Taller
“Análisis funcional y conformación de Redes Integrales e Integradas de Servicios de Salud”

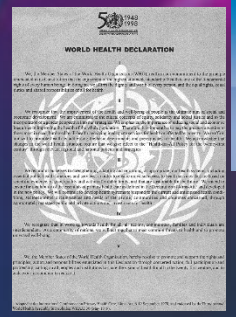
Bogotá, 27 a 29 de noviembre 2023

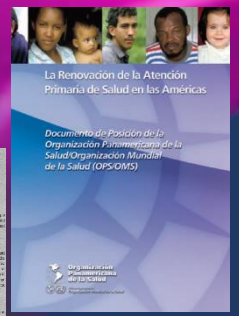
Marco para el trabajo de Redes Integradas de Servicios de Salud

Sergio Minué Lorenzo

OPS Organización Panamericana de la Salud
Organización Mundial de la Salud OFICINA REGIONAL PARA LAS Américas
COLOMBIA POTENCIA DE LA VIDA
Salud

45 años de Itinerario estratégico de la OMS

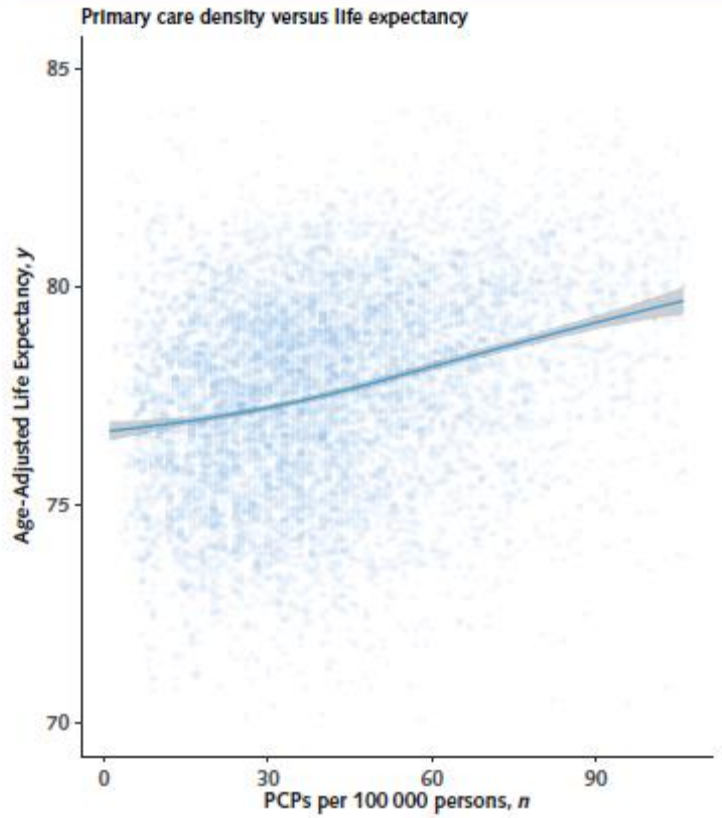




OPS
Organización Panamericana de la Salud
Organización Mundial de la Salud Américas

OPS 120 ANIVERSARIO

Figure 1. Relationship between PCP density (PCPs per 100 000 persons) and age-adjusted life expectancy (in years) among 3104 counties across 3 years (2010, 2015, and 2017).



ORIGINAL RESEARCH

Annals of Internal Medicine

Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States

Sanjay Basu, MD, PhD; Russell S. Phillips, MD; Seth A. Berkowitz, MD, MPH; Bruce E. Landon, MD, MBA; Asaf Bitton, MD, MPH; and Robert L. Phillips, MD, MSPH

OPS Organización Panamericana de la Salud | Organización Mundial de la Salud Américas

OPS 120 ANIVERSARIO

Health Policy 118 (2014) 56–65

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

The effect of physician supply on health status: Canadian evidence

Emmanuelle Piérard*

JAMA Internal Medicine | Original Investigation

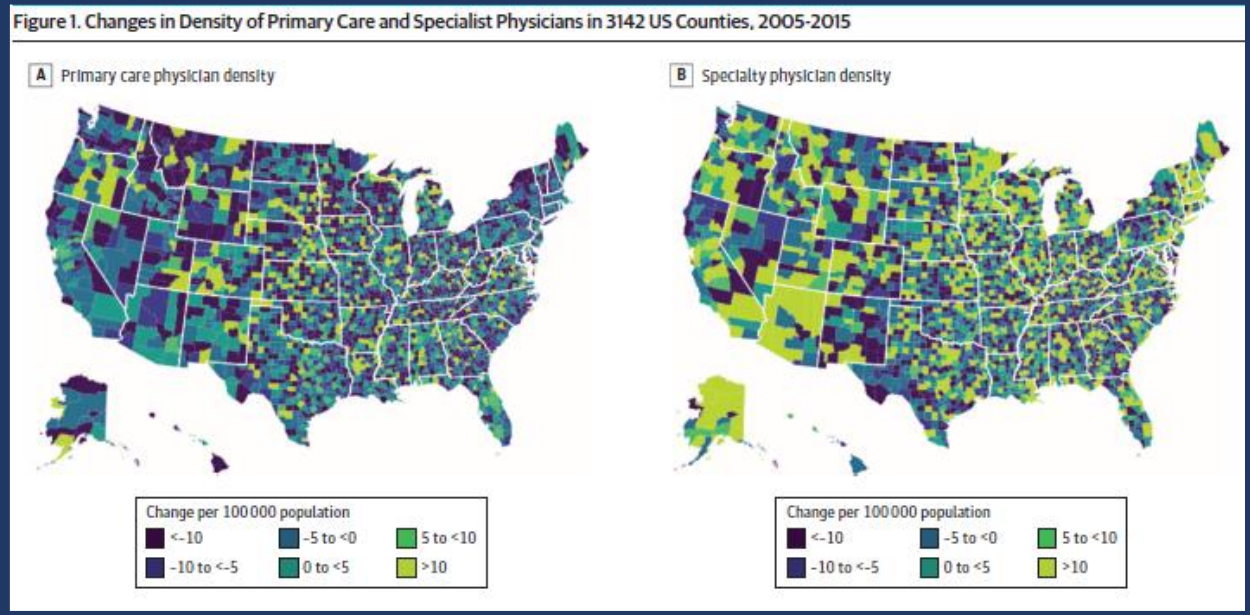
Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015

Sanjay Basu, MD, PhD; Seth A. Berkowitz, MD, MPH; Robert L. Phillips, MD, MSPH; Asaf Bitton, MD, MPH; Bruce E. Landon, MD, MBA; Russell S. Phillips, MD

Una mayor oferta de médicos generales se relaciona con mejores resultados de salud.

Una mayor oferta de especialistas se relaciona con peores resultados de salud.

Figure 1. Changes in Density of Primary Care and Specialist Physicians in 3142 US Counties, 2005-2015



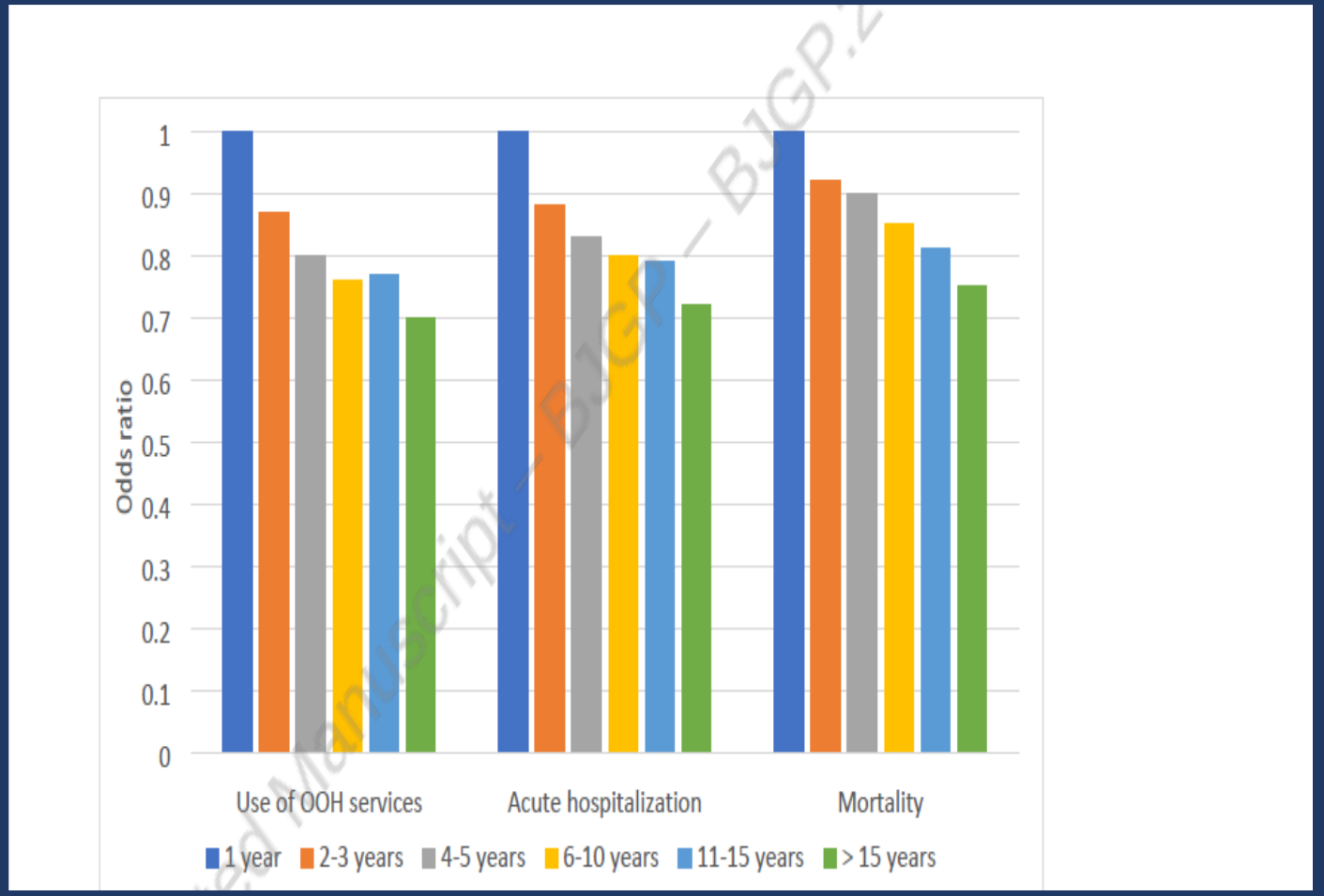
Más de 15 años con el mismo médico de Atención Primaria reduce la mortalidad hasta un 30%

