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

CONFERENCE

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

TITLE OF PRESENTATION

The health care services organization in chronic diseases

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

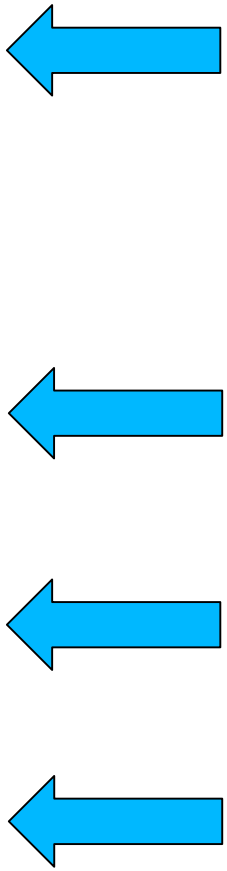
Mario Braga
Agenas

Ministero della Salute · Regione del Veneto · Regione del Veneto ULSS4 Veneto Orientale · Conferenza delle Regioni e delle Province Autonome

Piano Nazionale della Cronicità

Il macroprocesso di gestione della persona con malattia cronica

STRATIFICAZIONE E TARGETING DELLA POPOLAZIONE	1
PROMOZIONE DELLA SALUTE, PREVENZIONE E DIAGNOSI PRECOCE	2
PRESA IN CARICO E GESTIONE DEL PAZIENTE ATTRAVERSO IL PIANO DI CURA	3
EROGAZIONE DI INTERVENTI PERSONALIZZATI PER LA GESTIONE DEL PAZIENTE ATTRAVERSO IL PIANO DI CURA	4
VALUTAZIONE DELLA QUALITÀ DELLE CURE EROGATE	5



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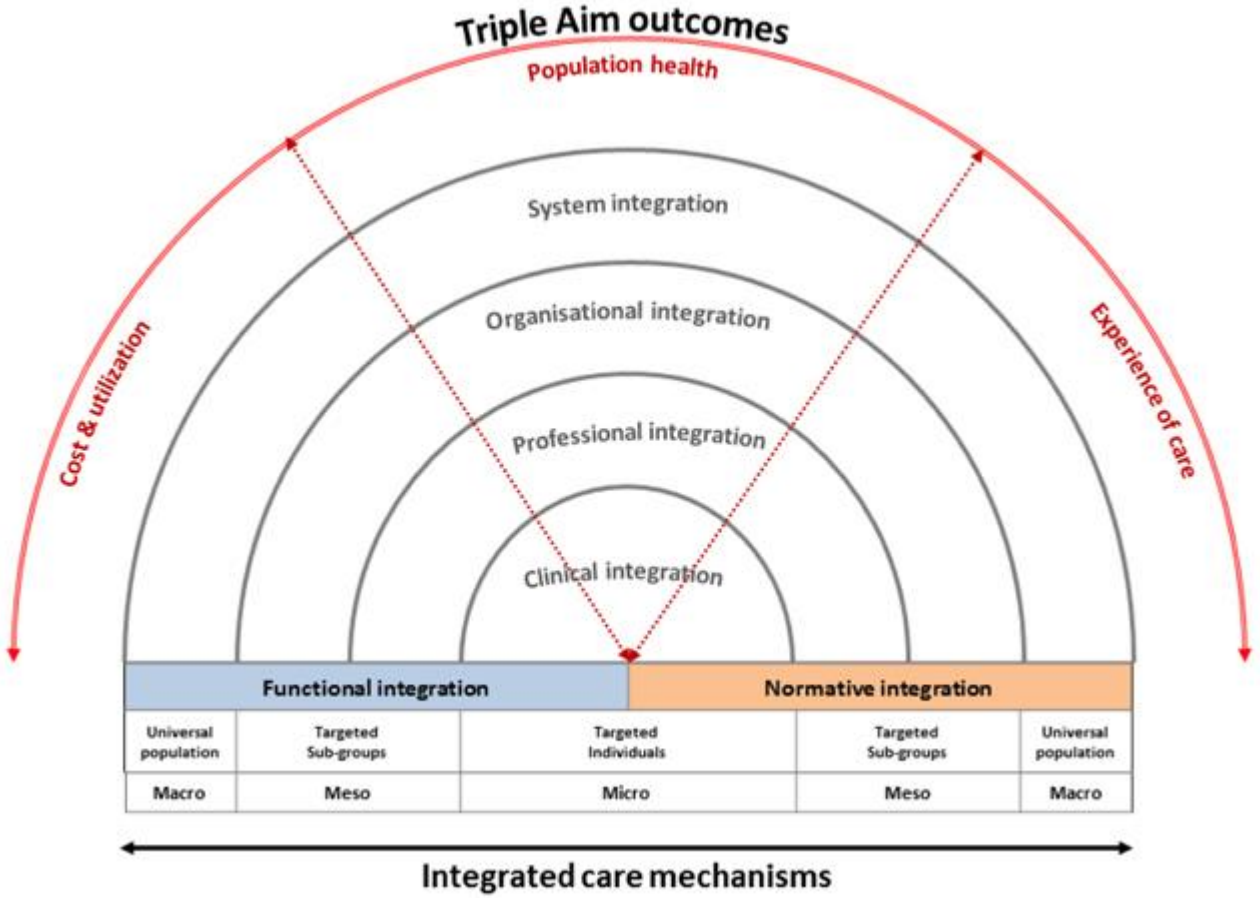
Integrated Health Service Delivery Networks

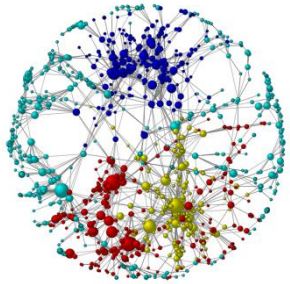
- “a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served.”

