



D5.1 Readiness of European Regions for Integrated Care

Annex E: Self-assessment process in Lithuania

WP5 Maturity Assessment for Integrated Care



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1. Introduction

Vilnius University Hospital Santaros Klinikos (VULSK) is one of the major hospitals in Lithuania, encompassing the provision of medical care in almost all key areas.

Vilnius University and the Lithuanian Ministry of Health are the founders of Santaros Klinikos. The activities of the Hospital encompass practical and scientific medicine, education of students and residents, continuing professional training of medical specialists, modern management based on modern information technology solutions is applied.

1.1 Characteristics of the healthcare system

Table 1. Characteristics of healthcare system

Item	Description
Country	Lithuania
Geographical scale of the country	National (Country-wide)
Geographical size and dispersion of the country (km ²)	65 286 km ²
Population size of the country (thousands)	2 794 184
Population density of country (inhabitants/km ²)	42,8
Life expectancy of the country (years)	75,8
Fertility rate of the country (births/woman)	1,676
Mortality rate of the country (deaths/1,000 people)	14,2
Top three causes of death of the country	Ischemic heart disease, Stroke, Alzheimer's disease
Organisation and governance of healthcare services	The organisation and governance of the system in Lithuania are typical of many European countries and have been remarkably stable in the past 20 years. The Ministry of Health (MoH) and the National Health Insurance Fund (NHIF) are the main central institutions, with local administrations playing an important role in service delivery. The MoH, supported by a handful of specialised agencies, formulates health policy and regulations. Insurance coverage is provided to the population by the NHIF. In order to obtain coverage, the active population must contribute to the NHIF. The economically inactive, including children and students, pensioners and the unemployed, constituting 54% of the population in

Item	Description
	<p>2016, are automatically covered. The NHIF purchases all personal health services, and contracts with public and private providers on equal terms. The 60 municipalities of Lithuania own a large share of the primary care centres, particularly the polyclinics, and small-to-medium sized hospitals. They are also responsible delivering public health activities.</p> <p>Service delivery continues to be dominated by a large and mostly public hospitals', but outpatient service delivery is increasingly mixed. Inpatient services remain mostly publicly provided and the total number of beds, 7 per 1000 population, is well above the OECD average of 4.7. Specialist outpatient care is delivered through the outpatient departments of hospitals or polyclinics, as well as by private providers. Private providers play an increasing role in the rapidly developing day care and day surgery segment as well as in diagnostic and interventional imaging services. In the Lithuanian system, primary care routinely acts as a first contact point with the health system for patients. It is delivered in public or private health care centres, where general practitioners (GPs) often practise alongside other primary care specialists such as paediatricians, gynaecologists and mental health practitioners.</p> <p>Primary care is provided in either municipality-owned facilities or typically smaller private practices.</p>
Healthcare spending of the country (% of GDP)	6,5
Healthcare expenditure of the country (thousands)	2,58 billion (2016)
Distribution of spending in the country/region	Approximate distribution: Primary care 20%, reimbursed medication 20%, Secondary and tertiary care 60%.
Size of the workforce (thousands) and its distribution (%) in the country.	Lithuania has more physicians and fewer nurses per capita than the OECD average and their geographic distribution is a concern. Despite emigration of health staff, Lithuania has retained a relatively high number of physicians: 4.3 per 1000 population versus 3.4 in the OECD. The ratio of nurses to population on the other hand is below the OECD average. Specialists, in particular, are unequally distributed across the country. In order

Item	Description
	<p>to attract staff in peripheral areas, GPs receive a higher capitation payment for patients living in rural areas, and hospitals/municipalities offer higher salaries. In conjunction with municipalities, the government has recently put in place grants for medical students willing to work in remote areas.</p> <p>In 21 municipalities, 70 mobile teams provide integrated services (nursing and social care) at home, including support to their informal care givers.</p>
Healthcare policies in the country/region	<p>Primary health care (an increase of the funding), prevention programs are being developed, and healthy lifestyle specialists are integrated into family health centers. Great attention is paid to e-health. Electronic disease historiography. Remote consultations. Image Database. Outpatient care is increasing (also in secondary and tertiary care).</p>

Sources: OECD REVIEWS OF HEALTH SYSTEMS: LITHUANIA 2018.

