PRO.M.I.S.
Programma Mattone Internazionale Salute

CONFERENCE

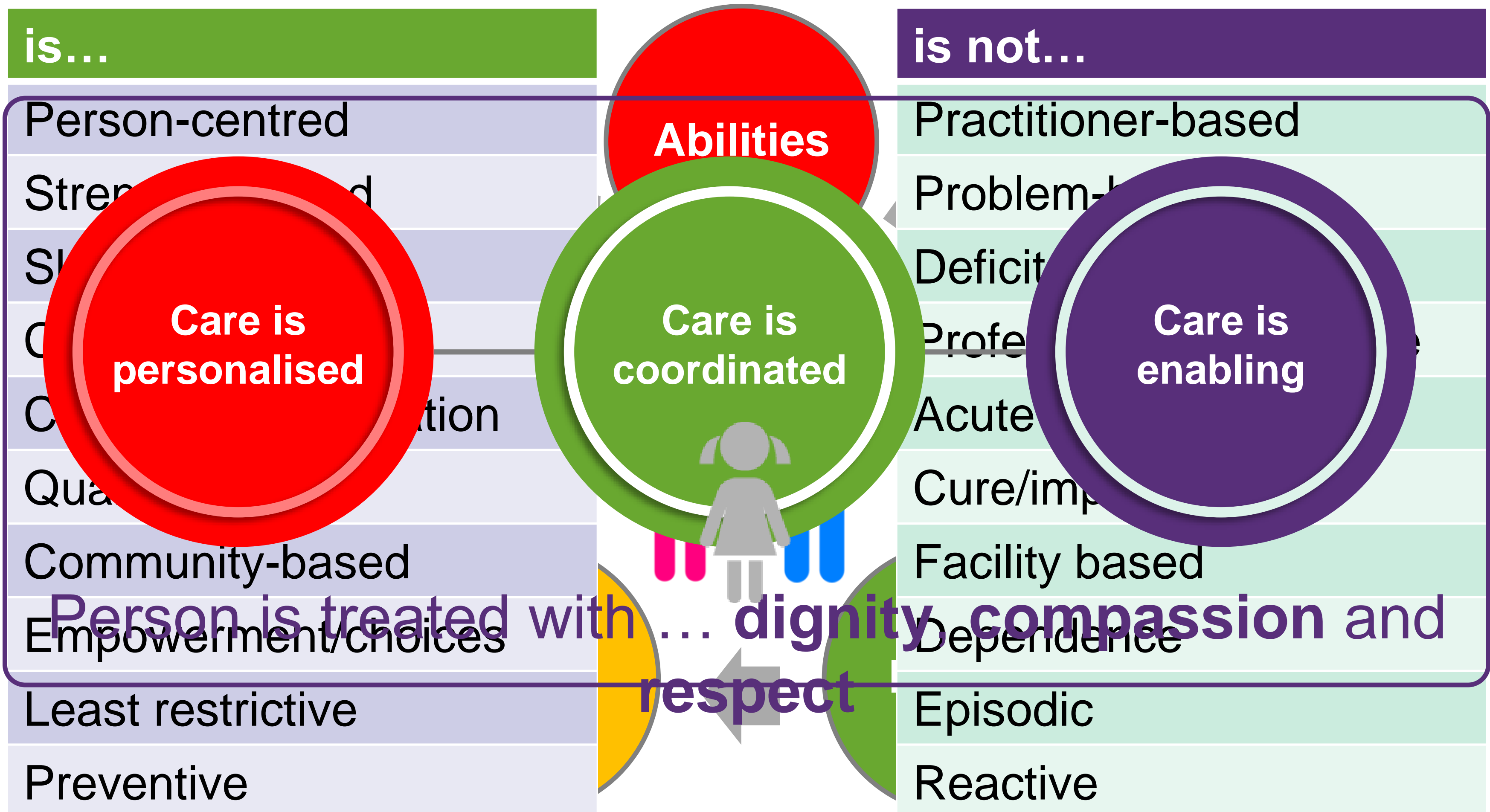
"Integrated services: organizational healthcare models in the framework of chronic diseases".