- SOURCE: Modified from Shortell SM; Anderson DA; Gillies, RR; Mitchell JB; Morgan KL. Building Integrated Systems:The Holographic Organization. Healthcare Forum Journal 1993; 36(2):20–6.

Rainbow Model of Integrated Care

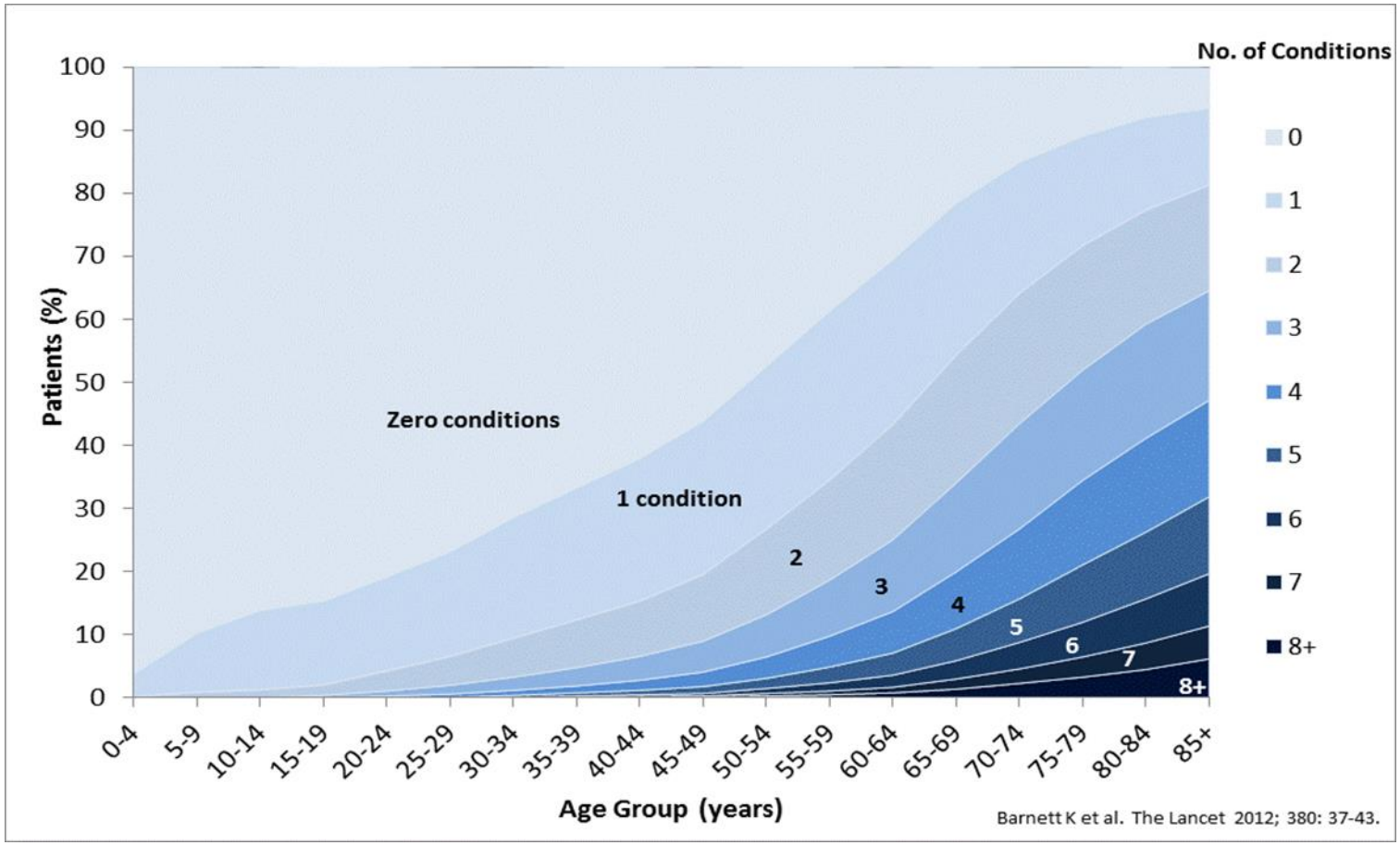


Integrated Services: DM/70 2015

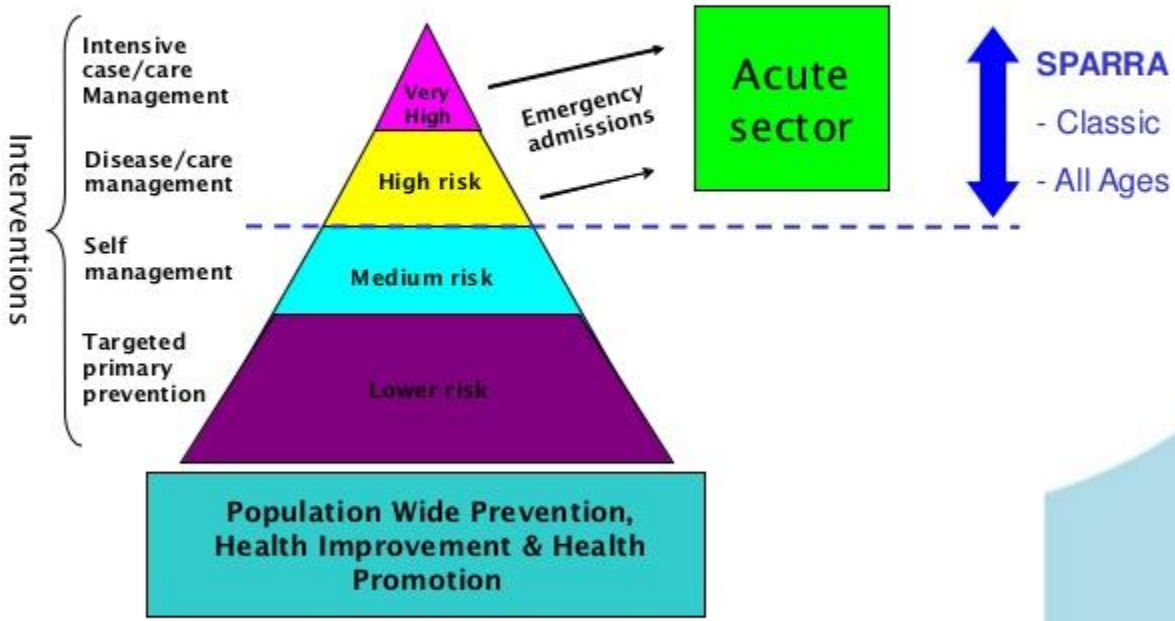


- CLASSIFICAZIONE DELLE STRUTTURE OSPEDALIERE
- BACINI DI UTENZA MINIMI E MASSIMI PER DISCIPLINA
- VOLUMI ED ESITI DI RICOVERO
- STANDARD DI QUALITÀ
- STANDARD ORGANIZZATIVI, TECNOLOGICI E STRUTTURALI
