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

CONFERENCE

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

National Plan for Chronic Disease: A regional roadmap

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

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Italy: National Plan for Chronic Diseases (NPCDs)

It defines at national level a "strategic design" for the management of chronicity, which the single Regions must implement on own territory, in consideration of the services and resources available (part I)

Dictate lines of address on pathologies with specific characteristics and care needs (Part II)

It marks an important turning point in the approach to the disease: the person becomes the center of the care system

Fundamentals Issues

- The role of primary care and GPs
- Organization and new roles and activities
- Training and participation of professionals responsible for the phases of the care pathway
- Networking (IT, organizational)
- Technology as an enabling tool for the organizational model and for the provision of services (National-Regional pact for eHealth development - 7 July 2016)
- Evaluation of outcomes and remuneration systems
- Data and information (stratification, care plans, quality of care, outcomes)
- A new role of the citizen (empowerment, ...)

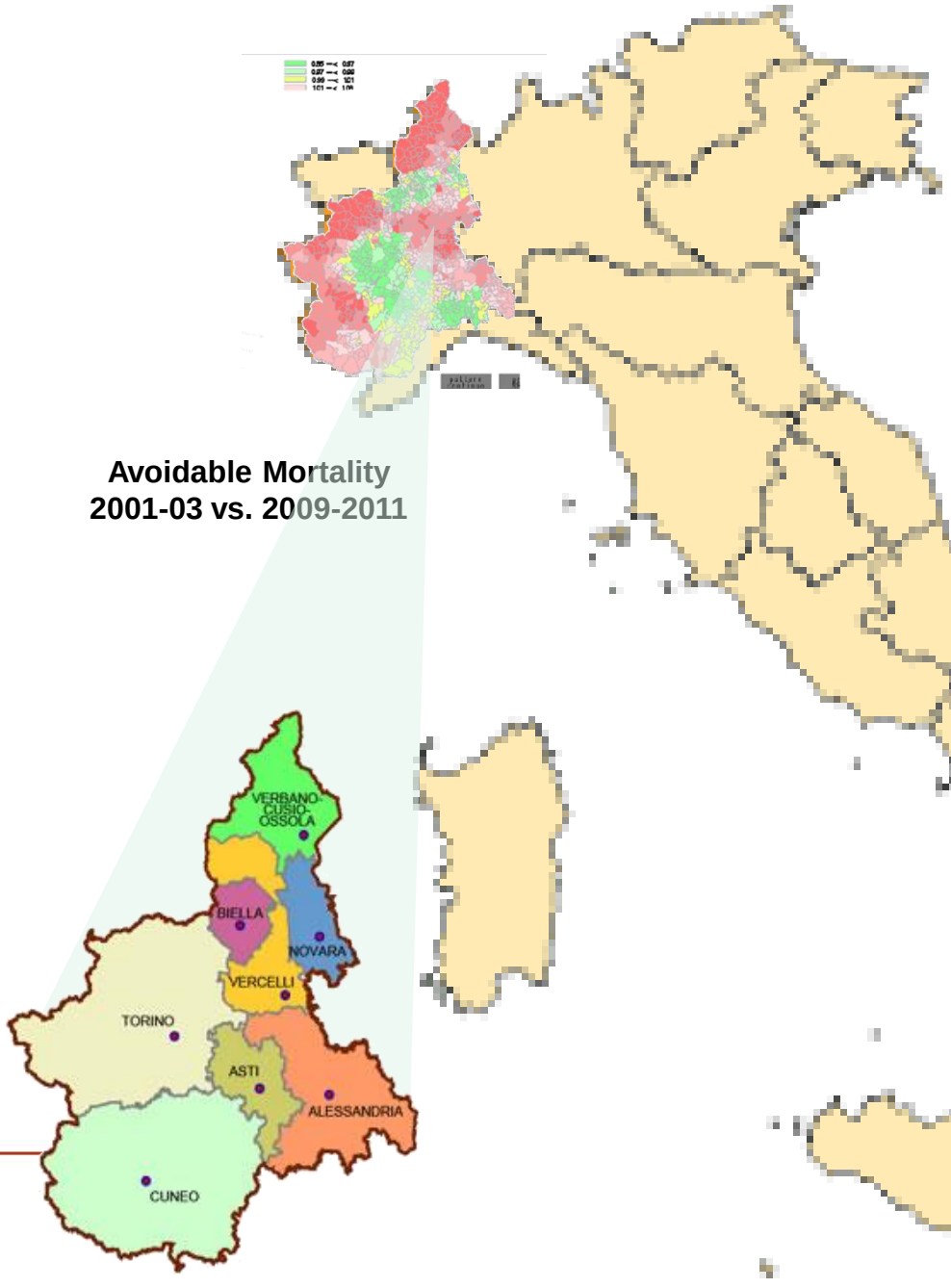
The NPCd foresees **5 macrophases**

Macrophase 0 **Fix health objectives**	
Macrophase 1 **stratification and targeting of the population**	
Macrophase 2 **health promotion, prevention and early diagnosis**	*Primary care*
Macrophase 3 **taking charge and patient management**	*Management of continuity of care* *Specialistic care*
