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
Piano Nazionale della Cronicità
Il macroprocesso di gestione della persona con malattia cronica

1. Stratificazione e targeting della popolazione
2. Promozione della salute, prevenzione e diagnosi precoce
3. Presa in carico e gestione del paziente attraverso il piano di cura
4. Erogazione di interventi personalizzati per la gestione del paziente attraverso il piano di cura
5. Valutazione della qualità delle cure erogate
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.”

Rainbow Model of Integrated Care
• 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

- Intensive case/care Management
- Disease/care management
- Self management
- Targeted primary prevention

- Very High
- High risk
- Medium risk
- Lower risk

Population Wide Prevention, Health Improvement & Health Promotion

Acute sector

SPARRA
- Classic
- All Ages
Regional Integrated models: examples
strategico degli appalti innovativi in sanità: PCP e PPI quali opportunità di finanziamento

LOMBARDIA REGION
Integrated Services: Lombardia case

CReG - Chronic Disease Management Service, Lombardy, Italy

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 Telebios 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 telmedicine services
- 200 hours training on telmedicine and telemonitoring

Diagram: 300 GPs (Case managers) connected to Community (40,000 patients), Co-ordinating with GPs, Scheduling appointments, Co-ordinating with GPs, Monitoring compliance with care plan, Educating and coaching patients, Telemonitoring, Care via Nurse Call, Tech Enabled Services.
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

<table>
<thead>
<tr>
<th>Level of complexity</th>
<th>N. of subjects</th>
<th>Health and Social Needs</th>
<th>Organizational needs</th>
<th>Care giver</th>
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<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>150,000</td>
<td>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.</td>
<td>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.</td>
<td>Public or Private accredited Providers (including GP’s enterprises)</td>
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<td><strong>Level 2</strong></td>
<td>1,300,000</td>
<td>Subjects with multiple chronic conditions requesting mainly community care services and outpatient care. Frequent user of health care, moderate socioeconomic frailty</td>
<td>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</td>
<td>Public or Private accredited Providers; Single General Practitioner (cooperate to the patient management); General Practitioner Associations (full management)</td>
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<td><strong>Level 3</strong></td>
<td>1,900,000</td>
<td>Individuals with chronic diseases at their initial stage, mainly single disease cases. Moderate/low consumption of ambulatory and home care</td>
<td>Strong adherence to Clinical and organizational Pathways; Case management and proactive attitude; Strong health promotion activities.</td>
<td>General practitioner (single practice or associated practice).</td>
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<td><strong>Level 4</strong></td>
<td>3,000,000</td>
<td>Individuals with sporadic access to health care services (first access)</td>
<td>Fair access to ambulatory care and diagnostic services; Health promotion; Prevention; Health education</td>
<td>General practitioner (single practice or associated practice).</td>
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<td><strong>Level 5</strong></td>
<td>3,500,000</td>
<td>healthy population</td>
<td>Health promotion; Prevention; Health education</td>
<td>General practitioner (single practice or associated practice).</td>
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</table>
strategico degli appalti innovativi in sanità: PCP e PPI quali opportunità di finanziamento
strategico degli appalti innovativi in sanità: PCP e PPI quali opportunità di finanziamento
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

Decentramento aziendale
Integrazione funzionale tra MMG

Integrazione strutturale e multi-professionale
Internalizzazione UCCP

Accentramento regionale
Modalità tradizionali di remunerazione

Rischio imprenditoriale
Esternalizzazione UCCP
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<thead>
<tr>
<th>Componenti</th>
<th>CdS T1</th>
<th>CdS T2</th>
<th>CdS T3</th>
<th>CdS T4</th>
<th>CdS T5</th>
<th>CdS T6</th>
<th>CdS ER 1</th>
<th>CdS ER 2</th>
<th>CdS ER 3</th>
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<td>Stratificazione del rischio</td>
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<td>Spazi fisici adeguati (Casa della Salute)</td>
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<td>Cartella clinica informatizzata condivisa da tutto il team</td>
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<td>Shared-care con medici specialisti</td>
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<td>Integrazione sociosanitaria</td>
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<td>Ruolo di care management assegnato ed agito</td>
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<td>Pianificazione delle cure</td>
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<td>Supporto all’autocura</td>
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<td>Medicina narrativa</td>
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<td>Approccio “cure simultanee”</td>
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## Documented frameworks and indicator sets for assessing the performance of integrated care

<table>
<thead>
<tr>
<th>Country/organisation</th>
<th>Context</th>
<th>Objective</th>
<th>Domains</th>
<th>Indicator selection: considerations and criteria</th>
<th>Indicators</th>
</tr>
</thead>
</table>
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. |
<table>
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<tr>
<th>Strategico degli appalti innovativi in sanità: PCP e PPI quali opportunità di finanziamento</th>
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<tr>
<td><strong>Table</strong></td>
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<tr>
<td><strong>MDT/ Single case manager</strong></td>
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<tr>
<td>Mortality (short-term)</td>
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<td>Mortality (long-term)</td>
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<td>Self-rated health (short-term)</td>
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<td>Utilisation of primary care (short-term)</td>
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<td>Utilisation of secondary care (short-term)</td>
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<td>Utilisation of secondary care (long-term)</td>
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**Legenda:**
- 🌟: A favore del case management
- 🔴: A favore dell’‘usual care’
- 🔵: A favore del case management
- 🔴: A favore dell’‘usual care’
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)