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INTEGRATED CARE IN MOSTAR: PRIORITIES FOR THE HEALTH SYSTEM

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Introduction: Integrated care could be defined differently and that is why the following terms can be found in the literature: integrated health, coordinated care, comprehensive care, seamless care, or trans-mural care. It has become a worldwide trend in health care reforms and new organizational arrangements focusing on more coordination between professionals and institutions and integrated forms of care or service provision. The Agency for Quality and Accreditation in Health Care in the Federation of Bosnia and Herzegovina (AKAZ) is using accreditation standards as a tool for quality improvement process aiming to increase the capacity of health care institutions in the Federation of Bosnia and Herzegovina in order to provide safe and quality care for the citizens. In the Agency, it is firmly believed that a wisely set and well-organized integrated care can help health professionals deliver health care in accordance with patient needs and even expectations. *Aim:* The aim of the study was to find out how to implement measures for integration of health care, to find out whether there are any gaps in the health care system, and how to bridge to the application of the best solutions of integrated care in the city of Mostar and Herzegovina-Neretva Canton (HNC). *Methods*: In this paper, we used feedback and results from the workshop held at the Federal Public Health Institute in Mostar as part of lectures for participants of the course within the Integrated Health Care module held in June 2019. The Integrated Health Care module is part of the Continuous Professional Education for Health Managers in the Federation of Bosnia and Herzegovina. Participants were experienced experts in different fields of medicine and pharmacists divided into two groups. *Results*: Participants identified the most common problems for both primary and hospital physicians, such as unclear referral system to specialist examination, inappropriate patient expectations from primary care, lack of communication between primary care and hospital care, and inadequate use of clinical practice guidelines. To solve these problems, both groups stressed the importance of common strategy documents and guidelines, which should provide clear framework for cooperation and integration including levels of competence and service prices. Furthermore, efficient information system is crucial for the integration or digitalization of, in strategy documents, agreed mechanisms of coordination and integration. Third, the growing proportion of elderly population should be taken in consideration, including the need of hospice and development of geriatric medicine in the Canton. Participants discussed and compared the results with feedback and results from three workshops held several years before. *Discussion*: The results of our study stressed the importance of better communication among different sectors, institutions and levels of health care involved in the treatment of patients, pointed to some measures for integration including standardized models of communication, training and education and highlighted priorities for integration. Analysis indicated the necessity for the following: regular analysis of unnecessary or inappropriate referrals and evaluation of such practices, as well as of any duplication of tests and prescriptions (failure to control costs); joint planning of preventive treatments (including the ministry and public health authorities); and clear responsibilities regarding screening programs and patient path analysis. *Conclusions*: Strong commitment of health care authorities and vision of integrated care and collaborative networks, as well as good communication and leadership were highlighted as key integrated care facilitators. Health care institutions at all levels of care have to organize multidisciplinary teams to work more on better and effective communication and to exchange information among key stakeholders in the system.

Key words: integrated health care, quality, communication, education

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INTRODUCTION

Integrated care could be defined differently and that is why the following terms are found in the literature: integrated health, coordinated care, comprehensive care, seamless care, or trans-mural care. It has become a worldwide trend in health care reforms and new organizational arrangements focusing on more coordination between professionals and institutions and integrated forms of care or service provision. Integrated care may be viewed as a response to the fragmented delivery of health services, which is especially important for the health-care system in the Federation of Bosnia and Herzegovina (1,2).

Integrated care covers a complex and comprehensive field, and there are many different approaches and definitions of the concept. The World Health Organization gives the following definition: "Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency" (3).

For the integration both ways are necessary, i.e. horizontal integration (linking services at the same level of care or institutions, such as multi-professional teams) and vertical integration (linking different levels of care, such as primary, secondary, and tertiary care).

The Agency for Quality and Accreditation in Health Care in the Federation of Bosnia and Herzegovina (AKAZ) uses accreditation standards as a tool for quality improvement process aiming to increase the capacity of health-care institutions in the Federation of Bosnia and Herzegovina to provide safe and quality care for the citizens. In the Agency, it is firmly believed that a wisely set and well-organized integrated care can help health professionals deliver health care in accordance with patient needs and even expectations. This is the reason why AKAZ management continuously works on integrated care finding the best applicable solutions and examples of good practice in order to improve accreditation standards and consequently the quality of services (4).