Macrophase 4 **provision of personalized interventions for patient management**	*Patient empowerment* *Adherence to the personalized care plan and self-care*
Macrophase 5 **evaluation of the quality of the care provided**	*Evaluation of the quality of care for programming purposes*

National Plan for Chronic Diseases at a regional level

Signed on September 15, 2016 (n.160 / CSR) the Agreement on the **National Plan for Chronic Diseases (NPCDs)** provides that "the Government and the Regions and the Autonomous Provinces of Trento and Bolzano agree:

1. to approve the " National Plan for Chronic Diseases (NPCDs)". The regions and the autonomous provinces of Trento and Bolzano undertake to incorporate the document with their own provisions and to implement its contents, in their respective territorial areas, without prejudice to their autonomy in adopting the most suitable organizational solutions in relation to the needs of the own programming;
2. to promote the implementation of the " National Plan for Chronic Diseases (NPCDs)“, activating all necessary and useful initiatives to promote the dissemination of ITC tools and technologies to support chronicity, enhancing access to other resources - European funds and cohesion funds - as well as **promoting innovation in the organization and management of health services**. "



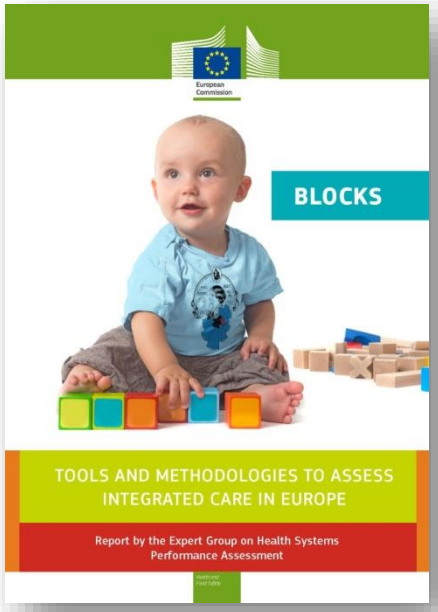
Avoidable Mortality
2001-03 vs. 2009-2011

PIEDMONT REGION

25.873 km²
4.392.526 inhabitants (2017)
1197 Municipalities
1.112 (92.2%) Municipalities < 7.232 resident = minimum number for GP association
8 Provinces
1 Metropolitan City
173 ab./km² Population density

