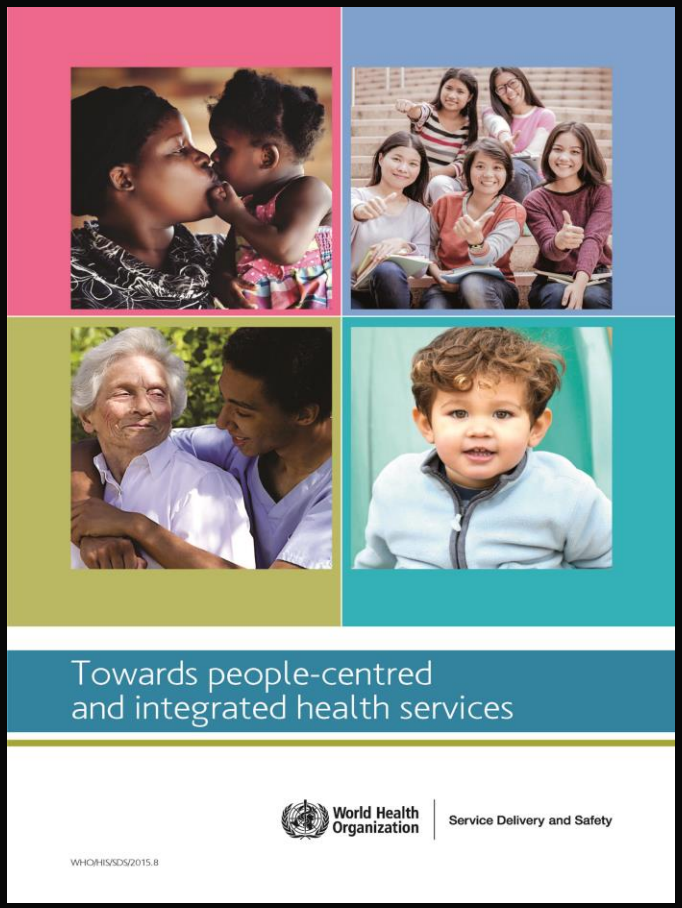
Jornada
Plan de Renovación de la Atención Primaria en Andalucía

La Atención Primaria en la encrucijada

Sergio Minué
Escuela Andaluza de Salud Pública
Sevilla, 7 de junio de 2016


SERIE
La Renovación de la Atención Primaria de Salud en las Américas
No. 1
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


Towards people-centred and integrated health services
World Health Organization
Service Delivery and Safety
WHO/HIS/SDS/2015.8

Triple Objetivo (Triple Aim)

Reducir el COSTE de la atención sanitaria
Mejorar la SALUD de las poblaciones
Mejorar la EXPERIENCIA INDIVIDUAL de atención

D.Berwick.Health Affairs 2008

Si la Atención Primaria es fuerte…

menor hospitalización

menor inequidad

mejores resultados en salud

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*

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.

Meditation XVII
John Donne

No man is an island entire of itself;
every man is a piece of the continent,
a part of the main;

if a clod be washed away by the sea,
Europe is the less,
as well as if a promontory were,
as well as any manner of thy friends or of thine own were;

any man's death diminishes me,
because I am involved in mankind.
And therefore never send to know for whom the bell tolls; it tolls for thee.

Ningún hombre es una isla,
entera en sí,
Cada hombre es una pieza del continente,
Una parte del todo.
Si el mar se lleva una porción de tierra, toda Europa queda disminuida.
Ya fuera un promontorio, o la casa de tus amigos o la tuya propia:
Toda muerte me disminuye,
Porque me encuentro unido al género humano
Por eso nunca preguntes por quién doblan las campanas;
Están doblando por ti.

EDITORIAL

No man is an island: disentangling multilevel effects in health services research

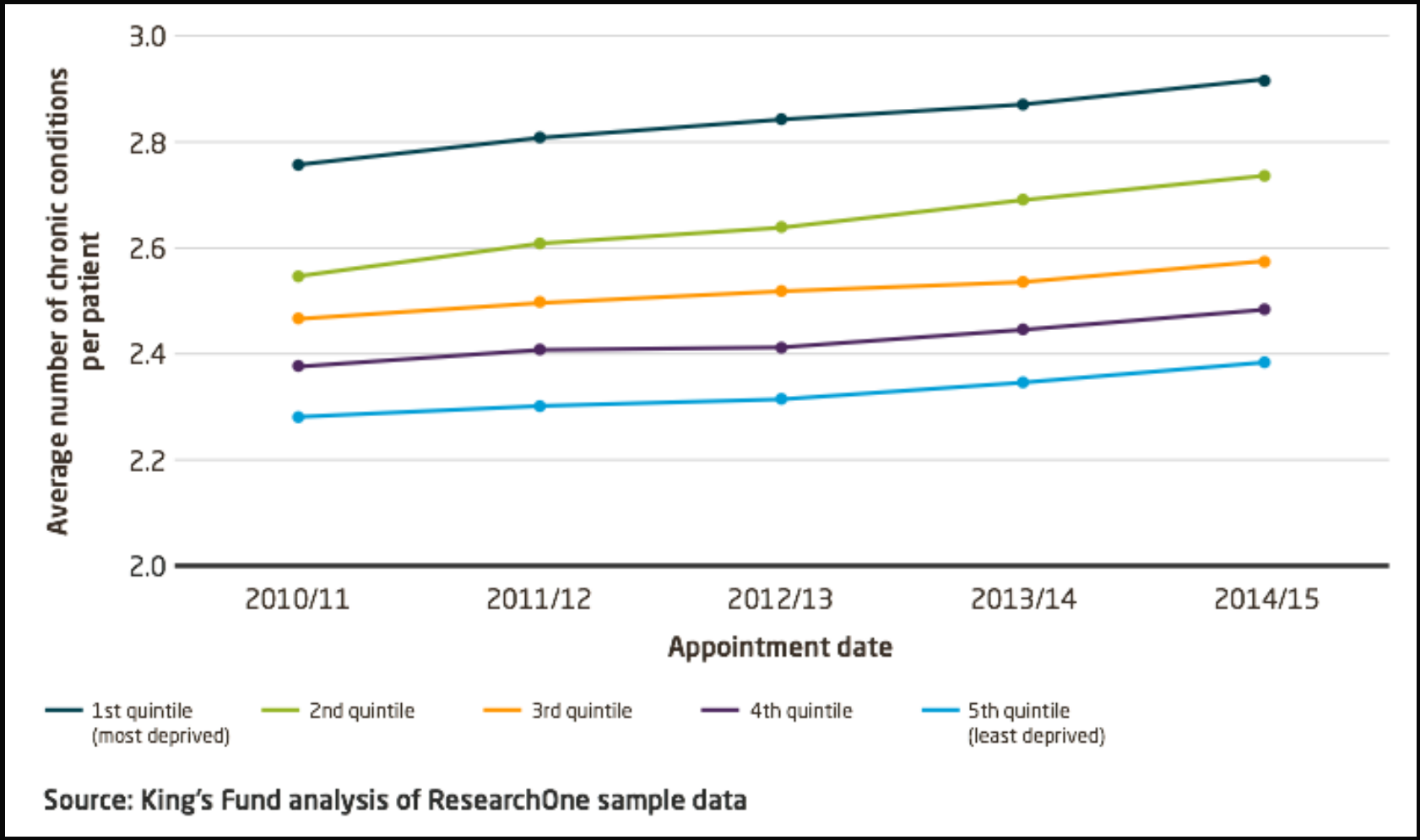
Michelle Ko, Andrew B Bindman

- Las personas no existen en el vacío; las experiencias y las conductas vienen moldeadas por el contexto en el que viven, trabajan y buscan atención sanitaria

- Residir en las áreas con menores ingresos se asocia con un 29% mayor riesgo de sufrir hospitalizaciones evitables

- Zonas más deprimidas- menor calidad de la atención primaria-más hospitalizaciones evitables

Lofqvist BMJ Qual Saf 2014;23:206–14.

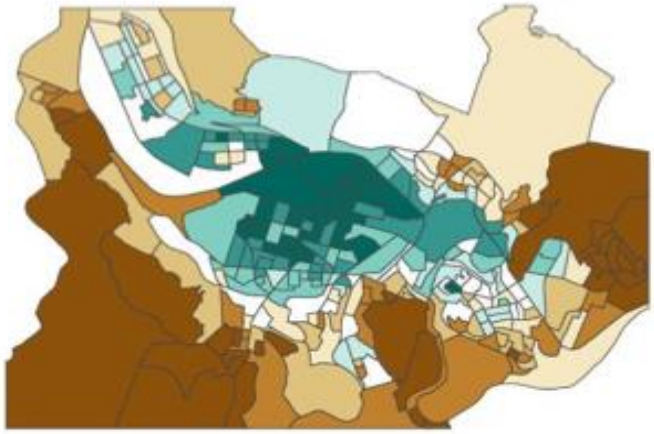


Source: King's Fund analysis of ResearchOne sample data

Mortalidad por diabetes en las mujeres Bilbao 1996-2003

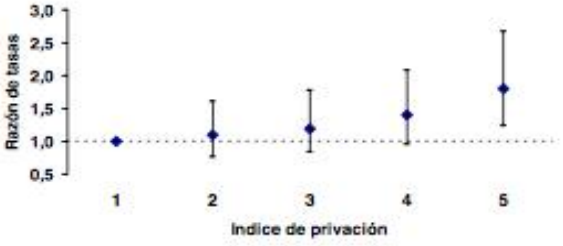
Mortalidad por diabetes

Trabajadoras manuales (%)



RMEs

≥ 1,50	(8)
≥ 1,25 – < 1,50	(14)
≥ 1,10 – < 1,25	(49)
≥ 1,05 – < 1,10	(30)
≥ 0,95 – < 1,05	(62)
≥ 0,91 – < 0,95	(37)
≥ 0,80 – < 0,91	(73)
≥ 0,67 – < 0,80	(15)
< 0,67	(0)

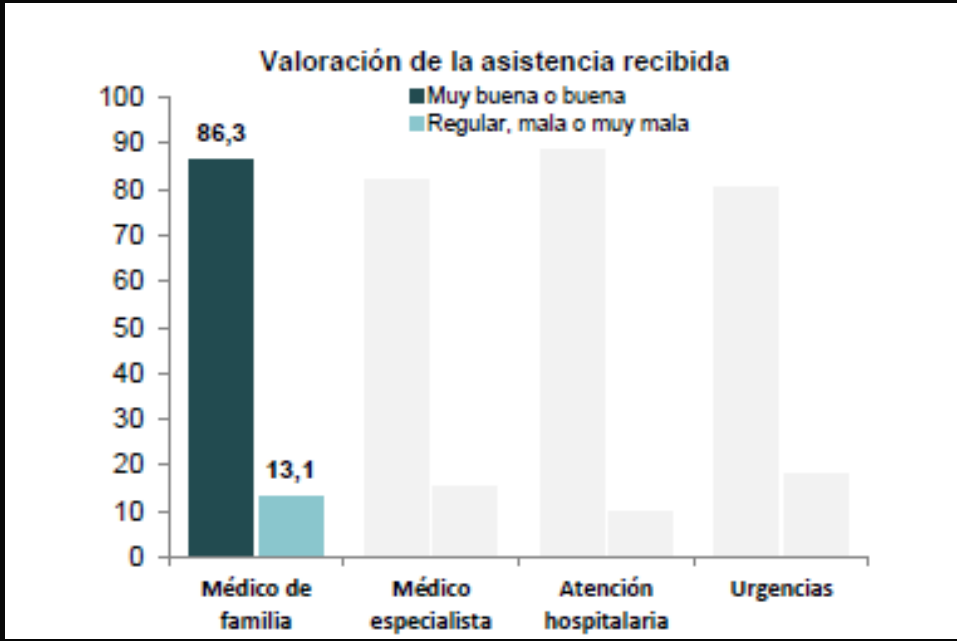


%

≥ 63,2
≥ 55,5 – < 63,2
≥ 48,0 – < 55,5
≥ 42,8 – < 48,0
≥ 37,0 – < 42,8
≥ 30,1 – < 37,0
≥ 23,2 – < 30,1
≥ 19,0 – < 23,2
< 19,0

