



**Changing Health**  
Liderando la transformación  
de la gestión sanitaria

2022

# El papel de los procesos: elemento clave de la gestión basada en valor

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IESE Business School – 28 de marzo del 2022

# Dirección de Operaciones (en una escuela de gestión)

- **Las Operaciones** consisten en el arte y la ciencia de hacer “cosas” (productos, servicios, experiencias,...).
- La Dirección de Operaciones estudia la forma en la que las organizaciones producen estos bienes y servicios y busca cómo mejorarlo.
- (Casi) todo lo que vestimos, comemos, bebemos, leemos, usamos para sentarnos, movernos, jugar, experimentamos, disfrutamos, ... es el fruto de los directores de operaciones que han organizado su aprovisionamiento, producción, transporte, ... Todo ha sido “producido”.
- Las operaciones existen en todos los departamentos, empresas, hogares,....



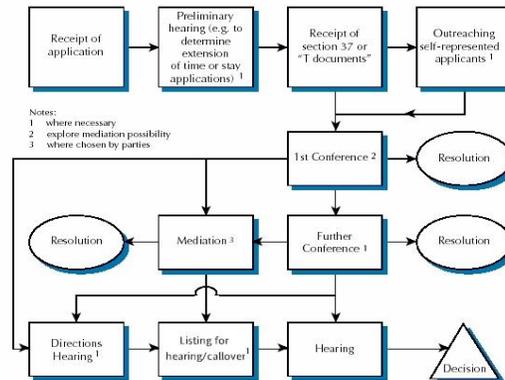
# ¿Cómo hacemos las “cosas”?

## PLANIFICACIÓN

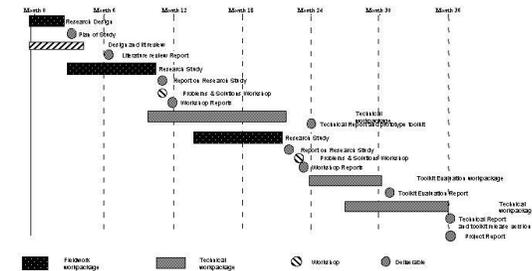
IMPROVISACIÓN



PROCESOS  
Repetitivos, bien  
definidos



PROYECTOS  
Su objetivo es crear un  
“producto” único



*Normalmente trabajamos con combinaciones de estos tres modos de funcionamiento*

# El Propósito del Propósito en Salud

- ¿Qué intentamos conseguir con y para las personas (ciudadanos, pacientes, ...) que servimos? ¿Qué es valor para ellas?
- Determinar la razón acordada por la que trabajamos juntos en un sistema de salud, una institución, ... que permita alinear distintos servicios y profesionales, permita enfocar su atención cuando trabajan en un entorno de ruido y distracciones, y les proporcione una buena regla de decisión cuando no haya otra mejor.
- Candidatos para este propósito común:
  - El “valor”
  - La triple meta (triple aim)
- ¿Qué aspectos de valor se esperan conseguir en esta parte del sistema?
- ¿Cuáles se conseguirán en otras partes del sistema?
- ¿Qué hacemos aquí para crear valor para las personas?
- Diseño de un sistema operativo - procesos



# La visión de valor (según M. Porter)

- La **gestión de la salud basada en el valor es uno de los temas más importantes en la transformación del cuidado de la salud en la actualidad**. Los enfoques basados en el valor para organizar la atención se consideran fundamentales para mejorar los resultados de salud de los pacientes en todo el mundo y controlar los costos de atención médica desbocados.
- El concepto central de la gestión de la salud basada en el valor es que, en el **rediseño de los sistemas de prestación de atención médica**, el principio fundamental **debe ser generar valor para los pacientes**.
- Definimos el valor como los **resultados** que son **importantes para los pacientes** y los **costos para lograr esos resultados**.

<https://www.isc.hbs.edu/health-care/value-based-health-care/Pages/default.aspx> (24/3/22)

# El concepto de “valor” en salud

$$\text{Valor} = \frac{\text{Resultados en salud}}{\text{Costes incurridos}}$$

El valor siempre debe estar definido centrado en el cliente, y en un sistema de atención de salud que funcione bien, la creación de valor para los pacientes debe determinar el retorno para todos los demás agentes del sistema.

M. Porter, 2010



NEJM Catalyst ([catalyst.nejm.org](http://catalyst.nejm.org)) © Massachusetts Medical Society

# Elementos necesarios en un sistema basado en valor

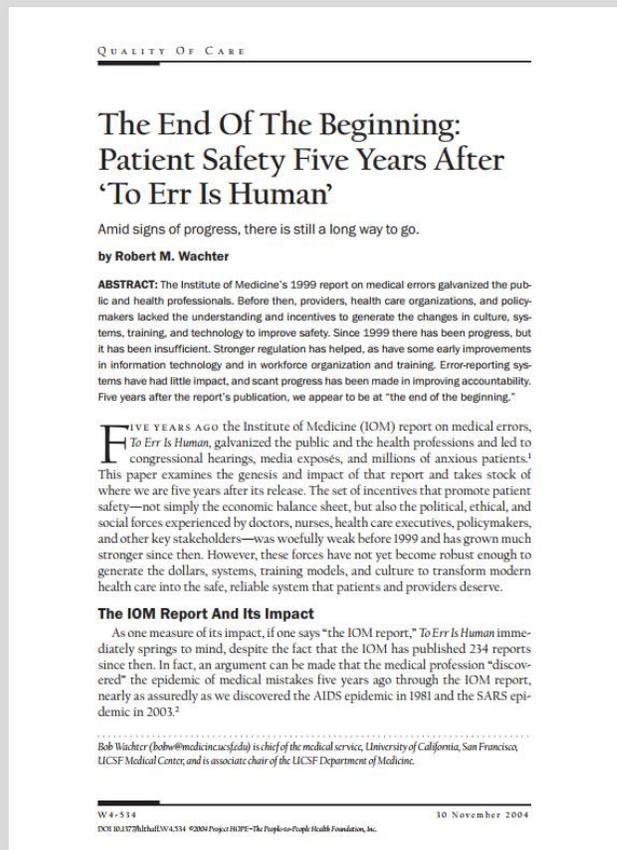
- **Organizar la atención en torno a las condiciones médicas** → La prestación de atención se organiza según las condiciones médicas de los pacientes o segmentos de la población.
- **Medir los resultados y el costo para cada paciente** → Los resultados y el costo se miden para cada paciente.
- **Alinear el reembolso con el valor** → Modelos de reembolso que recompensan tanto los mejores resultados como la eficiencia de la atención, como los pagos combinados.
- **Integración de Sistemas** → Prestación regional de atención organizada en torno al encaje del provisor adecuado, el tratamiento correcto y el entorno apropiado.
- **Geografía de la Atención** → Centros nacionales de excelencia en la atención de pacientes de extrema complejidad.
- **Tecnologías de la información** → Un sistema de tecnología de la información diseñado para apoyar los principales elementos de la agenda.

<https://www.isc.hbs.edu/health-care/value-based-health-care/Pages/default.aspx> (24/3/22)

# Dominios de “valor” en la atención en sanidad

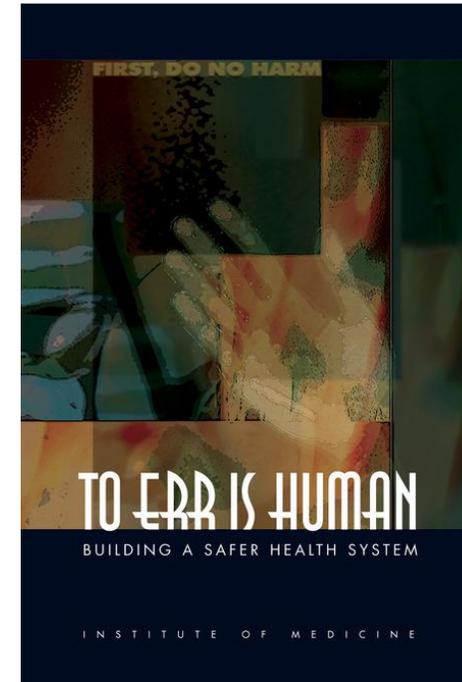
- **Accesible:** que permite el acceso al sistema a las personas que lo necesitan, sin barreras geográficas, económicas, culturales, de género,...
- **Segura:** evitando el daño a los pacientes generado por la atención que está destinada a ayudarles.
- **Efectiva:** los servicios que se prestan se apoyan en evidencia científica, se prestan a los que pueden beneficiarse de ellos y se limitan a aquellos que tienen pocas posibilidades de beneficiarse, es decir, evitando la subutilización y la mala utilización.
- **Centrada en el paciente:** Proporcionando atención que es respetuosa y sensible a las necesidades y preferencias individuales de los pacientes, asegurando que las decisiones clínicas tienen en consideración los valores del paciente
- **Puntual:** Reduciendo las esperas y eliminando las demoras que pueden resultar perjudiciales tanto para quienes reciben la atención como quienes la prestan.
- **Eficiente:** Eliminando todo despilfarro de recursos, energía, tiempos, esfuerzos,....
- **Equitativa:** Proporcionando una atención que depende de la necesidad y que no varía en calidad según las características personales como género, etnia, ubicación geográfica, y capacidad económica.
- ...