12 Health local authorities
3 Major Hospitals
3 University Hospitals

Success factors from european case studies



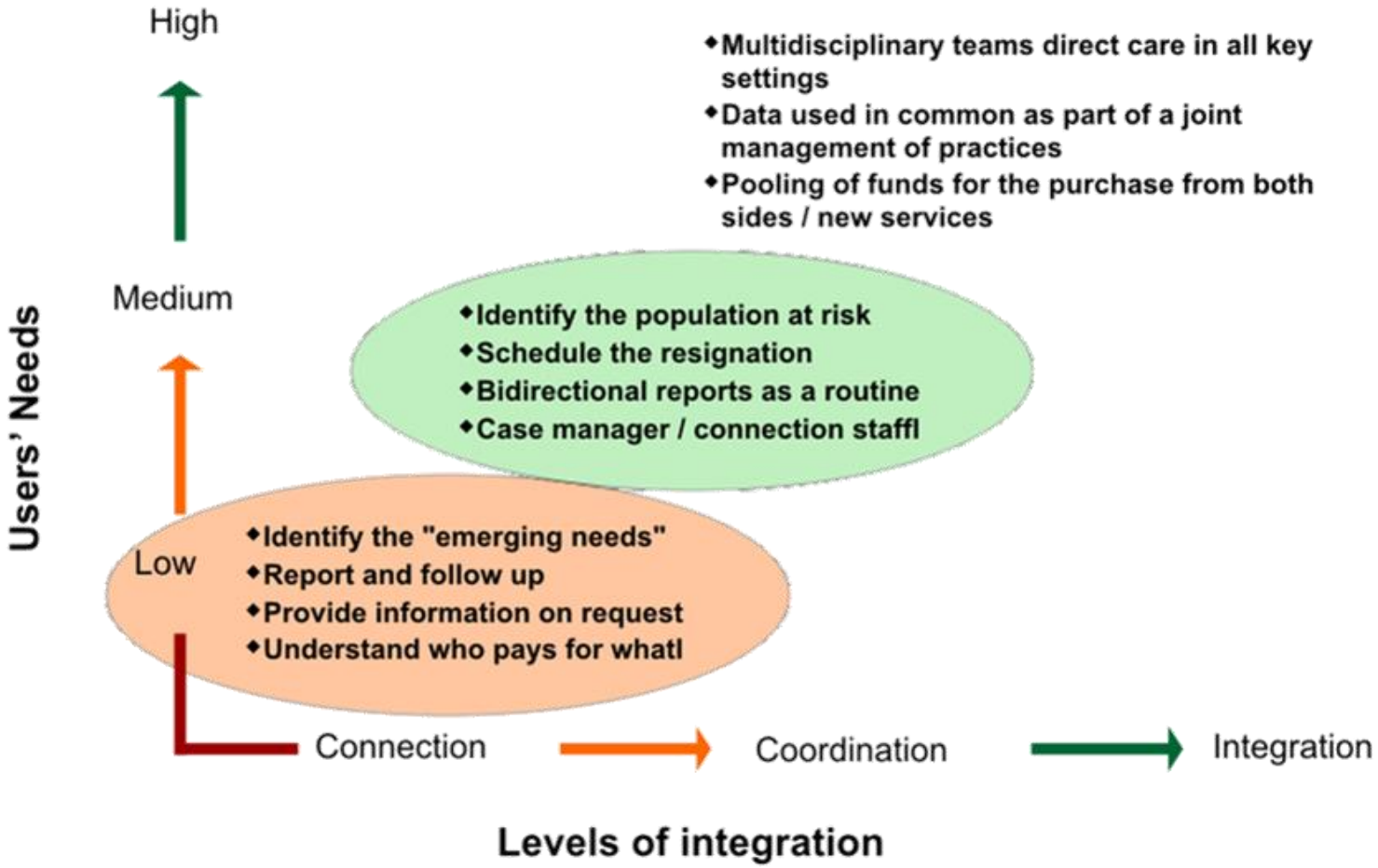
Tools and methodologies to assess integrated care in Europe

- ☐ Commitment and will on a political level
- ☐ Governance
- ☐ Involvement of stakeholders
- ☐ Actions for organizational change
- ☐ Digital leadership / champions
- ☐ Collaboration and trust (Pilot Area as an alliance area)
- ☐ Training of human resources
- ☐ Patient empowerment
- ☐ Financing and incentives
- ☐ ICT infrastructures and solutions
- ☐ Monitoring and evaluation systems

Integrated care's definition: where to go

Integrated care includes those initiatives that seek to improve treatment outcomes by **overcoming fragmentation** problems by linking or coordinating services from different providers **along the care continuum**.