<https://www.oecd.org/countries/lithuania/lithuania-9789264300873-en.htm> Statistics Lithuania, 2019.

<https://www.stat.gov.lt>

1.2 Integrated care in Lithuania

One of the main priorities in Lithuania is to strengthen public health services at local level, including disease prevention healthy lifestyle promotion and raising population's health literacy, implementing integrated health services.

A functional integration of primary health care and public health surveillance activities started in 2015.

Teamwork in family medicine has been introduced and expanded. Presently, the family physician team consist of family physician (GP), nurse, midwife, nurse assistant, physiotherapist, life style medicine specialist and social worker.

The Lithuanian government runs structural reform that focuses on the development of GPs for outpatient health care services. Special emphasis is on the implementation of innovative multimorbidity health service models at national level. Unfortunately, the ratio of nurses to population and the ratio of nurses to physicians are below the OECD average. Health care specialists are unequally distributed across the country.

Legislation to develop models on integrated care is approved by the government, but there are still many challenges to overcome in practice. We can conclude that integrated care in Lithuania is taking its first steps.

2. Self-assessment process in Lithuania

2.1 Identification process of the local stakeholders

The selection of the stakeholders was based on the idea to cover a more comprehensive overview of the situation to better expose the weaknesses of the local environment of integrated care in Lithuania. The scope of the assessment consisted of 4 stakeholders' groups:

- **The Primary Health Care Centers (PHCC) from different cities of Lithuania** were selected as the main stakeholders' group. This group consisted of the following stakeholders:
 - Public PHCC, Vilnius: administrator, chief, nurse, resident, a family physician.
 - Public Institution "Center for Integrated Health Services", Panevezys: a family physician, midwife, chief, lawyer, social worker.
 - Public PHCC: family physician, administrator, chief, nurse.
 - Private PHCC, Kaunas: family physician, chief, nurse.
 - Private PHCC, Vilnius: family physician, regional manager, administrator, chief, nurse.

All other groups were selected as stakeholders in the integrated care system. These groups were as follows:

- **Medical Doctors from different fields:** cardiologists, pulmonologists, allergist, endocrinologists, gastroenterologists, nephrologists, geneticists, pediatricians.
- **Government:** Ministry of Health.
- **Patients.**

2.2 Self-assessment survey

The assessment process was organised in several steps.

- The adaptive translation of the SCIROCCO Exchange Tool into Lithuanian language was provided on 15 July 2019.
- The pilot self-assessment process was performed on 20 July 2019. During this assessment, we learned that not all stakeholders are able and willing to understand the concept and the need for the assessment.
- To attract more stakeholders, a webinar was organised on 16 October 2019 to provide further insights on the process.
- After the webinar, other participants of the integrated care system were added to the self-assessment process.

Totally, 65 stakeholders took part in the self-assessment process of Lithuania, of which:

- 30 stakeholders were from PHHC group
- 20 Medical Doctors from different field
- 1 stakeholder from the Ministry of Health

- 14 patients.

Each stakeholder was given the presentation and the translated SCIROCCO Exchange tool. Some clarifications were needed most of the time, but we provided the support and explanations live or online. Stakeholders were not so willing to give feedback or some comments.

2.2.1 Outcomes of self-assessment survey

As the scope of the survey covers 65 stakeholders' opinions, the results of the self-assessment survey were analysed according to the stakeholders' groups, and finally, the spider diagram of the total results was done (Figure 1).