# “Primum non nocere”



Notas de progreso en 5 años:

Dimensión	
Regulación	A-
Reporte de errores	C
Tecn. Información	B-
Responsabilidad y mala praxis	D+
Personal & formación	B



# “Primum non nocere”



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## Patient safety

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## Data and statistics

European data, mostly from European Union Member States, consistently show that medical errors and health-care related adverse events occur in 8% to 12% of hospitalizations. For example, the United Kingdom Department of Health, in its 2000 report *An organisation with a memory*, estimated about 850 000 adverse events a year (10% of hospital admissions). Spain (in its 2005 national study of adverse events) and France and Denmark have published incidence studies with similar results.

Infections associated with health care affect an estimated 1 in 20 hospital patients on average every year (estimated at 4.1 million patients) with the four most common types being: urinary tract infections (27%), lower respiratory tract infections (24%), surgical site infections (17%) and bloodstream infections (10.5%). Multiresistant *Staphylococcus aureus* (MRSA) is isolated in about 5% of all infections associated with health care. The United Kingdom National Audit Office estimates the cost of such infections at £1 billion per year.

While 23% of European Union citizens claim to have been directly affected by medical error, 18% claim to have experienced a serious medical error in a hospital and 11% to have been prescribed wrong medication. Evidence on medical errors shows that 50% to 70.2% of such harm can be prevented through comprehensive systematic approaches to patient safety.

Statistics show that strategies to reduce the rate of adverse events in the European Union alone would lead to the prevention of more than 750 000 harm-inflicting medical errors per year, leading in turn to over 3.2 million fewer days of hospitalization, 260 000 fewer incidents of permanent disability, and 95 000 fewer deaths per year.

# Atención centrada en el paciente



## Death Takes a Weekend

Perri Klass, M.D.

I wanted my mother to write this essay. My mother was a writer all her life — novels, memoirs, essays, even blog entries — and in recent years she'd written some articles about aging and illness, about the indignities of becoming less independent.<sup>1,2</sup> So when she got sick, I decided that when she was better, I would urge her to write a piece about being in the hospital

— about pain and fear and comfort and cure, but also about unexpected revelations of hospital routine and custom, as seen from the patient's perspective. I even kept a list of topics for her, and the first one was the hospital weekend. Not too charged, I thought, not too personal — a good way to broach the subject of being a patient and to write about a practical problem while

touching on the fear and pain underneath. She would write it when she was better, when she was home, when she was cured. But there was no comfort and no cure, so here I am.

From the physician's perspective, weekends in the hospital are all about coverage. I remember, during residency, feeling that the attendings brought in doughnuts for weekend rounds because the

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The New England Journal of Medicine

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## PERSPECTIVE

DEATH TAKES A WEEKEND

world owed us something for being there, holding the fort. I came to take it for granted that hospital life slows on the weekend. And I remember a moment in my early years of doing primary care when it suddenly seemed vital to get an MRI and a neurology consult and a psych evaluation for a child as the clock ticked down to Memorial Day weekend. I called in favors, begged and borrowed, boasted about having managed it, as if I had personally evaluated, treated, and cured the problem, against impossible odds. I guess I assumed that patients and families must understand the hurdles: weekends are harder and slower, things don't necessarily get done.

But when you're sick and scared, or when your parent or child is sick and scared, it can be shocking to hear, over and over, about the ways that weekends are slower and things don't get done. The sick person's calendar is marked out in difficult days and sleepless nights, or in agonizing hours, but it takes no notice of

ple, I learned about the daunting outpatient blood-draw system at one hospital, where she had to give her name and wait to be called to register at one desk, then wait to be called to check in at a second desk, where they'd give her one of those restaurant papers that buzz and light up when your turn comes. Since my mother was increasingly deaf as well as legally blind, she couldn't always hear when her name was called, and she worried about

at the people who persisted in directing soft-spoken questions to me, as if what I'd said was, "I'll answer for her, she can't speak for herself, but let's just keep our voices down so we don't disturb the poor dear."

Then she got so sick that she really couldn't answer for herself. And I wasn't trying to make the medical system speak to her more clearly — I just wanted her cared for and attended to. And my old vision of hospital week-

***Every time the weekend comes around, you relearn that the hospital is not actually about patients. It's about doctors and nurses, physical therapists and nutritionists — people who are busily living their normal lives, when from the patient's side, nothing is normal.***

missing her cue. She also hated mechanical devices and regarded the pager as likely to explode in her hands. She asked me repeatedly when a hospital made things

ends named inside out. Instead of identifying with the residents who were stuck working on the weekend, heroically cross-covering, you see, many patients. I

# ¿Qué valoran los pacientes (clientes)?

## La visión de Porter:

$$Valor = \frac{Resultados\ en\ salud}{Costes\ incurridos}$$

## La visión operativa del paciente:

$$Valor = \frac{Calidad + Servicio}{Coste}$$

## La visión motivacional del paciente:

(Marca)

$$Valor = \frac{Resultados + Procesos + Aspectos\ emocionales}{Coste + Otros\ inconvenientes + Riesgo}$$

# ¿Qué valoran los pacientes?

Dimensión	%
Que un doctor les escuche	85%
Tener un médico atento y compasivo	71%
Tener un médico que se explique bien	69%
Acceso a la atención conveniente y rápido	47%
Interacciones positivas con el personal	41%
Poder hablar sobre el costo de la atención y la necesidad de pruebas y tratamiento	29%
Que los médicos sean transparentes con sus posibles conflictos de interés	22%
Que el médico ofrezca opciones holísticas de atención	8%
Que el consultorio médico se encargue de coordinar la atención	6%
Tener un médico que comparta idioma y cultura	4%
Que el médico me de opciones	4%

## What Do People Want from Their Health Care? A Qualitative Study

Leana S. Wen and Suhavi Tucker  
Research | Vol. 7, 2015 | June 25, 2015

### Abstract



**Summary:** Existing research on the patient experience has focused on patients in the hospital and other medical settings. We investigate the perceptions of people who may not self-identify as being patients. This innovative approach of the “street study” aims to understand what people want from health care. This cross-sectional descriptive study population was made up of adult volunteers who were randomly selected at four types of settings in Washington, DC: coffee shops, metro stops, senior centers, and community centers. Participants were asked to recall a positive and negative experience with health care and to explain the factors that made it such. They were also asked what can be done to most improve health care in the US. Data were analyzed using grounded theory methodology. Of the 51 subjects interviewed, 28 were female and 23 were male, with an age range of 20-89. Of the 12 themes identified, the three most cited as being critical to their health care experiences are having a doctor who listens to them, who is caring and compassionate, and who explains well. When people are asked about their health care experiences, they speak about the interaction between them and their doctors. The doctor-patient relationship remains at the heart of people’s perceptions of health care. Thus, the authors believe that innovations that aim for patient-centeredness should aim to strengthen the doctor-patient relationship.

**Keywords:** Doctor-patient relationship, patient-centered care, patient-centered innovation, research methodology, patient interviews.

**Citation:** Wen LS, Tucker S. What do people want from their health care? A qualitative study. J Participat Med. 2015 Jun 18; 7:e10.

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**Competing Interests:** The authors have declared that no competing interests exist.

**Disclosures:** There was no direct funding for this study. Dr. Wen is the founding director of Who’s My Doctor, a nonprofit campaign calling for transparency in medicine, and a member of the advisory council of the Lown Institute and Patient Centered Outcomes Research Institute.

# ¿Qué valoran los pacientes?

**Table 3** Multivariate predictors of unqualified willingness to recommend the hospital\*

Dimension of care†	Odds ratio‡	99% confidence interval
Treatment with respect and dignity	3.4	(2.8 to 4.2)
Confidence and trust in providers	2.5	(2.1 to 3.0)
Courtesy and availability of staff	2.5	(2.1 to 3.1)
Continuity and transition	1.9	(1.5 to 2.2)
Attention to physical comfort	1.8	(1.5 to 2.2)
Coordination of care	1.5	(1.3 to 1.8)
Having enough say about treatment	1.4	(1.1 to 1.6)
Information and education	1.2	(1.0 to 1.5)
Emotional support	1.2	(1.0 to 1.5)
Inclusion of family and friends	1.2	(1.0 to 1.5)
Regard for patients	0.8	(0.6 to 1.0)

- Relaciones con los cuidadores y las organizaciones de salud
- Confianza con el sistema
- Control en la toma de decisiones y respeto
- Información retrospectiva y de futuro. Buena comunicación
- Compasión
- Amabilidad, escucha, empatía, honestidad, contacto humano

## ORIGINAL ARTICLE

### What do patients value in their hospital care? An empirical perspective on autonomy centred bioethics

S Joffe, M Manocchia, J C Weeks, P D Cleary

J Med Ethics 2003;19:103-110

See end of article for authors' affiliations  
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Revised version received 30 March 2002  
Accepted for publication 5 June 2002