Research

Hogne Sandvik, Øystein Hetlevik, Jasper Blinkenberg and Steinar Hunskaar

Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care:

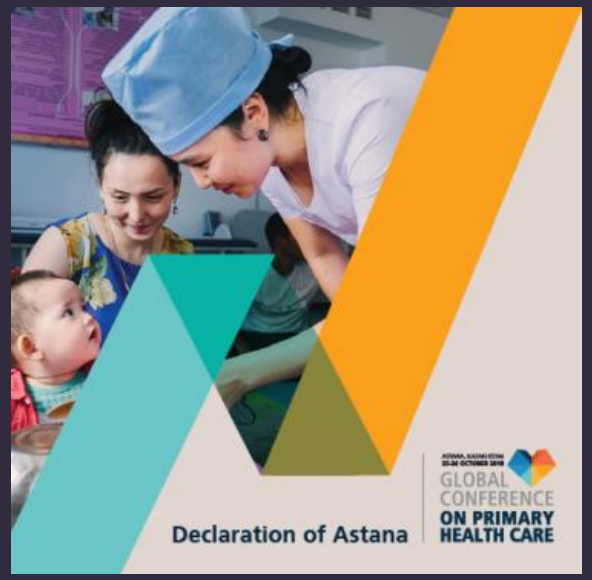
a registry-based observational study in Norway



OPS Organización Panamericana de la Salud | Organización Mundial de la Salud Américas

OPS 120 ANIVERSARIO

Declaración de Astana
Los tres componentes de la APS



SERIE

La Renovación de la Atención Primaria de Salud en las Américas

Redes Integradas de Servicios de Salud

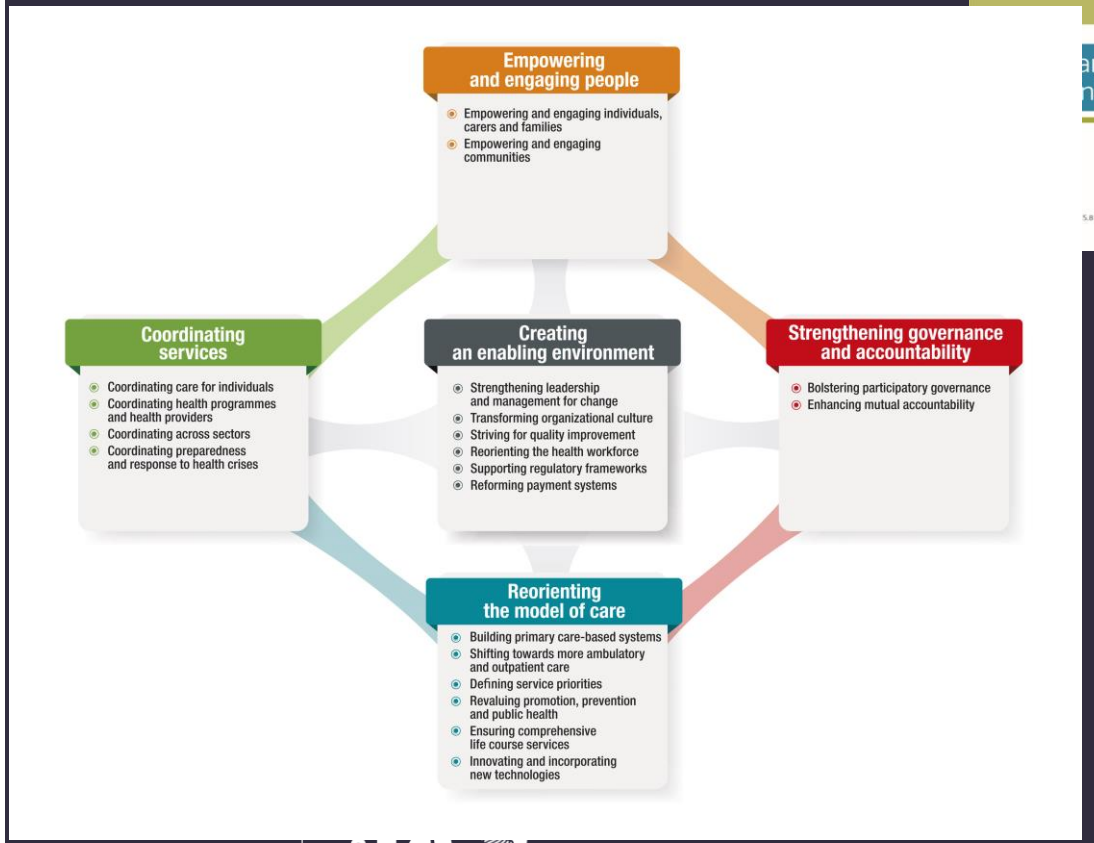
Conceptos, Opciones de Política y Hoja de Ruta para su Implementación en las Américas

Organización Panamericana de la Salud

Oficina Regional de la Organización Mundial de la Salud

Atributos esenciales de las RISS

Ámbitos de Abordaje		
Modelo asistencial	Población y territorio a cargo definidos y amplio conocimiento de sus necesidades y preferencias en cuestiones de salud que determinan la oferta de servicios de salud	1
	Una extensa red de establecimientos de salud que presta servicios de promoción, prevención, diagnóstico, tratamiento, gestión de enfermedades, rehabilitación y cuidados paliativos, y que integra los programas focalizados en enfermedades, riesgos y poblaciones específicas, los servicios de salud personales y los servicios de salud pública	2
	Un primer nivel de atención multidisciplinario que cubre a toda la población y sirve como puerta de entrada al sistema, que integra y coordina la atención de salud, además de satisfacer la mayor parte de las necesidades de salud de la población	3
	Prestación de servicios especializados en el lugar más apropiado, que se ofrecen de preferencia en entornos extra hospitalarios	4
	Existencia de mecanismos de coordinación asistencial a lo largo de todo el continuo de los servicios de salud	5
	Atención de salud centrada en la persona, la familia y la comunidad, teniendo en cuenta las particularidades culturales y de género, y los niveles de diversidad de la población	6
Gobernanza y estrategia	Un sistema de gobernanza único para toda la red	7
	Participación social amplia	8
	Acción intersectorial y abordaje de los determinantes de la salud y la equidad en salud	9
Organización y gestión	Gestión integrada de los sistemas de apoyo clínico, administrativo y logístico	10
	Recursos humanos suficientes, competentes, comprometidos y valorados por la red	11
	Sistema de información integrado que vincula a todos los miembros de la red, con desglose de los datos por sexo, edad, lugar de residencia, origen étnico y otras variables pertinentes	12
	Gestión basada en resultados	13
Asignación e incentivos	Financiamiento adecuado e incentivos financieros alineados con las metas de la red	14



ards people-centred
ntegrated health services

World Health Organization | Service Delivery and Safety

Organización Panamericana de la Salud | Organización Mundial de la Salud Américas

ANIVERSARIO

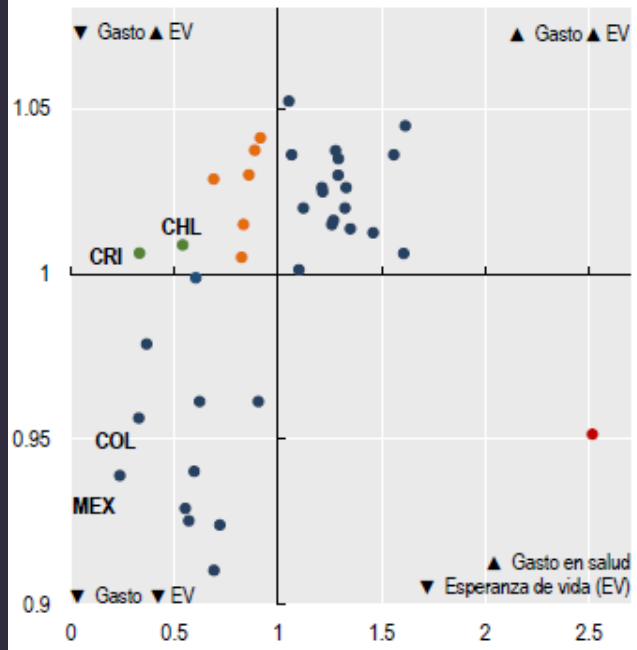
Panorama de la Salud 2023
Indicadores OCDE

Frederico Guanais
Jefe de división adjunto, División de la salud, OCDE

6 Noviembre 2023

Estado de salud – Costa Rica y Chile por encima, México y Colombia por debajo del promedio OCDE