Models designed to integrate care for individuals with chronic conditions

26-27 March 2018
Turin, C.so Regina Margherita, 174

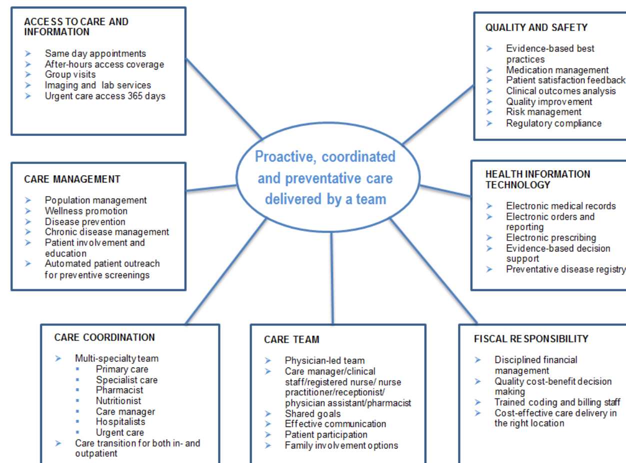
Leo Lewis
International Foundation for Integrated care

Person-centred, co-ordinated & integrated care



Individual models of integrated care

- Case-management
- Individual care plans
- Patient-centred medical home



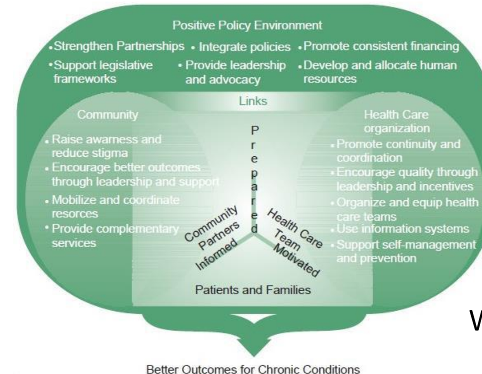
Overview of PCMH attributes delivered at Bend Memorial Clinic, USA

- Personal health budgets

Group and disease-specific models

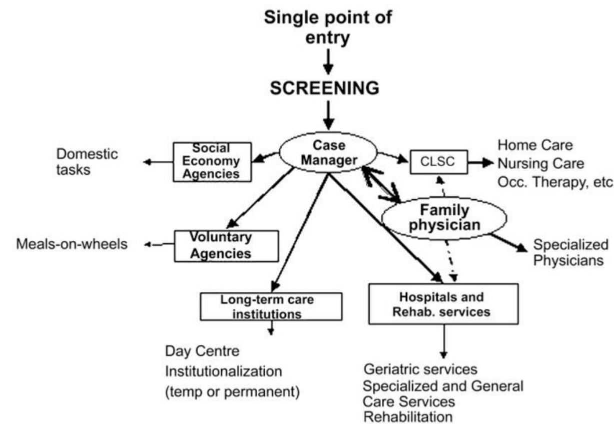
- Chronic care model

E H Wagner, 1999



World Health Organisation, 2002

- Integrated care models for elderly and frail

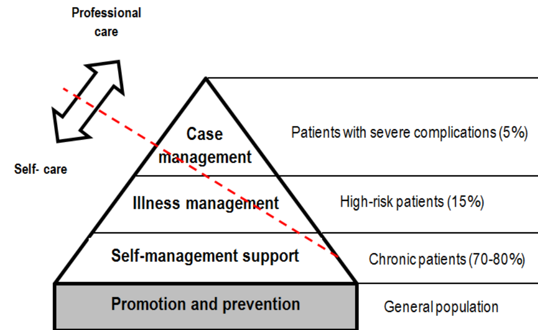


PRISMA community model

- Disease-specific integrated care models

Population-based models

- Kaiser Permanente



- Veterans Health Administration
- Integrated care in Basque country
- Prudent Co-operative Health & Care System for Wales