Expert Group on Health Systems Performance Assessment, in "*Tools and methodologies to assess integrated care in Europe*"



Promoting 4 Communities of Practices (CoP)

4 pilot areas, representative of different environmental and organizational contexts:

ASL Città di Torino: Chosen as it is a **metropolitan area**, unique for its wealth of specialist healthcare offer but even for the **difficulty to concentrate in health structure the primary care supply**, strong propensity to demand for services (especially for specialist services), strong segregation of needs between deprived areas and richer areas must be included in the survey

ASL of the province of Turin: the ASL TO3 has been chosen for the presence of organizational and community conditions such as to allow the sharing and reorganization of the different assistance's needs around a **structural solution (so-called "House of health")**

ASL of Southern Piedmont: ASL CN1 has been chosen to consider the **reality of remote areas on which insist other programs** (Internal Areas National Strategy, Structural Funds for Territorial Cooperation) with opportunities for integration between **innovation** in healthcare organization and other policies of **territorial development**, at the service of reality with a high concentration of health needs for deprivation, isolation and segregation

ASL of Eastern Piedmont: the ASL of the VCO has been chosen to investigate a **mixed, urban and dispersed reality**, which is also exposed to a particular attraction of the Lombard model of supply.

Promoting a Focus on Integrated care for Piedmont region

RWG – Regional Working Group
Officers from Healthcare delivery Programming, Informative Systems European Projects, Epidemiology and others

Defines the roadmap and the tools for qualitative Gap Analisys on the continuum of care, the criteria for identifying the pilot areas, the minimum composition of the Communities of practice, the stakeholders' involvement

Health Institutions Managers e Stakeholders
They are distinguished into Institutional and Economic and Social Partnerships

They are periodically informed of the route, results and products, to evaluate the transferability.
Suggest points of attention to the RWG

4 Pilot Areas with newly formed community of practice in each of them

1) They activate multiprofile and multi-level communities of practice
2) Each community of practice is encharged to prepare an integrated care implementation project

RWG – Regional Working Group
Officers from Healthcare delivery Programming, Informative Systems European Projects, Epidemiologiy and others

It analyzes common factors and contact points from the 4 pilot areas and defines the contents of the Document for the Regional Council Resolution on how to implement the NPCDs, identifying the lines of development and the elements of transferability and / or scaling up

Promoting tools for a Bottom up Qualitative Gap analysis (QGA) workshop

TABELLA 1 - ANALISI IMPATTO PNC – COMUNITÀ DI PRATICA DELL'AZIENDA....., Moderatore....., Tutor.....,
Sala.....