- *“Si los factores sociales influyen en la enfermedad a escala comunitaria, los profesionales de atención primaria deben interesarse por ellos como una parte más de su trabajo, no como un fleco de interés para alguno e ignorado por otros”*
  Julian Tudor Hart

Barómetro sanitario 2015. Ministerio de Sanidad



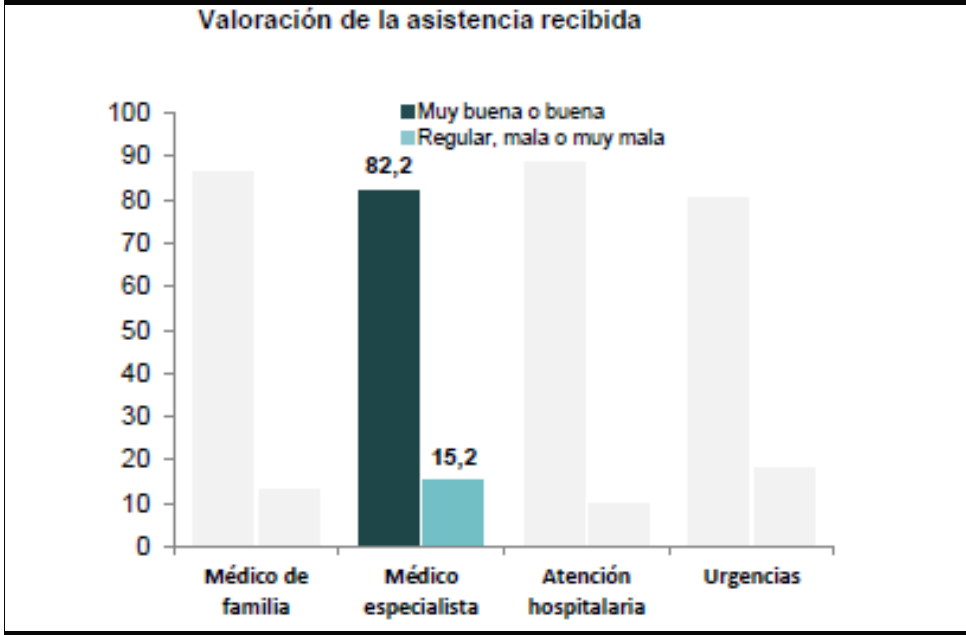
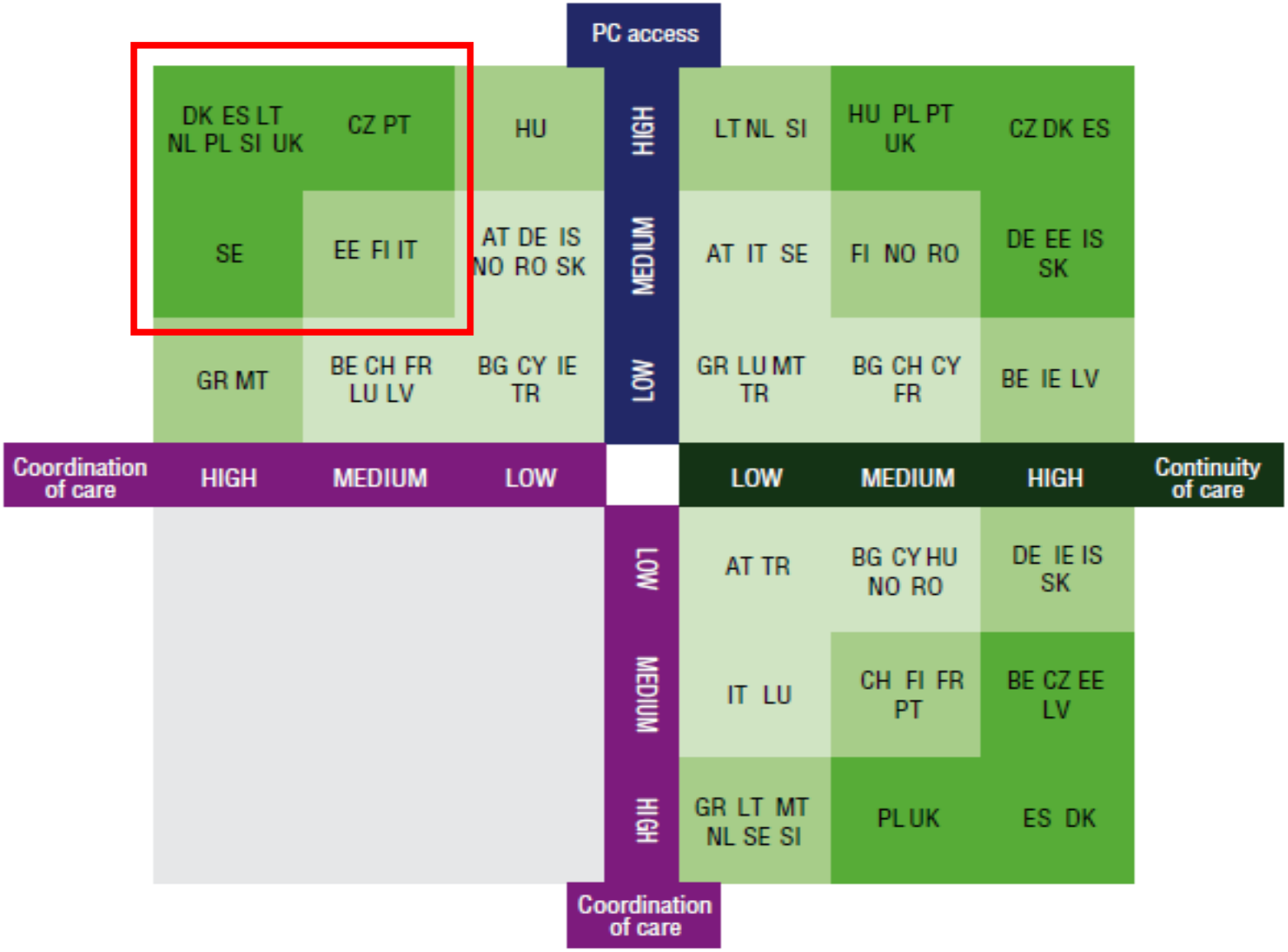


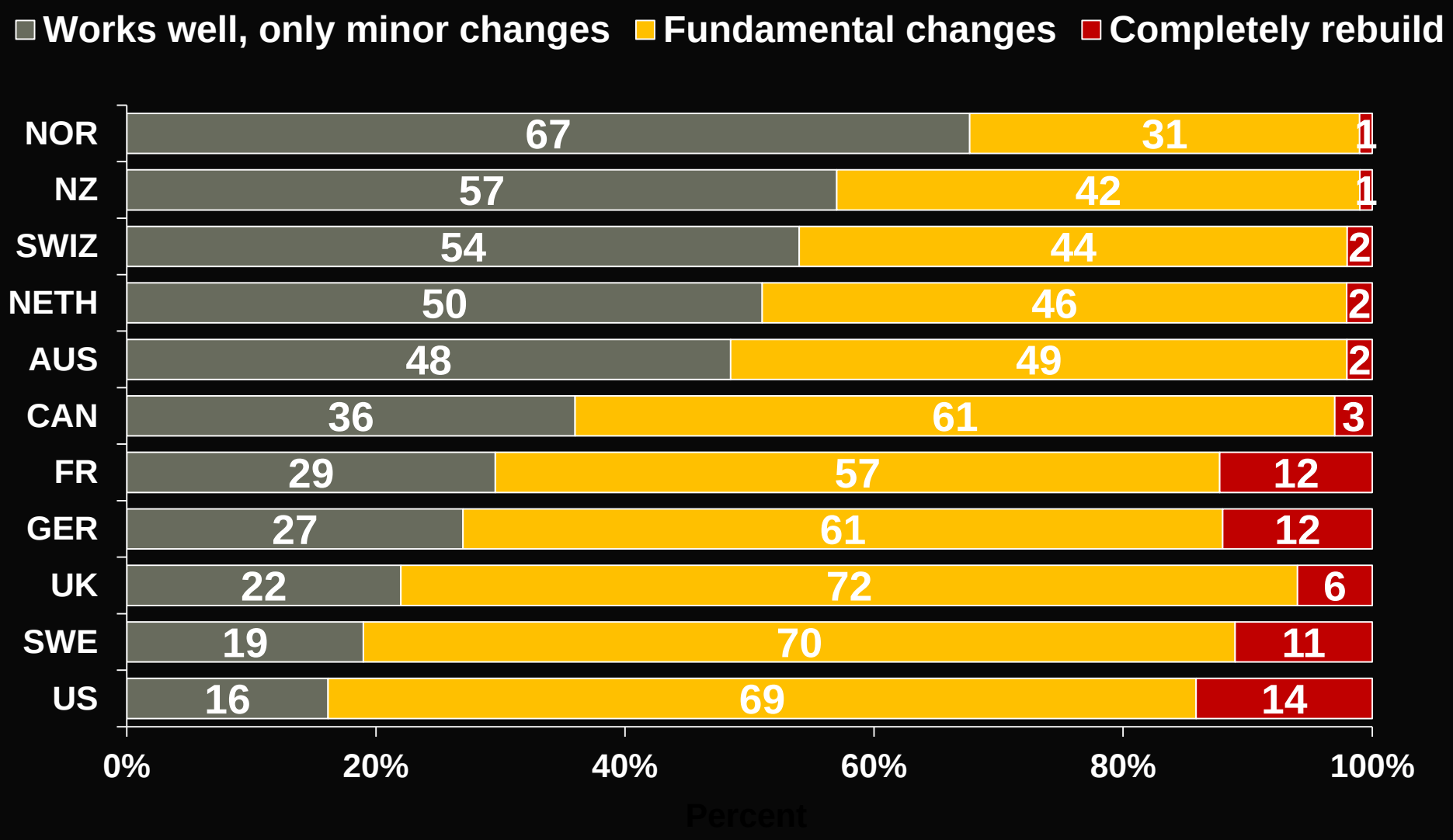
Fig. 3.5

Overall (high/medium/low) level of accessibility, continuity and coordination of primary care by country



