CONFERENCE
“Integrated services: organizational healthcare models in the framework of chronic diseases”.

TITLE OF PRESENTATION
NATIONAL STRATEGY IN THE FRAMEWORK CHRONIC DISEASE: THE NATIONAL PLAN

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WERE WE ARE

* HEALTH AGREEMENT 2014-2016

* CHRONICITY PLAN 2016

* DECREE ON ASSISTANCE LEVELS
“Health agreement 2014-2016”
The new Health Agreement was born in an economic, political and social context characterized by extreme complexity, addresses the major issues of Italian healthcare, establishes the pivot around which to found the new Italian health care.

It is the tool with which to secure the system for future generations, ensuring the sustainability of the National Health Service.
The Agreement considers health as an economic and social investment, outlining a strengthened and better Italian Health System, whose founding principles can be implemented with greater incisiveness.

The cardinal principles that led to the definition of the Agreement are the same on which our NHS is founded, firstly equity and universality, and the guarantee of the provision of Essential Assistance Levels (EAL) in an appropriate and uniform manner.

To this end, the Agreement provides the Levels revision and updating, in compliance with the planned balances of public finance.
The Agreement promotes a multi-professional and interdisciplinary model of care, through complex organizational models located throughout the territory.

To this end, it provides that the Regions establish the Primary Care Complex Units (UCCP) and the Territorial Functional Aggregations (AFT) that constitute organizational models of the general medicine, integrated with the staff of the Italian Health System, with the task of pursuing the health objectives defined by the Local Health Units, the District and the Municipalities.

Particular attention is given to the integration between Specialist medicine and General Practitioner.
This new organization will guarantee hospitality, collaboration and integration between professionals and health-social operators with shared care pathways in an initiative approach towards chronic patients.

With this in mind, the provisions of the Agreement are included in the preparation, by the Ministry of Health, of the "National Chronicity Plan" to be approved with the Agreement established in the State-Regions Conference.
The National Chronicity Plan was approved on September 15th, 2016 with the Agreement established by the Permanent Conference for relations among State, Regions and the autonomous province of Trento and Bolzano pursuant to the State-Regions Agreement of July 10th, 2014 concerning the "Health Agreement for 2014-2016"
The NCP answers to:

- European and national indications,
- Health Agreement

and reinforces the indications of national health plans:
- Prevention plan,
- Gaining Health Program,
- Diabetic disease plan,
- Specific ministerial documents on certain pathologies
Patient at the center of medical treatment
The care and the accompaniment of patients with a chronic disease implies that health professionals and others do manage the various dimensions related to the complexity of this type of activity.
The specific structure of NCP

NCP takes into account the "Model of Innovative and Chronic conditions (ICCC)" which adds to the CCM a vision focused on health policies.

The Model of Innovative Care and Chronic Conditions (ICCC)

Framework of Positive Policies
- Strengthening of alliances
- Development and assignment of human resources
- Policy integration
- Support from the legislative framework
- Guarantee of suitable financing
- Leadership and support

Community
- Awareness and taking away stigma.
- Promoting better results through leadership and support.
- Mobilization and coordination of resources.
- Provision of complementary services.

Health Organization
- Fostering continuity and coordination.
- Promoting quality through leadership and incentives.
- Organization and funding of the health care teams.
- Use of information systems.
- Support for self-care and prevention.

Better results for chronic conditions

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Key messages

A new culture of the system, services, professionals and patients
to involve and make responsible all the components, from the person to the health macrosystem

A different integrated hospital/territory model
the hospital conceived as a hub of high specialization of the healthcare system for person with chronic diseases, which interacts with the Outpatient Specialist and with Primary Care

Home care
keep the sick person as close as possible to his home and prevent or otherwise reduce the risk of institutionalization

A person-centered treatment system
The patient “Person” (and no longer “clinical case”), in turn expert as a carrier of knowledge linked to his history of “co-existence” with chronicity

