEASE MANAGEMENT PROGRAMS

How are reward and compensation systems designed in European DMPs?

- ✓ Most financial incentives in European countries are related to the **structure** or **process** of care. This is an advantageous choice: the outcomes achieved depend on a range of factors, which are not always directly related on the quality of services.

	Financial incentives		
	Structure	**Process**	**Outcome**
	✓		✓
	✓	✓	
1		✓	✓
2	✓		✓
	✓		

*Table 7**

**NOTE: *Structure*=To implement DMPs, and recruit and enroll patients in DMPs; To put in place "integrated" forms of care (mostly packages that cross institutional/sectoral boundaries); *Process*= To keep patients in DMPs for a target period of time; To ensure that the care protocols specified in DMPs are followed; To reach predefined targets on process measures; *Outcome*= To reach predefined targets or to reward the top y% of providers on an indicator

3. OPERATION MANAGEMENT FOR PREVENTION IN PRIMARY CAREURES

Operation management in primary care is about:

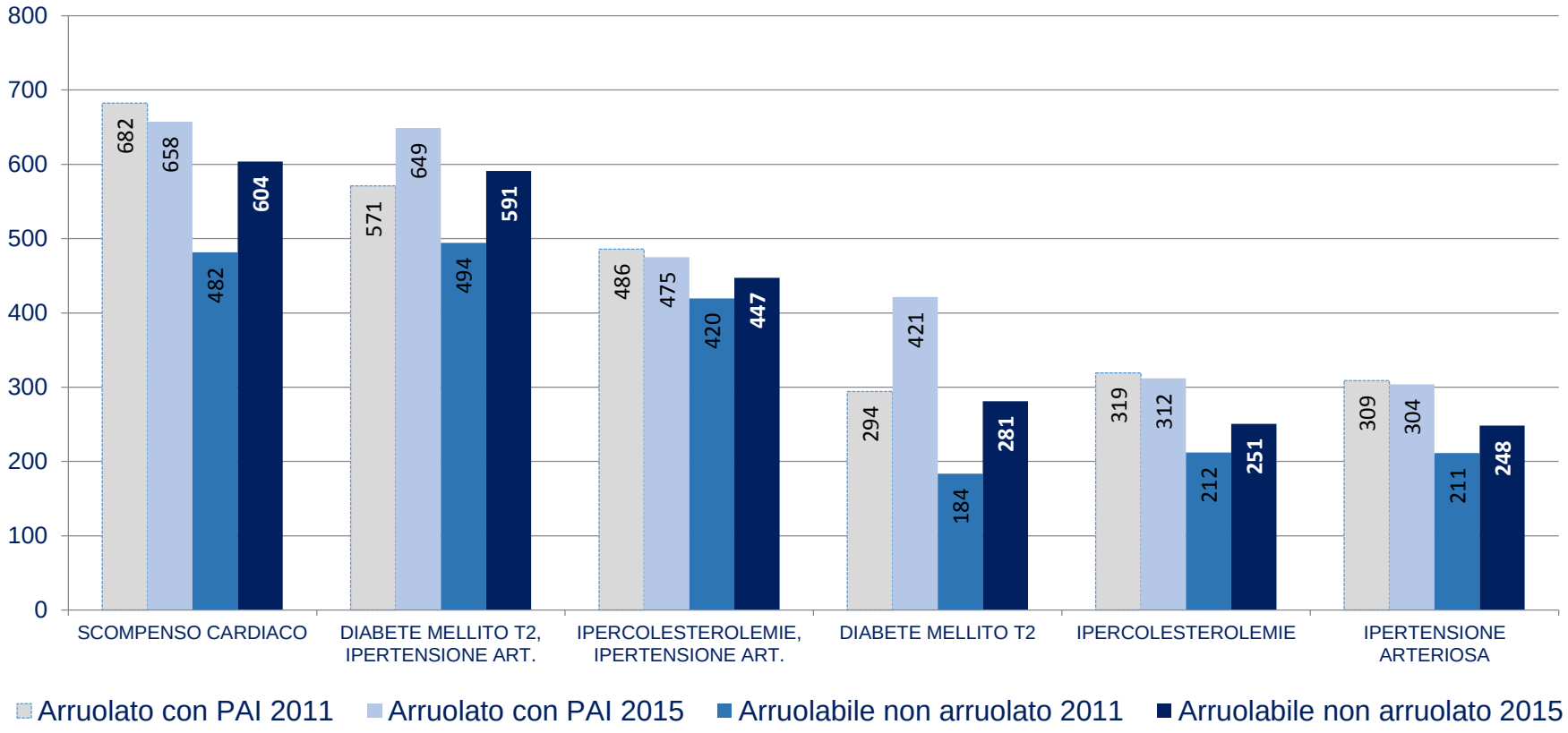
- Design service features (patient journey): no bureaucratic duties/direct access
- Clarify professional roles
- Target patients and proactively search for them
- CRM (patient relation management)
- ICT to support clinical decisions, to support patient compliance, to support professional integration

Operation management in health care is

- Opening the black box of service processes
- Searching for added value and cutting low value steps
- Setting epidemiological targets
- Considering different clusters of patients with different literacy and heterogeneous social networks