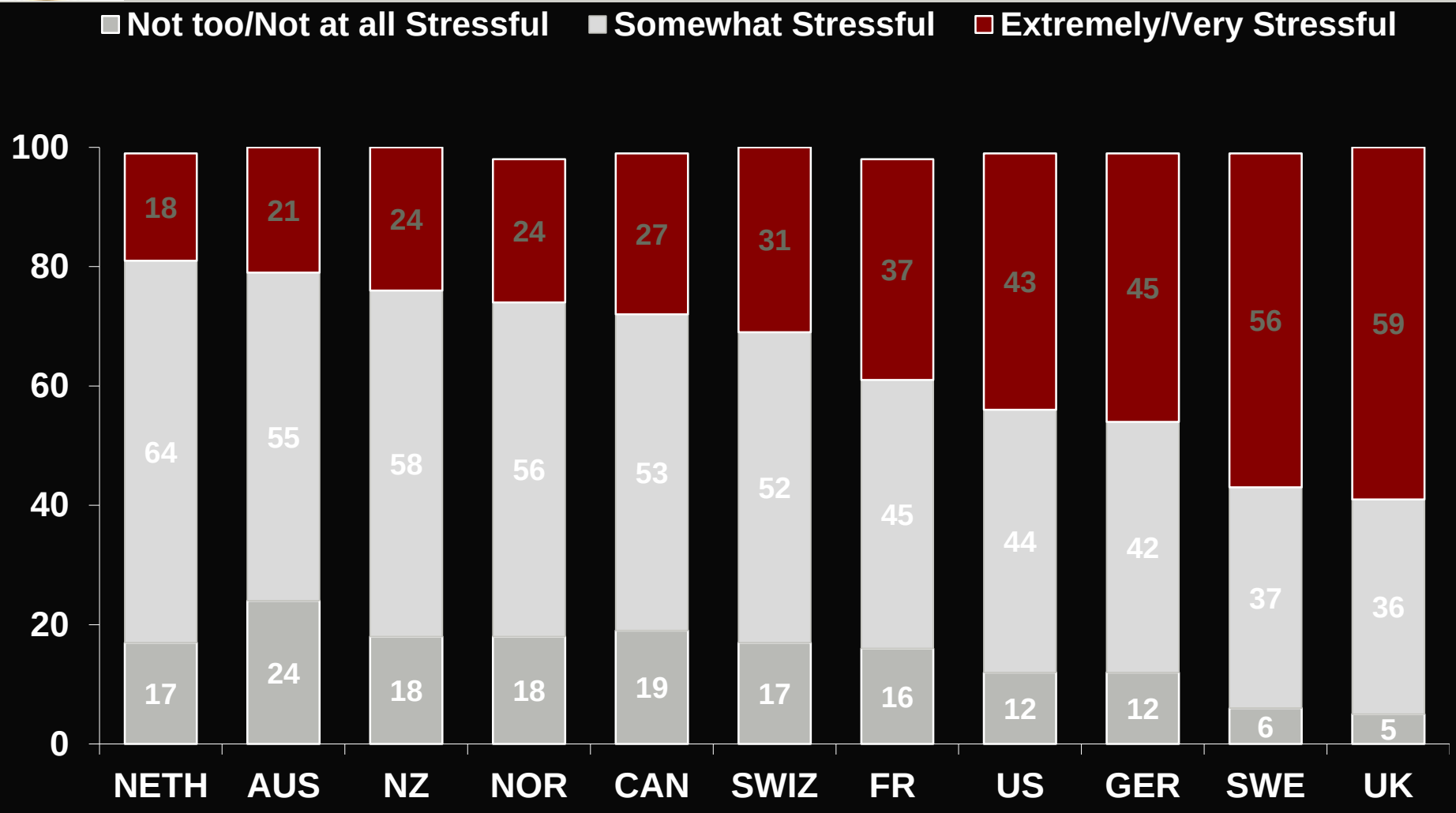
¿Necesita la Atención Primaria algún cambio?

Overall Views of Health Care System Among Primary Care Physicians, 2015



Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians. .

How Stressful is Your Job as Primary Care Physician?



Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Primary-care reform in the USA: a perfect opportunity?

As Americans grow accustomed to the reality of President Barack Obama's newly signed health-care bill, and the subsequent opening up of the health-care system to millions of previously uninsured individuals, the country's primary-care crisis has once again bubbled to the surface of collective thinking. The health policy journal *Health Affairs* this month dedicates its pages to the reinvention of what its Editor-in-Chief describes as America's "horribly broken" primary-care system.

The primary-care problem has been grappled with on many previous occasions, and usually begins with an attempt at definition. What is primary care? In its 1978 report *A Manpower Policy for Primary Health Care*, the Institute of Medicine described it as care that is "accessible, comprehensive, coordinated, continual...[and] delivered by an accountable provider of health services". Few, then, could suggest that primary care is a marginal or ignoble discipline. Yet it suffers now, as it did back in 1978, from a certain lack of respect among many specialty communities, and gross underinvestment by private, state, and federal payers (a primary-care physician earns, on average, US$3·5 million less over his or her career than does a specialist). Such a climate has led to a dismaying decline in the number of practising primary-care physicians, to the extent that a 2007 survey showed that only 7% of fourth-year students at 11 US medical schools were considering a career in adult primary care. Shortages are notably worse in rural and less wealthy areas.

Obama's new Patient Protection and Affordable Care Act makes a start on repairing these basic problems by improving primary-care scholarship and loan repayment schemes and giving 10% payment bonuses for primary-care providers who work in medically underserved areas. Provision has also been made for strengthening academic primary-care departments and for giving a small boost to the number of primary-care residency slots available by mandating that at least 65% of unfilled places in non-primary-care disciplines be reallocated to primary care. The Act thus recognises the cost-effectiveness of investment in preventive care, at a time when lifestyle-related diseases are a particular focus of concern.

But most health-policy analysts agree that simply increasing the primary-care workforce will not be sufficient to improve access to care: the way primary-care practice is organised is in need of serious reform. The model currently in favour, known as the patient-centred medical home, takes its principles from those outlined back in 1978 by the Institute of Medicine, and couples them with the use of information technology and evidence-based medicine. The medical home is being piloted in some facilities and is showing signs of bearing fruit. As Harris Meyer reports in *Health Affairs*, the not-for-profit health-care cooperative Group Health is in the process of transforming its Washington and Idaho health centres into medical homes. The process has involved a huge shift into the virtual, with as many patients' visits as appropriate being dealt with either through a secure email system or via telephone. All medical records are electronic. Task shifting has been another major reform, with physicians' assistants, nurse practitioners, clinical pharmacists, and others taking over roles previously solely in the domain of the physician. The result has been a reduction in the number of face-to-face visits, but an increase in the duration of each one, giving both patient and doctor more scope to work out best care. Almost 2 years into the pilot, Group Health reports 29% fewer emergency room visits, 6% fewer hospital admissions, less reported burnout among clinicians, and total savings of US$10·30 per patient per month. Up-front investments in the project were recouped in the first year.

So far, so good. However, the scheme works for Group Health because doctors are salaried, not paid per service, and because care and insurance are provided by the same body. To make it work across the country, all payers must reimburse practices for all essential primary-care services, including health education and preventive services, by whatever means they have been provided and by whomever within the team (physician or not).

Remarkably similar recommendations, and many more pertinent to attracting more medical students into primary care, can be found in the 1978 report by the Institute of Medicine, wherein the principles of the medical home also lie. The primary-care crisis, and many of its solutions, have therefore been familiar for decades. The missing ingredient has been a federally enforced incentive to change. Obama's health-care reform bill presents the perfect opportunity for health-care providers and insurers to take a good look at the potential for savings resulting from primary-care reform. Indeed, without such savings, the new obligations on insurers might prove impossible to achieve. ■ *The Lancet*

The printed journal includes an image merely for illustration

See Comment page 1588

For the **special issue of Health Affairs** see http://content.healthaffairs.org/content/vol29/issue5/

For the **Institute of Medicine report *A Manpower Policy for Primary Health Care*** see http://books.nap.edu/openbook.php?record_id=9932&page=1

NHS England

Reducir el documento

GENERAL PRACTICE FORWARD VIEW

APRIL 2016

Developed in partnership with:

Royal College of General Practitioners

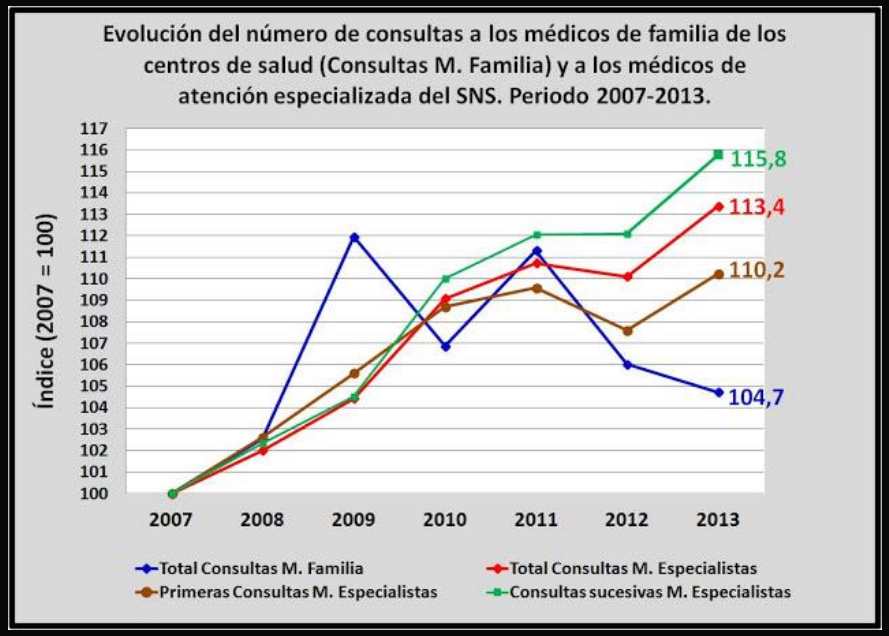
NHS Health Education England

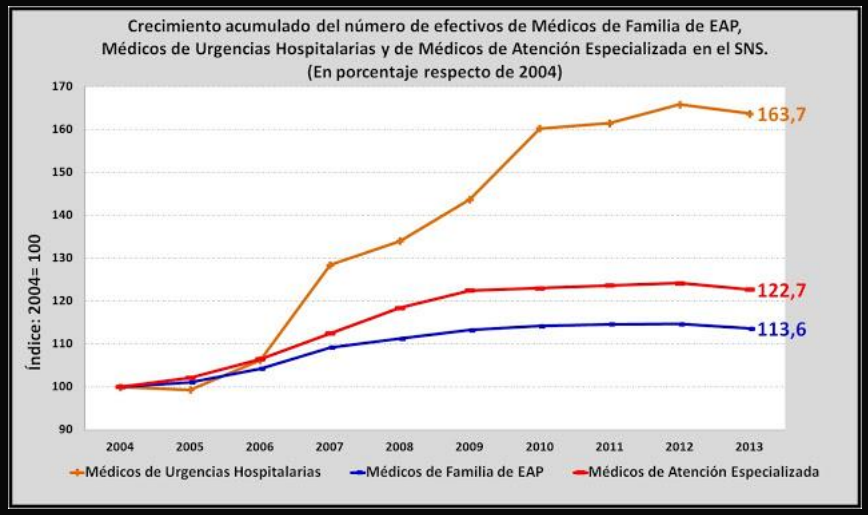
#GPforwardview

¿A qué retos se enfrenta?