Figure 1: The results of the self-assessment process of PHCC and Specialist



The spider diagram of PHCC

The spider diagram of Medical Doctors

Comparing the results of PHCC and Medical Doctors, it can be concluded that some similarities exist. The most significant discrepancies were observed in the following domains: Evaluation Methods (PHCC - 2, Medical Doctors - 0) and Breadth of Ambitions (PHCC - 3, Medical Doctors - 0). Both dimensions were ranked much more positively by PHCC. Such results may have been influenced by the specialists' more practical point of view as they rely on practice.

Figure 2: The results of the self-assessment process of Patients and the Ministry of Health



The spider diagram of Patients

The spider diagram of the MOH

Comparing the results of Patients and the Ministry of Health, it can be concluded that there are no similarities at all. It highlights the problem of miscommunication between patients and the government.

There could be several assumptions about why this happened. The Ministry of Health works on a legal basis, they are well informed and are defining the priorities, while patients have a completely opposite view, very practical, usually very biased, based on their personal experience, with limited information on theoretical priorities or strategic plans. Doctors, including family physicians and medical doctors from different fields, do have not enough time during the consultation time to explain all the possibilities and present additional options related to the integrated care to the patient. In any case, there is a considerable difference in the information available and the situation perceived between all groups involved.

Figure 3: The spider diagram of the total results



The spider diagram of the total results is the representation of the opinions of 65 stakeholders (Figure 3). The maximum score of the self-assessment survey is 3 out of 5. Only two dimensions were ranked with a score of 3; “Digital Infrastructure” and “Population Approach”. Only one dimension: “Process Coordination” was ranked with a score of 2. The dimensions of “Finance and Funding”, “Evaluation Methods”, and “Breadth of Ambition” were ranked with the lowest score of 0. The other 6 dimensions were ranked with 1.

2.3 Stakeholder workshop

The stakeholder workshop for the consensus-building was organised on 4 December 2019, in VULSK. The meeting was planned for 1,5 hours, but due to negotiation and consensus-building process, it went a bit longer than we expected, but the meeting was very fruitful. All stakeholder groups participated in the discussion.

The overall outcomes of the self-assessment survey were presented, and each dimension out of 12 was discussed separately.

D5.1 Annex E - Self-assessment process in Lithuania Region

The agenda of the workshop, photos and the list of participants are attached as the Annex 1.

2.3.1 Negotiation and consensus building

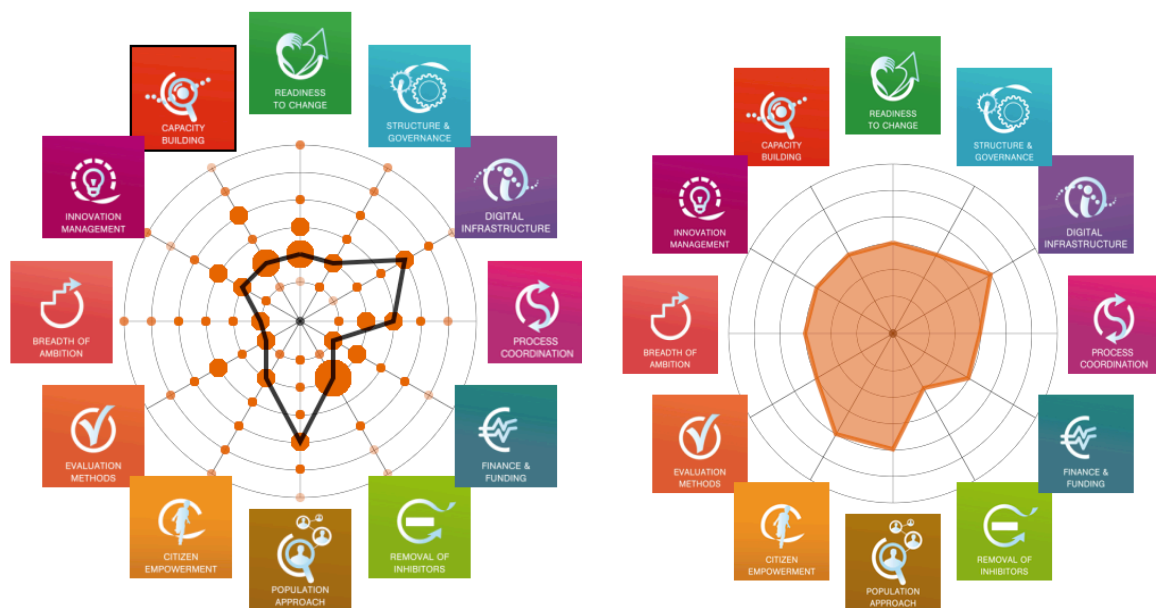
In the table below (Table 2) the total results of the self-assessment survey before and after the consensus workshop are expressed.

