Health System Review Slovenia

Optimizing Service Delivery

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On behalf of Working Group 5

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Slovenia faces the same challenges as many other high-income countries

- Rising number of people with (complex) chronic conditions combined with ageing population
- Need to develop delivery systems that bring together a range of professionals and skills from both the cure (health care) and care (long-term and social care) sectors
- Failure to better integrate or coordinate services may result in suboptimal outcomes
- Evidence that is available points to a positive impact of coordinated care on the quality of patient care and improved health or patient satisfaction outcomes
‘Coordination’ and ‘integration’: the same but different?

- Integrated care traditionally refers to linking the cure (health care) and care (long-term, social care) sectors.
- But: different terms are used in different contexts and often interchangeably: collaborative care, case management, seamless care, continuity of care....
- Commonality: to improve outcomes for those with (complex) chronic health and care needs by overcoming issues of fragmentation through linkage of services of different providers along the continuum of care.
- Different types of integration can occur at different levels within the system, e.g.
  - Target: functional, organisational, professional, clinical
  - Hierarchical level / breadth: horizontal, vertical

Sources: Nolte & McKee (2008); Nolte & Pitchforth (2012)
Primary care as a hub for coordination and integration

Slovenia has a strong primary care system...

Source: Kringos et al. (2013)
small decline possibly reflects declining trend in adult smoking prevalence following introduction of smoking restrictions at workplace and public places from 2007

some evidence of earlier detection and treatment of COPD through family medicine ‘model practices’ from 2011 (Poplas-Susič et al., 2015)
Hospital admissions for chronic complications of diabetes, 2008-2012

- Declining levels of admissions among 70+ between 2008 and 2010
- Small increase from 2011 but overall levels lower than in 2012
  - Better access to treatment or earlier detection or both?
  - Trend follows strong decline in diabetes mortality from 2003
  - Need for systematic data collection and monitoring
...but fragmentation of service organization and delivery remains major challenge

Aims

➢ to analyse what key stakeholders (providers and patients) perceive to be the main challenges hindering the provision of high quality care for people with chronic and complex health and care needs

➢ to identify ‘best practices’ and lessons that can be learned to improve care coordination between professionals and sectors

What we did

▪ document review

▪ analysis of routine data

▪ conducted interviews and focus groups and a survey of providers and stakeholders in the Slovenia health system
Factors hindering provision of high quality care for people with complex needs (1)

Organizational constraints

- Lack of clarity about roles and responsibilities
  - Differing views among family physicians and secondary care specialists (e.g. diabetologists) about who should lead on patient education and support
  - Some scepticism about the new roles assumed by nurse practitioners in primary care (‘model practices’) in patient education, which previously had been the task of the family physician

- Lack of continuity in primary care, and of communication between primary and secondary care

- Lack of opportunity of having more direct access to decision support such as joint consultations with secondary care specialists:

  “The thing I miss is when people take medicine, there is not a possibility of consulting the secondary level ... We often deal with polymorbid patients. Why can’t I consult someone at that moment, when the patient is in front of me [to] help me get out of that situation? This would mean many fewer referrals and hospitalisations; patients would feel safer, and I would feel safer.” (family physician #3)
Factors hindering provision of high quality care for people with complex needs (2)

Capacity and infrastructure

➢ Lack of appropriate information technology, in particular adequate clinical information systems

Problems arise when a patient has multiple chronic diseases and is seen by several specialists; each one of them writes his/her own medication and nobody coordinates all these medications (specialist outpatient physician #2.1)

➢ Lack of standardized processes and procedures for the handover of patients between providers and care levels
  ▪ Lack of standardization of discharge papers seen to pose considerable challenges in ensuring continuing care especially for vulnerable people who are being discharged from hospital

➢ Perceived need for better guidance and protocols to help meet the multiple needs of complex older patients; recognition that implementation of such guidance might be faced with professional resistance
  ▪ Need to involve frontline staff in the development of processes and procedures
Factors hindering provision of high quality care for people with complex needs (3)

Professional autonomy

- Lack of autonomy perceived as major obstacle by community nurses: acute service delivery on doctor’s orders; reimbursement rules