A personalized multi-dimensional evaluation and outcome
evaluation oriented on patient-person, achievable outcomes and social-health system

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Ho un dubbio su quale vada meglio
Renoldi, Mila; 05.03.2018
General structure of the Plan
The macro-processes of management of the person with chronic disease

The Plan, in the declination of the specific objectives and the lines of intervention, used a methodology that, by drawing the path of the chronic patient divided into phases, describes the peculiar aspects and macroactivity, proposing one or more objectives with related lines of intervention and expected results.
SKILLS DISSEMINATION (TRAINING)

THERAPY COMPLIANCE

SOCIAL INEQUALITY (FRAILTY)

THE ROLE OF PHARMACIES

THE ROLE OF ASSOCIATIONS

TRANSVERSAL ASPECTS

HUMANISATION OF CARE

APPROPRIATE USE OF THERAPIES AND TECHNOLOGIES

DIGITAL HEALTH

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In the SECOND PART the Plan identifies a first list of chronic diseases.

These pathologies have been identified through criteria such as epidemiological relevance, severity, disability, care and financial weight, difficulty in diagnosis and access to treatment.

For most of these diseases, there are currently no national programmatic acts
✓ COPD and respiratory failure;
✓ Chronic renal diseases and renal failure;
✓ rheumatoid arthritis (and chronic arthritis in childhood);
✓ ulcerative rectocolitis and Crohn disease;
✓ Chronic heart failure;
✓ Parkinson’s Disease (and Parkinsonisms)
The proposals originate from the examination of existing data and models, but above all from the "perceived knowledge" of the experts and from the "lived knowledge" of the patients and their representatives.

Through a work model with the privileged witnesses of the professional world, the regions, and that of Patients and active Volunteers, shared with regional representatives, the most vivid issues, the critical points and the potential solutions were highlighted.
MALATTIA DI PARKINSON E PARKINSONISMI

MACRO ATTIVITA’
- Diagnosi precoce e impostazione terapeutica comprese le terapie complesse (infusive e chirurgiche)
- Interventi collegati alla disabilità
- Mantenimento del buon stato di funzionamento e stadiazione dei bisogni per l’autonomia e il massimo livello di partecipazione sociale

OBIETTIVI GENERALI
- Migliorare la conoscenza della dimensione multidisciplinare e della complessità della gestione della patologia e ridurre la disomogeneità degli Interventi attuati sul territorio nazionale
- Ridare piena autonomia e stabilità clinica al paziente

OBIETTIVI SPECIFICI
- Migliorare la formazione dei professionisti per una gestione multidisciplinare del paziente
- Promuovere un monitoraggio adeguato delle terapie farmacologiche con una personalizzazione della terapia farmacologica per le differenti esigenze dei singoli con particolare attenzione per le condizioni di fragilità e/o esclusione sociale.
- Favorire la realizzazione di strutture con disponibilità di terapie complesse infusive (apomorfina e duodopa) e chirurgiche (stimolazione cerebrale profonda).
- Promuovere l’adozione di PDTA nazionali condivisi, codificati per ogni fase di malattia, sulla base dei bisogni assistenziali
- Promuovere un trattamento riabilitativo appropriato e personalizzato (Progetto Riabilitativo Individuale).

LINEE DI INTERVENTO PROPOSTE
1. Promuovere la formazione degli operatori delle cure primarie (MMG, infermieri) per indirizzare il sospetto diagnostico.
2. Migliorare la formazione dei professionisti sanitari per la gestione multidisciplinare del paziente.
3. Promuovere interventi per omogeneizzare le indicazioni terapeutiche spesso non aderenti alle linee guida.
4. Applicazione dei percorsi riabilitativi.
5. Avviare indagini conoscitivo sui dati epidemiologici regionali e sulla consistenza delle proprie strutture dedicate.
7. Definire criteri obiettivi (numero di pazienti trattati, disponibilità di risorse per diagnosi e cura, aderenza a linee guida, ecc.) per l’individuazione di strutture ospedaliere e strutture ambulatoriali territoriali dedicate e verificare la rispondenza delle strutture.
8. Promuovere la revisione dei criteri di “appropriatezza” del processo terapeutico/riabilitativo (ricoveri traienti farmacologici, trattamenti riabilitativi) con particolare attenzione ai momenti di cambiamento sintomatologico e all’aggravamento della disabilità.
9. Favorire l’adozione di strumenti di gestione condivisi e accessibili ai differenti livelli dagli operatori della Rete.
10. Favorire la realizzazione di strutture con disponibilità di terapie complesse infusive (apomorfina e duodopa) e chirurgiche (stimolazione cerebrale profonda).