**Objective:** Contemporary ethical accounts of the patient-provider relationship emphasise patient autonomy and shared decision making. We sought to examine the relative influence of treatment in decisions, confidence and trust in providers, and treatment with respect and dignity on evaluations of their hospital care.  
**Design:** Cross-sectional survey.  
**Settings:** Fifty one hospitals in Massachusetts.  
**Participants:** Stratified random sample of adults (N=27 414) discharged from a medical, or maternity hospitalisation between January and March, 1998. Twelve thousand six hundred a survey recipients responded.  
**Main outcome measure:** Respondent would definitely be willing to recommend the hospital and friends.  
**Results:** In a logistic regression analysis, treatment with respect and dignity (odds ratio (OR) 3.4, confidence interval (CI) 2.8 to 4.2) and confidence and trust in providers (OR 2.5, CI 2.1 to 3.0) were more strongly associated with willingness to recommend than having enough involvement in (OR 1.4, CI 1.1 to 1.6), courtesy and availability of staff (OR 2.5, CI 2.1 to 3.1), continuity of care (OR 1.9, CI 1.5 to 2.2), attention to physical comfort (OR 1.8, CI 1.5 to 2.2), and cost of care (OR 1.5, CI 1.3 to 1.8) were also significantly associated with willingness to recommend.  
**Conclusions:** Confidence and trust in providers and treatment with respect and dignity were most strongly associated with patients' overall evaluations of their hospitals than adequate involvement, while arguing for increased attention to trust and respect in ethical models of health care

Respect for persons is fundamental to the ethical provider-patient relationship. At least with regard to competent adults, however, "respect for persons" in bioethics has come to equal respect for patient autonomy.<sup>1</sup> The Belmont Report (which has had an enormous influence on clinical medicine despite its origins in human experimentation)<sup>2</sup> sets out that "respect for persons . . . divides into two separate moral requirements: The requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy".<sup>3</sup> Though other principles make claims upon us,<sup>4</sup> "there are relatively few bioethicists who argue that respect for autonomy is not the preeminent value governing the actions of health care providers".<sup>5</sup> In bioethics, autonomy occupies a place "at the top of the moral mountain".<sup>6</sup>

Without denying the importance of self determination, respect for persons seems intuitively to imply a broader set of obligations than just attention to patient autonomy. Childress has suggested that respect for autonomy might usefully be viewed as a subset (albeit a centrally important one) of respect for persons:  
The principle of respect for autonomy is ambiguous because it focuses on only one aspect of personhood, namely self-determination, and defenders often neglect several other aspects, including our embodiment. A strong case can be made for recognizing a principle of "respect for persons", with respect for their autonomous choices being simply one of its aspects—though perhaps its main aspect. But even then we would have to stress that persons are embodied, social, historical, etc.<sup>7</sup>

Weath's deontological principles governing the patient-physician relationship (autonomy, fidelity, veracity, avoiding

killings, and justice) are also helpful,<sup>8</sup> but still incomplete. A partial list of what we mean by the might add respect for the body, respect for family, its community, respect for culture, respect for the person (dignity) of the individual, and respect for the person. A richer understanding of respect for persons is particularly important in light of evidence suggesting respect is common in medicine.<sup>9</sup> Unfortunately, the respect has not received sustained analysis in the literature.<sup>10</sup>

The principle of respect for autonomy, as Schneider subject to a variety of conceptual interpretations.<sup>11</sup> One way to classify these interpretations, following Isaiah might be to array them along a spectrum from its positive. A negative, or antipaternalist, understatement that health professionals refrain "from in with efforts of individuals to . . . pursue [their] life. This view particularly rules out the use of force, coercion, deception."<sup>12</sup> Including when the provider's ultimate patient's best interests. The negative case autonomy rights need not be a weak one, demonstrated.<sup>13</sup> Most important for our current purposes, however, this antipaternalist model makes no assumptions about patients' affirmative responsibility make medical decisions. In contrast, the positive or "respect for persons" model holds that patients have an obligation to exercise self rule and therefore to take direct responsibility for most decisions.<sup>14</sup> Several grounds are put forward position. Some argue that individuals, including us as patients, have a duty to make the most of their freedom for moral agency.<sup>15</sup> Others suggest that only patients' values and preferences that are qualified, or critical to decisions affecting their health.<sup>16</sup> Finally, some do

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## What Patients Really Want From Health Care

Allan S. Detay, MD, PhD

IN 2012, PERHAPS THE MOST WIDELY SCRUTINIZED SECTOR of the economy in North America will be the health care industry. Politicians, policy analysts, academics, and the public share concerns about the state of health care in both the United States and Canada. However, each of these constituencies has a different perspective.

Most sectors of the economy are characterized by a supply side that focuses on minimizing costs, expanding sales, and maximizing profits and a demand side that considers consumer preferences, incomes, and alternative purchases. Markets use prices to link supply to demand. Health care is very different.<sup>1</sup> In the mid-20th century, patients' aversion to the risk of large health care expenses gave rise to a market for insurance, thereby separating patients from the true costs of care at the point of service delivery. This in turn greatly expanded demand for health care, resulting in cost escalation, which gave rise to government involvement in many ways (eg, tax subsidies, US Medicare, the Canada Health Care Act, and, most recently, the US Affordable Care Act).

Decades after this evolution began, the United States and Canada are struggling to contain the "bloat" of health care costs by setting priorities, an important step in policy formation. Politicians, the media, and academics often focus on important issues like cost increases, waste, inefficiency, access, cost-effectiveness, evidence-based medicine, and conflicts of interest.

This Commentary focuses specifically on what people want from health care services and rates these preferences from highest to lowest. The opinions are based on my 30 years of experience, both in performing research in health economics and as a practicing general internist who cares for inpatients, many of whom are elderly and very ill. Because preferences vary in health care, like preferences in every sector, the characterizations described may not apply to all.

### What the Public Wants Most

Restoring Health When Ill. Patients want a health care system that responds when care is needed; that is, when they develop signs or symptoms causing pain, disability, or anxiety. What they want most is to be returned to a state of good health, however they define it. In other words, they simply want to be better. Some patients understand the concept of preventive medicine.

Author Audio Interview available at [www.jama.com](http://www.jama.com).

2003 JAMA, December 14, 2011—Vol 306, No 22

and want the health care sector to provide services such as cancer screening that will prevent illness in the future. However, the majority of patients primarily focus on relieving illness and symptoms rather than disease prevention.

Timeliness. Patients desire access to services in a timely fashion. While many patients procrastinate seeking medical attention, those who do not delay seeking care want it immediately.<sup>2</sup> Kindness. Patients want to be treated with kindness, empathy, and respect for their privacy. In the days before health insurance, patients paid for care that consisted primarily of kindness.

Hope and Certainty. Even if patients are in a health state for which care is exceedingly unlikely, they want to have hope and be offered options that might help. Patients are uncomfortable with uncertainty about diagnoses and prognoses and often request tests to help alleviate those anxieties. As well, patients and their families feel guilty if they do not try to get better. These characteristics make patients and their families highly susceptible to accepting active test and treatment options, even when those options are unlikely to help.<sup>3</sup> This occurs especially at times when patients are emotionally vulnerable, such as when death is near. Although many patients prefer not to "know" or "try," the majority of those who seek health care prefer active strategies. An extra test or two, "just to be sure," is often preferred to possibly missing something.

Continuity, Choice, and Coordination. Patients want continuity of care and choice. They want to build a relationship with a health care professional or team in whom they have confidence and have that same person or team care for them in each episode of a similar illness. They want the members of their health care team to communicate with each other to coordinate their care.

Private Rooms. Patients want to be hospitalized in their own room, with their own bathroom and no roommate.<sup>4</sup> No Out-of-pocket Costs. Patients want to pay as little as possible from their own pocket at the point of service delivery. They also want to be assured that insurance or third-party coverage is always available to them.

The Best Medicine. Patients want to know that the clinicians delivering their care are highly qualified. Indeed, some seek "the best" physicians. Patients want information about clinician qualifications but they do not want it to be statistical. They prefer testimonials from other patients or clinicians they trust.

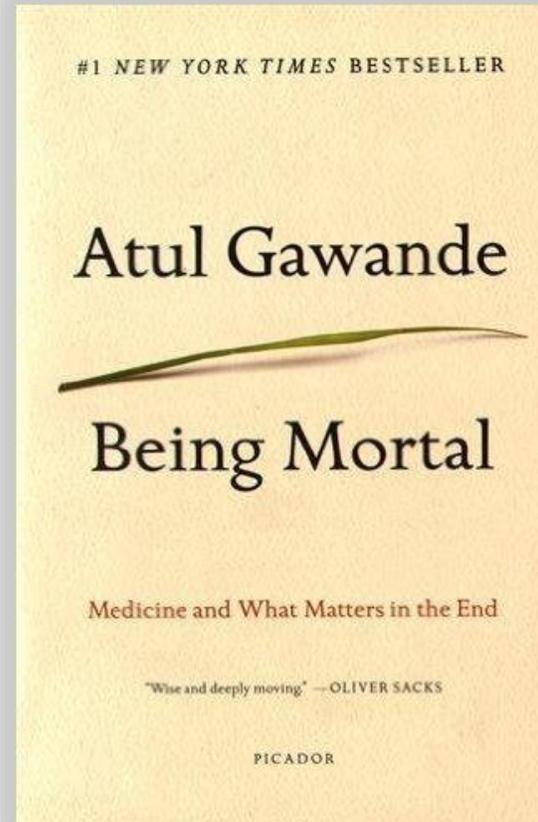
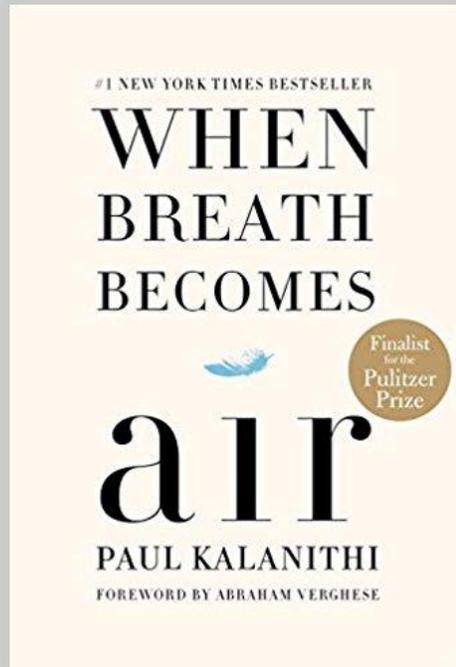
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# ¿Qué valoran los pacientes?