EV & gasto en salud comparado al promedio OCDE



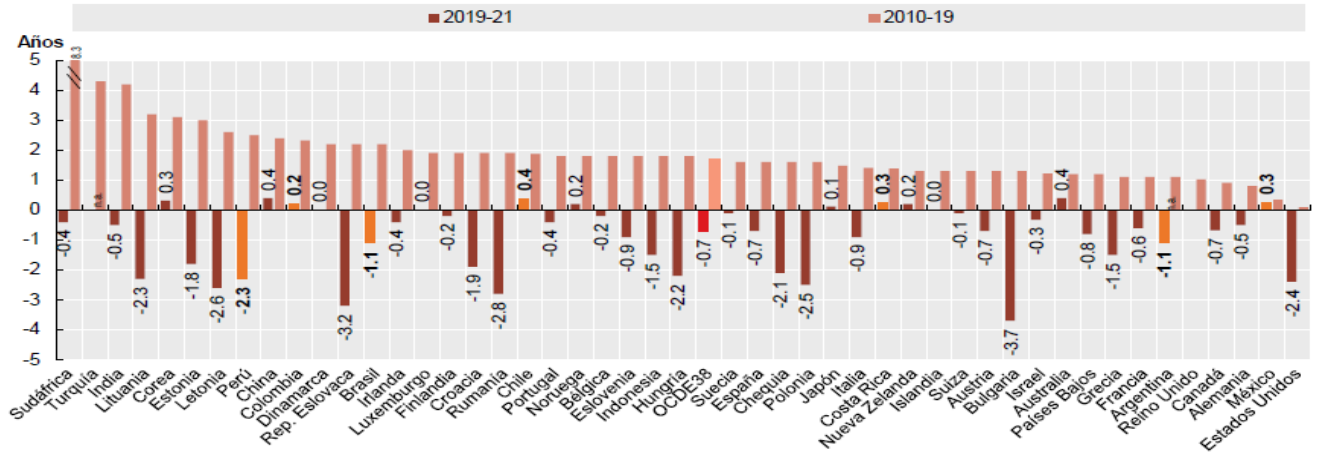
CHILE
- Mejor desempeño que el promedio OCDE en **63%** de los indicadores de estado de salud reportados en PdS 2023
- Esperanza de vida 22.º de 38 países OCDE, gasto en salud per capita 5 .º más bajo

COLOMBIA
- Mejor desempeño en **38%** de los indicadores de estado de salud
- Esperanza de vida 31.º de 38, gasto en salud 2.º más bajo

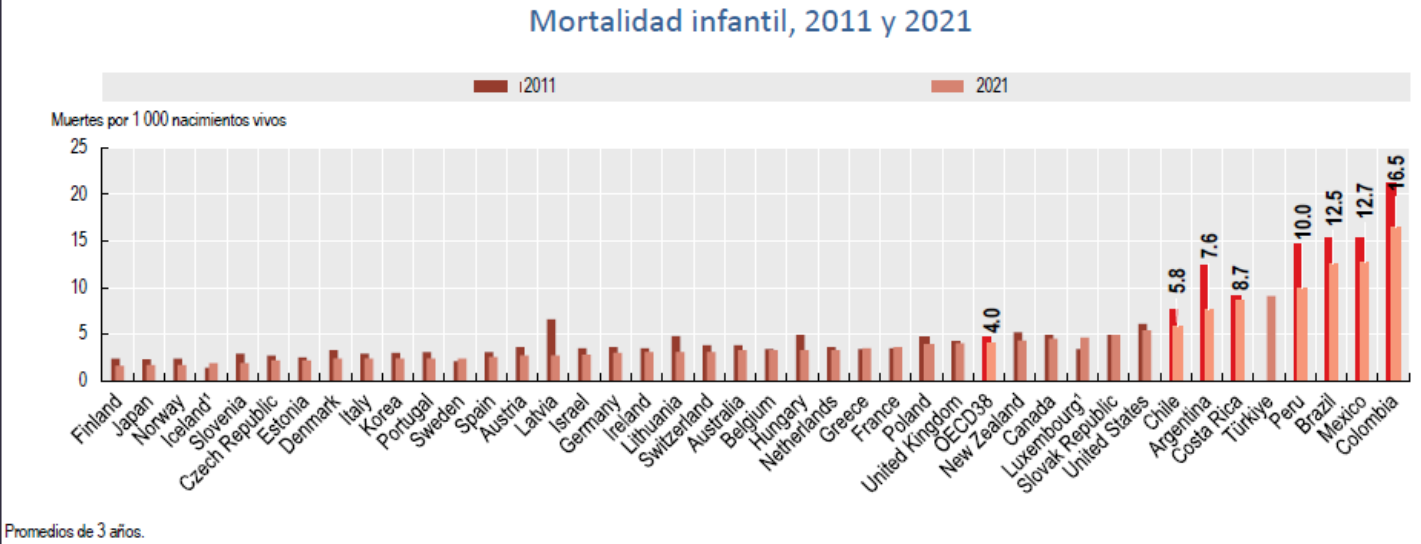
COSTA RICA
- Mejor desempeño en **75%** de los indicadores de estado de salud
- Esperanza de vida 23.º de 38, gasto en salud 3.º más bajo

MEXICO
- Mejor desempeño en **36%** de los indicadores de estado de salud
- Esperanza de vida 34.º de 38, gasto en salud 1.º más bajo

La esperanza de vida en los 4 países latinoamericanos de la OCDE subió ligeramente en la pandemia



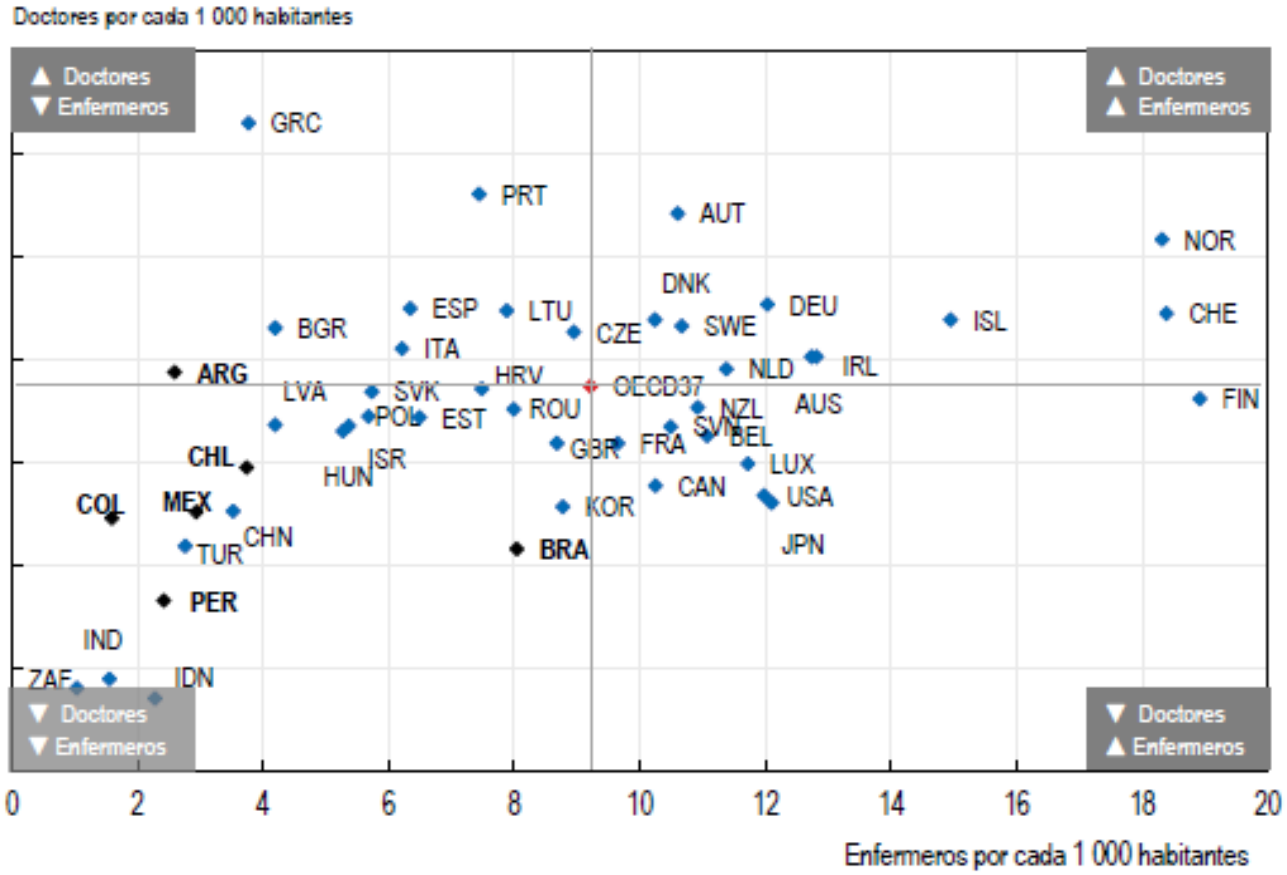
La mortalidad infantil sigue elevada en Latinoamérica comparada con el resto de la OCDE

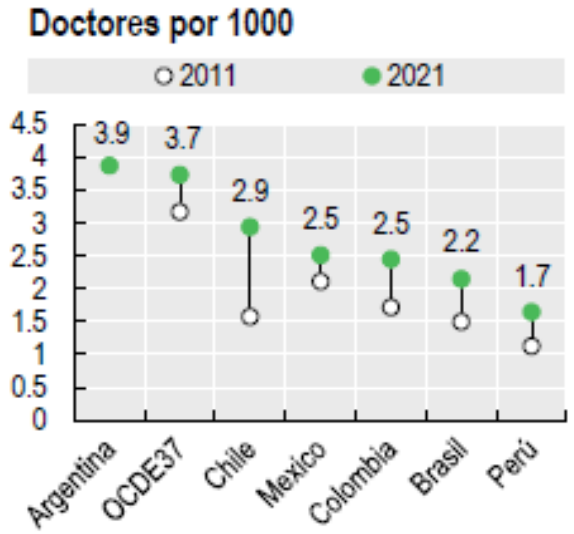


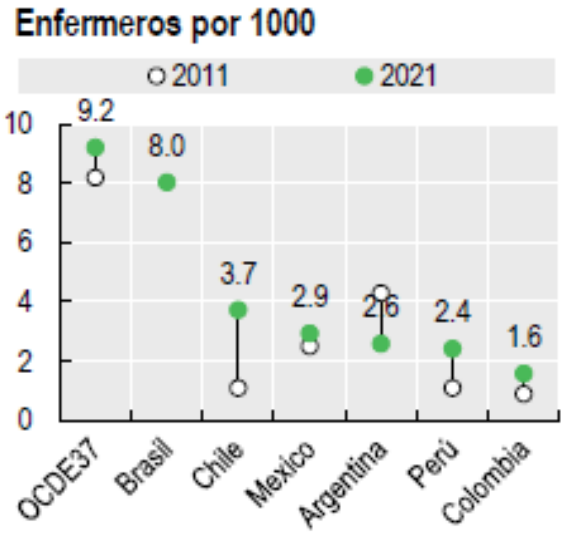
Promedios de 3 años.