Table 2. Total results of the self-assessment process before and after the workshop expressed (in values)

Dimension	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Results before workshop	1	1	3	2	0	1	3	1	0	0	1	1
Final consensus after workshop	2	2	3	2	2	1	3	3	2	2	2	2

The comparison of the total results of the self-assessment survey before the workshop and after the workshop is presented in Figure 4.

Figure 4: Total results of the self-assessment process before the workshop and after



The spider diagram of the total results before the workshop

The spider diagram of the total results after the workshop

During the negotiation and consensus-building process based on the total results of the self-assessment survey, all of the 12 dimensions were discussed thoroughly, especially those with the most significant differences in scoring and the consensus was built.

The following three dimensions were highlighted as priority dimensions for further improvement:

- Process Coordination
- Removal of inhibitors
- Capacity Building.

2.3.2 Final consensus

Figure 5: The final spider diagram of the results of the self-assessment process



Table 3: Scores, Justifications and Reflections assigned to each of the dimensions

Dimension	Scoring	Justifications & Reflections
Readiness to Change	2	There is lack of dissemination of information and of coherence between governance and practice. The need for change is strongly acknowledged. The vision and the form of change are clear enough, the consensus is achieved, actions and the plan for changes are being developed.
Structure & Governance	2	LITHUANIAN HEALTH STRATEGY FOR 2014-2025 was approved on 26 June 2014. National Development Strategy: Lithuania 2030, incorporates a horizontal dimension "Health for All" which describes the implications that state policies and programmes have on population health. The structure exists, but not everyone is familiar with it.
Digital Infrastructure	3	According to the Implementation Plan (The implementation of E-Health System Development Programme for 2009-2015), during the period of 2009 - 2015, 29 e-Health projects have been already implemented, including 16 national and 13 regional projects. Information systems of the national-level and university hospitals, an Online Booking System for outpatient consultation, registers of licenses of health care professionals and health care institutions (hereinafter - HCI), register of medicines ensuring the development of high-quality electronic services of HCI have been developed under the national projects. Regional projects are focused on information systems of regional medical institutions that provide data to the central e-health information system. However, the results of the maturity assessment highlighted that the digital infrastructure is designed, but is not integrated into a universal national system, data sharing is limited. Therefore, it should be stated that the digital infrastructure is under development.
Process Coordination	2	Lithuanian Ministry of Health runs structural reform 2017-2020 within 6 focus areas. One of them - PHCC. Health structural reform consists of 5 drivers with clear objectives, milestones and Key Performance Indicators (KPI). Some guidelines and recommendations for multidisciplinary approach are provided, including horizontal and vertical integration, patient transition (from pediatric to adult services structures) as the cooperation between professionals in different fields could be named more chaotic compared to "complex".
Funding	2	Funding is mostly project-based, with the initiative coming from the medical community, but not from healthcare policy-makers.
Removal of inhibitors	1	There are several Supervisory Commissions which propose measures for integrated care implementation, identify weaknesses in the legal framework and organisation of services, and actively participate in the drafting of legal documents. However, the Commissions' activities are inadequate, and meetings are not regular enough.
Population Approach	3	Health monitoring methodologies are updated regularly to assure data quality. Lithuania participated in the EU-funded InfAct project ¹ where health information system evaluation was performed. Health monitoring information are shared with EU networks and information systems. Health indicators are also monitored to form strategic documents. Not only health outcomes but also lifestyle and health behaviour of adults and children is monitored. However, there are skills shortages and cultural barriers, and some individuals' resistance to accept or get ready for changes.