- Recuperar la salud
  - Prevención de futuras enfermedades
  - Aliviar la enfermedad y los síntomas
  - Atención a tiempo
  - Amabilidad
  - Esperanza y certeza
  - Continuidad, elección & coordinación
  - Acceso a familia y amigos
  - Habitaciones individuales
  - Sin costes adicionales
  - Acceso a la mejor medicina (referencias)
- Con mucha menor importancia:*
- Eficiencia,
  - Equidad,
  - Estadísticas agregadas,
  - Costes reales,
  - Impacto en el PIB, ...

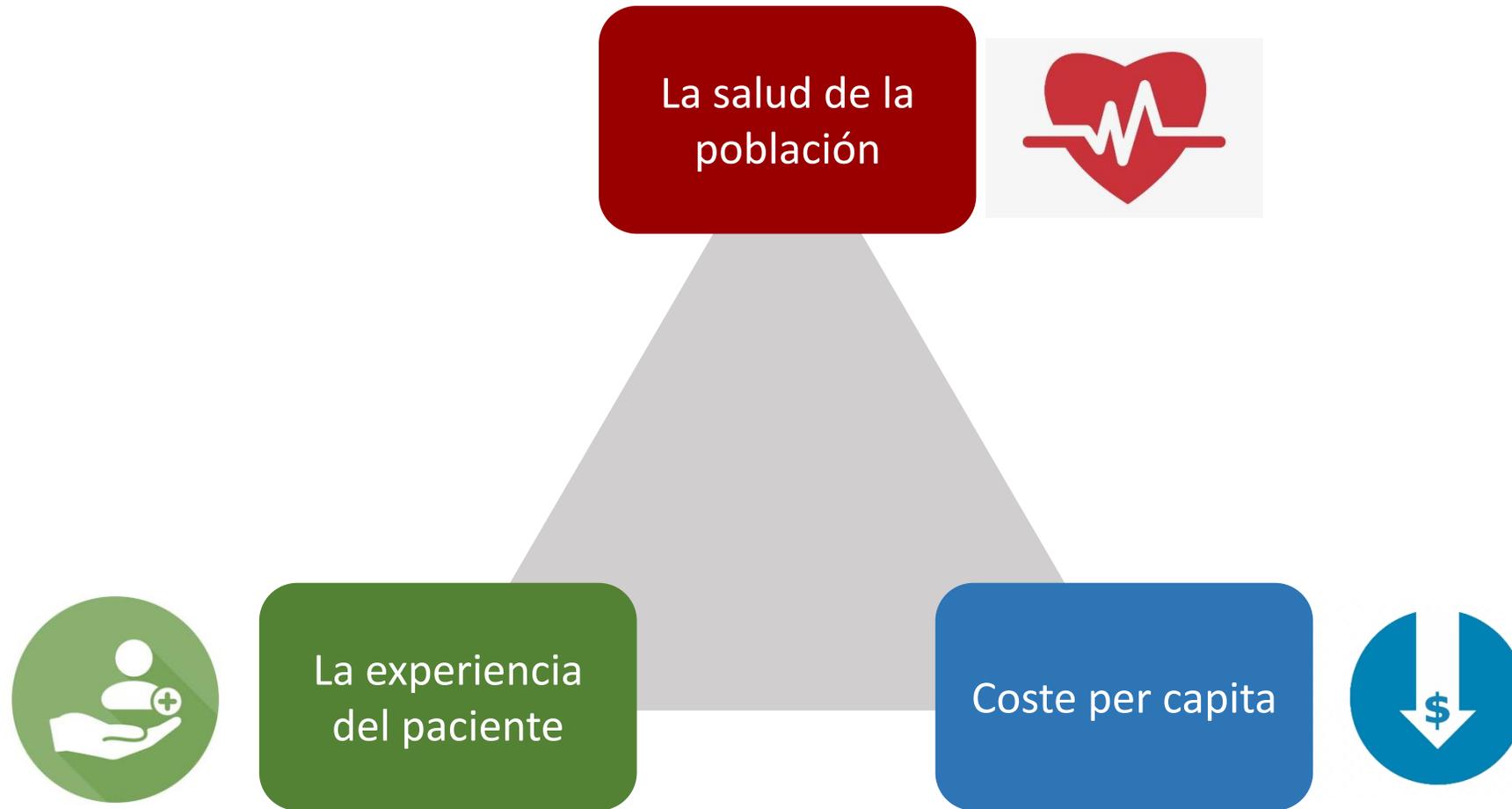
# Calidad de vida y Calidad de muerte



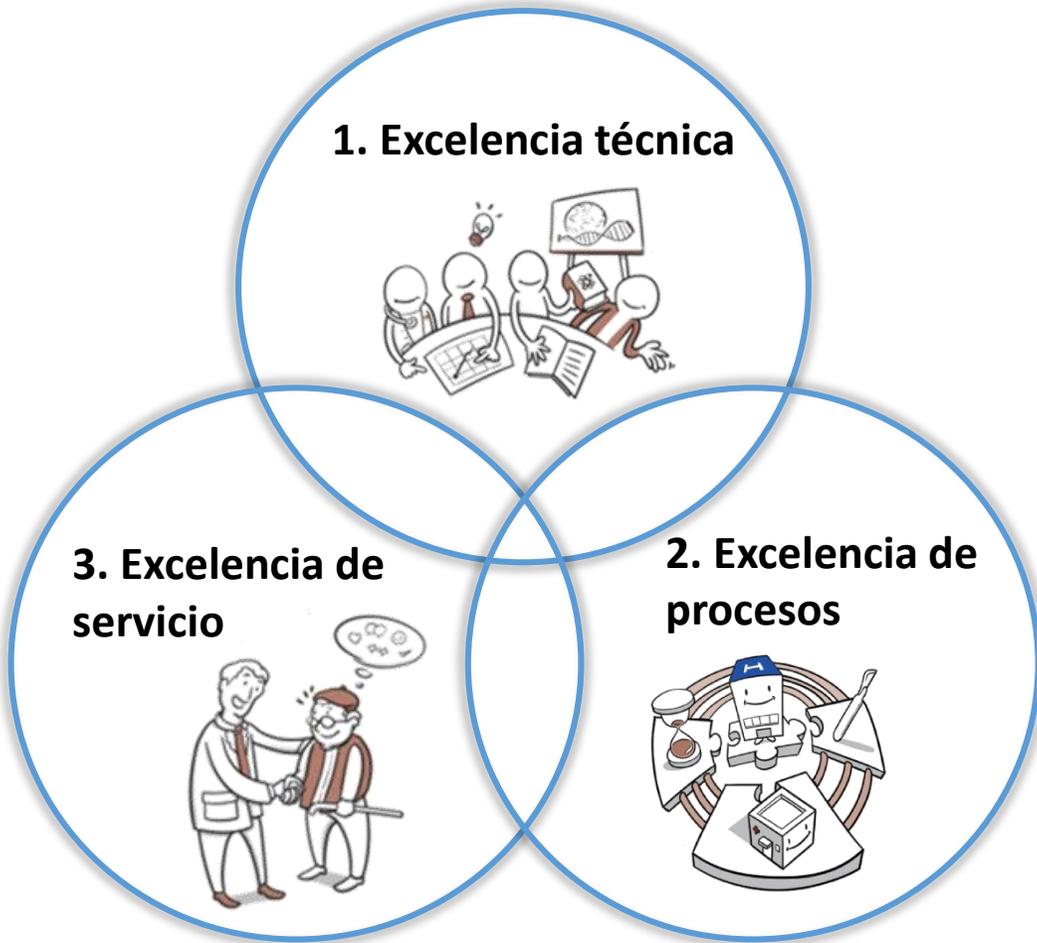
# ¿Qué valoran los pacientes?

- En un sistema de salud cada componente puede ofrecer distintas proposiciones de valor al paciente a lo largo de su **“viaje”**.
- Puede ser imposible identificar una única definición de valor para una población heterogénea. En otras industrias, las organizaciones **“segmentan”** y se enfocan en proporcionar un tipo de valor a un segmento de mercado.
- Es muy difícil identificar lo que los pacientes valoran en sus interacciones con diversas partes del sistema si no se les involucra.
- Las varias organizaciones/servicios que sirven grupos diferentes de población en diferentes procesos de su enfermedad tendrán que definir **qué valor quieren prestar** y cómo **diseñar los procesos para conseguirlo**.
- Un requisito esencial para poder ofrecer una atención integrada de salud es la determinación de **qué aspecto del valor será proporcionado por quién y donde**.