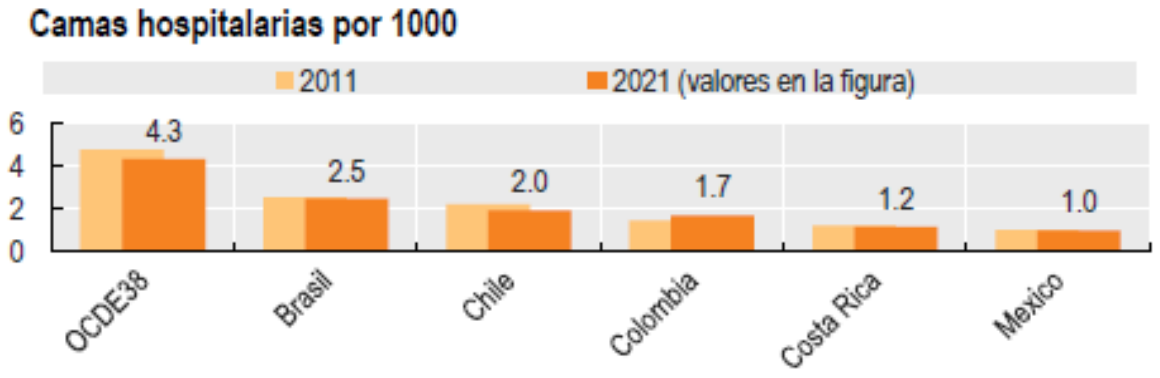
Latinoamérica cuenta con menos personal médico, menos camas hospitalarias que el promedio OCDE

Densidad de doctores y enfermeros, países OCDE, acceso y asociados, 2021









Colombia: poco personal de salud; alta mortalidad evitable y tratable; bajo gasto de bolsillo

Hay 2,5 médicos por cada 1 000 habitantes (promedio de la OCDE de 3,7); y 1,6 enfermeras (promedio de la OCDE de 9,2)

El consumo de alcohol fue inferior al promedio de la OCDE: 4,1 litros per cápita frente a 8,6

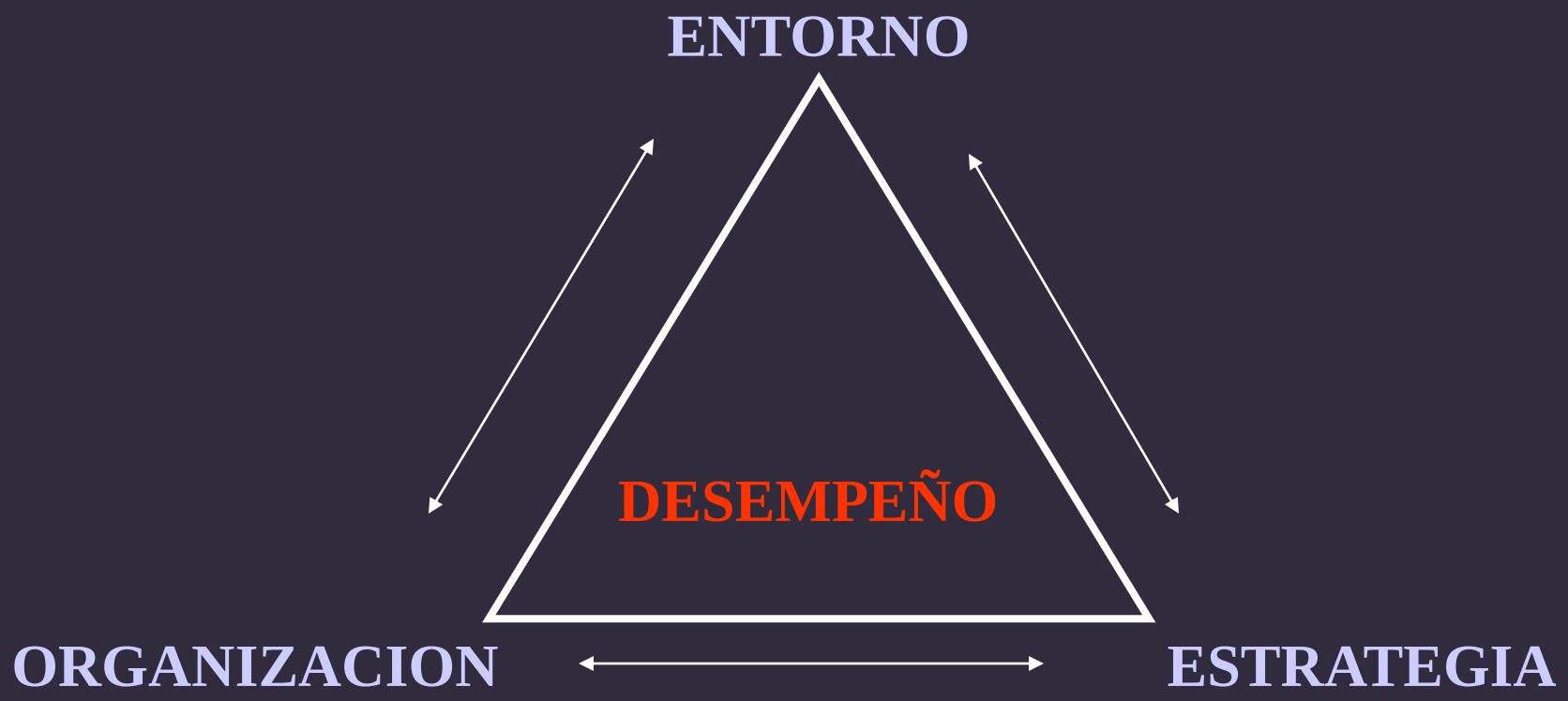
La mortalidad evitable fue de 223 por 100 000 (superior al promedio de la OCDE de 158); con una mortalidad tratable de 105 por 100 000 (más alta que el promedio de la OCDE de 79)

Colombia gasta $1 640 per cápita en salud, menos que el promedio de la OCDE de $4 986 (USD PPA), pero gasto de bolsillo es igual ao promedio OCDE (24%)

¿De que hablamos cuando hablamos de Integración?

375 defiiniciones de Integrated Care (Armitage 2009)

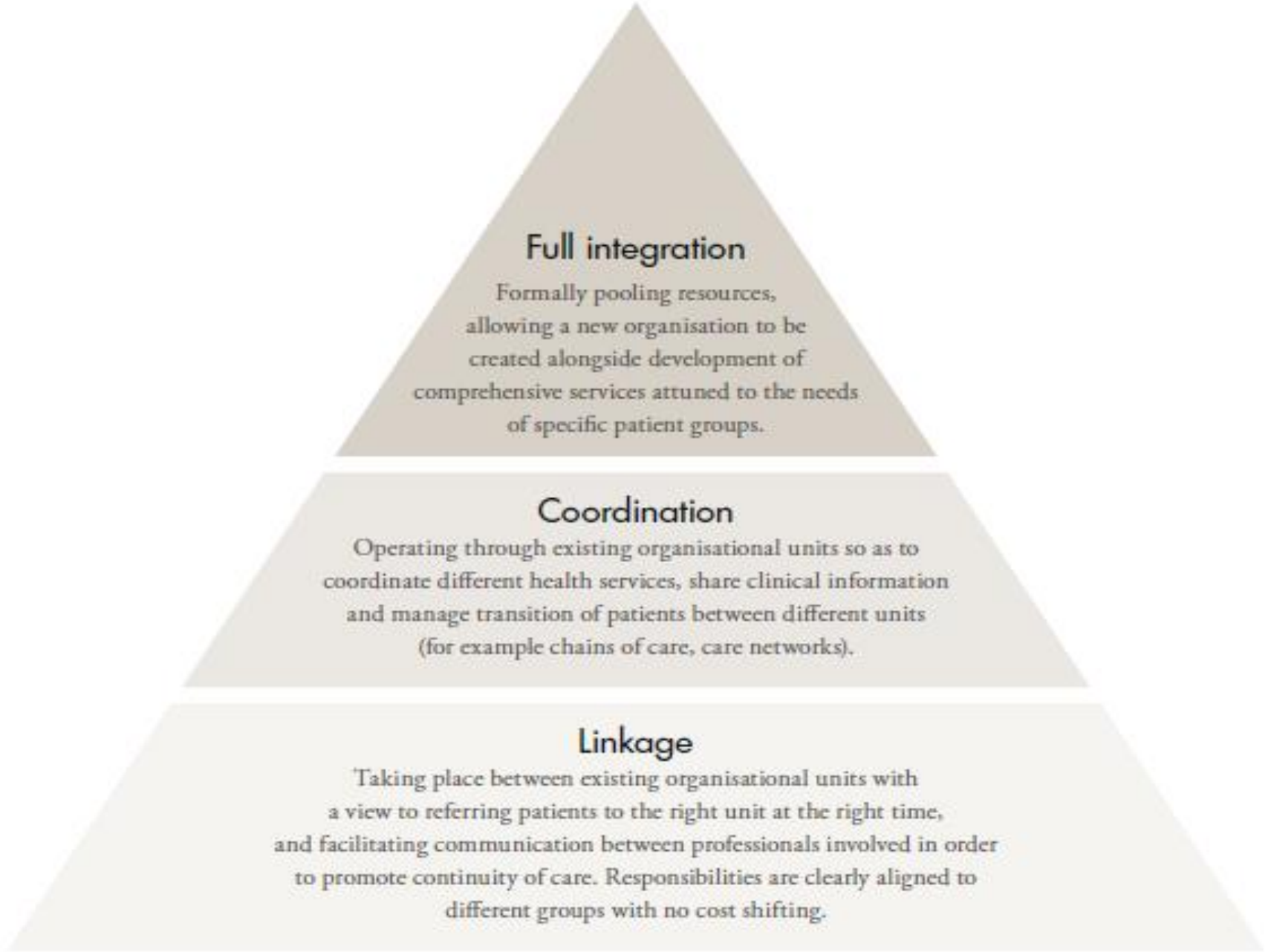
Imagen. Kings Fund web



(The modern firm.Roberts 2004)