AIM

The aim of our study was to find out how to implement measures for integration of health care, to find whether there are any gaps in health-care system and how to bridge to the application of the best solutions of integrated care in the city of Mostar and Herzegovina-Neretva Canton (HNC).

METHODS

In this paper, we used feedback and results from the workshop held at the Federal Public Health Institute in Mostar as part of lectures for participants of the course for the Integrated Health Care module held in June 2019. The Integrated Health Care module is part of the Continuous Professional Education for Health Managers in the Federation of Bosnia and Herzegovina.

There were 18 participants attending the Course for third level (top managers) of the Continuous Professional Education, Standardized education (SHCE), including 16 physicians and two pharmacists from Mostar. Most of them are hospital physicians employed in Mostar University Clinical Hospital (n=13) and cantonal hospital (n=1). Two of them were from primary health centre and two pharmacists from community pharmacies. Physicians were from different specializations, as follows: ophthalmology (n=3), internal medicine (n=2), anesthesiology (n=2), surgery (n=1), pulmonology (n=1), transfusion medicine (n=1), neurology (n=1) and oncology (n=1). All attendees had passed basic and intermediary course for health managers and attended final level, which is mandatory for health managers in the Federation of Bosnia and Herzegovina.

The methodology used at the workshop was the same as at the previous ones on Continuous Professional Education for Health Managers and included introduction of participants, a lecture entitled Interface Theory and Protection Blocks in the Health System. Participants received definitions of the interface in a particular concept and how the interface interferes with the quality of care. Various responsibilities at the level of interface, and possible forms and relationships between primary health care (PHC) and the hospital were discussed. The interface model, as defined by the European Working Group on Quality in Family Practice (EQuiP) (5,6), was presented. It gave perspectives from the position of the health system as quality and perspectives of the patients and service providers. Ten EQuiP strategic targets were developed to improve the interface and goals associated with the action plan. Protection blocks (PHC, hospital and local community) were presented, along with relevant participants in the acute problem areas, e.g., variations encountered in referring patients to specialists or the hospital, poor communication between PHC and local hospitals, problems with hospital admissions, patient pathway through the hospital system – management immediately upon admission, planning release and discharge, returning to the PHC physician, and the community including community pharmacies. This was followed by an instructive example of ordering and discontinuing drug taking through the PHC and the hospital, which demonstrated how uncoordinated and poor communication in prescrib-

ing therapy often leads to drug interactions, unwanted drug effects, incomplete medical history, incomplete list of medications for release, and re-admission to hospital because of medical errors.

The second part took the form of working groups. Two groups were formed according to the participant affinities and places of employment. The first group consisted mostly of PHC practitioners and the second one of hospital doctors. The PHC practitioners had to list the five most common problems in communication with local hospitals, while hospital doctors had to list five priority issues in communication with PHC service. The goal was to identify the problems the colleagues were encountering, as well as the common problems that need to be solved in order to satisfy both sides. The second task was to describe what kind of education and training are required for the interface, and the final task for both groups was to list three priorities for organizing integrated health care in Mostar and HNC and to propose a possible new design of the health-care system organization. For the purpose of this paper, at the end of the exercise, the results of both groups of the workshop participants were analyzed and processed to be published.

RESULTS

Participants divided into two groups identified several common problems for both primary and hospital physicians, such as unclear referral system for specialist examination, inappropriate patient expectation from primary care, lack of communication between primary care and hospital care, absence of consultant medical examination and multidisciplinary arrangements and teams, and inadequate use of clinical practice guidelines and standard operative procedures.

Primary care physicians claim that they are under pressure by their patients concerning referral to hospital for specialist examination. Hospital physicians think that most of these patients can have their diagnosis, therapy and rehabilitation at the PHC level and that most of them cause unnecessary burden and increase costs for hospitals. Further problems are diagnoses given to patients. Hospital physicians complain that PHC physicians change their diagnoses and modify therapy (drugs and dosages). Specialists from hospitals believe that they are experts and have authoritative knowledge, while their PHC colleagues say that hospital physicians care only for diagnoses from the narrow scope of their specialization, forgetting patient overall health condition. Also, they both complain of the lack of communication related to information on the patient admitted to the hospital. Hospital physicians say that their colleagues from health centers are not interested to have information on their patient health status; it is especially a problem after hospital treatment when they need to send the patient back to family medicine clinic or community. Primary care physicians claim that their colleagues are not willing to share information with them and that is very difficult to even reach them and have feedback. Physicians from both levels emphasize that a common problem is that they do not use clinical practice guidelines to establish the competencies and scope of treatment for particular diseases.