- **RETI OSPEDALIERE (hospital Network)**
- RETE DELL'EMERGENZA URGENZA
- **CONTINUITÀ OSPEDALE-TERRITORIO (Community-Hospital care integration)**

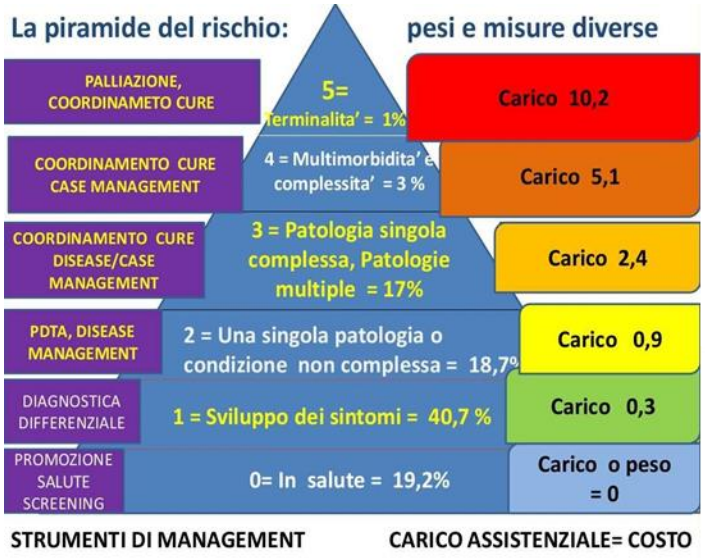
Multimorbidity and age



Kaiser-Permanente Pyramid

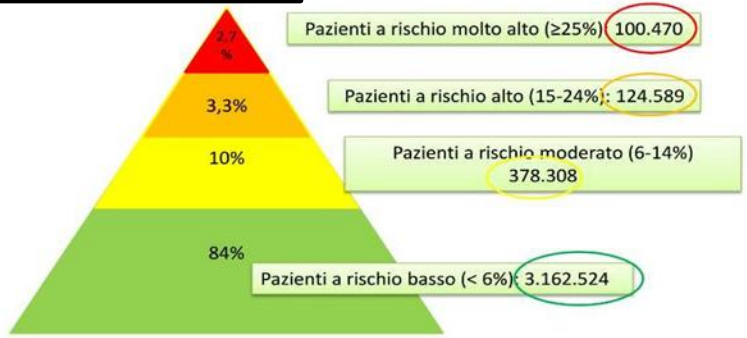


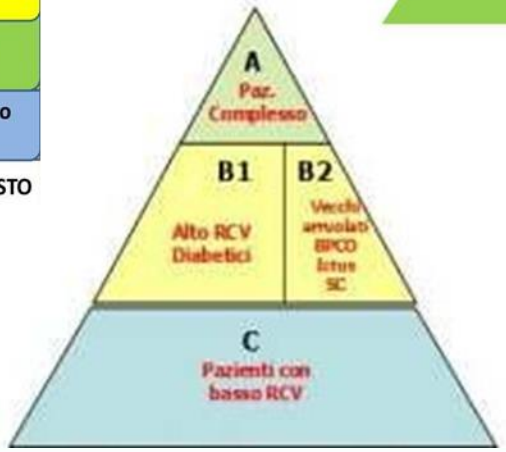
POPULATION STRATA



VENETO

EMILIA-ROMAGNA





POPOLAZIONE ≥18 ANNI - N= 3,765,891

TOSCANA

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Regional Integrated models: examples