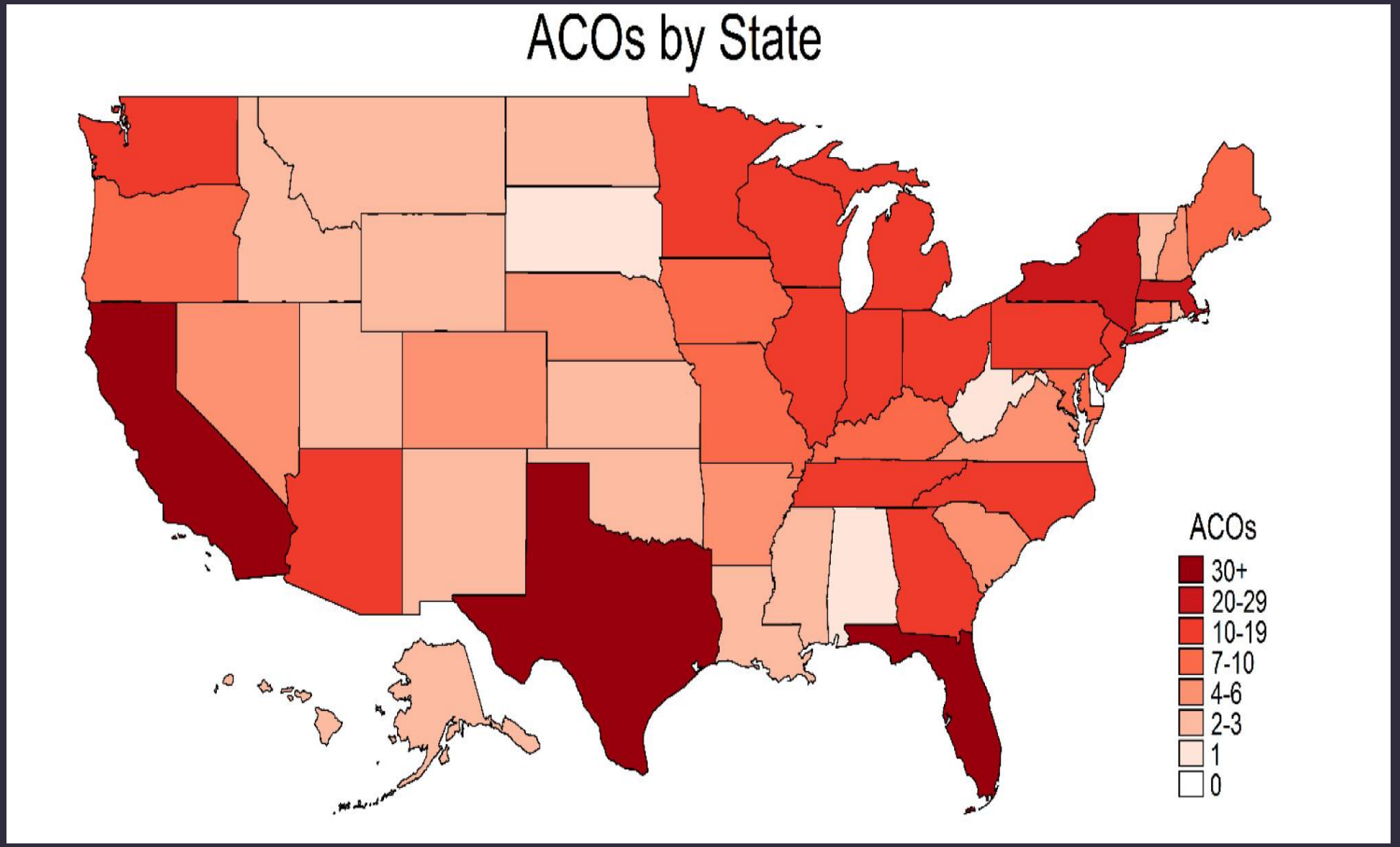
Redes integradas
Palabras clave

- **SHORTELL (1994)**
  - Red
  - Población
  - Coordinación
- **RISS (OPS 2010)**
  - Red
  - Población en territorio
  - Rendición de cuentas

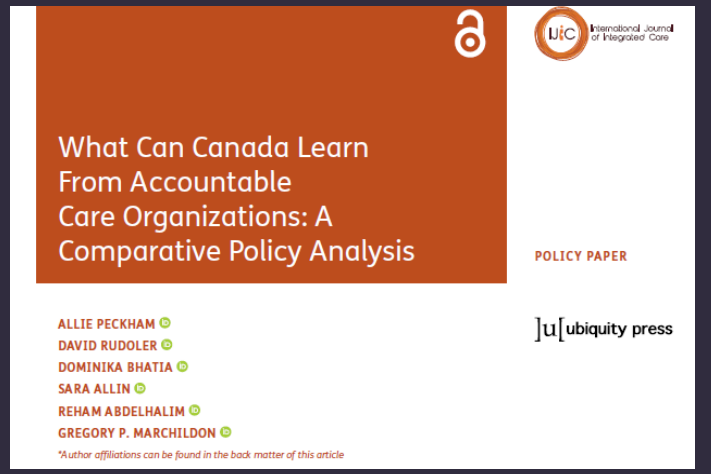


*Adapted from Leutz, 1999

517 ACO en 50 estados (2020)

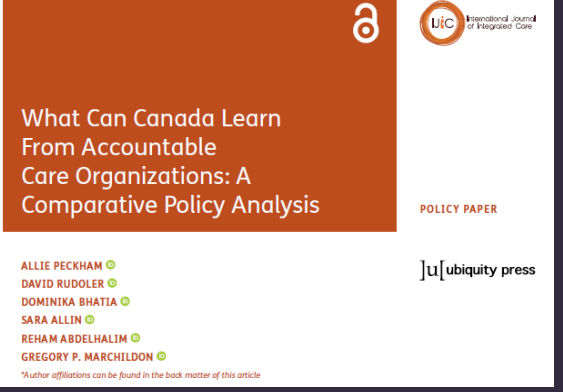


Health Affairs blog.



MODEL TYPE	RISK AND SHARED SAVINGS	NUMBER OF ACOS	NUMBER OF BENEFICIARIES
Medicare Shared Savings Program, MSSP (2012-ongoing) [29]	One-sided: Share savings with the CMS up to a maximum of 50% (if quality performance standards are met). Two-sided: Larger share of savings in exchange for sharing losses with CMS. Maximum 60% (if quality performance standards are met).	One-sided (2020): 325 Two-sided (2020): 192	Total (2020): 11.2 million Mean per ACO (2020): 21,663
Pioneer ACO Program (2012–2016) [34, 35]	Originally less financial risk. Not responsible to pay CMS for any losses during contract period.	32 launched (2012) 9 remaining in 2016	Total (2014): 816,362 Mean per ACO (2014): 35,494
Advanced Savings Model, ASM (2012–2015) [30, 31]	One-sided: Share savings only with the CMS 50%. Two-sided: Larger share of savings in exchange for sharing loses with CMS. Savings/loss rates: 2–3.9% based on ACO size (difference between an ACOs benchmark and actual spending).	36 launched (2012) 33 remaining in 2015	Total (2014): 288,278 Mean per ACO (2014): 8,237
ACO Investment Model, AIM (2015–2020) [32, 33]	Purpose of AIM is to enable smaller/rural ACOs to transition from one-sided to two-sided risk, wherein they become liable for paying CMS a percentage of Medicare spending above their benchmark.	45 launched (2015) 14 remaining in 2020 9 moved to two-sided risk by 2019 and 7 of these remained in 2020	Total (2017): 487,000 Mean per ACO (2017): 10,822
Next Generation ACO, NGACO (2016-ongoing) [36, 37]	Providers take on higher levels of financial risk for greater rewards. If spending exceeds benchmark 80–100% loss share rate. If spending is below the benchmark 80–100% savings share rate. Physicians eligible for 5% bonuses starting in 2019.	18 launched (2016) 41 operating in 2019	Total (2019): 1,399,398 Mean per ACO (2019): 34,132

Table 2 Major CMS ACO Models in the US.