Sherry Turkle. TED


24/7

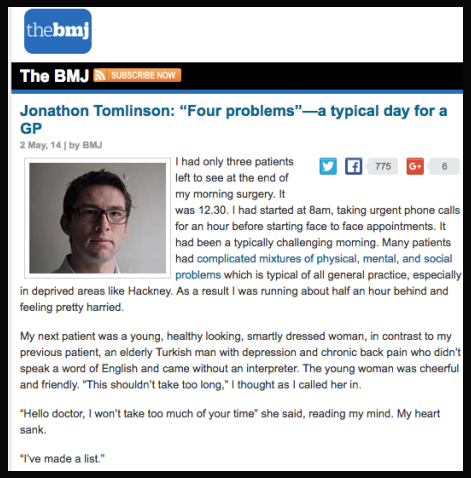




Juan Simó. 2016

Un día cualquiera…en 18 Tweets y 42 pacientes

(Clara Benedicto)



thebmj

The BMJ SUBSCRIBE NOW

Jonathon Tomlinson: "Four problems"—a typical day for a GP

2 May, 14 | by BMJ

I had only three patients left to see at the end of my morning surgery. It was 12.30. I had started at 8am, taking urgent phone calls for an hour before starting face to face appointments. It had been a typically challenging morning. Many patients had complicated mixtures of physical, mental, and social problems which is typical of all general practice, especially in deprived areas like Hackney. As a result I was running about half an hour behind and feeling pretty harried.

775 6

My next patient was a young, healthy looking, smartly dressed woman, in contrast to my previous patient, an elderly Turkish man with depression and chronic back pain who didn't speak a word of English and came without an interpreter. The young woman was cheerful and friendly. "This shouldn't take too long," I thought as I called her in.

"Hello doctor, I won't take too much of your time" she said, reading my mind. My heart sank.

"I've made a list."

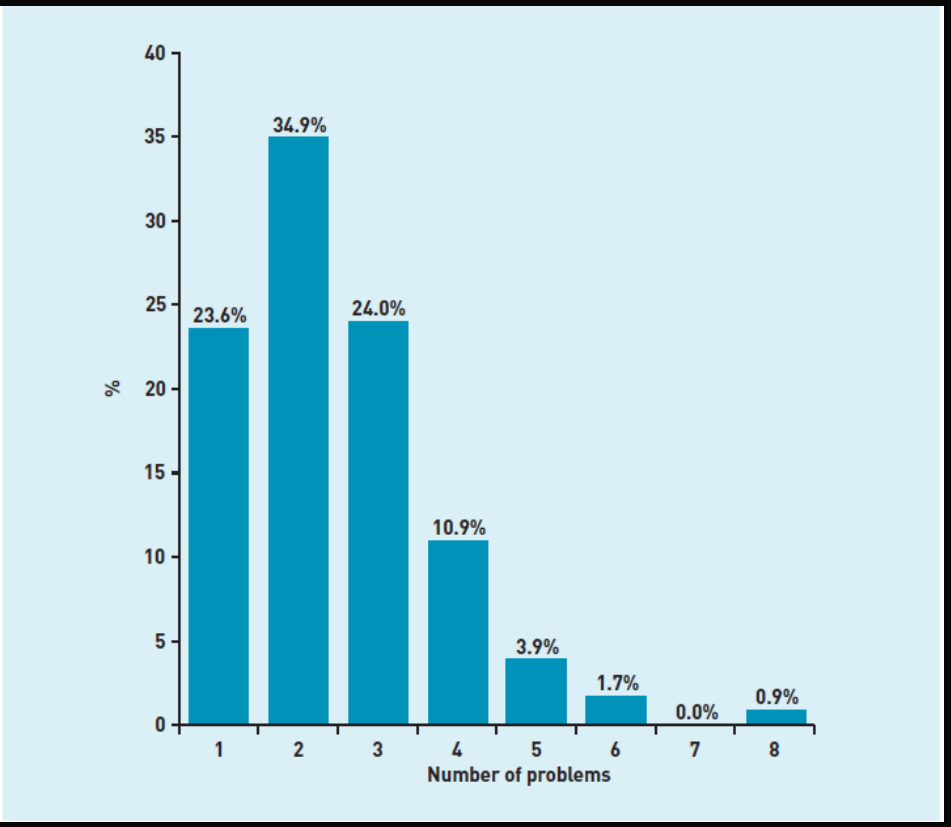
- Una baja que se prolonga porque ella puede trabajar, pero no levantar peso y la mutua no quiere reubicarle.
- Una adolescente triste y sola en una familia desestructurada que faltó el día que estaban citada
- Un diabético mal controlado que viene por pérdida de peso, pero le han cortado la luz, cobra 300 euros y espera el desahucio… y no va al banco de alimentos porque solo reparten hidratos de carbono
- Un paciente que pide analítica, luego PSA, luego RMN de columna, luego derivación al oftalmólogo
- Una mujer que tiene ansiedad porque tras conseguir paralizar su desahucio es agredida por sus propios vecinos
- La mujer de un diabético de 40 años que nunca viene, porque trabaja de lunes a sábado, fumador con glucemias altas.
- Una mujer angoleña que se cita para pedir que le recete algo a su madre, en Angola, que ha perdido la visión
- Una chica de mi edad a la que han hecho una colecistectomía por una colitis ulcerosa resistente a tratamiento, y que tiene miedo a la reconstrucción

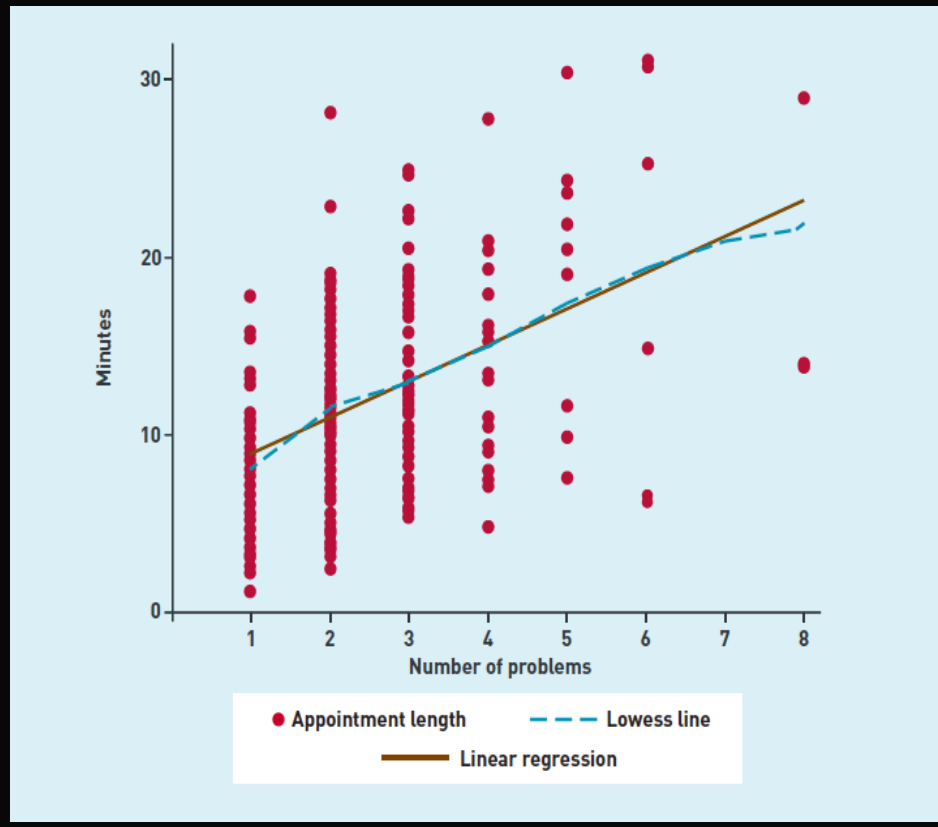
Research

Chris Salisbury, Sunita Procter, Kate Stewart, Leah Bowen, Sarah Purdy, Matthew Ridd, Jose Valderas, Tom Blakeman and David Reeves

The content of general practice consultations:

cross-sectional study based on video recordings





Annals of Internal Medicine | REVIEW

A Practical and Evidence-Based Approach to Common Symptoms

A Narrative Review

Kurt Kroenke, MD

1/3

Table 1. Proportion of Somatic Symptoms That Are Medically Unexplained

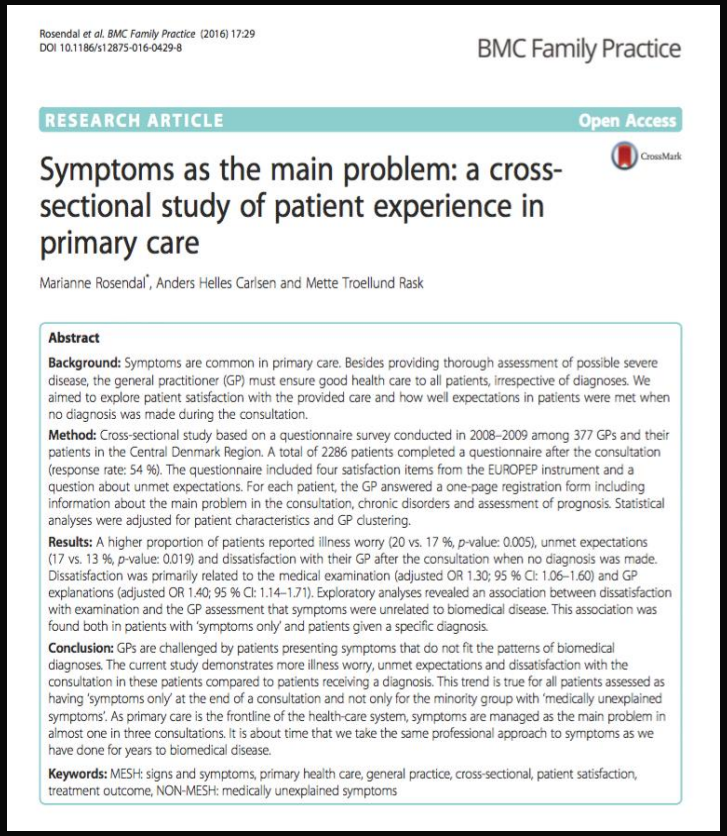
Study, Year (Reference)	Study Setting	Study Design	Patients, *n*	Method for Classifying Symptoms as Medically Unexplained	Medically Unexplained Symptoms (95% CI), %
Kroenke and Mangelsdorff, 1989 (6)	Primary care	Chart review	1000	One physician chart auditor using implicit criteria	74 (71–78)
Khan et al, 2003 (7)	Primary care	Chart review	450	Two physician chart auditors using explicit criteria; excellent interrater reliability ($\kappa = 0.75$)	34 (30–38)
Marple et al, 1997 (8)	Primary care	Prospective cohort	338	Clinical judgment of patient's primary care physician	33 (28–38)
Steinbrecher et al, 2011 (9)	Primary care	Survey	620	Clinical judgment of patient's primary care physician	37 (33–41)
Kroenke et al, 1994 (3)	Primary care	Survey	1000	Clinical judgment of patient's primary care physician	20* (18–22)
Reid et al, 2001 (10)	Specialty clinics†	Chart review	361	One physician rater reviewed consultations on frequent attenders to 12 clinic types; excellent rater reliability ($\kappa = 0.76$–0.88)	27 (22–32)
Kroenke and Price, 1993 (11)	General population	Survey	13 328	Structured interview using the Diagnostic Interview Schedule	35 (34–36)
Escobar et al, 2010 (12)	General population	Survey	4864	Two physician raters independently reviewed structured interview data; both had to agree that symptom was unexplained	31 (30–32)

Si no hay diagnóstico…

Mayor preocupación

Menor satisfacción

Menor cumplimiento de las expectativas



Rosendal *et al. BMC Family Practice* (2016) 17:29
DOI 10.1186/s12875-016-0429-8

BMC Family Practice

RESEARCH ARTICLE Open Access

Symptoms as the main problem: a cross-sectional study of patient experience in primary care

Marianne Rosendal*, Anders Helles Carlsen and Mette Troellund Rask

Abstract

Background: Symptoms are common in primary care. Besides providing thorough assessment of possible severe disease, the general practitioner (GP) must ensure good health care to all patients, irrespective of diagnoses. We aimed to explore patient satisfaction with the provided care and how well expectations in patients were met when no diagnosis was made during the consultation.