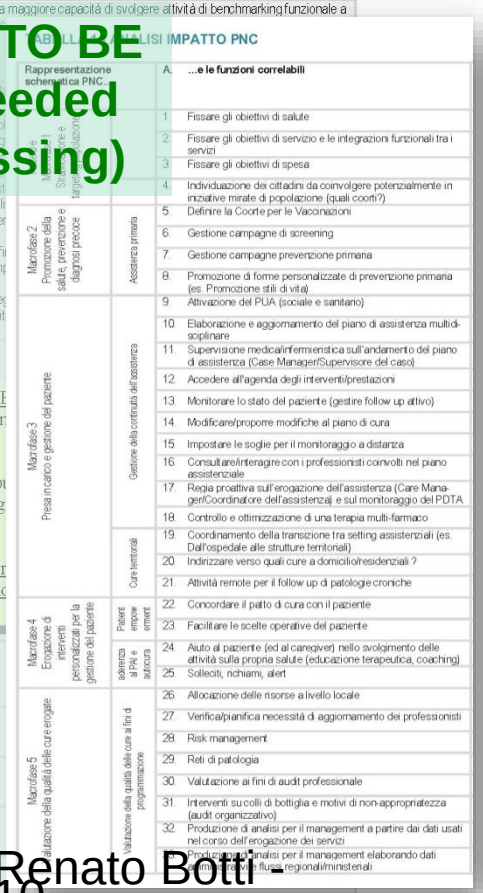
Rappresentazione schematica PNC...		A. ...e le funzioni correlabili	B. Chi lo fa (quale centro di responsabilità?)	C. Come lo fa	D. Quali informazioni usa?	E. Chi le usa (a chi sono destinati)	F. COSA SERVE? (Chi dovrebbe/potrebbe farlo/usarlo meglio e perché? Quali informazioni servono e a cura di chi?)	G. COSA MANCA?
Fase 0		1. Fissare gli obiettivi di salute	Livello regionale ma parzialmente Multilivello (Regione e Aziende sanitarie)	Condizionati da Piano di rientro e discendenti da pianificazione nazionale. Spesso in modo frammentario	Si basa prevalentemente su dati elaborati dal ministero riportati negli atti di pianificazione e su Sistemi Informativi che producono informazioni a livello locale	Livello regionale e livello aziendale	Attivare la funzione (peraltro già matura) di analisi e proposta epidemiologica, integrabile con il sociale	Metodi per fissare priorità che diano contezza delle specificità del territorio in base a cui operare le scelte. Formazione ad hoc. Ci sono dati sociali derivabili dalla fonte censuaria disponibili su tutto il territorio; Torino ha una ricchezza di informazione superiore perch può contare su fonti informative locali.
		2. Fissare gli obiettivi di servizio e le integrazioni funzionali tra i servizi	Livello regionale, ma solo su alcune aree (prevenzione, Diabete, [illegible] cliniche)	In base ad atti di programmazione che declinano la pianificazione [illegible] gestendo [illegible] professionisti	Flussi rielaborati da professionisti delle reti	Livello aziendale	Un livello regionale più vocato a fissare obiettivi [illegible] salute e a delegare al livello aziendale gli obiettivi di servizi [illegible] Distretto	Una maggiore capacità di svolgere attività di benchmarking funzionale a un [illegible]
		3. Fissare gli obiettivi di spesa	Livello regionale Livello aziendale	Controllo di gestione e tetti di spesa per silos	Flussi	Livello aziendale	Meccanismi di [illegible]	
Macrofase 1 Stratificazione e targeting popolazione		4. Individuazione dei cittadini da coinvolgere potenzialmente in iniziative mirate di popolazione (quali coorti?)	Lo fa l'epidemiologia a Livello regionale	In base a flussi e in base a elaborazioni da parte dell'osservatorio epidemiologico, ma in modo episodico e parziale (Ondate di calore)	NSIS, SIS, ISTAT, Flussi locali per alcune informazioni di tipo sociale	Distretti per assegnazione ai MMG	Fornire le informazioni agli operatori sanitari con [illegible] Rendere disponibili attraverso la piattaforma FSE i bilanci di salute e patient summary al FSE. Gestire in maniera integrata il consenso espresso dai cittadini. Superare le barriere normative sulla Privacy e assicurare la sicurezza degli applicativi informatici aziendali.	
Macrofase 2 Promozione della salute, prevenzione e diagnosi precoce	Assistenza primaria	5. Definire la Coorte per le Vaccinazioni						
		6. Gestione campagne di screening						
		7. Gestione campagne prevenzione primaria						
		8. Promozione di forme personalizzate di prevenzione primaria (es. Promozione stili di vita)						
Macrofase 3 Presa in carico e gestione del paziente	Gestione della continuità dell'assistenza	9. Attivazione del PUA (sociale e sanitario)						
		10. Elaborazione e aggiornamento del piano di assistenza multidisciplinare						
		11. Supervisione medica/infermieristica sull'andamento del piano di assistenza (Case Manager/Supervisore del caso)						
		12. Accedere all'agenda degli interventi/prestazioni (CUP)						
		13. Monitorare lo stato del paziente (gestire follow up attivo)						
		14. Modificare/proporre modifiche al piano di cura						
		15. Impostare le soglie per il monitoraggio a distanza						

Describing AS IS

Describing TO BE (what is needed what is missing)