Características de los ACO con buenos resultados

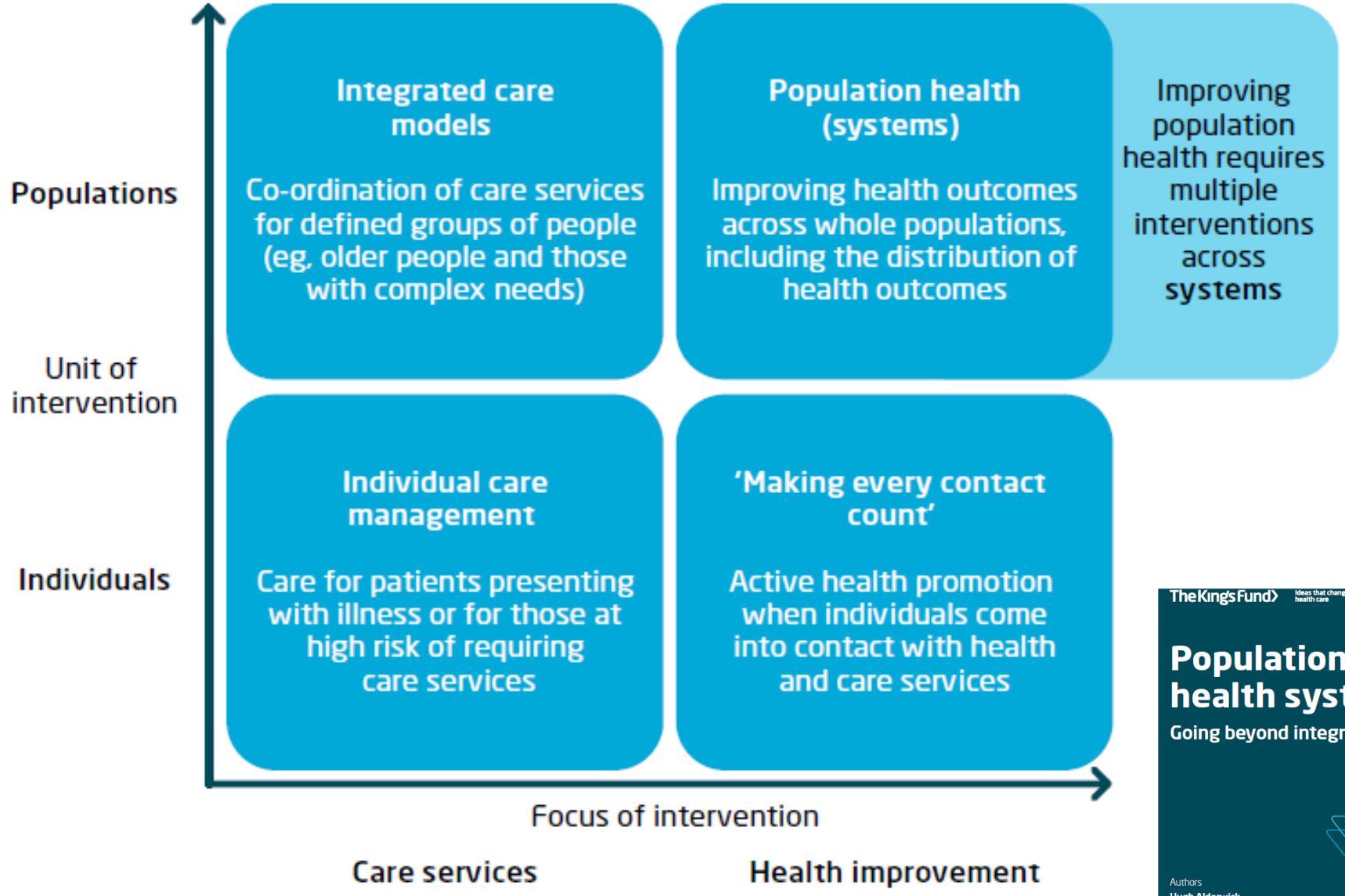
- Lideradas por grupos de médicos independientes y no por hospitales
- Fondo global (basado en gasto histórico con ajustes de casuística en ocasiones) que tenga en cuenta uso de HCE, estimación riesgo de reingreso
- Trabajo en equipo multiprofesional
- Colaboración intersectorial

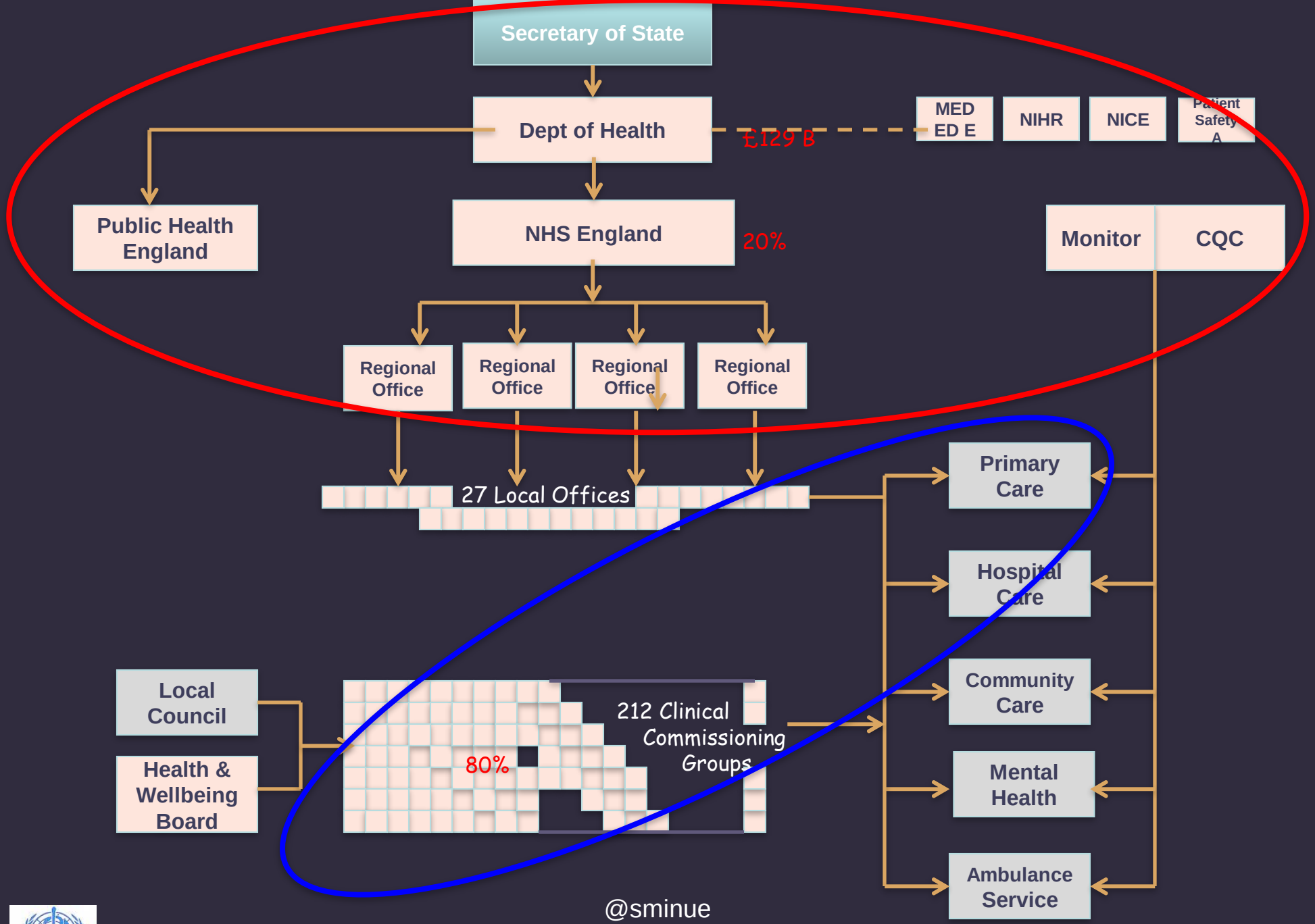
ACA Provisions Catalyzing a Shift from Fragmented Care to Coordinated Care.	
Summary	**Implications**
Patient-Centered Medical Homes (§3502)	
Community-based, interdisciplinary, interprofessional teams that support primary care practices	Will drive improved organization of outpatient care
Government to provide grants or enter into contracts with eligible entities	Will fund care coordination and a team-based approach
Accountable Care Organizations (§3022)	
Shared-savings program that encompasses primary care, specialist practice, and hospitals	Requires vertical coordination
Care processes to be redesigned for the efficient delivery of high-quality services	Most of the savings are likely to come from hospitals
Bundled Payments (§3023)	
Pilot program	Will provide incentives for care-delivery systems to reduce costs in order to increase margins
Applicable to eight conditions selected by the secretary of health and human services	
An "episode of care" defined as the period from 3 days before admission through 30 days after discharge	
Readmissions Reduction Program (§3025)	
Reduces payments for readmissions	Will motivate hospitals to engage with care coordinators and organize delivery systems better
Applicable to three conditions selected by the secretary of health and human services; to be expanded in 2015	
Secretary to determine what is considered a readmission (i.e., minimum time between admissions)	
Hospital-Acquired Conditions (§3008)	
Payments for care for hospital-acquired conditions to be reduced, starting in 2015	Will provide hospitals an incentive to standardize protocols and procedures to reduce hospital-acquired conditions
Individual hospitals' infection data to be made available online	

Proposed Measures for ACO Quality-Performance Standards.*	
Aim: improved care	
Patient and caregiver experience	• Getting timely care, appointments, and information • How well your doctors communicate • Helpful, courteous, respectful office staff • Patients' ratings of doctor • Health promotion and education • Shared decision making • Health status or functional status
Care coordination — transitions	• Risk-standardized, all-condition readmission • 30-Day post-discharge physician visit • Medication reconciliation • Care transitions measure • Management of ambulatory-sensitive conditions: diabetes; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dehydration; bacterial pneumonia; urinary tract infections (UTIs) • % of all physicians meeting HITECH meaningful use requirements
Care coordination — information systems	• % of PCPs meeting HITECH meaningful use requirements • % of PCPs using clinical decision support • % of PCPs meeting eRx incentive program requirements • Patient registry use
Patient safety	• Health care–acquired conditions composite (includes foreign object retained after surgery, central-line–associated bloodstream infections [CLABSI], falls and trauma, catheter associated UTI, and others) • CLABSI bundle use
Aim: improved health	
Preventive health	• Influenza immunization • Pneumococcal vaccination • Mammography screening • Colorectal cancer screening • Cholesterol management for patients with cardiovascular conditions • Adult weight screening and follow-up • Blood-pressure measurement • Tobacco-use assessment and intervention • Depression screening
At-risk population — diabetes	• Composite and individual measures (glycated hemoglobin, LDL cholesterol <100 mg/dl, blood pressure <140/90 mm Hg, tobacco nonuse, aspirin use) • Poor glycemic control (glycated hemoglobin >9%) • Blood pressure control in diabetes • Screening rates for microalbuminuria • Dilated eye exam; foot exam
At-risk population — heart failure	• Left ventricular function assessment • Left ventricular function testing • Weight measurement • Patient education • Heart failure prescription rates for left ventricular systolic dysfunction (LVSD) • Angiotensin-converting–enzyme inhibitor or angiotensin-receptor blocker (ACE/ARB) rates for LVSD • Warfarin therapy for patients with atrial fibrillation
At-risk population — coronary artery disease	• Coronary artery disease (CAD) composite and individual measures (oral antiplatelet therapy for patients with CAD; drug therapy for lowering LDL cholesterol; beta-blocker for patients with CAD with prior myocardial infarction; LDL cholesterol <100 mg/dl; ACE/ARB therapy for patients with CAD and diabetes, LVSD, or all of the above)
At-risk population — hypertension	• Blood-pressure control rates (<140/90 mm Hg) • Hypertension plan of care
At-risk population — COPD	• Spirometry evaluation • Smoking-cessation counseling • Bronchodilator therapy based on FEV_1
At-risk population — frail elderly	• Screening for fall risk • Osteoporosis management in women who had a prior fracture • Monthly INR for beneficiaries on warfarin