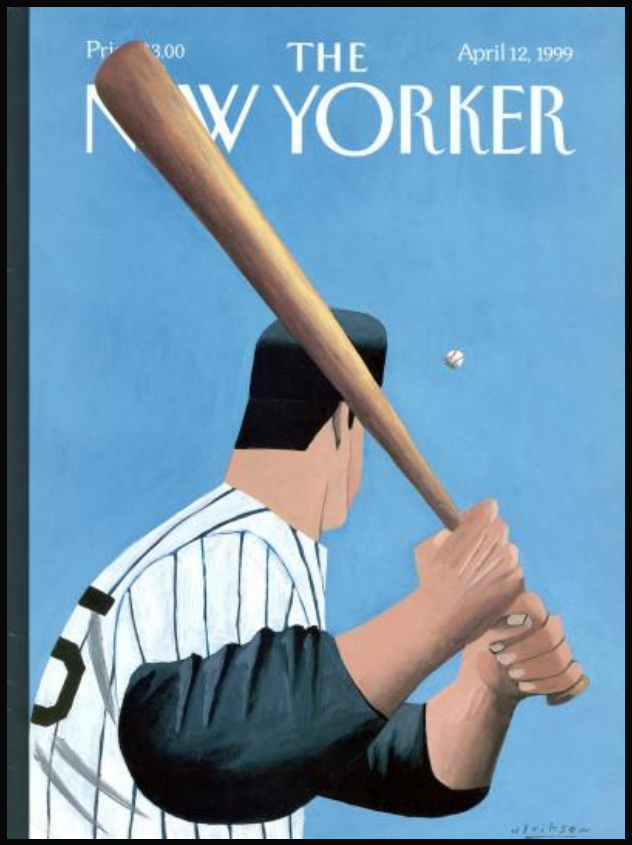
Method: Cross-sectional study based on a questionnaire survey conducted in 2008–2009 among 377 GPs and their patients in the Central Denmark Region. A total of 2286 patients completed a questionnaire after the consultation (response rate: 54 %). The questionnaire included four satisfaction items from the EUROPEP instrument and a question about unmet expectations. For each patient, the GP answered a one-page registration form including information about the main problem in the consultation, chronic disorders and assessment of prognosis. Statistical analyses were adjusted for patient characteristics and GP clustering.

Results: A higher proportion of patients reported illness worry (20 vs. 17 %, *p*-value: 0.005), unmet expectations (17 vs. 13 %, *p*-value: 0.019) and dissatisfaction with their GP after the consultation when no diagnosis was made. Dissatisfaction was primarily related to the medical examination (adjusted OR 1.30; 95 % CI: 1.06–1.60) and GP explanations (adjusted OR 1.40; 95 % CI: 1.14–1.71). Exploratory analyses revealed an association between dissatisfaction with examination and the GP assessment that symptoms were unrelated to biomedical disease. This association was found both in patients with 'symptoms only' and patients given a specific diagnosis.

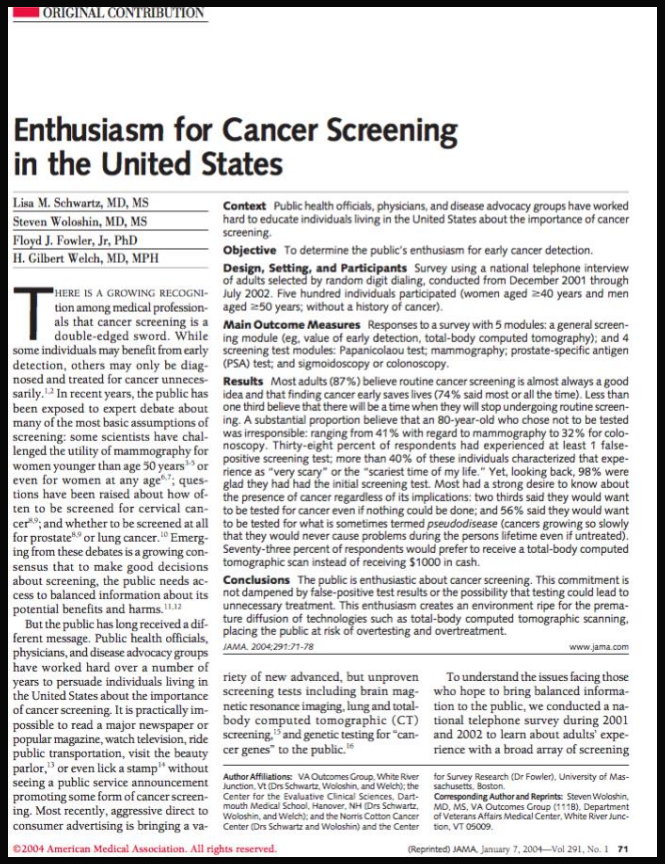
Conclusion: GPs are challenged by patients presenting symptoms that do not fit the patterns of biomedical diagnoses. The current study demonstrates more illness worry, unmet expectations and dissatisfaction with the consultation in these patients compared to patients receiving a diagnosis. This trend is true for all patients assessed as having 'symptoms only' at the end of a consultation and not only for the minority group with 'medically unexplained symptoms'. As primary care is the frontline of the health-care system, symptoms are managed as the main problem in almost one in three consultations. It is about time that we take the same professional approach to symptoms as we have done for years to biomedical disease.

Keywords: MESH: signs and symptoms, primary health care, general practice, cross-sectional, patient satisfaction, treatment outcome, NON-MESH: medically unexplained symptoms

- La pesadilla del hombre sano
  (J. Epstein)



- El Entusiasmo por el screening
  (HG Welch et al . JAMA 2004)



ORIGINAL CONTRIBUTION

Enthusiasm for Cancer Screening in the United States

Lisa M. Schwartz, MD, MS
Steven Woloshin, MD, MS
Floyd J. Fowler, Jr, PhD
H. Gilbert Welch, MD, MPH

Context Public health officials, physicians, and disease advocacy groups have worked hard to educate individuals living in the United States about the importance of cancer screening.

Objective To determine the public's enthusiasm for early cancer detection.

Design, Setting, and Participants Survey using a national telephone interview of adults selected by random digit dialing, conducted from December 2001 through July 2002. Five hundred individuals participated (women aged ≥40 years and men aged ≥50 years; without a history of cancer).

Main Outcome Measures Responses to a survey with 5 modules: a general screening module (eg, value of early detection, total-body computed tomography); and 4 screening test modules: Papanicolaou test; mammography; prostate-specific antigen (PSA) test; and sigmoidoscopy or colonoscopy.

Results Most adults (87%) believe routine cancer screening is almost always a good idea and that finding cancer early saves lives (74% said most or all the time). Less than one third believe that there will be a time when they will stop undergoing routine screening. A substantial proportion believe that an 80-year-old who chose not to be tested was irresponsible: ranging from 41% with regard to mammography to 32% for colonoscopy. Thirty-eight percent of respondents had experienced at least 1 false-positive screening test; more than 40% of these individuals characterized that experience as "very scary" or the "scariest time of my life." Yet, looking back, 98% were glad they had had the initial screening test. Most had a strong desire to know about the presence of cancer regardless of its implications: two thirds said they would want to be tested for cancer even if nothing could be done; and 56% said they would want to be tested for what is sometimes termed *pseudodisease* (cancers growing so slowly that they would never cause problems during the persons lifetime even if untreated). Seventy-three percent of respondents would prefer to receive a total-body computed tomographic scan instead of receiving $1000 in cash.

Conclusions The public is enthusiastic about cancer screening. This commitment is not dampened by false-positive test results or the possibility that testing could lead to unnecessary treatment. This enthusiasm creates an environment ripe for the premature diffusion of technologies such as total-body computed tomographic scanning, placing the public at risk of overtesting and overtreatment.

JAMA. 2004;291:71-78 www.jama.com

THERE IS A GROWING RECOGNITION among medical professionals that cancer screening is a double-edged sword. While some individuals may benefit from early detection, others may only be diagnosed and treated for cancer unnecessarily.[1,2] In recent years, the public has been exposed to expert debate about many of the most basic assumptions of screening: some scientists have challenged the utility of mammography for women younger than age 50 years[3-5] or even for women at any age[6,7]; questions have been raised about how often to be screened for cervical cancer[8,9]; and whether to be screened at all for prostate[8,9] or lung cancer.[10] Emerging from these debates is a growing consensus that to make good decisions about screening, the public needs access to balanced information about its potential benefits and harms.[11,12]

But the public has long received a different message. Public health officials, physicians, and disease advocacy groups have worked hard over a number of years to persuade individuals living in the United States about the importance of cancer screening. It is practically impossible to read a major newspaper or popular magazine, watch television, ride public transportation, visit the beauty parlor,[13] or even lick a stamp[14] without seeing a public service announcement promoting some form of cancer screening. Most recently, aggressive direct to consumer advertising is bringing a variety of new advanced, but unproven screening tests including brain magnetic resonance imaging, lung and total-body computed tomographic (CT) screening,[15] and genetic testing for "cancer genes" to the public.[16]

To understand the issues facing those who hope to bring balanced information to the public, we conducted a national telephone survey during 2001 and 2002 to learn about adults' experience with a broad array of screening

Author Affiliations: VA Outcomes Group, White River Junction, Vt (Drs Schwartz, Woloshin, and Welch); the Center for the Evaluative Clinical Sciences, Dartmouth Medical School, Hanover, NH (Drs Schwartz, Woloshin, and Welch); and the Norris Cotton Cancer Center (Drs Schwartz and Woloshin) and the Center for Survey Research (Dr Fowler), University of Massachusetts, Boston.
Corresponding Author and Reprints: Steven Woloshin, MD, MS, VA Outcomes Group (111B), Department of Veterans Affairs Medical Center, White River Junction, VT 05009.

73% prefiere un TAC total body a 1000$ en efectivo

El “ cliente”…¿siempre tiene razón?

Mayor satisfacción del paciente se asocia con …

-Menor uso de urgencias

- Mayor uso de la hospitalización
- Mayor coste global
- Mayor mortalidad

ORIGINAL INVESTIGATION

ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Scan for Author Audio Interview

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N=51 946) to the 2000 through 2007 national Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2005 subsample (n=36 428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.9 years.