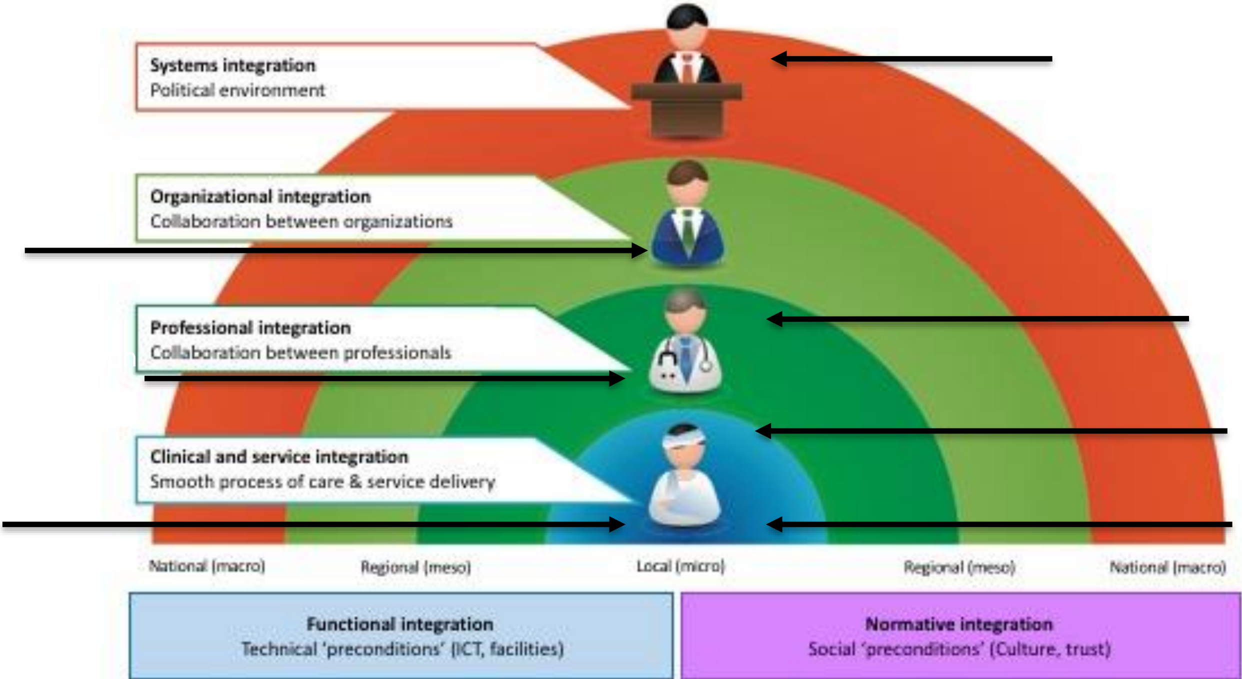
Key lessons for implementing integrated care - 1

- Identify and **agree** common cause with **stakeholders**
- Develop and **agree** a **shared narrative** which reflects **local environment** and **population needs**
- Create a **compelling** and **persuasive transformational vision** including anticipated stakeholder **benefits and value** and **communicate** progress regularly
- Identify **impactability** levels of different population cohorts
- **One size does not fit all** and journey should centre on **discovery and learning** rather than defined design
- **Bottom-up** alignment with strategy **and top-down** support
- Align **financial incentives** or removal of **financial disincentives** including resource utilisation rather than cost reduction