LOMBARDIA REGION

Integrated Services: Lombardia case

CReG - Chronic Disease Management Service, Lombardy, Italy

S3 Connected Health

Introduction

S3 Connected Health was responsible for defining and designing the innovative chronic disease management service and related technology and processes for CReG (Chronic Related Grouping), which was launched in Lombardy in 2011. Of the 40,000 plus people suffering from chronic conditions such as asthma, diabetes, COPD and heart failure, who were enrolled in the service, 74.77% of the patients believed the service helped manage their disease

For Who?

The Regional Health Council of Lombardy, Italy

What?

Service Design of Co-ordination Care. Designed minimum care plan, based on best practice, input from GP meetings, related technology and integration of additional services

Why?

To move the locus of care from the hospital to the community with GPs becoming case managers, with the goal of supporting patients and GPs to stay adherent to their care plan.

Background

The Lombardy region has a population of 10 million, including over 4.6 million chronic patients, most over the age of 65 years and affected by three or more pathologies. Chronic diseases are a growing burden for the regional health and social economy.

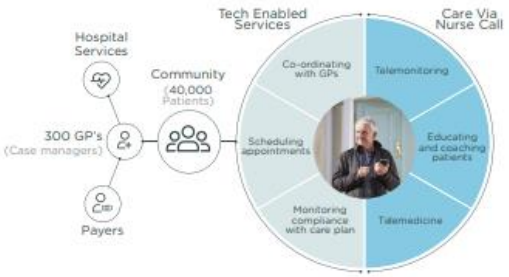
Operating since December 2011, CReG is delivered in partnership with Telbios Technology, the Regional Health Council of Lombardy and over 300 GPs.

Buongiorno CREG

The European Commission has recognised the CReG programme as a model for the management of chronic diseases for its Innovation on Active and Healthy Ageing (a reference model for the development of best practices for the management of chronically ill patients).

The Service

- 400,000 scheduled services per year
- 100,000 care plans issued in May 2015
- 10,000 interactions between the service center and patients
- 20,000 readings from home monitoring
- 2,000 telemedicine services
- 200 hours training on telemedicine and telemonitoring



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Integrated Services: Lombardia case

The rational, underlining the Lombardia reform, was:

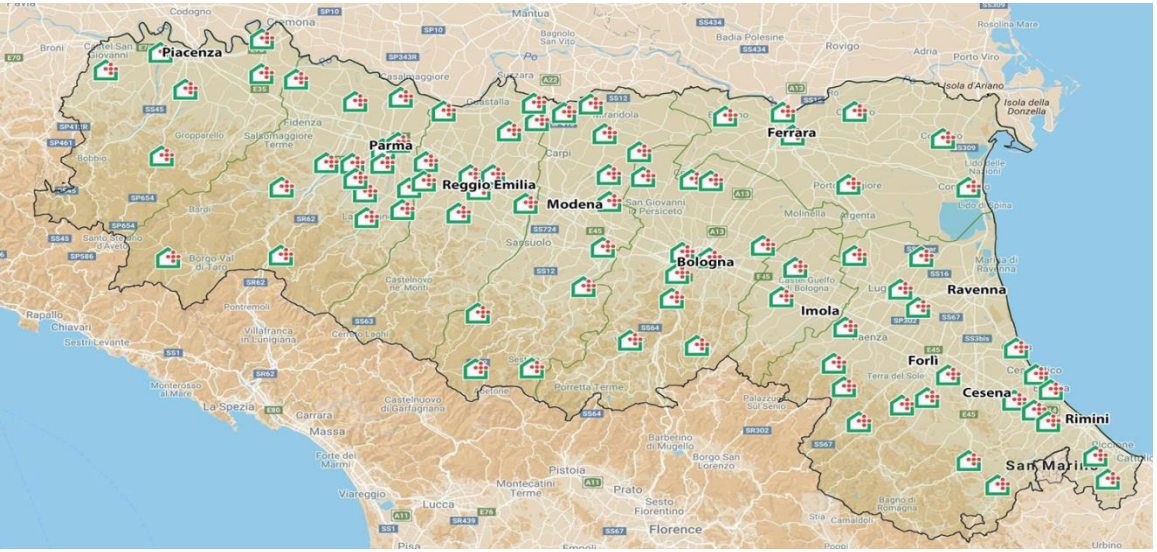
- ✓ to assure a better management of the health of the population, particularly in the case of the most needed, placing them at the centre of the health and social case organization;
- ✓ to overcome the relevant degree of fragmentation and verticalization characterizing the health and social care delivery of services which was in place;
- ✓ to program the care of the population on the following axis:
  - the intensity and type of care needs;
  - the personal preferences of the sick individuals