Results: Adjusting for sociodemographics, insurance status, availability of a usual source of care, chronic disease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit (adjusted odds ratio [aOR], 0.92; 95% CI, 0.84-1.00), higher odds of any inpatient admission (aOR, 1.12; 95% CI, 1.02-1.23), 8.8% (95% CI, 1.6%-16.6%) greater total expenditures, 9.1% (95% CI, 2.3%-16.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

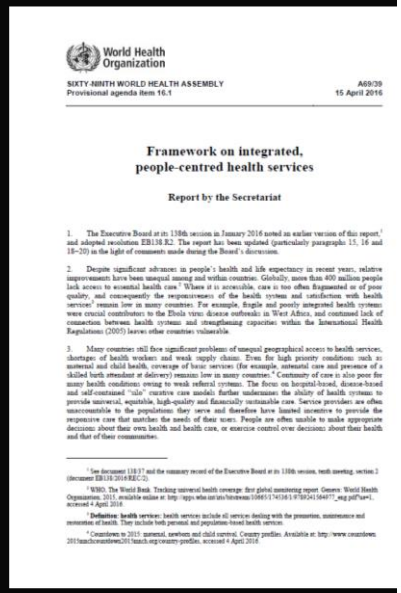
Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Arch Intern Med. 2012;172(5):405-411.
Published online February 13, 2012.
doi:10.1001/archinternmed.2011.1662

SEMINARIO DE INNOVACIÓN EN ATENCIÓN PRIMARIA 2014 Barcelona

- …Todos estos pacientes y situaciones explican que en atención primaria haya "camas", como en el hospital, pero situadas en los domicilios de los pacientes. Para un cupo de 2000 pacientes se pueden estimar unas veinte "camas" de pacientes crónicos recluidos en domicilio que pueden exigir unas 20 visitas mensuales.

Framework on integrated people-centred health services



World Health Organization

SIXTY-NINTH WORLD HEALTH ASSEMBLY
Provisional agenda item 16.1

A69/39
15 April 2016

Framework on integrated, people-centred health services

Report by the Secretariat

1. The Executive Board at its 138th session in January 2016 noted an earlier version of this report,[1] and adopted resolution EB138.R2. The report has been updated (particularly paragraphs 15, 16 and 18–20) in the light of comments made during the Board's discussions.

2. Despite significant advances in people's health and life expectancy in recent years, relative improvements have been unequal among and within countries. Globally, more than 400 million people lack access to essential health care.[2] Where it is accessible, care is too often fragmented or of poor quality, and consequently the responsiveness of the health system and satisfaction with health services[3] remain low in many countries. For example, fragile and poorly integrated health systems were crucial contributors to the Ebola virus disease outbreaks in West Africa, and continued lack of connection between health systems and strengthening capacities within the International Health Regulations (2005) leaves other countries vulnerable.

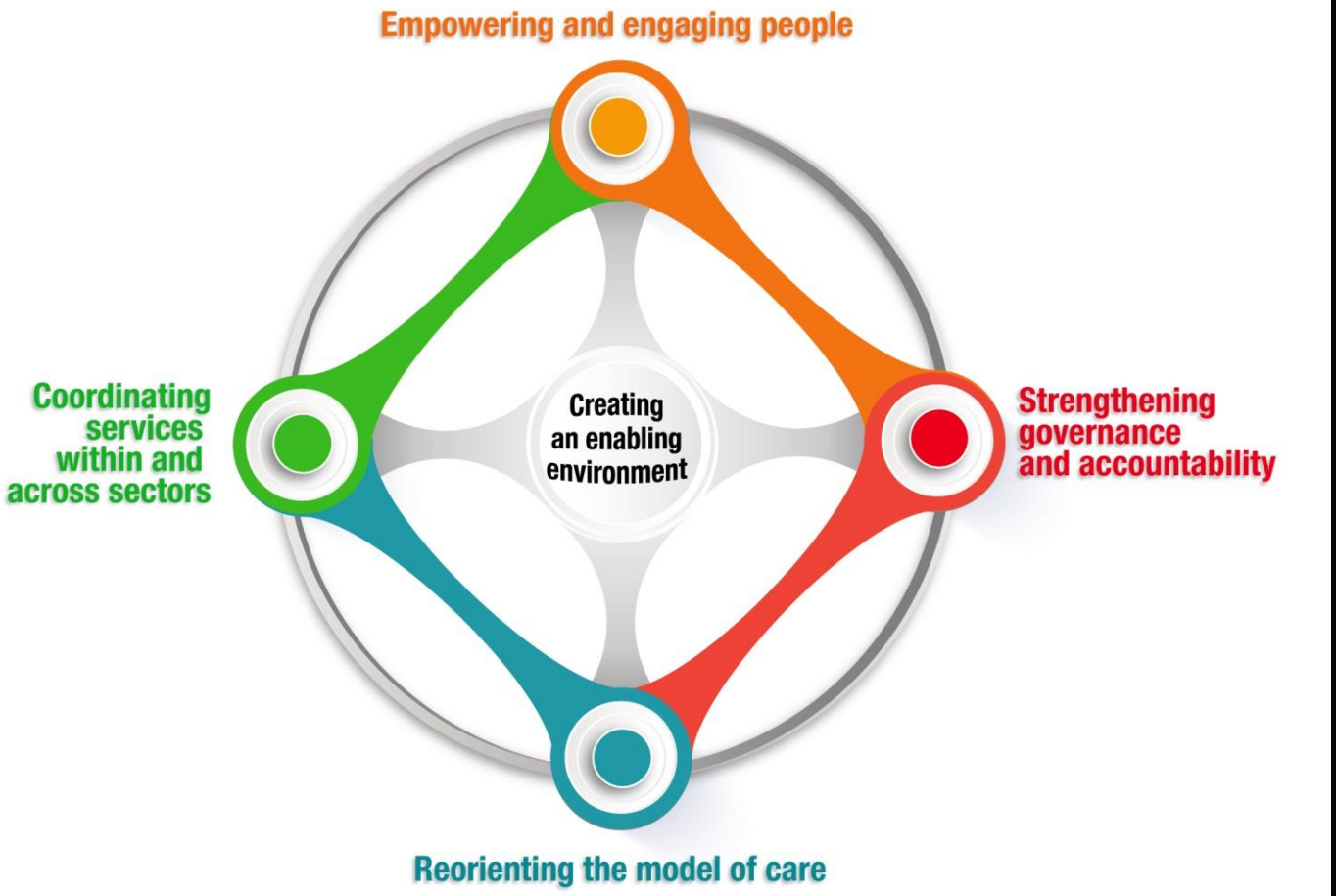
3. Many countries still face significant problems of unequal geographical access to health services, shortages of health workers and weak supply chains. Even for high priority conditions such as maternal and child health, coverage of basic services (for example, antenatal care and presence of a skilled birth attendant at delivery) remains low in many countries.[4] Continuity of care is also poor for many health conditions owing to weak referral systems. The focus on hospital-based, disease-based and self-contained "silo" curative care models further undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care. Service providers are often unaccountable to the populations they serve and therefore have limited incentives to provide the responsive care that matches the needs of their users. People are often unable to make appropriate decisions about their own health and health care, or exercise control over decisions about their health and that of their communities.

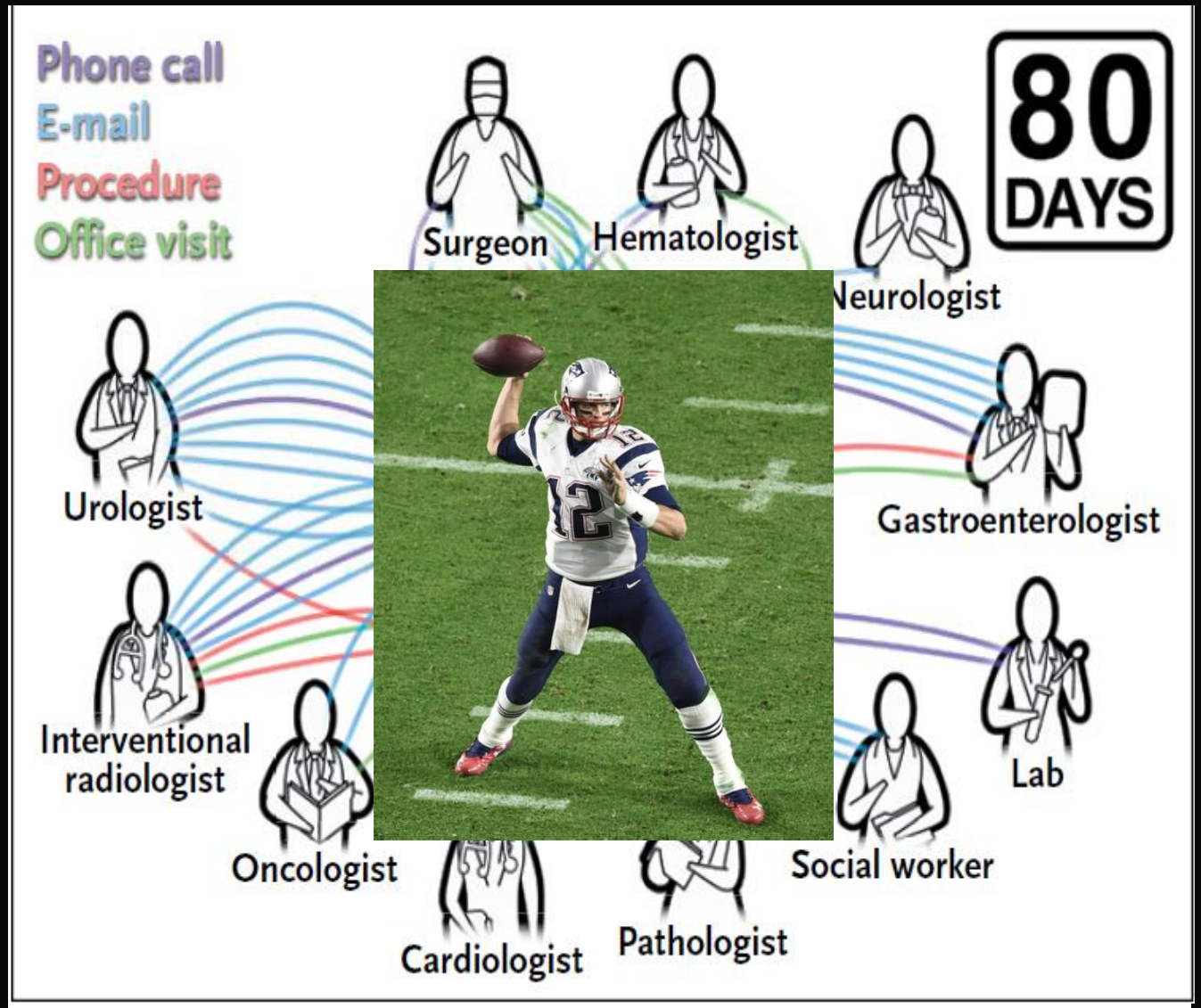
[1] See document EB138/37 and the summary record of the Executive Board at its 138th session, tenth meeting, section 2 (document EB138/2016/REC/2).

[2] WHO, The World Bank. Tracking universal health coverage: first global monitoring report. Geneva: World Health Organization, 2015, available online at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1, accessed 4 April 2016.