33 issues highlighted to analyze how is organized the Continuum of care and how should it be

MORE THAN 100 PROFESSIONAL INVOLVED



Renato Botti – Giada Li Calzi

QGA workshop: **take home messages** when implementing NPCDs

Regional Objectives

Connect prevention with primary care

Integrate Community and Healthcare

Enable teamworking

Increase Homecare

Empowerment, health outcomes and contrast to inequality

Give value to who and to what produces values: accessibility, continuity, completeness, adherence, coordination, timeliness

Leverages to be developed

Stratification	Stratification and targeted population strategies, health promotion and initiative medicine
Infrastructure	Digital management of the consent for stratification and regional register of individual assistance plans
	Regional infrastructure for the management of individual and / or PDTA therapeutic plans (Coherence between welfare and information processes)
	Technology supporting services (Telemonitoring and remote assistance services center, 116-117 management, etc.)
Rules	Requirements (accreditation and authorizations) and remuneration systems
	Reducing bottlenecks
	Monitoring, cost-effectiveness evaluation and evaluation results
Social Capital	(plans of) Training, knowledge transfer and Human resources policies
	Communication between professionals and towards patients
	Empowerment, self-care and adherence to therapie
	Community Welfare

What to do next? Regional Council Resolution

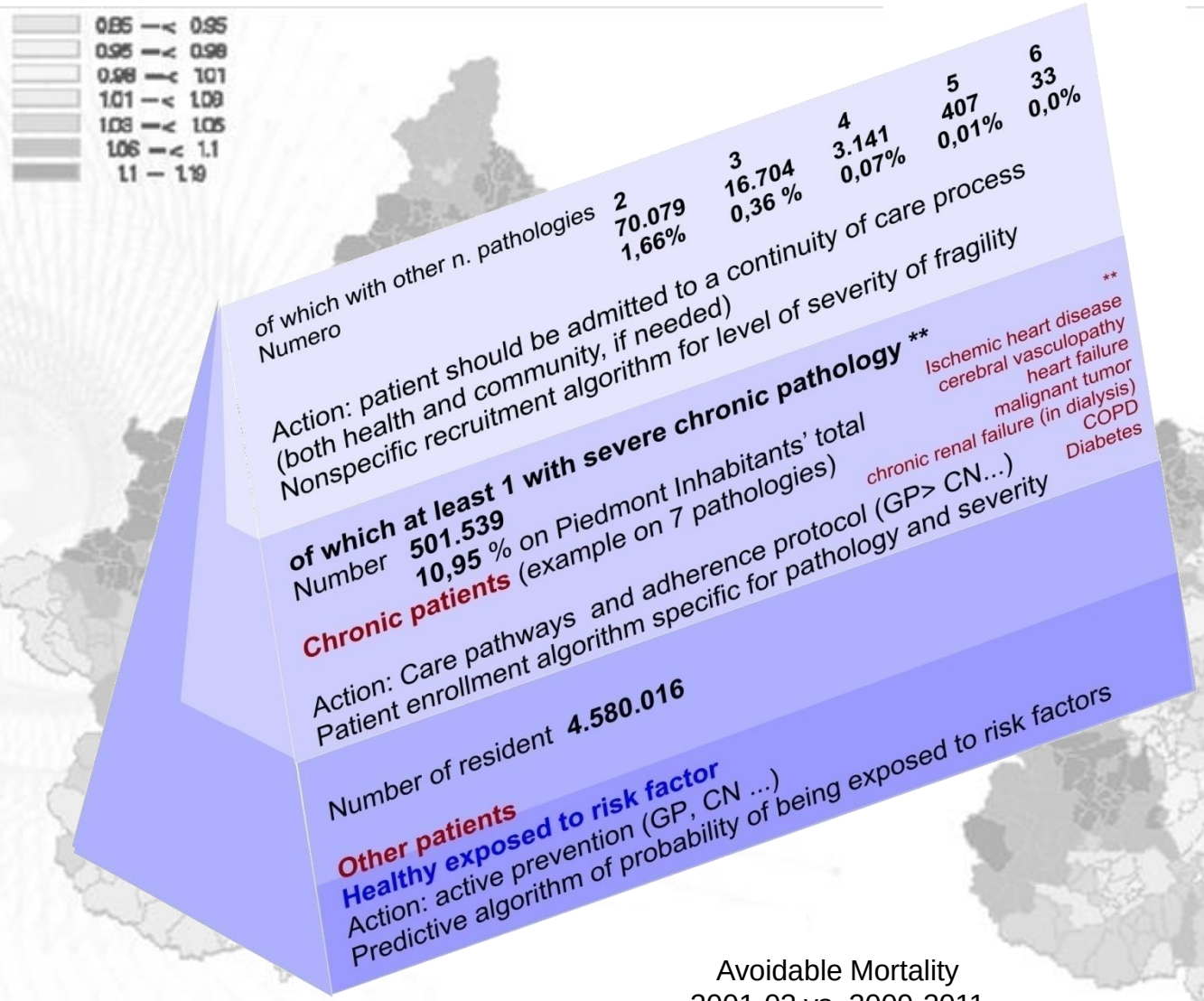
Regional Council Resolution n. 22-2018

Guidelines for the implementation of the NPCDs in Piedmont Region

the strengths' issues

- ❑ GP Role
- ❑ District functions
- ❑ Social stratification in two steps
- ❑ From Care Pathways towards Personalised Care Pathways (PDTA >> PCP)
- ❑ Increase homecare
- ❑ Introducing ICT and telemonitoring services as a support
- ❑ Consider Community context

Social stratification: a process in more steps



Avoidable Mortality