Integrated Services: Lombardia case

Level of complexity	N. of subjects	Health and Social Needs	Organizational needs	Care giver
Level 1	150.000	fragile (clinical and/or functional-social frailty) individual with prevalent need of institutionalized care (hospital, residential, semi-residential, home care). High level of health and social care consumption.	Hospital and community care integration; Health and social care integration. Strong and of assuring continuity of care within and among services; Strong inter-professional collaboration.	Public or Private accredited Providers (including GP's enterprises)
Level 2	1.300.000	Subjects with multiple chronic conditions requesting mainly community care services and outpatient care. Frequent user of health care, moderate socioeconomic frailty	Interdisciplinary and inter-professional Coordination; Strong adherence to Organizational and clinical pathways; Need for developing pathways for multiple chronic conditions; Integration of health and social care; Strong case management. Emphasis on a proactive attitude and health care promotion	Public or Private accredited Providers; Single General Practitioner (cooperate to the patient management); General Practitioner Associations (full management)
Level 3	1.900.000	Individuals with chronic diseases at their initial stage, mainly single disease cases. Moderate/low consumption of ambulatory and home care	Strong adherence to Clinical and organizational Pathways; Case management and proactive attitude; Strong health promotion activities.	General practitioner (single practice or associated practice).
Level 4	3.000.000	Individuals with sporadic access to health care services (first access)	Fair access to ambulatory care and diagnostic services; Health promotion; Prevention; Health education	General practitioner (single practice or associated practice).
Level 5	3.500.000	healthy population	Health promotion; Prevention; Health education	General practitioner (single practice or associated practice).

EMILIA ROMAGNA REGION

CasadellaSalute



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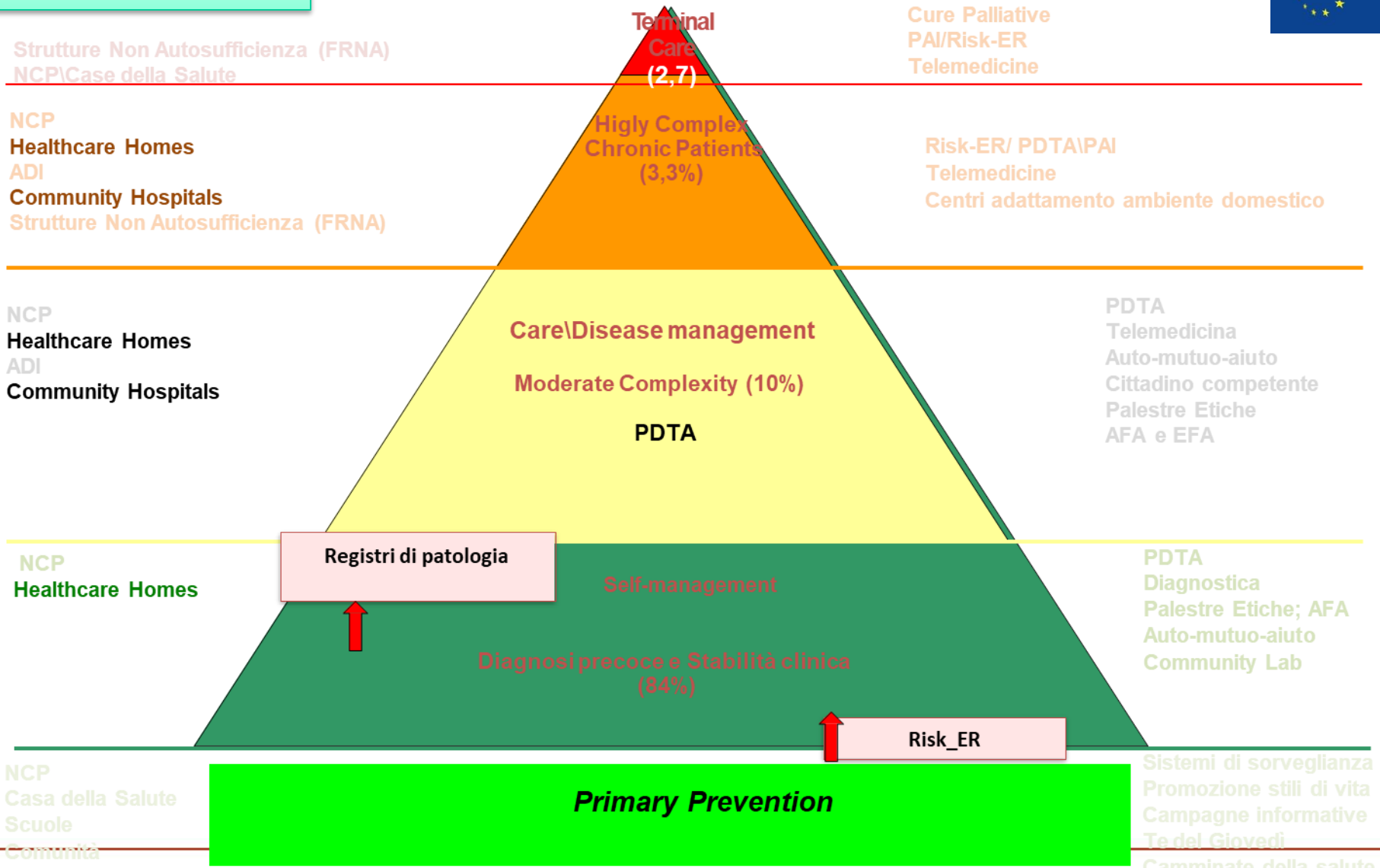
Emilia Romagna Model

