



Convegno nazionale

**I modelli organizzativi della
medicina generale nella
gestione delle patologie
croniche**

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TRANSFORMING CARE FOR CANADIANS WITH CHRONIC HEALTH CONDITIONS

Put People First, Expect the Best, Manage for Results



Chronic care models

- Chronic care model (E. Wagner, 1998)
- Kaiser Permanente's risk stratification model (Lieu, Quesenberry, Sorel, Mendoza, & Leong, 1998)
- Expanded chronic care model (Barr et al., 2003).
- "Medical home" (Berenson, Hammons, Gans, & Zuckerman, 2008)

These chronic care models have several themes in common that are linked with improving outcomes and satisfaction:

- a shift from reactive to proactive care;
- population-based care, including delivering levels of care based on risk-stratification;
- recognizing primary care as the hub for prevention and care support, with strong interfaces with the rest of the healthcare system;
- providing care that focuses on the individual needs of the person, in his or her specific social context;
- meaningful health information systems;
- leveraging community partnerships;
- supporting self-management and caregivers;
- using clinical practice guidelines in a way that acknowledges multiple conditions;
- and continued practice redesign and improvement.

- Primary healthcare teams are a critical hub of the comprehensive approach required for person-centred, integrated care that can improve healthcare system efficiency, patient outcomes and satisfaction, and quality of care.
- This may imply that the traditional solo family physician is not a viable model for the future and that team-based, interprofessional care is the only way to provide the comprehensive services needed.

- **Canada's healthcare system will be integrated, person-focused, and population-based, with primary care practices as the hub for coordination and continuity of care with specialty and acute care and community-based services.**

This integrated healthcare system will:

- have primary care practices that are responsible for a defined population;
- be person focused (and family or friend caregiver focused);
- provide comprehensive services through interprofessional teams;
- link with other sectors in health and social care; and
- be accountable for outcomes.

The distinction between care that is disease-focused and that which is patient-focused is **at the heart** of rational organization of health systems



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