¹ <https://www.infactproject.eu>

D5.1 Annex E - Self-assessment process in Lithuania Region

Dimension	Scoring	Justifications & Reflections
Citizen Empowerment	3	The drafts of the legal acts are consulted with the public by publishing them in the legal information system (LRS). The Ministry of Health invites representatives of relevant patient organisations to participate in working groups on the amendment of legislation. Although hospitals work closely with patient organisations, patients' associations and associations that coordinate patient integration should be more involved in this process.
Evaluation Methods	2	The Law of the Republic of Lithuania on Health Systems sets the objective of Health Technology Assessment to ensure optimal use of material, financial and human resources of health care and to improve the quality of health care. However, there is currently no independent, standardised, regular evaluation of integrated care services. Evaluation takes place in fields directly related to finance, but no integrated, evidence-based assessment criteria are introduced.
Breadth of Ambition	2	University Hospitals deliver horizontal integration and multidisciplinary care for rare disease patients. A significant part of the services is based on the use of ICT and vertical integration, data transfer and communication with primary and secondary care institutions. Social services and counselling are provided, but there is a lack of integration of these services with local service structures closer to the patient's home. The lack of any sustainable funding and solutions in national systems are critical issues in providing the principles of integrated care.
Innovation Management	2	Representatives from University Hospitals participate in the Monitoring Committee of the National Plan for Rare Diseases, offering innovative tools for the implementation of integrated care for rare diseases, often based on international experience. However, there is currently no mechanism to systematically collect and use this experience to stimulate and implement innovation. Innovation is encouraged, but the necessary human and financial resources are not allocated.
Capacity Building	2	Individual approaches exist at the level of the Ministry of Health, but there is a lack of communication, collaboration with services. Sharing innovations with each other in small gatherings of office staff exist, but it is very little or no sharing of innovation between services.

3. Analysis of the outcomes

1. It could be stated that the outcomes of the self-assessment reflect the overall maturity, even though the results vary considerably between the stakeholder groups. With a considerable number of responders, it also reflects the actual situation of the region.
2. The results of stakeholders' groups, patients and the Ministry of Health, were extremely different. It highlights a possible miscommunication between patients and the policy makers, which might not help when debating on the priorities for the integration of the health services.
3. Many connections could be distinguished between all 12 dimensions, as each of the dimension more or less interacts with each other. Though the dimensions Funding, Breadth of Ambition, Innovation Management and Removal of Inhibitors could be distinguished as there are some connections via financing, more specifically, - the lack of funding.
4. In comparing with the overall consensus diagram, the Digital Infrastructure dimension could be considered as the current strength in terms of integrated care in the region. In addition, Population Approach and Citizen Empowerment could be named as having stronger maturity, but there is no dimension where enough maturity was reached. All 12 dimensions in the region require further improvements.
5. In comparing the overall consensus diagram, Removal of inhibitors has the lowest maturity and should be considered as our main area of weakness. Besides this, the other two dimensions, Process Coordination and Capacity Building, were highlighted as priority dimensions for changes / improvement in the region.
6. From the cultural perspective, the lack of willingness to deal into complex issues could be named as one of the factors which restricted the scope of the assessment process. The bigger scope of stakeholders participating in the assessment could have varied the assessment scores significantly, but it would not change the final consensus results.