Risk Pyramid



Strutture Non Autosufficienza (FRNA)
NCP\Case della Salute

Cure Palliative
PAI/Risk-ER
Telemedicine

NCP
Healthcare Homes
ADI
Community Hospitals
Strutture Non Autosufficienza (FRNA)

Risk-ER/ PDTA\PAI
Telemedicine
Centri adattamento ambiente domestico

NCP
Healthcare Homes
ADI
Community Hospitals

PDTA
Telemedicina
Auto-mutuo-aiuto
Cittadino competente
Palestre Etiche
AFA e EFA

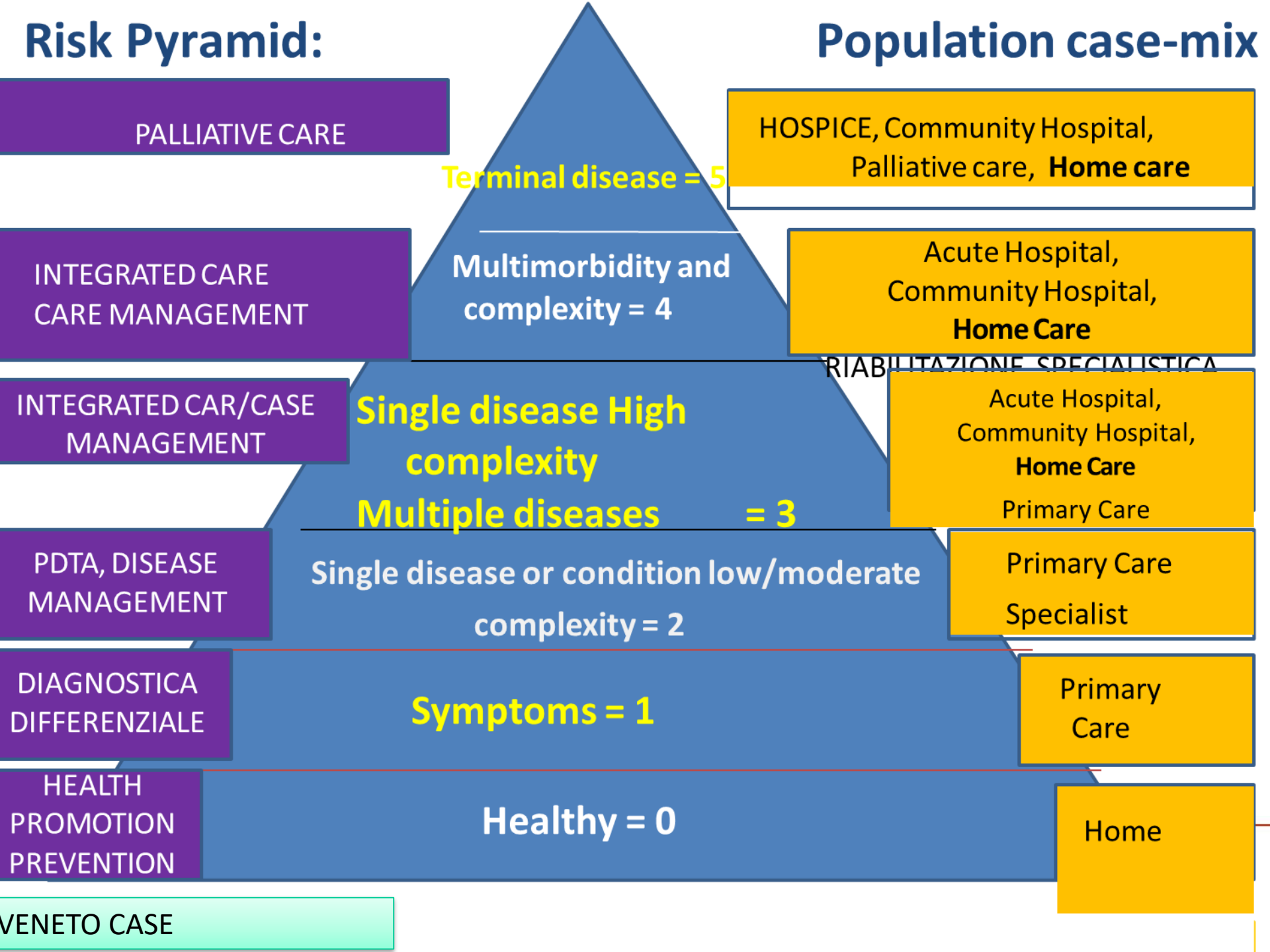
NCP
Healthcare Homes

PDTA
Diagnostica
Palestre Etiche; AFA
Auto-mutuo-aiuto
Community Lab

NCP
Casa della Salute
Scuole
Comunità
Parrocchie, circoli…

Sistemi di sorveglianza
Promozione stili di vita
Campagne informative
Te del Giovedì
Camminate della salute

