e-ISSN 2544-1620

Medical Science Pulse 2019 (13) 1

Reviews

Published online: 25 Apr 2019

DOI: 10.5604/01.3001.0013.1713

CAN COMMUNITY AND HOSPITAL MEDICINE MEET? A NOVEL INTEGRATIVE CARE EXPERIENCE AT ASSUTA UNIVERSITY MEDICAL CENTER

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A – study design, **B –** data collection, **C –** statistical analysis, **D –** interpretation of data, **E –** manuscript preparation, **F –** literature review, **G –** sourcing of funding

ABSTRACT

The ageing of the population, along with the rise in chronic complex illnesses, requires extensive interprofessional, individualized care, mainly in the community, but also in hospitals. Fragmentation results in suboptimal care, higher cost due to duplication and poor quality of care. Hence, collaboration between health systems is essential to prevent further complications and provide enhanced medical care to patients. Integrative care creates bridges between community and hospital health. Integration should be pursued at different levels within a system to facilitate the continuous, comprehensive, and coordinated delivery of services to individuals and populations. To be applied and to make a difference in patient care and outcome, its significance needs to be understood and embedded at the management level. Health systems should abandon familiar paradigms and collaborate with other health systems on the macro level. Several studies describe integrative care from its different aspects. Division of integration into levels: systemic to clinical, horizontal vs longitudinal and according to the degree of integration (from linkage to full integration). Maccabi Health Services is the first Israeli health organization to place an integrative care team at Assuta Hospital in Ashdod. The multiprofessional team, situated in the hospital, sees every Maccabi patient in the hospital. Through close communication and collaborative work with the hospital team – a shared continuity of the care plan is prepared. The team coordinates future care in the community from the hospital to ease the release process and improve outcomes.

KEYWORDS: integration, multiprofessional, collaboration, continuity of care

Background

Society is ageing concurrently with improvement in healthcare. Paradoxically, the number of chronically ill patients is increasing. The complexity of their illnesses requires an interprofessional support system to manage their care. Community health takes the leading role in the treatment of these patients [1]. Yet, during their illness exacerbation and health deterioration, acute care centers, hospitals, and secondary care institutions are crucial components of their treatment. In addition, newly hospitalized patients with no chronic medical condition can unexpectedly encounter a new illness which requires continuation of care in the community.

The importance of health system collaboration cannot be emphasized enough. Lack of communication leads to medical errors, repeat hospitalizations, extra medical costs, patient dissatisfaction, and poor patient outcomes. During the patient discharge period, such collaboration and communication are especially important. At this critical time, the frail patient faces numerous barriers from different community services, while trying to follow hospital recommendations [2].

The EU Expert Group on Health Systems Performance Assessment report defined integrated care as the following: "Initiatives seeking to improve outcomes of care by overcoming issues of fragmentation through linkage or co-ordination of services of providers along

the continuum of care" [3]. It aims to provide a seamless continuum of care at the patient level, as well as augmented effective use of limited resources at the organization level. Its guiding principle across levels of care is the health system's accountability to its patient population [4].

Shortell et al. (1994) divided integrative care into 4 levels: Ranging from clinical integration, that is person focused at the micro level, to systemic integration, that is population based at the macro level (Fig. 1) [4,5]. Leutz (1999) refers to integrative care as longitudinal or horizontal. Horizontal integration connects different services on the same treatment level (e.g., services in the community). Longitudinal integration means collaboration between different health systems at different levels of care (e.g., hospital and community) [6].

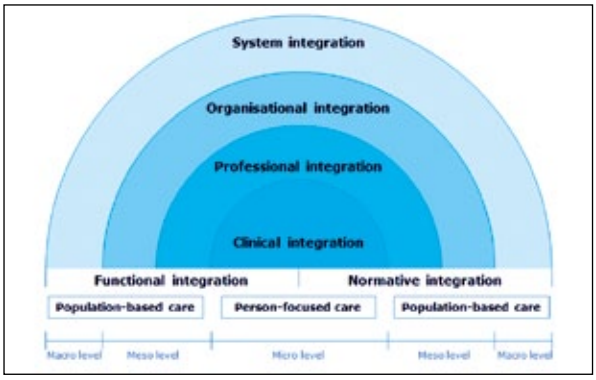

Figure 1. Different levels of care integration.

Integrative care ranges from linkage (occurring between existing organizational units) through coordination (entailing a more structured type of integration but still operating largely through existing organizational units) to full integration (pooling resources of different organizational units to create a new organization). There is a correlation between a patient's needs and level of integration needed from the health system (Fig. 2) [7].

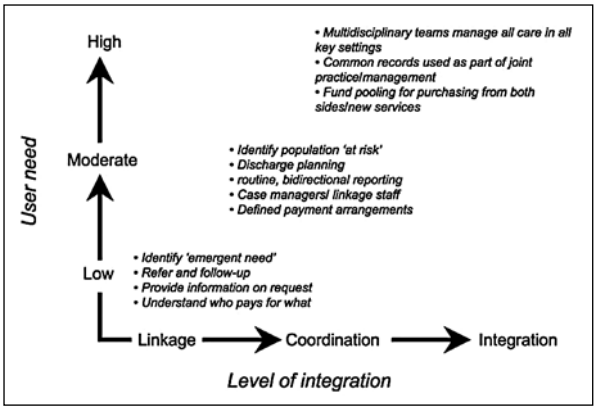

Figure 2. Setting the level of integration against user need to optimise care.