# El “triple aim” (triple objetivo)



# Las dimensiones de la excelencia operativa



Capacidad de monitorización y control

# El “Quadruple Aim”



La experiencia  
del profesional

La salud de la  
población



La experiencia  
del paciente

Coste per capita



# La cuarta meta (profesionales)

¿Qué valoran los profesionales?

La visión motivacional:

$$\text{Valor} = \frac{\begin{array}{ccc} \text{¿QUÉ?} & & \text{¿CÓMO?} & & \text{¿POR QUÉ?} \\ \text{Salario y} & + & \text{Calidad del} & + & \text{Propósito} \\ \text{otros beneficios} & & \text{puesto de trabajo} & & \end{array}}{\begin{array}{ccc} \text{Tiempo} & + & \text{Esfuerzo} & + & \text{Riesgo} \end{array}}$$

# La cuarta meta (profesionales)

¿Qué valoran los profesionales?

**Los valores individuales de Schwartz:**

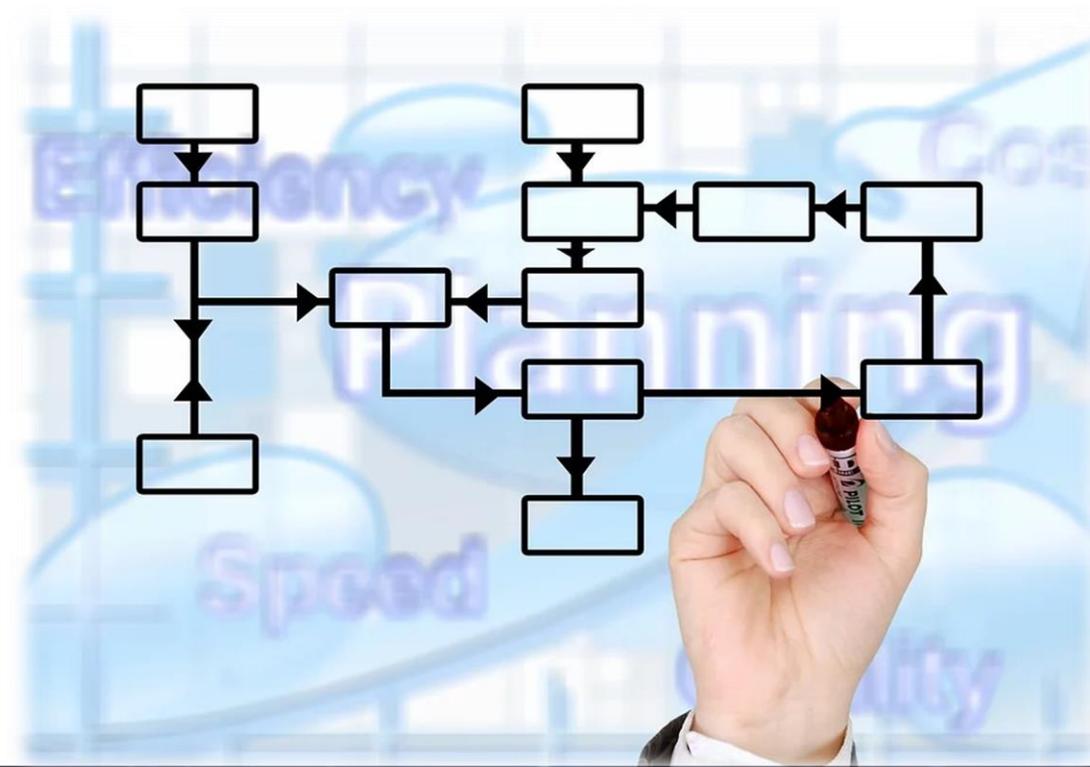
- ✓ Autoridad/Poder
- ✓ Capacidad, Éxito, Logro
- ✓ Placer
- ✓ Estímulo intelectual
- ✓ Pensamiento crítico, Autonomía
- ✓ Equidad, Justicia Social
- ✓ Altruismo, Benevolencia
- ✓ Moralidad, Tradición
- ✓ Profesionalismo, Conformidad
- ✓ Estabilidad, Seguridad
- ✓ Trascendencia, Espiritualidad

# Las dimensiones de la excelencia operativa

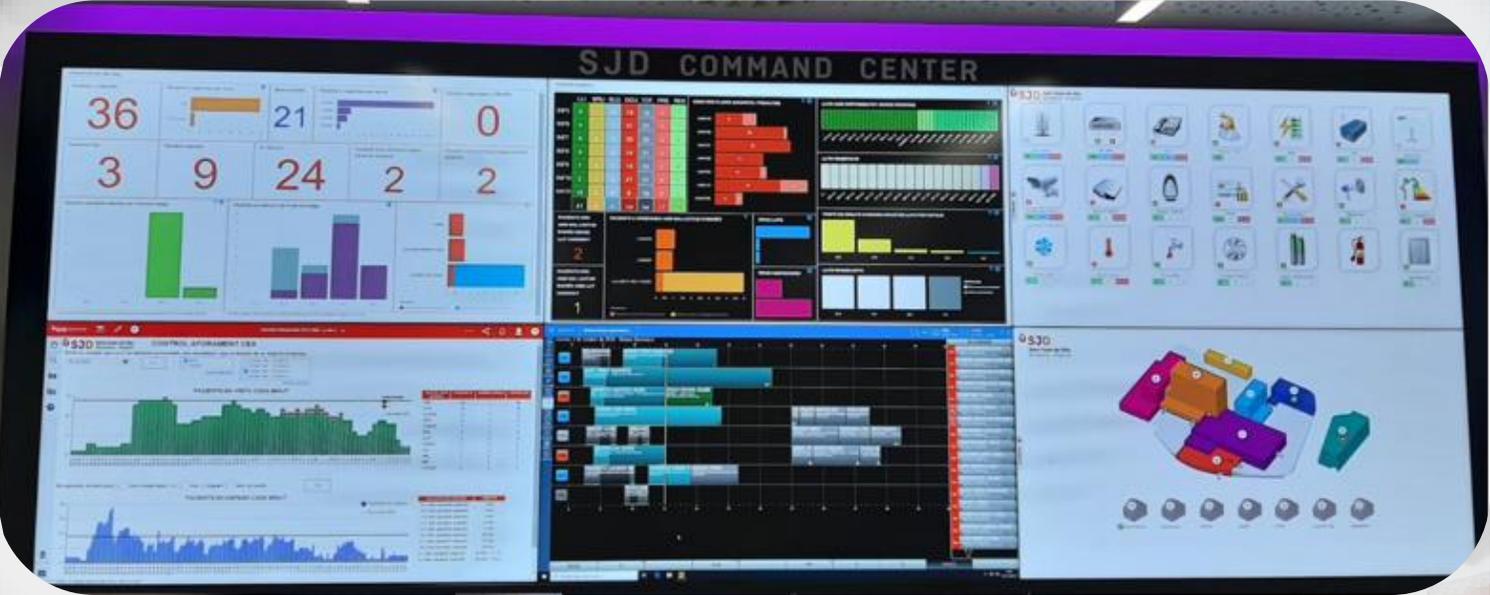
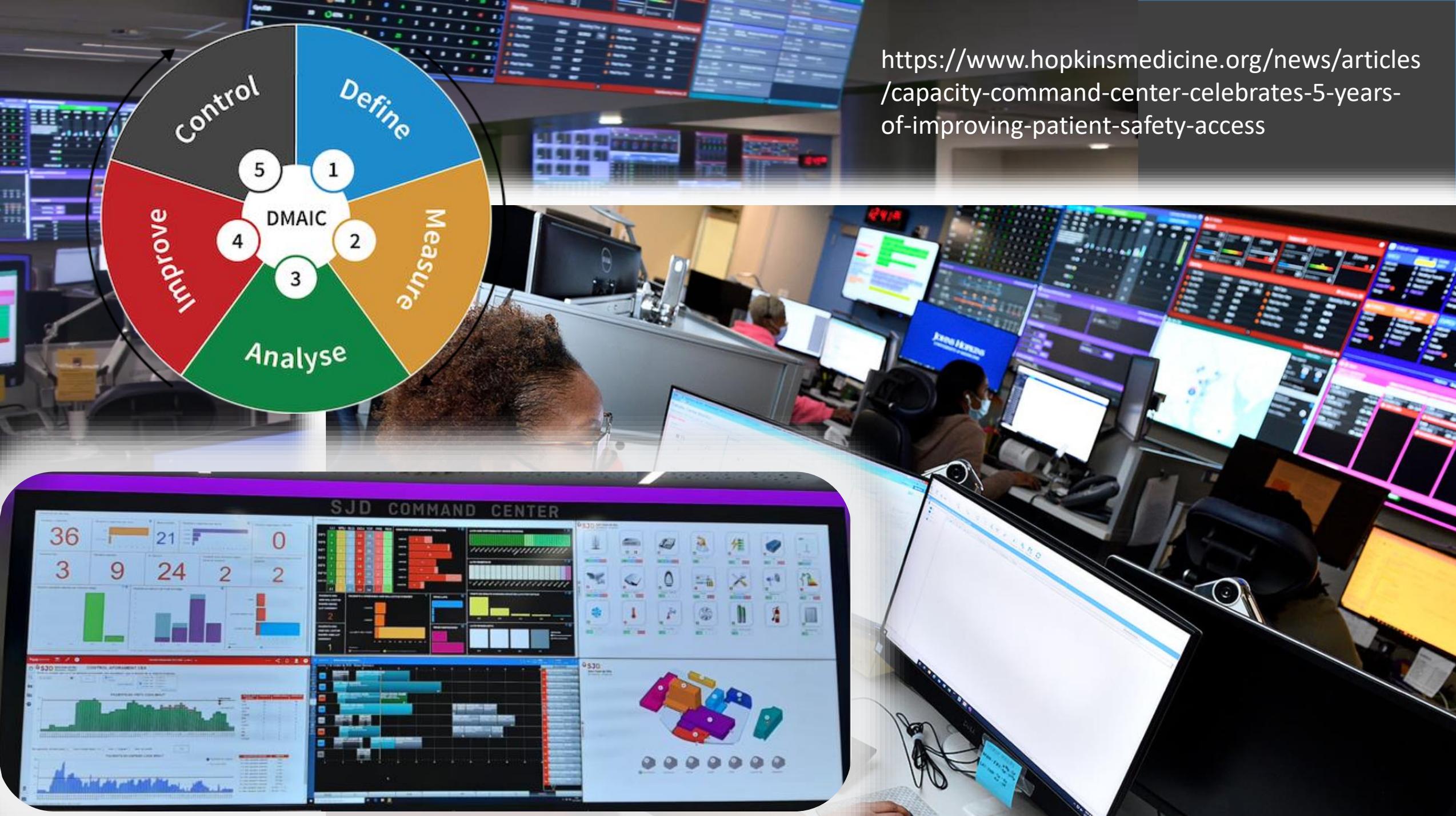
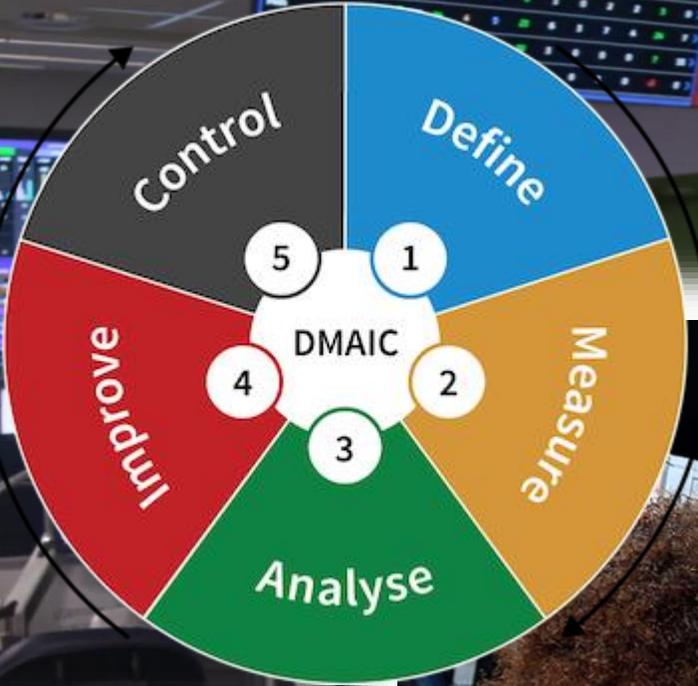