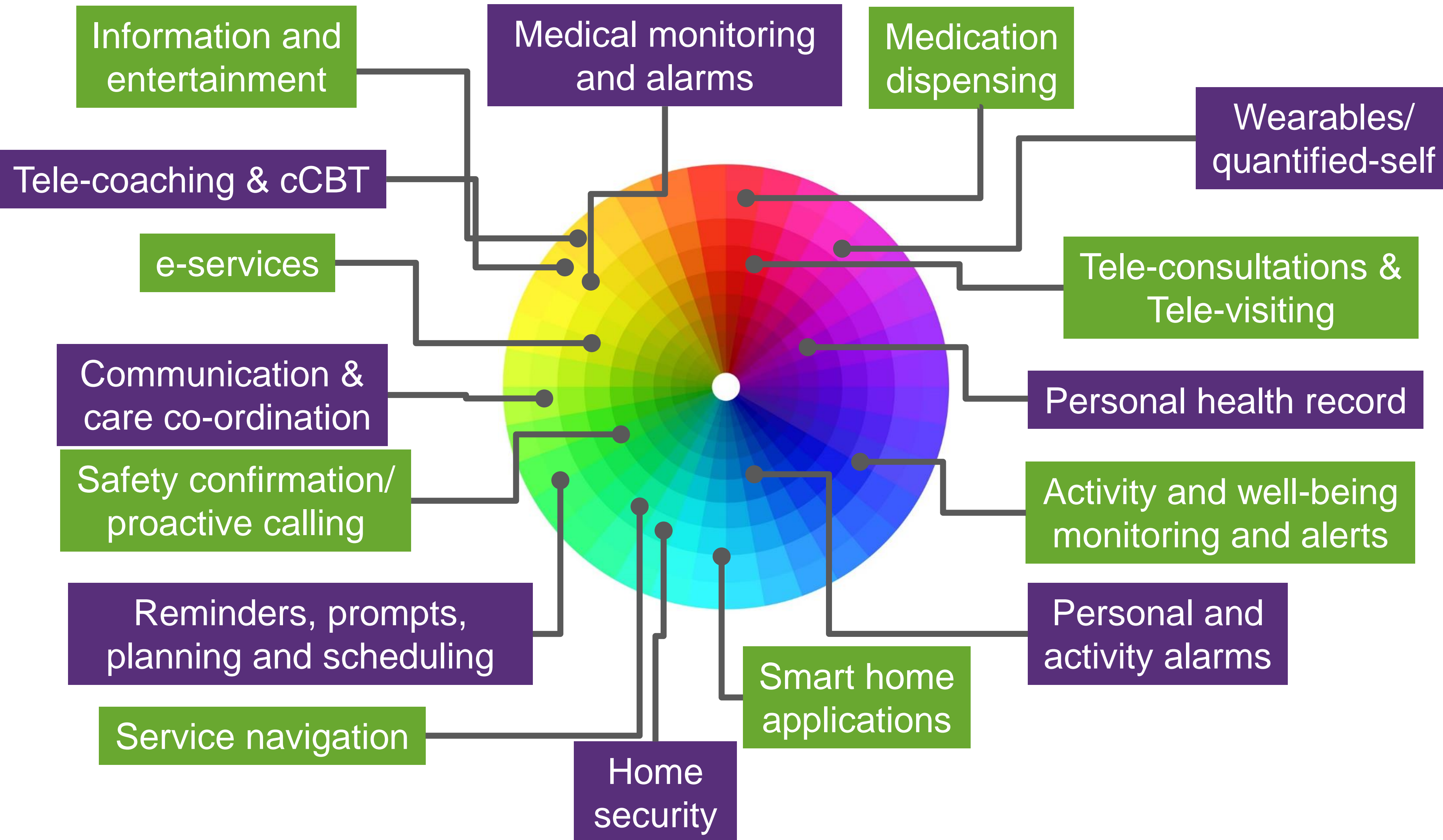
Key lessons for implementing integrated care - 2