* Most measures and standards would be based on rates within the total eligible population. HITECH denotes the Health Information

Figure 1 The focus of population health systems




Secretary of State
Dept of Health
£129 B
MED ED E
NIHR
NICE
Patient Safety A
Public Health England
NHS England
20%
Monitor
CQC
Regional Office
Regional Office
Regional Office
Regional Office
27 Local Offices
Primary Care
Hospital Care
Community Care
Mental Health
Ambulance Service
Local Council
Health & Wellbeing Board
80%
212 Clinical Commissioning Groups
@sminue

BMJ 2010;360:k343 doi: 10.1136/bmj.k343 (Published 30 January 2010)

ANALYSIS

Why we should be concerned about accountable care organisations in England's NHS

The government and NHS England's plans for a major reorganisation of the health and adult social care system must come under greater scrutiny, argue **Allyson Pollock** and **Peter Roderick**

Allyson M Pollock *professor of public health*, Peter Roderick *principal research associate*

Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK

The introduction of accountable care organisations (ACOs) into the English NHS signals a major reorganisation of the health and adult social care system. Plans for ACOs were proceeding without the usual public consultation followed by an act of parliament. However, after the launch of a judicial review (in which AMP is a claimant and PR is assisting the claimants), the government and NHS England have now announced there will be a national public consultation in the spring.[1] Consultation and legislation are necessary safeguards to ensure that the plans are consistent with the fundamental principles of the NHS of a universal and comprehensive service that is publicly funded, accountable, and free at the point of delivery.

The term ACO (accountable care organisation) emerged in the US in 2006,[2] and became a central feature of President Obama's health reforms.[3] In the United States, ACOs consist of groups of doctors, hospitals, and other providers who are given incentives to improve quality of care and control costs. Providers within the ACO are entitled to a share of any "savings" to the public budget that are achieved.[4]

ACOs were designed to improve patient experience and control federal expenditure within the US healthcare system, which is dominated by private health and insurance companies. So far the evidence of the effect of ACOs on quality is contested, and at best mixed.[5] The projected savings to federal budgets translated into a net loss in 2015, and spending may have actually increased.[6]

The US insurance based healthcare system is fundamentally different from the NHS, not least in that it does not seek to provide universal care, giving rise to several questions and uncertainties about how the ACO model will apply in the NHS.

ACOs in the NHS

Sustainability and transformation partnerships seem to be the forerunner for ACOs in England,[7] but it is unclear how closely the introduction and expansion of ACOs in England will reflect the model that has evolved in the US.

We base the following analysis on NHS England's draft ACO contract published in August 2017 and its associated policy documents, although these might now change as a result of the recently announced consultation. According to NHS England, the "ACO model simplifies governance and decision making, brings together funding streams and allows a single provider organisation to make most decisions about how to allocate resources and design care for its local population."[8]

The draft ACO contract is intended to facilitate the use of two new models of care—fully or partially integrated "multispecialty community providers" and "primary and acute care systems." In the fully integrated model, the ACO will have "full responsibility for provision and integration of care"[9] for up to 15 years.[10]

How will ACOs be funded?

The government's intention is to move to a capitation system (lump sum per patient) with a linked outcomes and incentives payment scheme. The list based capitation payments made to the ACO will be derived from current commissioner expenditure on services.[11] The complexity in deriving risk adjusted capitation is enormous and well known.[12] Personal health budgets are also being proposed. We are concerned that these changes will further undermine risk pooling, social solidarity, and equity, which are required for universality, for reasons outlined in Boxed Text on page 2box 1.[13]

Correspondence to: A M Pollock allyson.pollock@newcastle.ac.uk

BMJ 2017;358:j4105 doi: 10.1136/bmj.j4105

FEATURE

BRIEFING

Accountable care systems and accountable care organisations in the NHS: progress or route to privatisation?

Sustainability and transformation partnerships are evolving into these new organisations, which will have responsibility for all NHS and social care. **Tom Moberly** explains what this means

Tom Moberly *UK editor, The BMJ*

What are accountable care systems and accountable care organisations?

In an accountable care system (ACS) several healthcare organisations agree to provide all health and social care for a given population. An accountable care organisation (ACO) is a body that manages the agreements to establish such a system and is accountable for all care. Distinctions between the two terms are often overlooked, and they are sometimes used interchangeably.

How did the terms originate?

Accountable care organisations began in the US, with groups of healthcare providers coming together to provide care for a given population. Examples include the Group Health Cooperative of Puget Sound, Washington State; the Geisinger Health System, western Pennsylvania; and Intermountain Healthcare in Salt Lake City.[1] ACOs are accountable to patients and funders for care that meets particular quality metrics within set costs, often based on a capitation funding model. For some time, ACOs have been suggested as a way to help the UK improve integration of health and social care providers.

How are they likely to function in the NHS?

In the English NHS, ACSs are being established as a new phase in the development of sustainability and transformation partnerships (STPs). In June, Simon Stevens, NHS England's chief executive, told delegates at the NHS Confederation conference that eight of the most advanced STPs in England would be the first to evolve into ACSs. One of these areas is Greater Manchester, which last year took control of its £6bn (€6.5bn; $7.8bn) health and social care budget in a historic devolution of power.[2] These ACSs will integrate funding for, and be responsible for delivery of, all health and social care within a geographical area. All STPs should become ACSs over the next few years, but it is expected to be several years before the ACSs formally become ACOs.

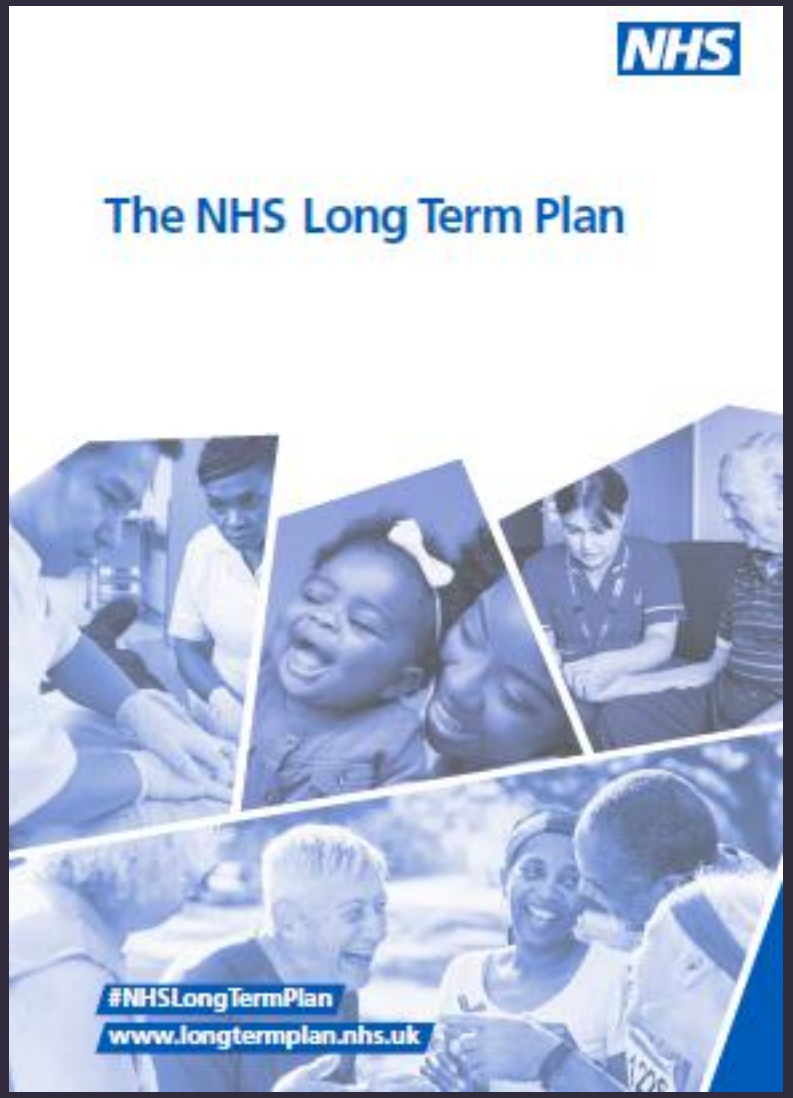
How do they relate to existing NHS structures?

The 2012 Health and Social Care Act established clinical commissioning groups (CCGs), which replaced primary care trusts in England in 2013. In 2014, Stevens published the *Five Year Forward View*, a plan to save the NHS in England £22bn a year. Stevens argued that these savings were necessary to help close the widening gap between funding and demand for services. In 2015, 44 STPs (partnerships between CCGs, NHS trusts, and local authorities) were announced to develop plans to implement the *Five Year Forward View* at local level. These STPs are expected to evolve into ACSs to deliver the savings envisaged.

