The Bellagio Model
Population-oriented Primary Care

A diagnostic grid to assess, improve and enhance primary care

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The Bellagio Model of Population-oriented primary care

- Introduction
- Key features
- Testing the model
  - Integration experience in Copenhagen
  - Innovation experience in Catalonia
- Discussion
- Summing up
What it is

- The Bellagio Model is a comprehensive **reference framework** for accessible, continuous, comprehensive, population-oriented primary care for the 21st century.

- Ten distinct and synergistic key features make the Bellagio Model a **diagnostic grid** to assess and advance primary care in any given health system, and at the same time a **guide for practice improvement**.
Where we met

The Rockefeller Foundation
Bellagio Study and Conference Center, Italy
April 2008

Improving primary care in Europe and the US: Towards patient-centered, proactive and coordinated systems of care
Who we are

Top row: Nick Goodwin, Chuck Kilo, Jennifer Dixon, Josep Argimon, Michel Wensing, Chris Ham, Bert Vrijhof, Jochen Gensichen, John Tooker, Ed Wagner, Derek Feeley, Marianne Samuelson, Zbigniew Krol

Front row: Anne Frølich, Norbert Donner-Banzhoff, Yann Bourgueil, Barbara Starfield, Sophia Schlette, Tino Martí, Melanie Lisac, Sophia Chang, Thomas Heil, Frede Olesen, Ain Aaviksoo
Where we are from

- United Kingdom (England, Scotland)
- Denmark
- Spain (Catalonia)
- Poland
- Estonia
- France
- The Netherlands
- Germany
- United States
Chronic care & change-ready PC

DSS guidelines, care standards, quality management system

Community

Society

Personal agent

Registration: defined, pop
- Comprehensiveness
- Structured access (gatekeeping)
- Coordination: agreements
- Flow of information
- PC Team: multi-disciplinary
- Basic + complementary - Learning: CPD
- Payment: blended (capitation)
- Governance: democratic
- High-quality care ≠ cost-effect
- High-quality care ≠ proactive
- Through time for leadership
- Care manager: continuity
- Reactive

Specialty services

Mental

Long-term
The relational model

To here...
From there...

INGREDIENTS TO A POP ORIENTED PC
- Leadership
- Standardized measurement
- Payment/incentives "best for patients"
- Infrastructure: Guidelines
- Nurse care mnpst
- Self management supp
- Active plan practice change
- Networking of professionals

What else?
Health system governance

Primary Care

Social Care

Community Care

Hospital Care

Population oriented management

Active program for practice improvement

Payment mix

Standardized measurement

Infrastructure

Professional networks

Research & Development

Vertical-Horizontal Integration

Public trust

Shared leadership

Health system governance

Complexity and interdependency

To here...

10 features guiding model
Shared leadership – collaboration between health care providers and institutions, health system experts, and political leadership of the health care system develops and implements a shared vision of health for a population.

As a public good, primary care needs protection and endorsement from independent governance or umbrella organizations that can strategically guide the redesign of (primary) health care systems.

- The system will not adapt naturally as a ‘complex adaptive system’
- Leadership is required at every level
- Joined-up governance and shared responsibility through accountability
Public Trust – results from reliability of policy makers and governance structures based on accountability and transparency, as well as from positive experiences with providers to deliver accessible, high-quality, safe and efficient health care

• The public (patients) must have trust in the reliability, accessibility and quality of care, and in the people who are in charge of shaping the system.
• Trust can develop through accountability & transparency; by bringing in people’s experiences; by establishing quality markers; by tapping in to underlying societal values
**Horizontal Integration** – Integration with health and social professionals in the local community, healthcare centers, general practitioners, social workers, community nurses, physiotherapists, dieticians, etc.

**Vertical Integration** - Integration in the organisations. Leaders at the different levels communicate on important issues and share information

- ‘Horizontal’ integration in primary & community care settings to promote ‘holistic’ management of the person – effective treatment and care management
- ‘Vertical’ integration from primary care settings – effective diagnosis & rapid access to specialist care
Networking of professionals

**Networks** supporting hospital, ambulatory care and community-based care. Networking between specialists and primary care providers offer opportunities for collaborative learning and quality improvement

- Knowledge-sharing
- Trust-building
- Vision-making
- Culture-crossing
- Innovation-developing
- Partnership-inducing
- Policy-shaping
- Educational
- Collective core business
Systematic recording, evaluation, and feedback of results on **accessibility**, **usability**, **safety**, **integration**, and **efficiency** of healthcare services using standardized and validated indicators is a demand to ensure provision of high quality care

Both internal and external reporting data will have to be taken into account, as well as different reporting to different users

- Evidence required to convince on efficacy of approaches
- Systemic generation of evidence and use of improvement methods
- Standardized measurement for benchmarking performance in primary care
Combined **clinical effectiveness** and **health services research** with a focus on populations and primary care is vital for appropriate decision making and organization of care by both clinicians and policy makers.

The use of information technology is equally vital to better understand the nature of changing health needs and better ways to deal with them.

- **Focus on needs in the population and in clinical primary care**
- **Focus on best ways to organize care**
- **Focus on most effective ways of developing quality and enabling implementation of change**
Payment mix – capitation fee with additional incentives that are “best for patients”. Primary care clinics should receive a basic capitation based fee for defined preventive and curative duties; aligned with incentives for high quality clinical performance

- Incentives that ‘crowd-in’ professional and organisational behaviours that are best for patients
- Mix of capitation payments and pay for performance
- Incentives linked to system or health outcomes vs activity
**Infrastructure** – application of evidence-based guidelines in clinical care; information technology across all care settings; care management by medical professionals other than doctors; integrated and coordinated disease management programs; self-management support for patients, combined cost and clinical effectiveness research that is vital for appropriate decision making by both clinicians and policy makers.