4. EVIDENCES FROM 90.000 PATIENTS IN LOMBARDY (CREG)

Drugs consumptions: a comparison between patient in CCM and others (2011; 2015), €

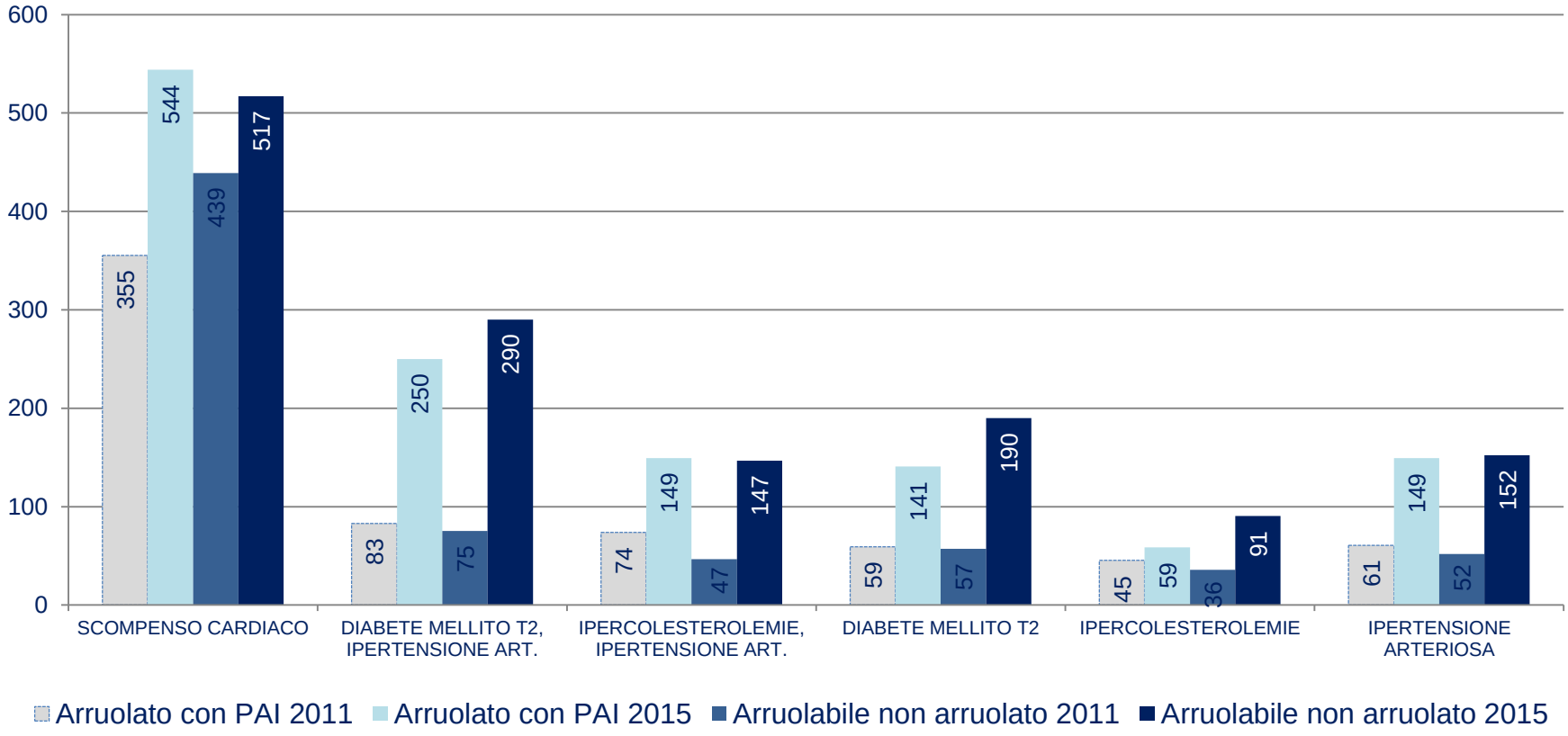


Patients selected for CCM are more expensive

From 2011 to 2015 the drug consumption gap between CCM patients and other has reduced

4. EVIDENCES FROM 90.000 PATIENTS IN LOMBARDY (CREG)

Hospital exenditures: a comparison between patient in CCM and others (2011; 2015), €, age 50-90



Hospital admission has a slower progression rate for CCM patients

5. SUGGESTION FOR THE FUTURE

THE RIGHT ATTENTION HAS BEEN GIVEN TO:

- EBM

- ORGANIZATIONAL STRUCTURES AND INCENTIVES

WE NEED A THIRD PILLAR: OPERATION MANAGEMENT IN PRIMARY CARE

IMPLEMENTATION ISSUES

Operation and process management in PRIMARY CARE IS:

- Outside GPS professional core competences;
- Far away from LHA management scope;
- Complex and clusterized
- For different disease stages the professional roles in the arena change: low standardization

To implement:

- **Results can be measured**
- **Enthusiasm can be generated improving results and patients commitment**
- **An interesting room for practical experiments**

Thank you for your attention