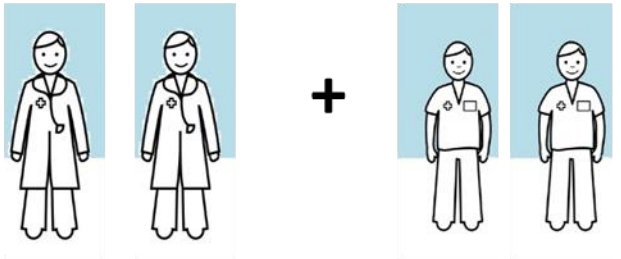
VENETO REGION


Risk Pyramid:
Population case-mix
PALLIATIVE CARE
Terminal disease = 5
HOSPICE, Community Hospital, Palliative care, Home care
INTEGRATED CARE CARE MANAGEMENT
Multimorbidity and complexity = 4
Acute Hospital, Community Hospital, Home Care
INTEGRATED CAR/CASE MANAGEMENT
Single disease High complexity
Multiple diseases = 3
Acute Hospital, Community Hospital, Home Care
Primary Care
PDTA, DISEASE MANAGEMENT
Single disease or condition low/moderate complexity = 2
Primary Care
Specialist
DIAGNOSTICA DIFFERENZIALE
Symptoms = 1
Primary Care
HEALTH PROMOTION PREVENTION
Healthy = 0
Home
VENETO CASE

CARE MANAGEMENT MODEL
REGIONE VENETO

22 HEALTH PARTITIONS:

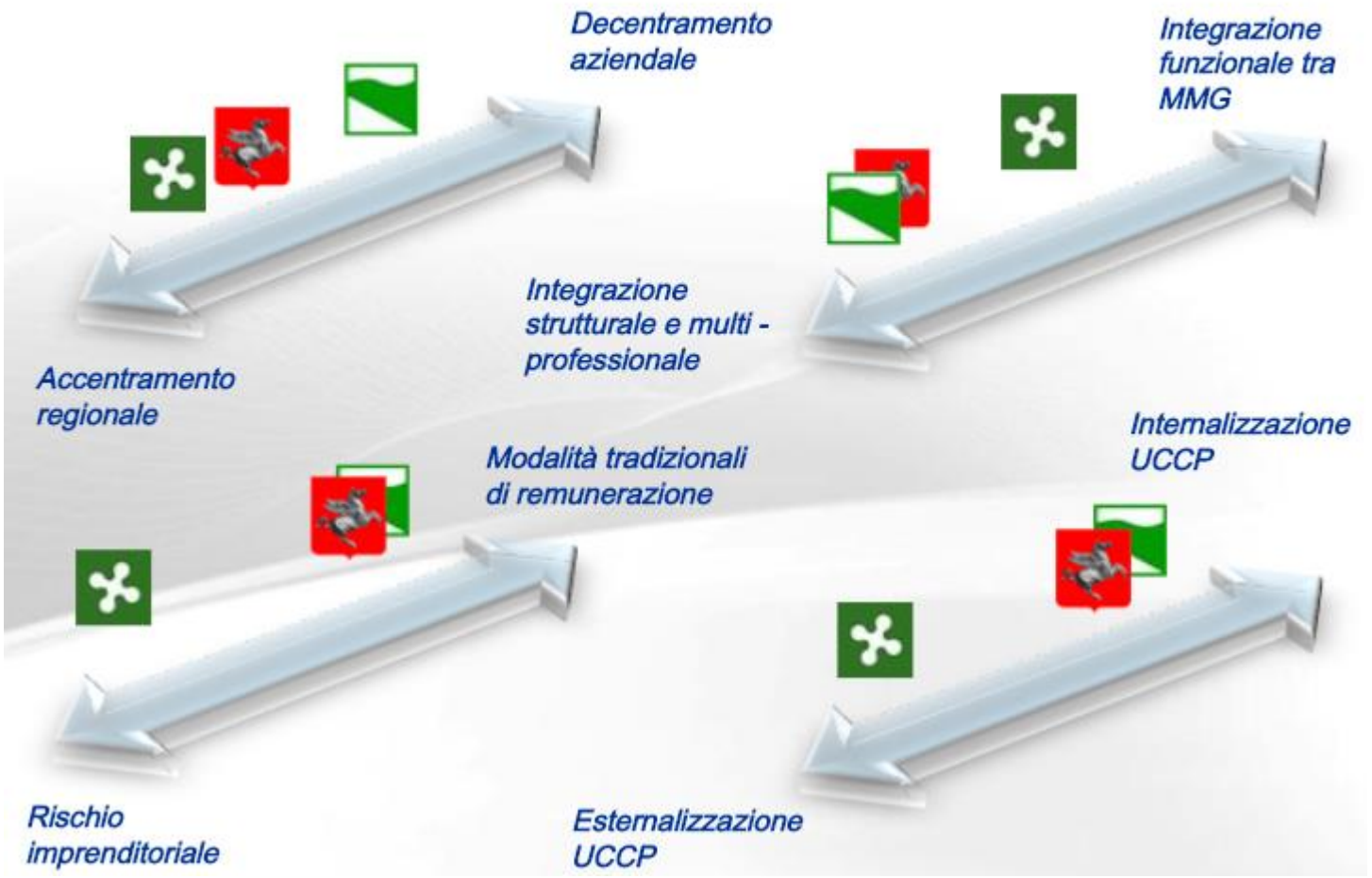
2 GPs **2 NURSES Care Manager**



Tot 42 GPs + 42 CM

6. Considerazioni conclusive

Spunti per il confronto tra modelli



Componenti	CdS T1	CdS T2.	CdS T3	CdS T4	CdS T5	CdS T6	CdS ER 1	CdS ER 2	CdS ER 3	CdS ER 4	CdS ER 5	Sardegna	MMG Ven
Stratificazione del rischio													
Spazi fisici adeguati (Casa della Salute)													
Cartella clinica informatizzata condivisa da tutto il team													
Coordinamento medico-infermiere													
Shared-care con medici specialisti													
Integrazione sociosanitaria													
Ruolo di care management assegnato ed agito													
Pianificazione delle cure													
Supporto all'autocura													
Medicina narrativa													
Approccio "cure simultanee"													
Attività di audit													