- **Promote innovation** in use of procurement, contracting and reimbursement mechanisms
- Invest in **supporting and empowering people** to look after themselves with appropriate **digital tools** and **information sharing**
- **Re-configure** and **re-design workforce** roles and responsibilities
- **Re-configure asset utilisation** from hospitals to primary, community and home-based care
- Identify **outcome measures across the care continuum**, including **stakeholder experiences**
- Achievement of integrated care is a **long-term programme** – costly in terms of time and investment in enabling tools
- **Success** is more likely when **key lessons** are translated into a **comprehensive, coherent system-wide transformational approach**

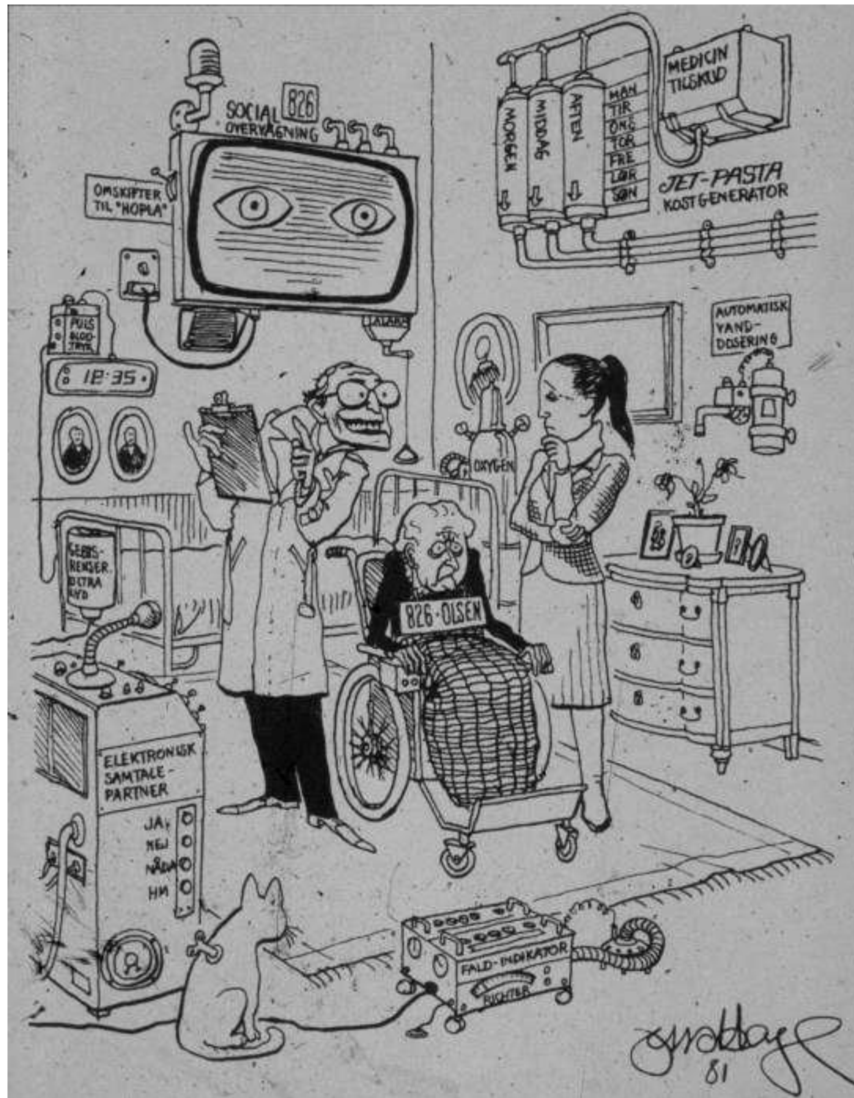
Understanding integrated care: the role of digital health solutions