**Capacidad de monitorización y control**

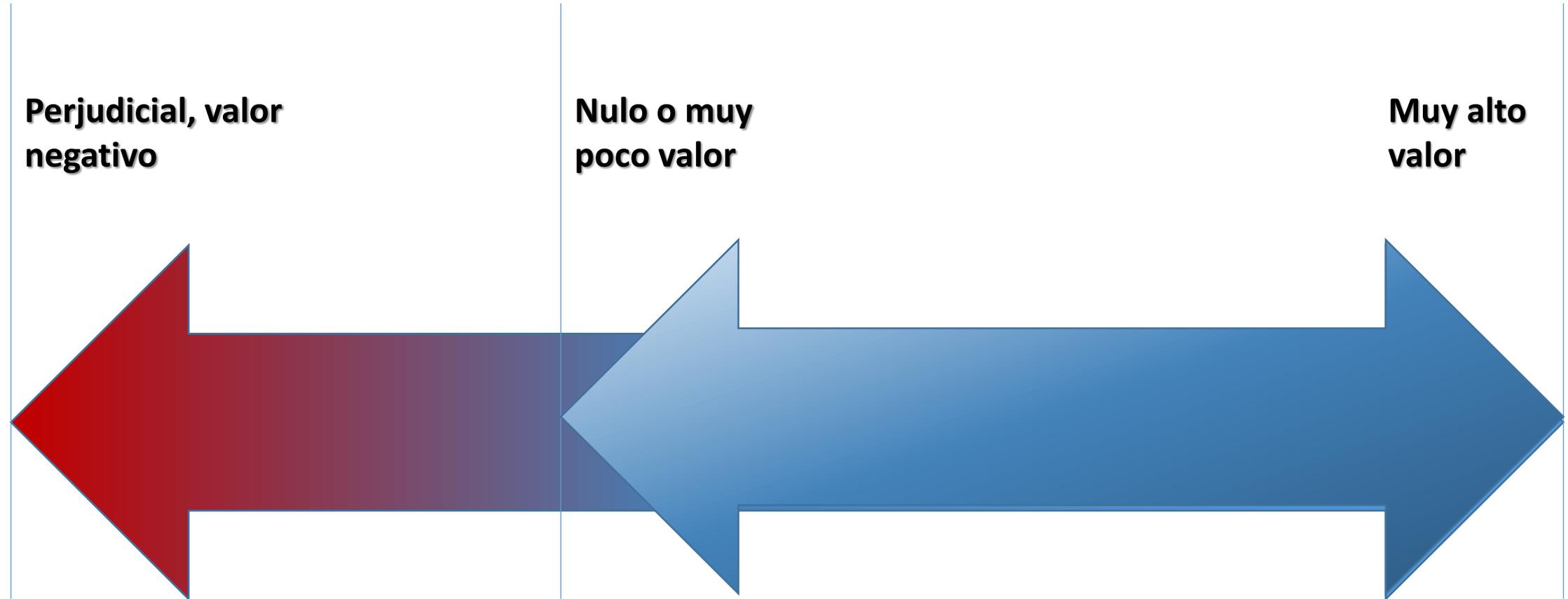
# Las dimensiones de la excelencia operativa



<https://www.hopkinsmedicine.org/news/articles/capacity-command-center-celebrates-5-years-of-improving-patient-safety-access>



# Valor y despilfarro



# Clasificación de actividades, tiempos, esfuerzos, ...

**Valor añadido (VA)**

Tratando al paciente, realizando una prueba, ...

**Necesario (pero No-VA)**

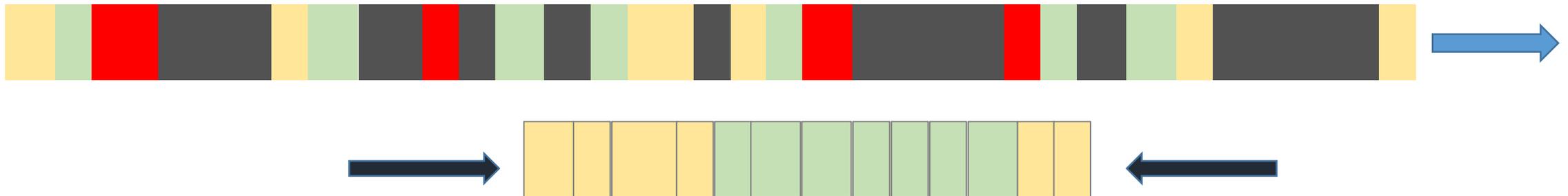
Registro, datos del seguro, transportar al paciente a radiología, ...

**No Necesario (y No-VA)**

Repetición de prueba, repetir preguntas, rellenar impresos...

**Demoras, esperas, ...**

Doctor tratando otro paciente, no se localiza al especialista,...