RISULTATI ATTESI
- Diagnosi precoce entro i tempi stabiliti dalle linee guida
- Omogeneità dei percorsi diagnostici, di follow-up e riabilitativi

INDICATORI
- % di pazienti con diagnosi entro i tempi previsti dalle linee guida
- % di pazienti inseriti in un PDTA che assicuri l’aderenza alle linee guida e le risposte ai bisogni complessi dei pazienti
Parkinson’s Disease and Parkinsonisms

**Macro-activities**
- early diagnosis and therapeutic setting including complex (infusive and surgical) therapies
- interventions related to disability
- Maintenance of good functioning and staging of needs for autonomy and maximum level of social participation

**GENERAL OBJECTIVES**
- To improve knowledge of multidisciplinary dimension and complexity of the pathology management and to reduce the lack of homogeneity of the interventions implemented on national territory
- To restore full autonomy and clinical stability of the patient

**SPECIFIC OBJECTIVES**
- To improve the training of professionals for multidisciplinary patient management
- To promote an appropriate monitoring of drug therapies with a personalization of the same for the different individual needs, with particular attention to the conditions of frailty and/or social exclusion
- To promote the creation of structures with the availability of complex infusive (apomorphine and duodopa) and surgical (deep brain stimulation) therapies
- To promote the adoption of shared national health pathways, codified for each stage of the disease, on the basis of care needs
- To promote an appropriate and personalized rehabilitation treatment (Individual Rehabilitation Project)

**PROPOSED INTERVENTION LINES**
1. To promote the training of primary care workers (GPs, nurses) to address the diagnostic suspicion
2. To improve the training of health professionals for multidisciplinary patient management
3. To promote interventions to homogenize therapeutic indications often not adherent to the guidelines
4. Application of rehabilitation paths
5. To launch cognitive surveys on regional epidemiological data and on the consistency of dedicated structures
6. To improve the knowledge of the number of subjects with Parkinson and parkinsonism
7. To define criteria and objectives (number of patients treated, availability of resources for diagnosis and treatment, adherence to guidelines, etc.) for the identification of dedicated hospital and territorial ambulatory facilities and to verify the compliance of the facilities
8. To promote the revision of the “appropriateness” criteria of the therapeutic/rehabilitative process (admissions and pharmacological treatments, rehabilitation treatments) with particular attention to moments of symptomatic change and aggravation of disability
9. To promote the adoption of shared management tools that are accessible at different levels by Network health operators.
10. To favor the realization of structures with the availability of complex infusive (apomorphine and duodopa) and surgical (deep brain stimulation) therapies

**EXPECTED RESULTS**
- Early diagnosis within the time established by the guidelines
- Uniformity/homogeneity of diagnostic, follow-up and rehabilitative pathways

**INDICATORS**
- % of patients diagnosed within the time prescribed by the guidelines
- % of patients included in a health pathway that ensures adherence to the guidelines and responses to complex patient needs
General objectives

1. To improve knowledge of multidisciplinary dimension and complexity of the pathology management and to reduce the lack of homogeneity of the interventions implemented on the national territory.

2. To restore full autonomy and clinical stability of the patient.
Specific objectives

1. To improve the training of professionals for multidisciplinary patient management.

2. To promote adequate monitoring of drug therapies with a personalization of therapy

3. To promote the creation of structures with the availability of complex infusive (apomorphine and duodopa) and surgical (deep brain stimulation) therapies.