Also, they have common understanding that joint training courses and education sessions will help a lot in solving most of these problems, and that they should preferably work together to develop clinical practice guidelines. They believe that clinical practice guidelines jointly developed and used by health-care professionals from both levels of care would improve communication between the sectors and the quality of care provided. Clinical practice guidelines should define the lines of responsibility between PHC and hospital doctors and establish the line of authority/competencies. Furthermore, health authorities should help in forming multidisciplinary teams to work more on better communication and exchange of information between the levels of care.

To solve these problems, both groups stress the importance of common strategy documents and guidelines which should give clear framework for cooperation and integration including the levels of competence and service prices. Furthermore, efficient information system is crucial for the integration or digitalization of strategy documents, and agreed mechanisms of coordination and integration. Third, considering the growing proportion of elderly population, there is the need for hospice and development of geriatric medicine in the Canton. The participants discussed and compared the results presented with feedback and results from three workshops previously held in Tuzla on October 16, 2007, Bihać on December 9, 2013, and Sarajevo on November 24, 2018, which have already been analyzed and published (7).

DISCUSSION

The results of our study emphasize the importance of better communication among different sectors, institutions and levels of health care involved in the treatment of patients, point to some measures for integration including standardized models of communication, training and education and highlight the priorities for integration.

Political support and commitment, as well as clear strategies at the national or regional level are fundamental to enable integrated care at the system level (8). It is important to point out that integrated care is not a goal by itself but a tool to address complex care needs of people that require a systemic approach involving professionals and skills from the health care and social care sectors. The complexity of this intervention is a challenge for policy makers, health economists and health-care providers (9).

From the beginning, the management of the AKAZ has been working continuously on the integration of health care as one of the most important elements of the system with a large potential to improve the quality of care. Their work includes research, analysis and implementation of findings of AKAZ activities through the use of accreditation standards and their implementation in practice (10,11). Also, global changes and future trends in shaping modern health systems have been taken into account (12). The Tuzla Workshop was part of the Quality Improvement and Accreditation Program sub-project presenting accreditation standards to family medicine teams at the Tuzla, Kladanj and Orašje Health Centers and to hospital representatives from the Tuzla University Clinical Centre and Orašje Cantonal Hospital. The Bihać Workshop was part of staff training at the Cantonal Hospital with colleagues from health centers in Bihać, Sanski Most, Bosanska Krupa and Ključ. Also, a workshop was held at the Business Academy of the Economics and Business Faculty of Sarajevo University as part of a lecture course for the Integrated Health Care at the Second Level of Continuous Professional Education for Health Managers. The purpose of these workshops was to identify the main problems encountered by family medicine teams, local hospitals and other key actors in the health-care system and to address issues in ensuring continuity of coverage and better communication among family medicine, hospitals and patient-focused pharmacies. The analysis indicated the necessity for the following: regular analysis of unnecessary or inappropriate referrals and evaluation of such practices, as well as of any duplication of tests and prescriptions (failure to control costs); joint planning of preventive treatments (including the ministry and public health authorities); and clear responsibilities regarding screening programs and patient path analysis (7).

CONCLUSIONS

Strong commitment of health-care authorities and vision for integrated care and collaborative networks, as well as good communication and leadership were highlighted as the key facilitators of integrated care. Health-care institutions at all levels of care have to organize multidisciplinary teams to work more on better and effective communication and to exchange information among key stakeholders in the system. The analysis pointed to gaps such as unnecessary or inappropriate referrals to the hospital, unclear responsibilities among various levels of care, especially after patient discharge from the hospital. Also, the role of standardized communication protocols and forms should be in place to define and improve communication among health professionals at different levels of care, to moderate integration processes, and to protect data and patient privacy. The participants recognized the importance of joint training course and education sessions, and that they have to work together on development of clinical practice guidelines, improved communication between sectors and overall quality of health care provided, as well as to build an efficient information system to support health professionals.