- Application of evidence-base;
- Shared IT across all settings;
- Multidisciplinary care teams and care management by medical professionals other than doctors;
- Integrated and coordinated care management;
- Individualised care plans;
- Self-management support
Active program for practice improvement

- Enhancing practice change at many levels:
  - Medical and inter-professional education;
  - Professional development;
  - Use of improvement methodology to formulate goals, take action, measure and evaluate outcomes and seek continuous improvement
**Population-oriented management** across the care continuum, following and managing both the well and those with acute and chronic conditions/problems. An inescapable premise for the Bellagio Model to succeed is universal coverage and access for all.

- Use public health and routine data to identify at-risk patients and communities;
- Develop pro-active systems that manage care in the community;
- To prevent disease onset to those at risk and to manage those already with disease.
The Danish case: Integrated Care in Chronic Conditions

- Contextualization
- Main drivers
- Action plan
National Board of Health – Publication with Recommendations in 2005

“Chronic Conditions. Patient, Healthcare System and Society - Requests for a Successful Care Path”
Methods and Material

Project started in Copenhagen in 2004

City of Copenhagen: 503,000 citizens

Østerbro local area: 80,000 citizens

Bispebjerg Hospital: 700 beds and 3,500 employees

General practitioners: 57 GP’s, 50% in solo practices

Chronic Conditions: COPD
Type 2 diabetes
Heart failure
Balance problems
Integration of Care at the Macro, Meso and Micro level

**Macro level**  State level

**Meso level**  Organizational level

**Micro level**  Patient-provider level
Integration – Governance Level

- Structure Reform
- New Health Act demanding “Healthcare agreements between regions and municipalities”
Integration – Management Level

- Cross-sector leadership - horizontal and vertical cultures and goals for patient care aligned
- Knowledge sharing meetings
- Teaching programs across sectors for nurses and therapists and for physicians
- Disease management programs identical and developed in collaboration between hospital, municipality and general practitioners
- Agreed stratification of patients between sectors ex. COPD FEV1% of expected magnitude limit at 50% changed to 30%
- Use of identical measures including, diagnosis, diagnosis specific, general measures (BMI, smoking rates, etc., ), physical measures (senior fitness tests), quality of life: general and disease specific,
Integration at the Practice Level

- Patient education – Activation of the patient
- Action plans - Agreements between patient and provider for goals of the rehabilitation
Model for integrated Care in Chronic Conditions

- Between-sector leadership
- Collaboration between health professional leadership
- Collaboration between health professionals

Copenhagen Municipality

Bispebjerg Hospital

General Practitioners

Patient

Disease Management Programs

Patient
The Catalan case:
**Primary Care Innovation Plan (2007-2010)**

- Contextualization
- Main drivers
- Action plan
The Catalan case:
Primary Care Innovation Plan (2007-2010)

- 25 years from previous reform
- Government mandate to reinforce integral care to persons through PC&CH and better care to dependents and chronic patients
- Need for change
The Catalan case: Primary Care Innovation Plan (2007-2010)

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<th>CITIZEN</th>
<th>HEALTH SYSTEM</th>
<th>PROFESSIONALS</th>
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<td>1. Integrated care</td>
<td>1. Integrate community services for each territory</td>
<td>1. Territorial health teams (PC&amp;CH)</td>
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<td>2. Health professionals as referents</td>
<td>2. Interoperability of HIS</td>
<td>2. Skill mix empowerment</td>
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<td>3. Share health information and give access to individuals</td>
<td>3. Talent and knowledge management</td>
<td>3. Nurses as referents and with direct access</td>
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<td>5. Health as a personal value</td>
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<td>5. Professional accountability of care processes</td>
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- Territorial health teams (PC&CH)
- Skill mix empowerment
- Nurses as referents and with direct access
- Management autonomy for PCTs
- Professional accountability of care processes
- Individualised CPD
Primary Care Innovation Plan vs the Bellagio Model Grid

- Shared Leadership
- Public trust
- Vertical Horizontal Integration
- Professional Networks
- Payment mix
- Infrastructure
- Standardized measurement
- Research and development
- Active program for practice improvement
- Population oriented management

- Current level
- Goal level
- Gap
### Primary care key ingredients: how well is your country or system doing?

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Bellagio Model: What’s unique

- Serves as a reference framework, a diagnostic tool, and as a guide for practice improvement
- Combines governance, management and practice roles
- Embraces leadership, accountability and public trust
- Facilitates complexity management
- Has a transatlantic horizon and multiprofessional endorsement
Bellagio Model: Putting it in place

- Singling out selected features can only be a first step, as all of these features do work together in a synergistic and reinforcing fashion.
- With R & D and practice improvement tools built into it, the Bellagio Model is a dynamic learning system, ready to change and to adapt.
- More combined cost and clinical effectiveness research is needed, and the use of HIT is vital in this.
Summing up

In advancing and redesigning primary care, the Bellagio Primary Care Group postulates the implementation of the ten features identified as key, all equally necessary and sufficient. Not every feature on its own may be innovative everywhere; it is their integrative function and simultaneous pursuance that make a difference and that makes the Bellagio Model unique.
www.bellagioprimarycare.org

stay tuned - more to come