2001-03 vs. 2009-2011

First provide health profiles and then decide how / what to stratify on the basis of the strategic assessments from the pilot areas (practice community):

- **by Intensity of care,**
- **by disease's burden**
- **Etc**

Example of estimation of the prevalence of some severe chronic diseases in Piedmont region in 2016 elaborated by SEPI

Regional eHealth infrastructure plan

First financing Act: Regional Council Resolution n. 19-4900 (20 april 2017) about European Structural funds POR FESR 2014-20 - Axis II. Specific subject II.2c.2. "Digitization of administrative processes and dissemination of fully interoperable services"

Evolution and diffusion of online services to citizens in a multichannel logic (mobile, web, totem, etc.)

Evolution and diffusion of the architecture and of the HeR interoperability infrastructure and integration with the information systems of accredited public and private healthcare companies, General Practitioners and Free Choice Pediatricians

D.G.R. Linee di indirizzo Sanità Digitale

Digitization and archiving of clinical health documents

Implementation of the information system for chronicity management
The information system will support the regional model currently being defined, ensuring at least the management of the following aspects: chronic and / or fragile patient data, performance data (including telemedicine), patient assessment, Personalized Care Plan (PCP), planning of the care path, of the Diagnostic Therapeutic Assistance Paths (PDTA) and related monitoring functions.
This information system will be part of the territorial information system of the Healthcare Companies but will have to be functionally integrated with the information systems of the social assistance services and their Managing Authorities to allow the assessment, planning, management and monitoring of personalized plans even for chronic patients greater frailties that require integrated social and health interventions.