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SAŽETAK

INTEGRIRANA SKRB U MOSTARU: PRIORITET ZA ZDRAVSTVENI SUSTAV

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Uvod: Integrirana skrb može se različito definirati i to je razlog zbog kojeg se u literaturi mogu naći sljedeći pojmovi: integrirano zdravlje, koordinirana njega, sveobuhvatna njega, besprijekorna njega ili transmuralna njega. Postala je svjetski trend u reformama zdravstva i novim organizacijskim aranžmanima koji su usredotočeni na veću koordinaciju između stručnjaka, institucija i pružatelja usluga. Agencija za kvalitet i akreditaciju u zdravstvu u Federaciji Bosne i Hercegovine koristi akreditacijske standarde kao alat za poboljšanje kvalitete s ciljem povećanja kapaciteta zdravstvenih ustanova u Federaciji Bosne i Hercegovine za pružanje sigurne i kvalitetne skrbi za građane. U Agenciji čvrsto vjeruju da mudro postavljena i dobro organizirana integrirana skrb može pomoći zdravstvenim radnicima da pruže zdravstvenu skrb u skladu s potrebama, pa čak i očekivanjima pacijenta. ***Cilj:*** Otkriti i analizirati kako se provode mjere za integraciju zdravstvene zaštite, postoje li nedostatci u zdravstvenom sustavu i kako ih premostiti za primjenu najboljih rješenja integrirane skrbi u gradu Mostaru i Hercegovačko-neretvanskoj županiji. ***Metode:*** U ovom smo radu koristili povratne informacije i rezultate radionice Federalnog zavoda za javno zdravstvo u Mostaru u sklopu predavanja za polaznike tečaja u okviru modula Integrirana zdravstvena zaštita održanog u lipnju 2019. Integrirani modul zdravstvene zaštite je dio kontinuiranog stručnog usavršavanja za zdravstvene menadžere u Federaciji Bosne i Hercegovine. Sudionici radionice bili su iskusni liječnici specijalisti različitih specijalnosti i farmaceuti podijeljeni u dvije skupine. ***Rezultati:*** Sudionici su odredili najčešće poteškoće za uspostavljanje integrirane zdravstvene zaštite kako za primarne, tako i za bolničke liječnike, a to su: nejasan sustav upućivanja na specijalistički pregled, neprimjereno očekivanje pacijenta od liječnika primarne zdravstvene zaštite, nedostatak komunikacijskog kanala između primarne i tercijarne bolničke skrbi i nedosljedna uporaba smjernica za kliničku praksu. Za rješavanje ovih problema obje skupine ističu važnost zajedničkih strateških dokumenata i smjernica koje bi trebale dati jasan okvir za suradnju i integraciju uključujući razinu stručnosti i cijene usluga. Nadalje, učinkovit informacijski sustav ključan je za integraciju ili digitalizaciju, u strateškim dokumentima, dogovorenih mehanizama koordinacije i integracije. Treće, potrebno je uzeti u obzir starenje populacije, nužne potrebe za hospicijima i razvoj gerijatrijske medicine u Županiji. Sudionici su raspravljali i uspoređivali svoje rezultate s povratnim informacijama i rezultatima ostalih triju istovjetnih radionica održanih ranijih godina. ***Rasprava:*** Rezultati naše studije istaknuli su važnost bolje komunikacije između različitih sektora, institucija i razina zdravstvene zaštite uključenih u liječenje pacijenata te istaknuli određene mjere integracije uključujući standardizirane modele komunikacije, obuke i obrazovanja te istaknute prioritete integracije. Analiza je ukazala na potrebu za sljedećim: redovitim analizama nepotrebnih ili neprikladnih uputnica i procjenom takve prakse, kao i podvostručenja testova i recepata (propust u kontroli troškova); zajedničko planiranje preventivnih tretmana i jasne odgovornosti u vezi s programima probira i analizom puta pacijenta. ***Zaključci:*** Snažna predanost zdravstvenih vlasti, vizija integrirane skrbi i suradničke mreže, kao i dobra komunikacija i vodstvo istaknuti su kao ključni pokretači integrirane skrbi. Zdravstvene ustanove sa svih razina skrbi moraju organizirati multidisciplinske timove koji će raditi na boljoj i učinkovitijoj komunikaciji i razmjeni informacija između ključnih dionika u sustavu.

Ključne riječi: integrirana zdravstvena zaštita, kvaliteta, komunikacija, obrazovanje