4. Key messages

Some cultural factors restricted the smooth completion of the questionnaire, and the lack of willingness to delve into complex issues caused some difficulties in cooperating with the stakeholders.

Unfamiliar wording / terminology meant some clarifications were needed most of the time.

Different stakeholders' involvement allows reflection on the situation from different angles, providing very different results, when comparing patients and policy-makers, suggesting a lack of common views and communication between the groups. Stakeholder debates were fruitful to agree on the priorities and/or reflect on the actual situation when considering different perspectives.

Despite the obstacles, the assessment process was fruitful, generating 65 answers from 4 different stakeholders' groups. The assessment Tool, which is designed for an international purpose, is recognised as valuable and evaluated positively.

5. Conclusions and next steps

As the scope of the survey covers 65 stakeholders' opinions, the results of the self-assessment survey were analysed according to the stakeholders' groups (PHCC, Medical Doctors from different fields, Government, and Patients) and finally, the spider diagram of the total results was produced.

Comparing the results of PHCC and Medical Doctors, it can be concluded that some similarities exist. Such findings may have been influenced by the specialists' more practical point of view as they rely on practice.

Comparing the results of Patients and the Ministry of Health, it can be concluded that there are no similarities at all - thus highlighting the problem of miscommunication between patients and the government. The Ministry of Health works on a legal basis, while patients have low medical literacy, and they don't access the information.

The results of the self-assessment process before the consensus-building workshop and after varied quite strongly. The following three dimensions were highlighted as priority dimensions for changes / improvement:

- Process Coordination
- Removal of inhibitors
- Capacity Building.

Annex 1. Self-Assessment Workshop - Agenda

Agenda of the workshop at VULSK



VIEŠOJI ĮSTAIGA
VILNIAUS UNIVERSITETO LIGONINĖ
SANTAROS KLINIKOS



SCIROCCO integruotos priežiūros brandos modelio vertinimo rezultatų pristatymas ir įrankio vertinimas

2019 m. gruodžio 4 d.

Vieta: Vilniaus universiteto ligoninės Santaros klinikos, 11 aukštas, A1157 auditorija,
Santariškių g. 2, Vilnius

PROGRAMA

14.05– 14.05 Dalvių registracija. Seminaro tikslų ir darbotvarkės pristatymas.

14.05 – 14.15 SCIROCCO brandos modelio integruotai priežiūrai vertinimo rezultatų
apžvalga.

14.15 – 14.45 Diskusija: vertinimo rezultatų išgryninimas ir bendro prioritetų sąrašo
sudarymas.

Klausimai diskusijai:

- ▶ Didžiausi vertinimo skirtumai ir to priežastys.
- ▶ Faktoriai galintys lemti keletą dimensijų vertinimą.
- ▶ Galutinis kiekvienos dimensijos įvertis (priimtas bendru sutarimu).
- ▶ Kurios iš 12 dimensijų yra pasirengusios pakankamai.
- ▶ Kurias iš 12 dimensijų galime laikyti kaip barjerus integruotos priežiūros plėtrai.
- ▶ Kokie specifiniai regiono aspektai gali padėti/pakenkti integruotai priežiūrai.

14.45 – 14.50 SCIROCCO brandos modelio integruotai priežiūrai panaudojimo vertinimas.

14.50 – 15.15 Diskusija.

Klausimai diskusijai:

- ▶ Kokia jūsų patirtis naudojant įrankį? Ar konsultavotės atlikdami vertinimą? Kas galėtų būti patobulinta?
- ▶ Konkrečios sveikatos ir socialinės sistemos išvalgos, į kurias būtina atkreipti dėmesį? Kokiu pokyčių reikėtų jūsų regione siekiant labiau vystyti integruotą priežiūrą.
- ▶ Pagrindiniai faktoriai bei veiksmas lemiantys integruotos priežiūros plėtrą.

15.15 – 15.30 Seminaro išvados ir apibendrinimas.

Highlights from the workshop