Will they supersede other NHS structures?

An ACS will ultimately supersede the STP from which it is formed. It is also likely that, to increase efficiency and reduce costs, they will subsume the functions of some other NHS bodies, such as CCGs. However, many of the organisations founded after the 2012 act, including CCGs, were established on a statutory basis. Legislation would be needed for ACSs to replace organisations such as CCGs. However, with the government focused on Brexit negotiations, there is unlikely to be parliamentary time over the next 18 months to develop such legislation.

tmoberly@bmj.com



thebmj

BMJ 2019;364:l304 doi: 10.1136/bmj.l304 (Published 21 January 2019)

NEWS

NEWS ANALYSIS

The rise of primary care networks

Community networks centred on groups of general practices are one of the major tenets of the NHS's long term plan. **Gareth Iacobucci** looks at how these groups are developing and what will be needed to make them a success

Gareth Iacobucci

The BMJ

What are they?

Small networks of neighbouring general practices working together in multidisciplinary teams, typically serving around 30 000 to 50 000 people. They are designed to be small enough to retain the personal care and continuity provided by individual practices but large enough to offer a wider range of services by pooling some staff and resources. They aim to foster better collaboration among practices, pharmacists, district nurses, physiotherapists, social care, the voluntary sector, and others. They are not statutory bodies, and they differ from GP federations, which are usually larger provider groups that cover populations of around 200 000. GP leaders describe primary care networks as "delivery units" that support general practice and in which services are embedded. "The principle is to build it around a population where people know one another, and the clinicians working within that area can develop relationships across that area and support one another," says Richard Vautrey, chair of the BMA's General Practitioners Committee.

Why are they in vogue?

NHS England thinks primary care networks hold the key to creating "fully integrated community-based health care." They enable care to be organised at a population level, which is one of the big themes of the NHS's long term plan.[1] Primary care networks received prominent backing in the plan and in the government commissioned review of the GP partnership model.[2] Hundreds of networks have developed across England to provide services such as extended GP access, backed by extra investment from clinical commissioning groups. Some have already initiated other services such as first point of contact musculoskeletal services, integration with community nursing, and mental healthcare. It is hoped that new impetus and funding will help them offer a more ambitious range of services, such as outpatient services, diagnostics, physiotherapy, and diabetes care.

How does NHS England plan to develop them?

An analysis in May 2018 by the *Health Service Journal* identified almost 350 primary care networks already in existence.[3] The BMA General Practitioners Committee estimates that 80% of practices in England now belong to one. But NHS England wants them to cover every area of the country, to enhance their offering, and to formalise how they operate. Its planning guidance for 2019-20 says that every CCG should have a network in place by 30 June 2019.[4] To help with this extra resources will be available. CCGs have been told to commit a recurrent £1.50 spend per head of population on "developing and maintaining" networks. The General Practitioners Committee and NHS England are currently negotiating changes to GPs' contracts for 2019-20 that will require all practices to join a primary care network in exchange for additional funding. A deal is expected to be announced soon.

> NHS England says that every CCG should have a primary care network in place by 30 June 2019

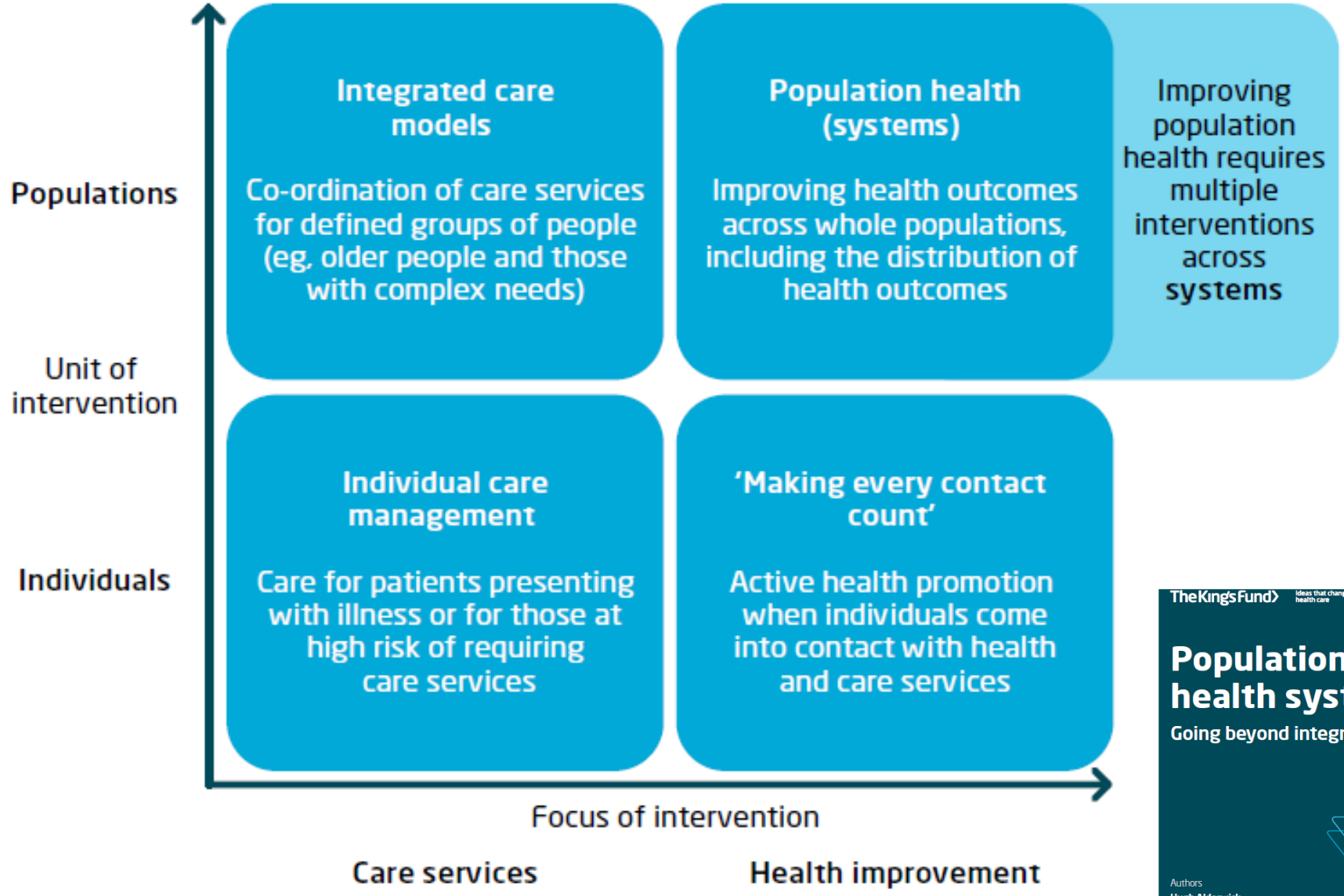
What will happen to GPs' contracts?

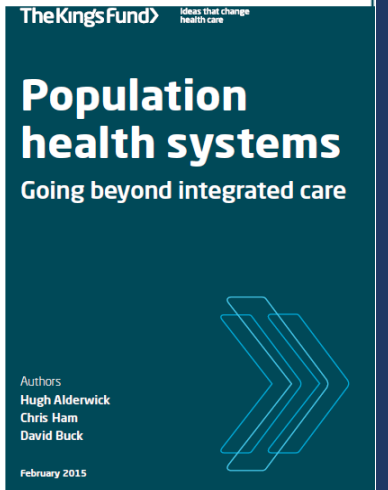
Practices will not have to give up their general medical services (GMS) or personal medical services (PMS) contracts to belong to a network. But they will be required to enter into a network contract as part of a set of "multi-year contract changes" that will serve as "as an extension of their current contract," says the long term plan. It also suggests that local contracts for enhanced services would usually be added to network contracts under new arrangements.

What incentives will there be for practices to join?

Practices will be free to decide the extent to which they engage in their local network, but GP leaders hope the financial incentives in the new contract will make it beneficial for them and their patients. In addition to the network contract, the long term plan says that NHS England will agree with the General Practitioners Committee "significant changes" to the Quality and Outcomes Framework (QOF) to support this new way of working. The GP partnership review, which was led by Nigel Watson, chief executive of Wessex Local Medical Committees, says that networks may provide solutions to workforce challenges and help strengthen the partnership model and

Figure 1 The focus of population health systems





Nicholson *et al. BMC Health Services Research* 2013, **13**:528
http://www.biomedcentral.com/1472-6963/13/528

BMC Health Services Research

RESEARCH ARTICLE Open Access

A governance model for integrated primary/secondary care for the health-reforming first world – results of a systematic review

Caroline Nicholson[1,2*], Claire Jackson[1] and John Marley[1]

- Planificación conjunta
- Tecnologías de la comunicación e información integradas
- Gestión del cambio
- Prioridades clínicas compartidas
- Incentivos
- Enfoque poblacional
- Evaluación y mejora continua
- Desarrollo profesional continuo que apoye el trabajo conjunto
- Implicación de pacientes y comunidades
- Innovación

¿Cómo hacer que suceda?

(C. Ham)

1. *Encontrar una causa común con los socios, estando dispuestos a compartir "soberanía".*
2. *Desarrollar una "narrativa" compartida para explicar por qué la integración importa.*
3. *Desarrollar una visión persuasiva para describir lo que la integración puede lograr.*
4. *Establecer un liderazgo compartido.*
5. *Generar tiempo y espacio para desarrollar entendimiento mutuo y nuevas formas de trabajo.*
6. *Identificar los servicios y grupos de usuarios donde los beneficios potenciales de las redes integradas sean mayores.*
7. *Innovar en las modalidades de contratación y pago, utilizando también al sector independiente.*
8. *Reconocer que no existe "un único camino" para la integración.*

Muchas gracias

OPS Organización Panamericana de la Salud

Organización Mundial de la Salud
OFICINA REGIONAL PARA LAS Américas