# MUDA: Waste elimination

1. **D**efectos
2. **S**obreproducción
3. **E**speras
4. **T**alento mal aprovechado
5. **T**ransportes
6. **E**xistencias
7. **M**ovimiento
8. **P**roceso innecesario

*Ohno's  
traditional  
muda's*



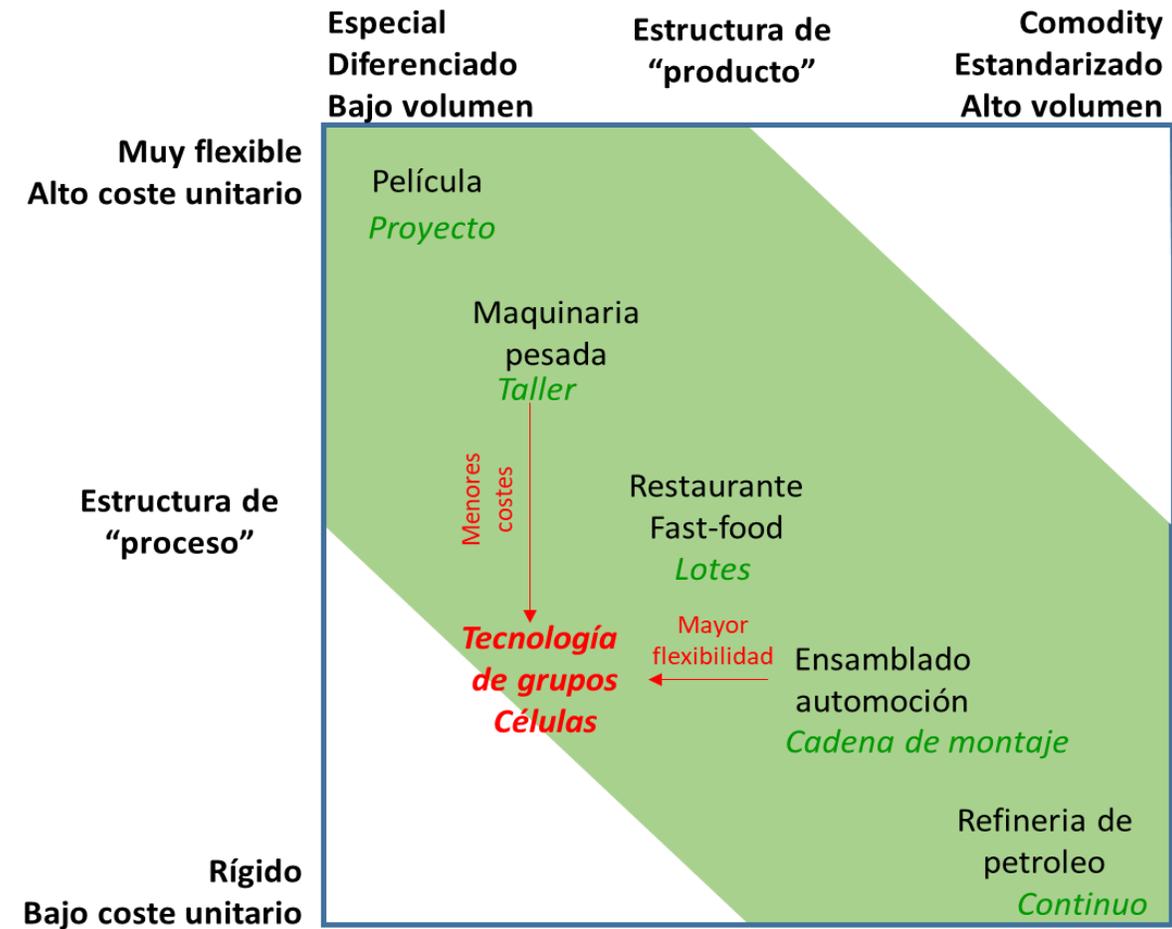
# Otra clasificación de despilfarro en salud

- 5% • **Despilfarro en producción** – ineficiencias en la “producción” de “unidades de salud”. E.g., tiempo de enfermería para una tarea determinada, uso excesivo de reactivos en un laboratorio, ...
- 50% • **Despilfarro por caso** – uso innecesario o sub-óptimo de los recursos en el proceso de un paciente. E.g., Repetición de exploraciones de imagen porque no se encuentra la primera, duplicación de pruebas de laboratorio porque el doctor del hospital no tiene acceso a los resultados de primaria (o no confía en ellos), ...
- 45% • **Despilfarro de población** – casos en la población en los que la actividad es innecesaria, ineficiente, no efectiva o prevenible. E.g., intervenciones intensivas al final de la vida, visitas al centro hospitalario por temas que podrían ser resueltos en primaria, obesidad, diabetes mal controlada, tabaquismo, ....

James & Poulsen, The Case for Capitation, HBR Jul-Aug. 2016

# Dirección de Operaciones – tipos de procesos

- El nivel de estandarización posible (hacia a la derecha) depende de la etapa de conocimiento sobre el proceso.
- Para muchas enfermedades, el nivel de conocimiento es todavía limitado, muy variable de una enfermedad a otra, y evoluciona con el tiempo, lo que dificulta el enfoque.
- Una forma de crear enfoque es agrupar productos similares en "grupos". Otra es dividirlos en partes (módulos) y tratarlos por separado, ensamblándolos según sea necesario.



# Modos de atención en urgencias

## ❖ Triage & Registro

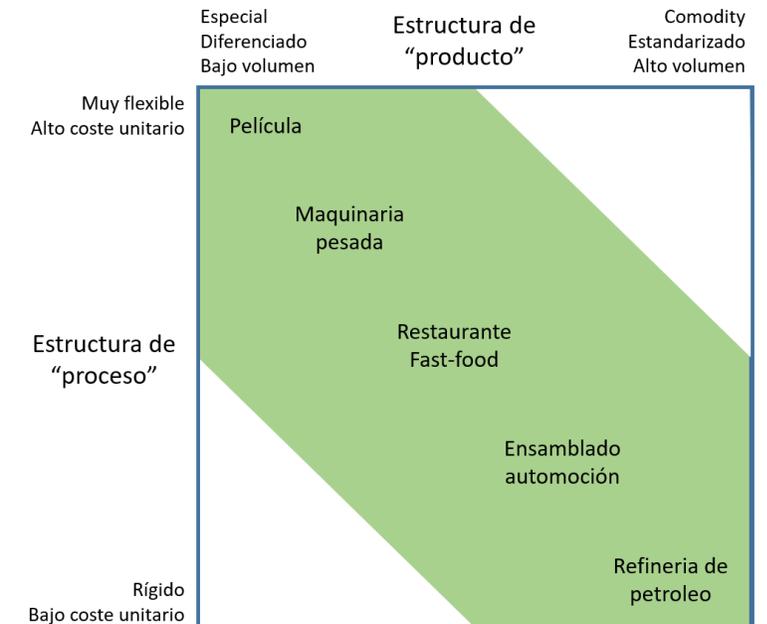
1. Reanimación
2. Cuadro agudo o complicaciones
3. Estable, posible empeoramiento
4. Sin riesgo de funciones vitales
5. Pacientes no urgencia

### Clasificación por tecnología de grupos

- Complejidad
- Nivel de consulta/tests esperados
- Tiempo de atención esperado
- Constantes vitales
- Nivel de dolor
- Edad
- Género

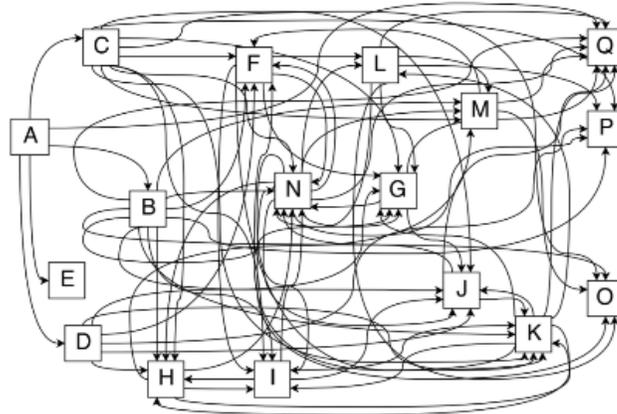
## Canadian Triage & Acuity Scale

Level	Canadian	
	Serv. Time (min)	Fractile
1	immed.	98%
2	Nurse: 0 / Phys : 15	95%
3	30	90%
4	60	85%
5	120	80%