[3] **Definition: health services:** health services include all services dealing with the promotion, maintenance and restoration of health. They include both personal and population-based health services.

[4] Countdown to 2015: maternal, newborn and child survival. Country profiles. Available at: http://www.countdown2015mnch.org/country-profiles, accessed 4 April 2016.

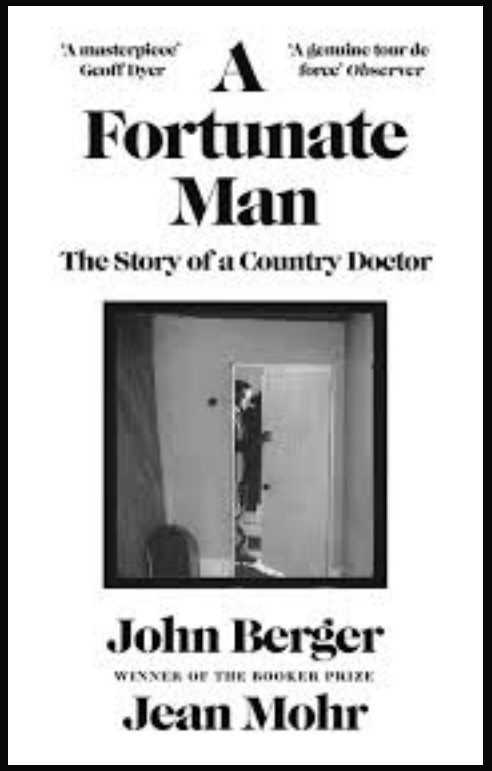




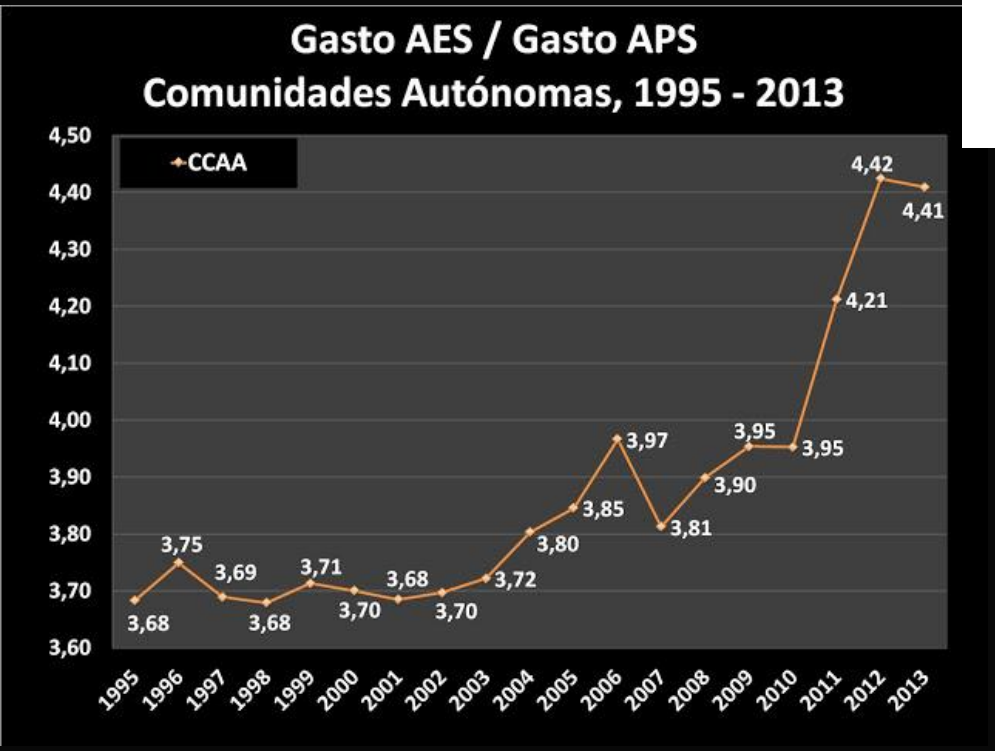
Perspective
AUGUST 7, 2014

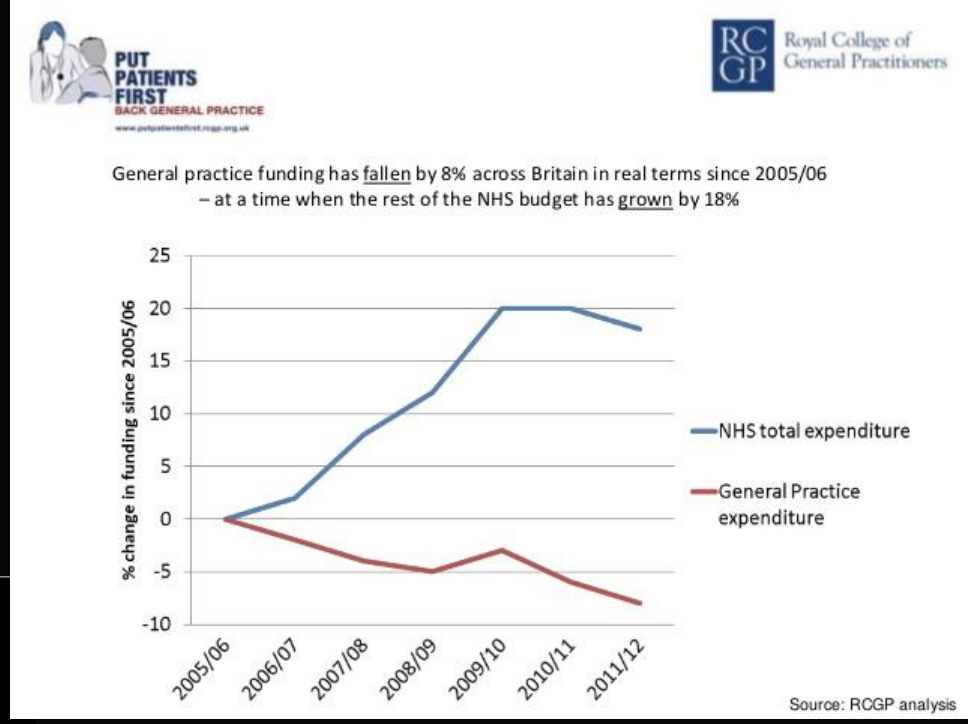
Instant Replay — A Quarterback's View of Care Coordination

Matthew J. Press, M.D.

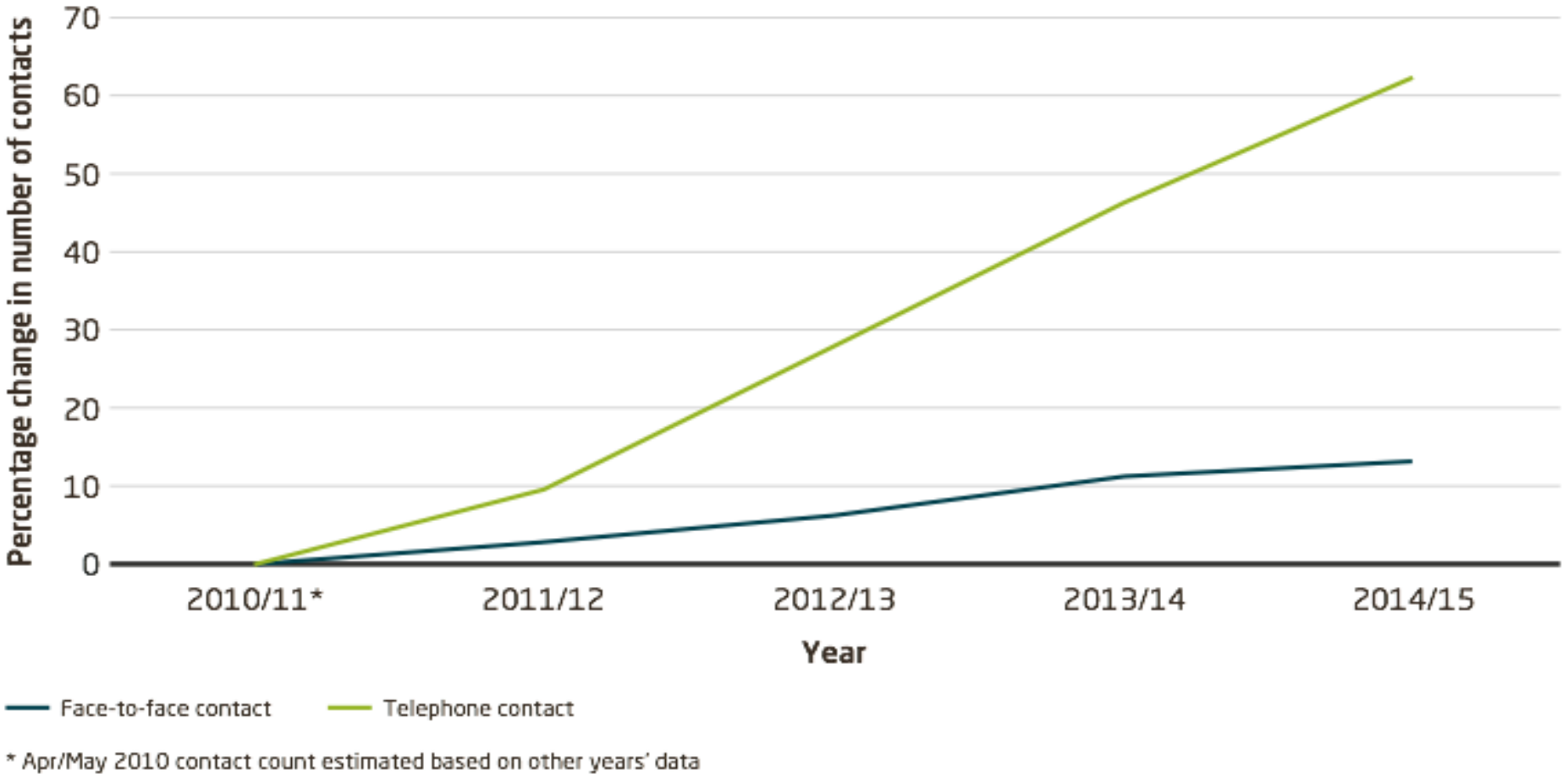


Sassall lleva 25 años practicando la medicina. Hasta la fecha debe haber tratado unos 100.000 casos. Se diría que es una buena marca. ¿Pero sería una marca peor si solo hubiera tratado 10.000?
Este tipo de estimación parece absurda.
Preguntémonos, pues:
¿Cuál es el valor social de aliviar el dolor?,
¿Cuál es el valor social de salvar una vida?
¿Cómo se compara el valor de cuidar una enfermedad grave con el mejor poema de un poeta menor¿
¿Cómo se compara dar un diagnóstico correcto y extremadamente complicado con pintar un gran cuadro?