Documented frameworks and indicator sets for assessing the performance of integrated care

Country/ organisation	Context	Objective	Domains	Indicator selection: considerations and criteria	Indicators
Italy					
Ministry of Health/National Agency for Regional Services	*National Plan for Chronic Diseases(2016)/National Outcome Evaluation Programme (ref 30a e 30b: http://www.regioni.it/sanita/2016/09/27/conferenza-stato-regioni-del-15-09-2016-accordo-tra-il-governo-le-regioni-e-le-province-autonome-sul-documento-piano-nazionale-della-cronicita-478007/; http://95.110.213.190/PNEedizione16_p/index.php)*	To implement and evaluate effectiveness of an integrated care plan for chronic diseases	The Ministry of health in agreement with all the regions has approved in September 2016 a national plan to address chronic diseases, proposing: 1. a new cultural approach at system, service, professional, and patient level 2. an integrated model between hospital and community 3. support for home care 4. patient-centred approach 5. multidimensional and outcome evaluation	The National Outcome program already includes indicators to evaluate integrated care indirectly. Indicator selection was framed according to: homogeneous data quality across Regions, interconnecting capacity of health databases, scientific evidence, implementation within regional or local evaluation systems. Clinical and organizational appropriateness were considered. Specific indicators to evaluate integrated care have also been developed but not yet calculated, identifying a model of integrated care and results of implementation to be measured through HSPA indicators specifically developed.	1. Process indicators: adherence to clinical guidelines, timeliness of interventions; 2. Outcome indicators: mortality, avoidable hospitalisation, disease complications: • Avoidable hospitalisation for ambulatory care sensitive conditions (ACSC) • 1 year mortality and MACCE after admission for Acute Myocardial Infarction • Medium term complications (mortality, revascularisation and amputation) after admission for severe artheropathy • Long term complication for diabetes 3. Indicators of interaction process/outcome.

PLOS ONE

RESEARCH ARTICLE

Effectiveness of Case Management for 'At Risk' Patients in Primary Care: A Systematic Review and Meta-Analysis

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OPEN ACCESS

Abstract

Background

An ageing population with multimorbidity is putting pressure on health systems. A popular method of managing this pressure is identification of patients in primary care 'at-risk' of hospitalisation, and delivering case management to improve outcomes and avoid admissions. However, the effectiveness of this model has not been subjected to rigorous quantitative synthesis.

Methods and Findings

We carried out a systematic review and meta-analysis of the effectiveness of case management for 'at-risk' patients in primary care. Six bibliographic databases were searched using terms for 'case management', 'primary care', and a methodology filter (Cochrane EPOC group). Effectiveness compared to usual care was measured across a number of relevant outcomes: **Health** – *self-assessed health status*, mortality; **Cost** – *total cost of care*, healthcare utilisation (*primary and non-specialist care* and *secondary care* separately), and; **Satisfaction** – *patient satisfaction*. We conducted secondary subgroup analyses to assess whether effectiveness was moderated by the particular model of case management, context, and study design. A total of 15,327 titles and abstracts were screened, 36 unique studies were included. Meta-analyses showed no significant differences in *total cost*, mortality, *utilisation of primary or secondary care*. A very small significant effect favouring case management was found for *self-reported health status* in the short-term (0.07, 95% CI 0.00 to 0.14). A small significant effect favouring case management was found for *patient satisfaction* in the short- (0.26, 0.16 to 0.36) and long-term (0.35, 0.04 to 0.66). Secondary subgroup analyses suggested the effectiveness of case management may be increased when delivered by a multidisciplinary team, when a social worker was involved, and when delivered in a setting rated as low in initial 'strength' of primary care.

	MDT/ Single case manager	Low/ Intermediate high PHC	Judge-ment/ Modelling	Social worker included/ Not included
Mortality (short-term)	👍	👉	👍	👍
Mortality (long-term)	👉	👍	👉	👉
Self-rated health (short-term)	👍	👍	-	👍
Utilisation of primary care (short-term)	👉	👉	-	👉
Utilisation of secondary care (short-term)	👍	👉	👎	👍
Utilisation of secondary care (long-term)	👉	👉	👉	👉

👉 Uguale

👍 A favore del case managment

👎 A favore dell' 'usual care'

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Conclusions

- **Population stratification is performed via different methods.**
- There is considerable diversity with regard to the extent and quality of chronic diseases interventions and strategies across the REGIONS (country), or even across local health authorities within regions, with many initiatives tending to be located in the north of the country.
- In addition, as in other countries, there is considerable fragmentation between social (municipalities) and health care services (local health agencies).

THANKS FOR YOUR ATTENTION

(Speaker's contacts)