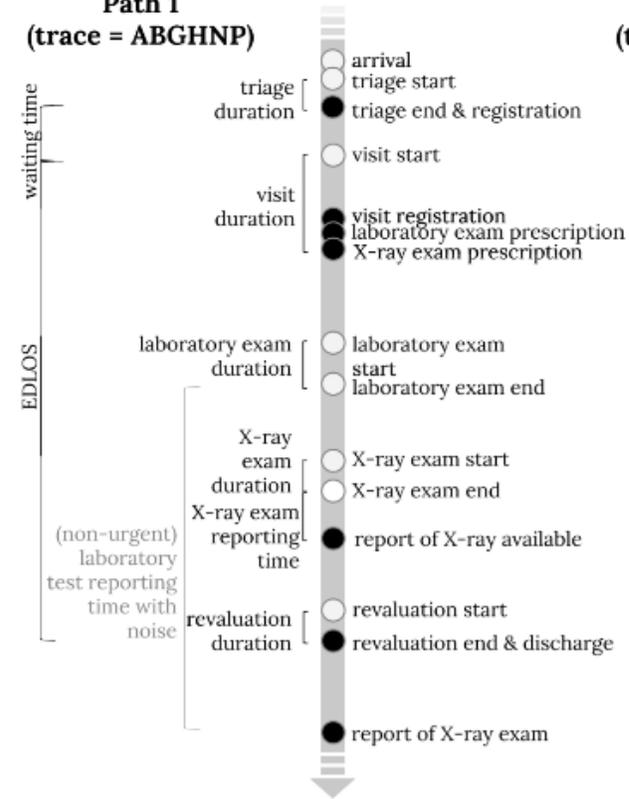


# Process mining – rutas de pacientes

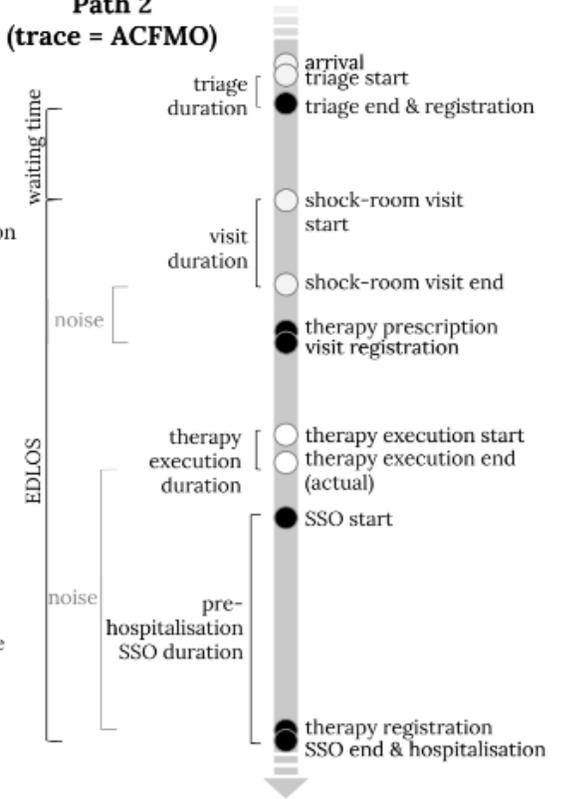
Id	Description	Class	ED comp.	Timestamps
A	Triage	Triage	✓	$t_E$
B	Medical visit	Visit	✓	$t_E$
C	Shock-room	Visit	✓	$t_E$
D	MCA visit	Visit	✓	$t_E$
E	Paediatric fast-track	Discharge		$t_P$
F	Therapy	Tests & Care	✓	$t_P, t_E$
G	Laboratory exams	Tests & Care	✓	$t_P, t_R$
H	X-ray exams	Tests & Care	✓	$t_P, t_R$
I	Computed tomography (CT)	Tests & Care		$t_P, t_R$
J	Ecography	Tests & Care		$t_P, t_R$
K	Specialist visit	Tests & Care		$t_P, t_R$
L	Short-Stay Observation (SSO)	Tests & Care	✓	$t_S, t_E$
M	Pre-hospitalisation SSO	Tests & Care	✓	$t_S, t_E$
N	Revaluation visit	Revaluation	✓	$t_E$
O	Hospitalisation	Discharge	✓	$t_E$
P	Discharge (ordinary)	Discharge	✓	$t_E$
Q	Interruption	Discharge		$t_E$



**Path 1**  
(trace = ABGHNP)



**Path 2**  
(trace = ACFMO)



- Determinar *clusters* y grupos de pacientes
- Organizar el proceso del paciente según las rutas necesarias

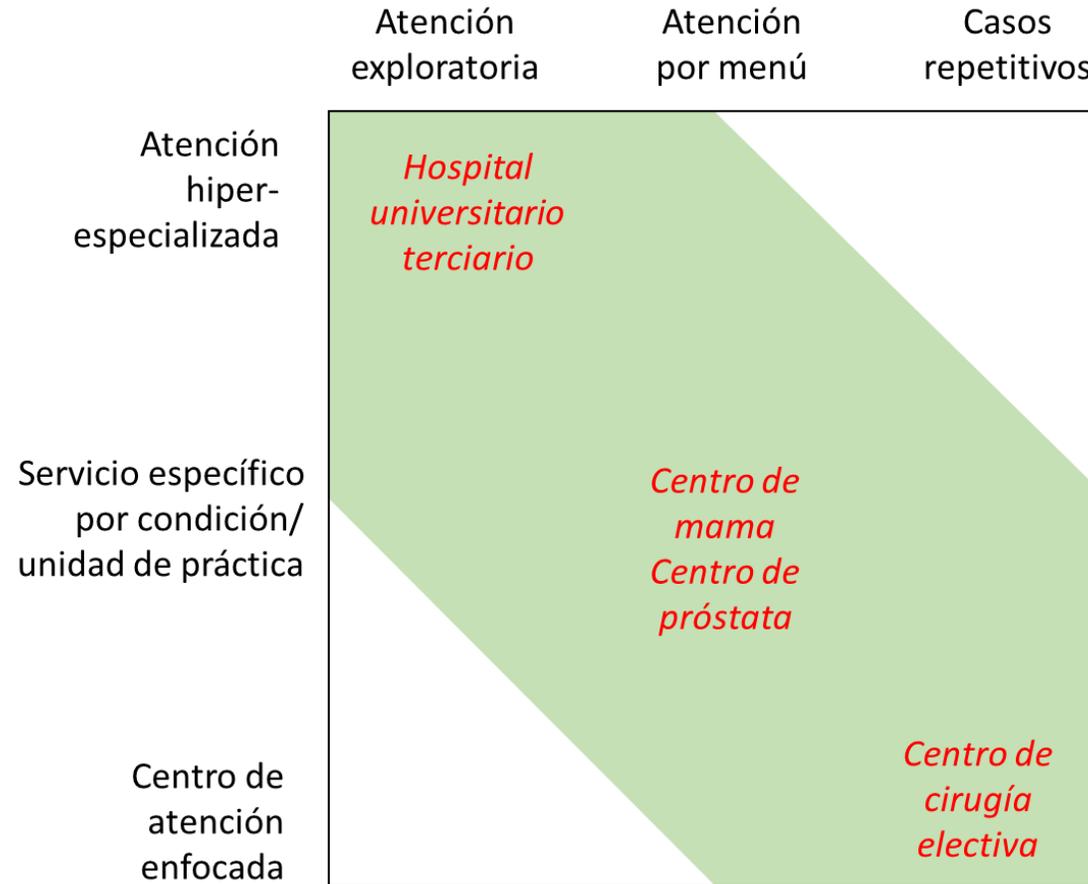
# Estados de conocimiento



Estado	Nombre	Comentario	Descripción
8	Completo	Nirvana	Conocimiento de todas las posibles interacciones
7	Saber por qué	Ciencia	Completa caracterización científica, causas y efectos
6	Caracterización	Posibles equilibrios	Conocer el impacto de cambios pequeños
5	Proceso capaz	Receta local	Control en un ámbito limitado
4	Control media	Posible método científico	Control posible, pero no preciso. Mucha variabilidad.
3	Medida	Pre-tecnológico	Variable medida, pero no controlada
2	Consciencia	Puro arte	Algunas variables influyentes detectadas
1	Ignorancia		Fenómeno no conocido. Todo parece aleatorio.

R. E. Bohn, Measuring and managing technological knowledge, Sloan Management Review, Fall 1994.

# Tipos de procesos segun nivel de conocimiento



R. M. J. Bohmer, Managing Care, Berret-Koehler, 2021.

# Palancas de control operativo

1. **El proceso de atención** – Secuencia de decisiones y tareas para diagnosticar y tratar un posible problema de salud o prevenir uno futuro
  2. Equipo profesional clínico y de gestión
  3. Infraestructura – recursos técnicos y de apoyo
  4. Palancas de control
- Especificación y estandarización
  - Secuencia, sencillez, conexión, linealidad, aprendizaje (ADN TPS)
  - Segmentación
    - *Especialización*
    - *Estandarización de partes*
    - *Ubicación – donde se hace qué*

R. M. J. Bohmer, Managing Care, Berret-Koehler, 2021.

# Palancas de control operativo

1. El proceso de atención – Secuencia de decisiones y tareas para diagnosticar y tratar un posible problema de salud o prevenir uno futuro
  2. **Equipo profesional** clínico y de gestión
  3. Infraestructura – recursos técnicos y de apoyo
  4. Palancas de control
- Ajuste de conocimiento, habilidades y actitudes a las necesidades
  - Decisiones de especialización
  - Asignación de tareas y decisiones
  - Planificación y asignación de turnos
  - Desarrollo profesional – *Make or buy*
  - Empoderamiento
  - Nuevos roles

R. M. J. Bohmer, Managing Care, Berret-Koehler, 2021.

# Palancas de control operativo

1. El proceso de atención – Secuencia de decisiones y tareas para diagnosticar y tratar un posible problema de salud o prevenir uno futuro
  2. Equipo profesional clínico y de gestión
  3. **Infraestructura** – recursos técnicos y de apoyo
  4. Palancas de control
- Espacio físico, instalaciones
  - Flujos de pacientes
  - Políticas de adquisición de tecnología
  - Nuevas formas de atención

R. M. J. Bohmer, Managing Care, Berret-Koehler, 2021.

# Palancas de control operativo

1. El proceso de atención – Secuencia de decisiones y tareas para diagnosticar y tratar un posible problema de salud o prevenir uno futuro
2. Equipo profesional clínico y de gestión
3. Infraestructura – recursos técnicos y de apoyo
4. **Palancas de control**
  - Sistema de control diagnóstico
    - Mediciones
    - Planificación y evaluación del trabajo
    - KPI's
  - Límites de actuación
  - Sistemas de valores y creencias
  - Sistemas de control interactivos

R. M. J. Bohmer, Managing Care, Berret-Koehler, 2021.

¿Por qué cuesta tanto la transferencia de conocimiento de  
otros sectores al sector de la salud?  
¿Y dentro del propio sector?





## Changing Health

Liderando la transformación  
de la gestión sanitaria

2022