To achieve effective integration, an appreciation of the importance of a good relationship between primary care givers and the health organizations is required. Barriers such as mixed financial incentives, lack of communication between clinical information systems, absence of adequate geographic concentration of facilities, ambiguous roles and responsibilities, inability to execute the system's strategy, and incapacity to "manage" managed care limit the power to apply integrative care as extensively as expected.

In summary, integration requires creating an organizational and systemic platform to provide comprehensive patient care. Maccabi Health Services Community Health Organization, in collaboration with Assuta Ashdod Hospital, has adopted the integrative care model. It is the first health organization in Israel to create a hospital-based community integrative care unit.

Assuta Ashdod University Medical Center opened on November 1, 2017. It is the first hospital in Israel to define itself as a community-oriented hospital. The Maccabi Health Service integrative care unit began working in accordance with the opening of the hospital. The unit comprises an interprofessional team including a medical director (a family physician also practicing in the community), administrative director, nurses, social workers, dietician, physiotherapist, clinical pharmacologist, and medical secretary. The team is situated in the hospital, with staff on duty during the entire day.

The goals of the unit are ensuring continuity of care between hospital and community services for the Maccabi patient and creating a bridge between the hospital and community medical staff, and thus preventing prolonged and unnecessary repeat hospitalizations, effectively utilizing resources, and improving patient satisfaction. The target population includes every patient who is a member of Maccabi Health Services in the inpatient and outpatient setting. Treatment is based on patient needs, ranging from administrative services to multiprofessional patient care and release plan, including referral to appropriate continuity care institutions (e.g., rehabilitation, hospice). The integrative care team receives a daily list of all inpatients and their clinical condition. Members of the team visit every patient at the bedside and evaluate individual medical and social needs. The appropriate staff members are involved, and the hospital staff is consulted about certain patients. Hospital case managers also locate patients and identify their needs and deliver the information to the team. The integrative care team creates an individual release plan for each patient and begins coordinating continuity of care with community services at the outset of the hospital stay. Patients from the ER or the outpatient settings are located by hospital staff and referred to the team. The patient's primary care physician is contacted and receives an update. Upon release, the patient returns to the community with all appointments arranged in advance. Follow up is provided to the hospital staff from the community (Fig. 3).

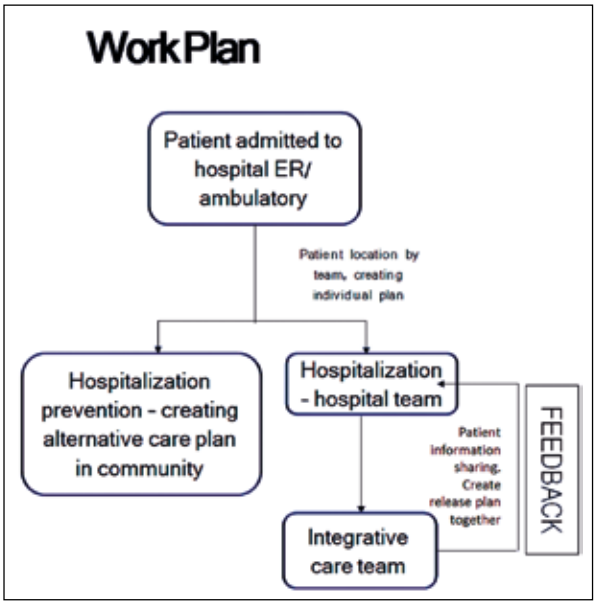

Figure 3. Work plan for Maccabi patient entering Assuta Ashdod Hospital.

Additional roles of the medical director include a „learning together" monthly program where community and hospital physicians meet to learn a clinical topic together. A clinic for hospital employees is also run by the medical director. This fosters familiarity with hospital personnel and brings the community into the hospital by providing community services in house for staff. Evaluation and feedback are preformed daily. Data are collected regarding patient satisfaction, hospital and community health staff satisfaction from integrative work with the team, length of hospital stay, number of referrals to continuity care institutions, and the like. Preliminary data after being in operation for approximately 16 months demonstrate that the program has led to shorter hospital stays (owing to community solutions, such as IV treatment), reduced unnecessary repeated hospitalizations, decreased costs, and improved patient and staff satisfaction (data collection is still in process).

In summary, integrative care addresses the challenges of the aging, complex, chronically ill society. The continuity of care between hospital and the community improves patient outcomes and has an impact on all levels of healthcare. Collaboration between the hospital and community at the management level creates opportunity to provide better care at the individual patient level.

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Word count: 1027 • Tables: – • Figures: 3 • References: 7

Sources of funding:
The research was funded by the authors.

Conflicts of interests:
The authors report that there were no conflicts of interest.

Cite this article as:
Yeshayahu M, Shechter K, Jacubovsky T, Rotlevi E.
Can community and hospital medicine meet? A novel integrative care experience at Assuta University Medical Center.
MSP 2019; 13, 1: 26–28.

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Received: 8.04.2019
Reviewed: 18.04.2019
Accepted: 23.04.2019