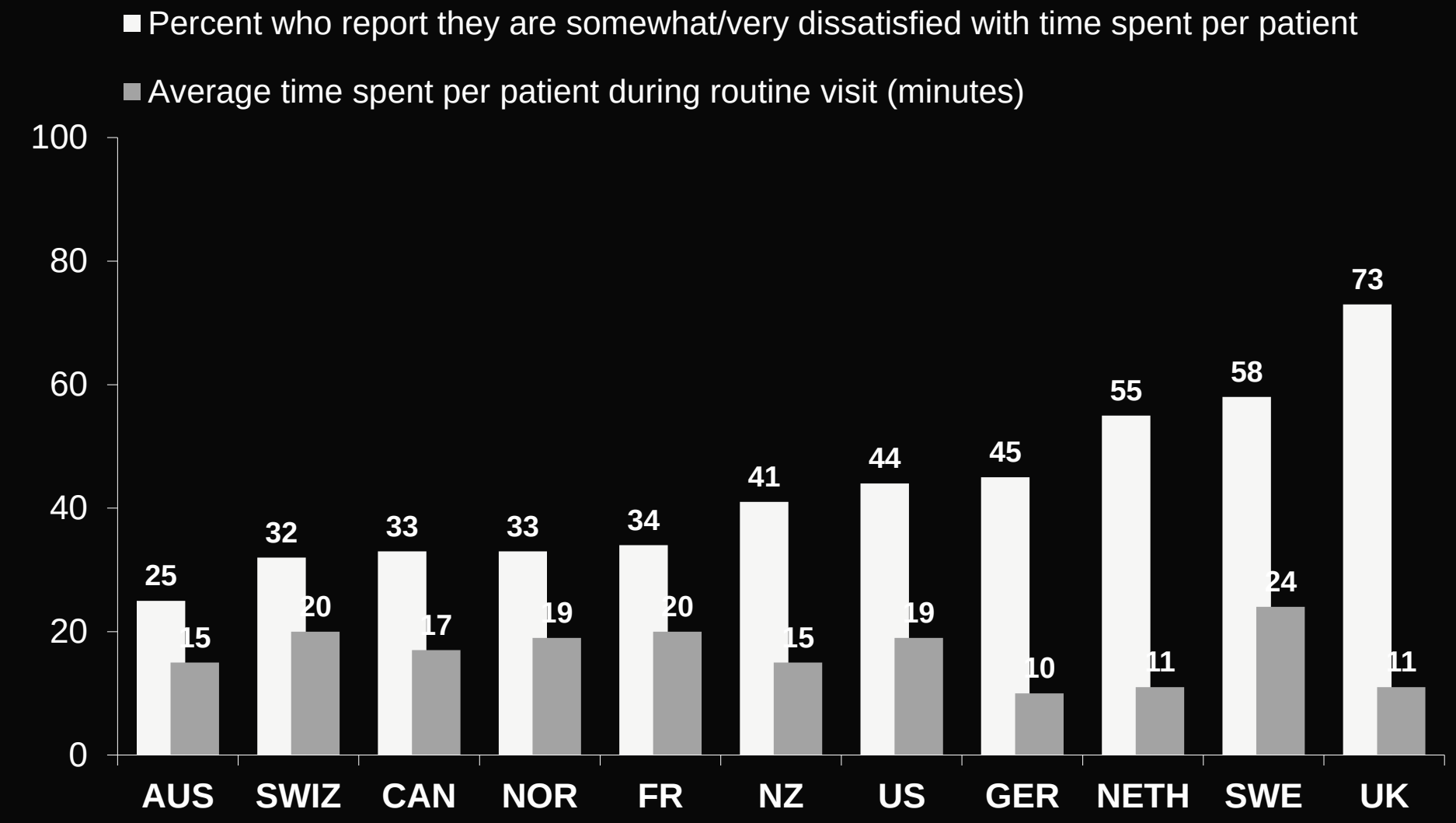
Salud, dinero y Atención Primaria. Juan Simó



* Apr/May 2010 contact count estimated based on other years' data

Source: King's Fund analysis of ResearchOne sample data

Physician Dissatisfaction with Time Spent per Patient



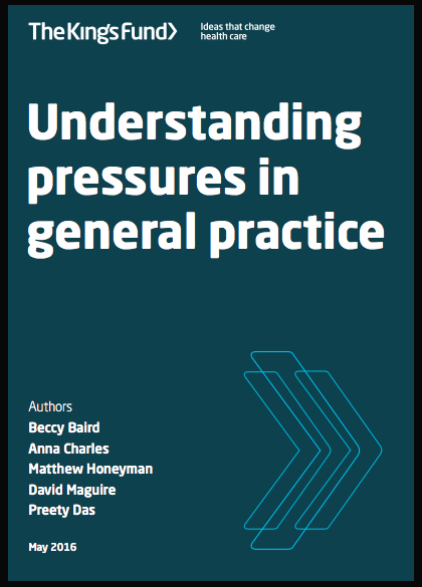
Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

El trabajo diario en AP….

Escasa atracción

Escasa vinculación

Escasa retención



- Razones de un rechazo:
  - Intensidad del trabajo diario (76%)
  - Compromisos familiares (65%).
  - Larga jornada laboral (59%)
  - Trabajo burocrático (49%)
  - Estrés laboral (37%)
  - Interés en otro trabajo (35%)

Clasificación de consultas
(Gervas, Casajuana 2013)

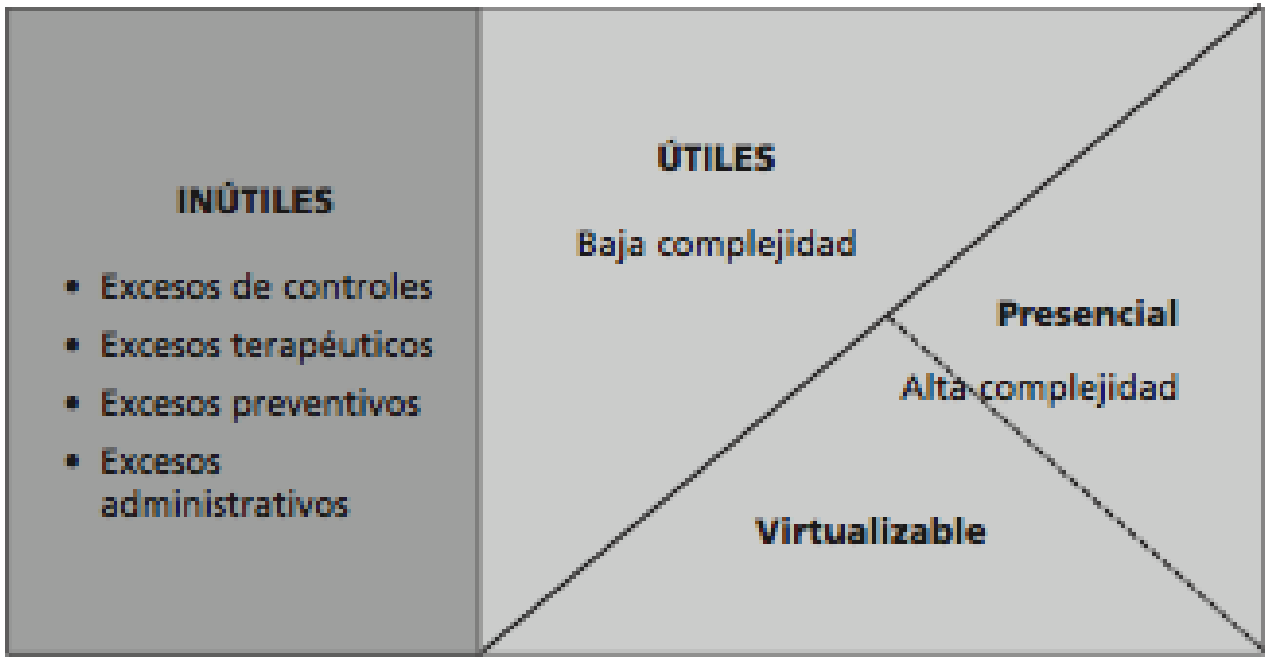


Figura 2-2. Clasificación de los contenidos de la consulta según utilidad y complejidad.

Transformando la práctica en AP
(Bodenheimer NEJM 2008;359:2086-9)

- *Los pacientes son interrumpidos a los 23 segundos (de media) por los médicos que les atienden.*
- *55% de los pacientes abandonan la consulta sin entender lo que les han dicho.*
- *Un médico necesitaría 18 horas por paciente para poder darle todos los consejos preventivos y de atención a sus problemas crónicos.*
- *Los médicos disponen SOLO de 15 minutos por paciente*

- **Nuevos enfoques:**
  - Revisión sistemática de la atención a los pacientes asignados.
- **Diversificación de las funciones.**
  - La atención a la población: "Panel Manager".
  - La atención a los crónicos: enfermería.
  - El seguimiento preventivo: Physician Assistant.
  - Los pacientes complejos: el médico de familia.
- Variedad de entornos de interacción:
  - La consulta.
  - Los grupos de pacientes.
  - El teléfono.
  - El correo electrónico.
  - Internet

Mensajes para llevar

- Fortalecer la atención primaria es clave para mantener la calidad y sostenibilidad de los sistemas sanitarios
- Atender a pacientes con necesidades complejas precisará de una atención primaria capaz de:
  - Trabajar en equipos multidisciplinarios
  - Disponible por correo electrónico, atención fuera de horario y atención domiciliaria
  - Utilizando de forma efectiva las tecnología de la información
  - Prestando Atención integrada dentro y fuera del sistema sanitario
- Re-diseñar los sistemas de prestación de servicios requerirá ensayo y evaluación para entender que es lo que funciona mejor.
- Dado que las reformas perturban el funcionamiento los sistemas, gestionar los efectos de las reformas es crítico.
- Es importante para los decisores políticos escuchar a los médicos de “trinchera”
- Observar a otros paises ofrece una oportunidad para aprender lecciones de aplicación global

“Siento que juego en una posición que exige un trabajo generoso y poco vistoso, pero es mi trabajo y me gusta. A mi me da igual morder la salida del balón que barrer la zona porque estoy para eso. Para facilitar el trabajo de los demás. Mi posición exige ser inteligente, pensar rápido, decidir rápido y ejecutar fácil”

Ilusión y significado
(Leape)

"Pensar de forma positiva sobre:

- el trabajo que hacemos
- La gente con la que trabajamos.
- La organización a la que pertenecemos"

thebmj

The BMJ SUBSCRIBE NOW

Richard Smith: Time for GPs to be leaders not victims

9 Jun, 15 | by BMJ

94 77

General practitioners are overworked, underappreciated, and perhaps underpaid. Politicians are unsympathetic to their plight and expecting more of them. Hospital doctors dump work on them. Nurses are after their jobs. Patients are demanding and ungrateful. Bureaucrats and regulators are making their professional lives a misery. General practitioners have replaced farmers as the profession that complains the most.

I have no sympathy for them. I want them to stop being victims and become leaders, people who solve problems rather than complain about them and expect others to solve them. I've preached this message to meetings of GPs several times in the past, which has not made me popular, but the current orgy of moaning has urged me to put finger to iPad.

My first argument is that even if you are a victim you gain nothing by thinking of yourself

Propongo una moratoria en los lamentos y un festival de ideas para reinventar la medicina general

“Un mapamundi en que no figurase la **utopía** no valdría la pena de ser mirado, pues faltaría en él el único país al que la Humanidad arriba a diario. Y apenas e él, mira más allá, y divisando una tierra aún más atractiva, vuelve a poner proa hacia ella.

El progreso no es más que la realización de las utopías”

“Robert Johnson solo existió en sus discos
Fue pura leyenda”
Martin Scorsese

Muchas gracias ¡

@sminue