A spectrum of digital health solutions for people living with chronic conditions



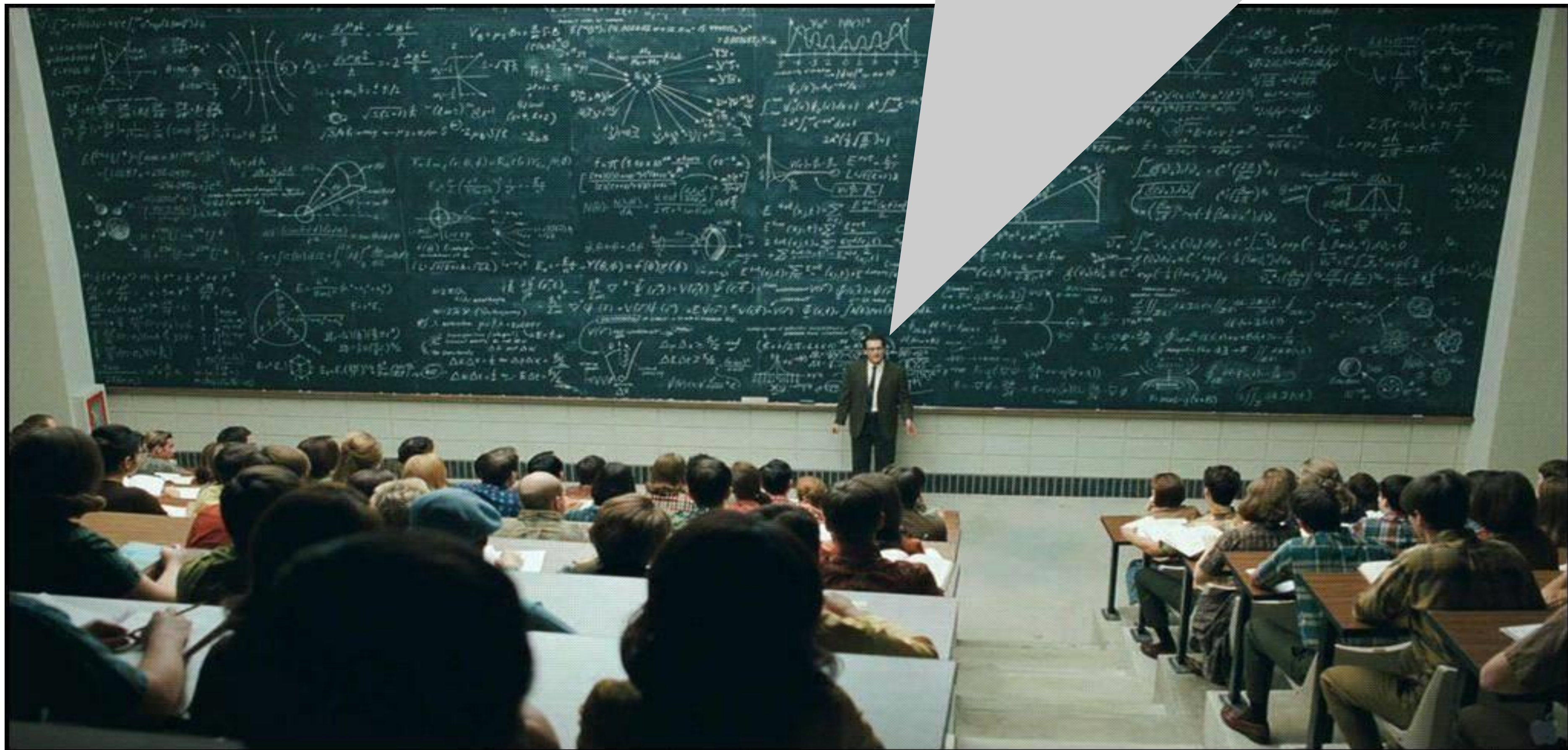
But, be careful what you wish for…



'Thanks to the smarter home, a home help is only required once a year to adjust the clock'

Conclusion!

So, finally I can reveal the key activities for integrating care for people living with chronic diseases is complex!



THANKS FOR YOUR ATTENTION

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