4. To promote the adoption of shared national health pathways, codified for each stage of disease,

5. To promote an appropriate and personalized rehabilitation treatment (Individual Rehabilitation Project).
Proposed intervention lines

1. To promote the training of primary care workers (GPs, nurses) to address the diagnostic suspicion.

2. To improve the training of health professionals for multidisciplinary patient management.

3. To promote interventions to homogenize therapeutic indications that often do not adhere to the guidelines.


5. To start cognitive surveys on regional epidemiological data and on consistency of dedicated structures.
6. To promote the revision of the "appropriateness" criteria of the therapeutic/rehabilitative process (admissions to pharmacological treatments, rehabilitation treatments) with particular attention to moments of symptomatic change and aggravation of disability.

7. To promote the adoption of shared management tools that are accessible at different levels by Network health operators.

6. To promote the creation of structures with the availability of complex infusive (apomorphine and duodopa) and surgical (deep brain stimulation) therapies.
Expected results

1. Early diagnosis within the time established by the guidelines.

2. Uniformity/Homogeneity of diagnostic, follow-up and rehabilitative pathways.

Proposed indicators (monitoring)

1. % of patients diagnosed within the time limits set by the guidelines.

2. % of patients in a health pathway that ensures adherence to the guidelines and responses to complex patient needs.
National chronicity plan
For a concrete implementation ...

Much will be played on the capacity of governance ("Cabina di Regia"- Directorate) and collaboration between central government and regions in the phases that characterize the concrete realization of the Plan.

• Coordinate and direct the implementation
• Monitor the realization of the results
• Spread good practices
• Evaluate innovative models (including remuneration systems)
• Propose, when necessary, the update of the Plan.

A SYSTEM CHALLENGE
Need for rules and tools that accompany the transformation of the NHS from a model of vertical sylos to integrated and transversal paths (integrated care)

- evaluation systems (New Guarantee System see next slide)
- information systems (see next slide)
- remuneration systems for the performance of providers
- compensation of professionals
- elasticity / flexibility of the places where the treatment is provided
- accreditation and authorization systems
- telemedicine rules (accreditation, remuneration, definition of services)
WE KNOW THE TERRITORY? Integration of information contents for the management of chronic patients on the territory

Getting more value out of data that currently exists by overcoming barriers to linkage across databases.

NSIS flows specific for territorial assistance:

- Outpatient specialist - art. 50 L. 326/2003
- Home care (SIAD flow), Ministry Decree 17.12.2008 fully operational since 2012
- Residential and day care (FAR flow), Ministry Decree 17.12.2008 fully operational since 2012
- National Information Addiction System (SIND), Ministry Decree 11.6.2010 fully operational since 2012
- Information system for mental health (SISM), Ministry Decree 15.6.2010 fully operational since 2012
- Information system for monitoring Hospice assistance, Ministry Decree 6.6.2012 fully operational since 2013

New flows under activation pursuant to the 2014-2016 Health Pact/Agreement

- Information system on the performance of territorial rehabilitation structures
- Information system monitoring the services provided in the Primary Care Residential Units - Community Hospitals
- Information system for monitoring the services provided as part of primary care

Electronic health record Ministry President Decree (DPCM) 29.09.2015, n. 178. 'Regulation on the electronic health record'. Data interconnection decree: The decree scheme on the procedures for data interconnection has had the positive opinion of the State-Regions Conference
Updating essential assistance levels

The new outline of the Prime Minister's decree replaces the DPCM of November 29th 2001 on "Definition of Essential Assistance Levels".

The provision was prepared in implementation of the 2016 Stability Law (article 1, paragraphs 553 and 554, Law December 28, 2015, No. 208), which has allocated 800 million euros annually to update the EAL.

The new decree scheme is the result of a shared work among state, regions and scientific societies

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THANKS FOR YOUR ATTENTION