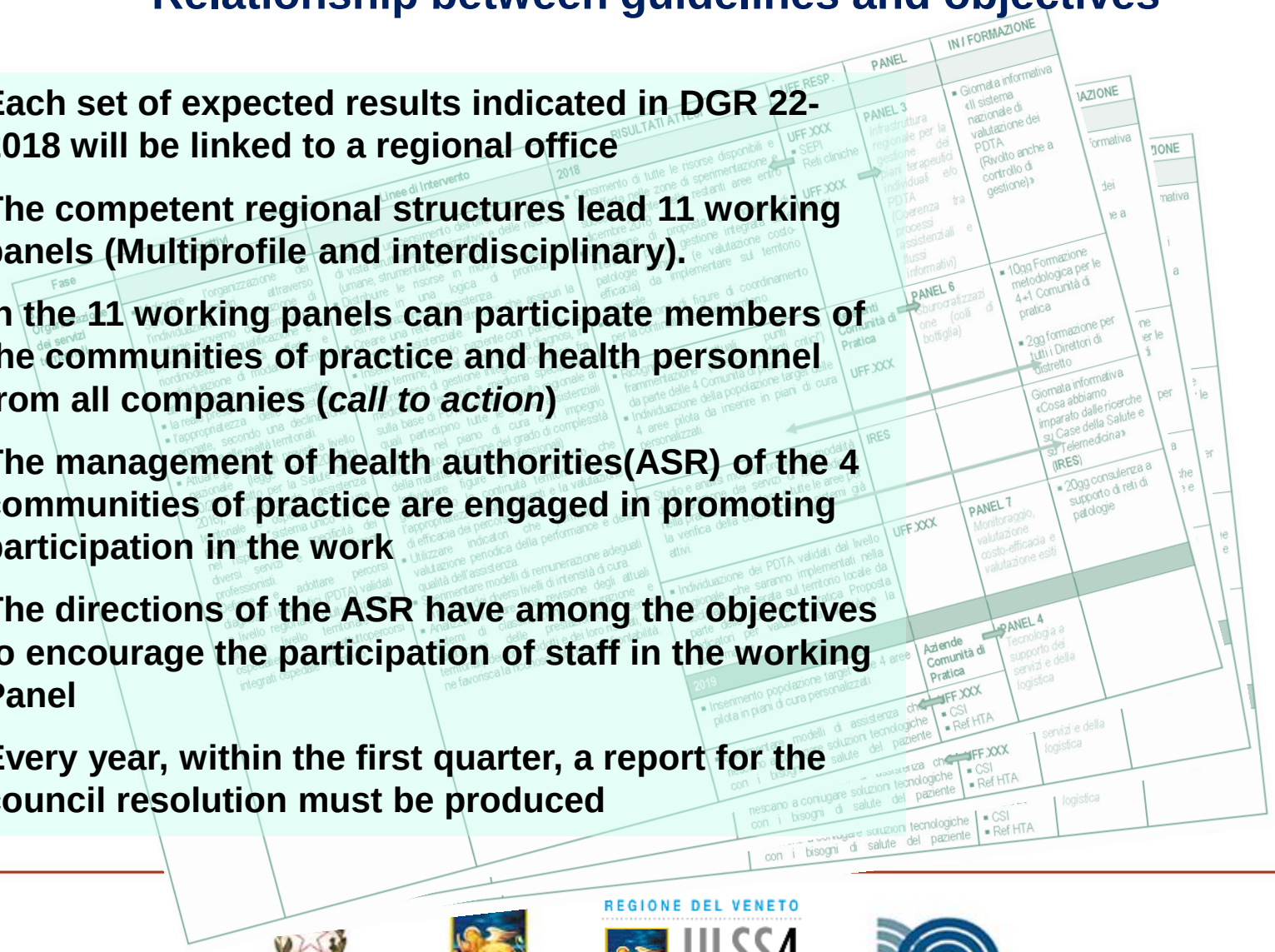
Realization of services and telemedicine services center integrating the operative devices in the territory.

Evolution of the systems for the prevention and the territorial assistance: vaccinations, residency and domiciliary, mental health, drug addiction, child neuropsychiatry, veterinary, and prevention, strengthening of the communication between hospital and territory.

DGR PRC – which governance tools?

Relationship between guidelines and objectives

- **Each set of expected results indicated in DGR 22-2018 will be linked to a regional office**
- **The competent regional structures lead 11 working panels (Multiprofile and interdisciplinary).**
- **In the 11 working panels can participate members of the communities of practice and health personnel from all companies (*call to action*)**
- **The management of health authorities(ASR) of the 4 communities of practice are engaged in promoting participation in the work**
- **The directions of the ASR have among the objectives to encourage the participation of staff in the working Panel**
- **Every year, within the first quarter, a report for the council resolution must be produced**



THANKS FOR YOUR ATTENTION

Renato Botti