  [Because of the ZZZS rules] we can visit patients only if they are alone and socially endangered... I cannot visit an elderly man in a family, check his blood pressure, his glucose level, activate his personal doctor, activate a specialist clinic at the primary level and warn that this person is living in circumstances where diabetes cannot be treated and managed appropriately because he does not have food, or water to wash legs at the primary ulcer stage. We could do many things, but our hands are tied. (community nurse #1)

External constraints

- Current reimbursement structure perceived to incentivize acute health problems and interventions over advising or counselling patients

  Quick services are valued most by ZZZS; for instance, when a person comes with angina and you indicate a check-up, this will be substantially better financed than someone for whom you took an hour and solved many problems, which will be financially positive for the state in long-term, because such patient also present a smaller burden for health care. But it is catastrophically evaluated, which is completely illogical! (family physician #6)
But there are several examples of good practice in Slovenia

Primary care level
- Family medicine ‘model practice’ widely regarded to be a promising step in enhancing care for those with multiple needs as they allow for a more systematic multi-disciplinary team approach to patient care
- Consultations with clinical pharmacist consultant for patients who use more than 8 medications, to enhance the management of drug side effects, drug interaction, and polypharmacotherapy more broadly (North East region)

Secondary care level
- ‘Care continuum and coordination nurses’ (North West region): important function in coordinating a given patient’s discharge from the hospital and as a case manager who takes on wider responsibilities in the coordination of different services to address the patient's needs
- Institute of Oncology in Ljubljana routinely shares the results from patient consultations with specialists with the patient’s family physician
- The creation of protocols and checklists according to the principles of orthogeriatric collaboration in Ljubljana, which has been found to significantly improve outcomes for older people with hip fracture
Family medicine ‘model’ practices acknowledged as promising model

- Evidence shows that specialised nursing practice for chronic disease management into the primary care setting can benefit outcomes
- But introducing new roles into a given system is widely acknowledged to create challenges for those affected
  - As family medicine ‘model practices’ are further rolled out in the Slovenia, there may be a need to adopt a more integrated programme for change
    - mechanisms to ensure that as new ways of working are adopted, old ones are abandoned and the roles and responsibilities are clarified
    - the needs of those giving up responsibilities are being considered
    - staff are involved in the change process
Measures to enhance coordination between care levels and providers (2)

Consider testing consultation liaison in primary care

- Established in a number of countries in Europe, found to lead to fewer referrals and diagnostics in secondary care in the Netherlands
- Good practice example: University Medical Centre Ljubljana has established joint consultations between care levels, perceived to “function well”
  - Roll-out across Slovenia will require assessment of pre-conditions that allow for this approach to ‘work’ at UMC Ljubljana and the extent to which conditions are replicable across other settings

Consider enhancing scope of practice for community nurses

- Core role in providing care to people in their homes and in strengthening care coordination and integration in the community and across sectors (Netherlands, UK)
  - If community nursing in Slovenia is to contribute to strengthening care outside hospital and care coordination there may be a need to reconsider the current restrictions placed upon community nurses’ scope of practice in terms of reimbursement modalities and more widely with regards to professional regulation and role definition
Measures to enhance coordination between care levels and providers (3)

Need to strengthen information technology to enable information sharing across levels

- consider evaluating initiative within National Diabetes Plan seeking to pilot sharing data on diabetes through electronic health records from autumn 2015

Consider rolling-out ‘Care continuum and coordination nurses’ (NW region) widely seen as example of good practice

- International evidence suggests that comprehensive support after discharge can reduce readmissions and might improve outcomes
- Roll-out will require systematic assessment of pre-conditions within which this model works in the NW region and the extent to which conditions are replicable across other settings

Consider revisiting 2004 Instructions for discharge procedures and to strengthen implementation as a ‘test case’ to identify key enablers

- Instructions for discharge procedures were formally issued in 2004, following an adverse event at that time. Instruction is as yet to be implemented, highlighting the need to raise awareness about existing guidance and reinforce implementation
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Thank you!

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