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

Renato Botti
General Director Piedmont region
Fundamentals

- 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, ...)

It defines at national level a "strategic design" for the management of chronicity, which the single Regions must implement on their 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.
The NPCd foresees **5 macrophases**

<table>
<thead>
<tr>
<th>Macrophase 0</th>
<th>Fix health objectives</th>
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<tbody>
<tr>
<td>Macrophase 1</td>
<td>stratification and targeting of the population</td>
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<td>Macrophase 2</td>
<td>health promotion, prevention and early diagnosis</td>
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<td></td>
<td><strong>Primary care</strong></td>
</tr>
<tr>
<td>Macrophase 3</td>
<td>taking charge and patient management</td>
</tr>
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<td></td>
<td><strong>Management of continuity of care</strong></td>
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<td><strong>Specialistic care</strong></td>
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<td>Macrophase 4</td>
<td>provision of personalized interventions for patient management</td>
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<td><strong>Patient empowerment</strong></td>
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<td><strong>Adherence to the personalized care plan and self-care</strong></td>
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<tr>
<td>Macrophase 5</td>
<td>evaluation of the quality of the care provided</td>
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<td></td>
<td><strong>Evaluation of the quality of care for programming purposes</strong></td>
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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."
PIEDMONT REGION

- **25.873 km²**
- **4,392,526 inhabitants (2017)**
- **1197 Municipalities**
- **1,112 (92.2%) Municipalities < 7,232 residents = 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

☐ 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

Tools and methodologies to assess integrated care in Europe
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 Analysis 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 and Stakeholders
They are periodically informed of the route, results and products, to evaluate the transferability.
Suggest points of attention to the RWG

<table>
<thead>
<tr>
<th>4 Pilot Areas with newly formed community of practice in each of them</th>
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<tbody>
<tr>
<td>1) They activate multiprofile and multi-level communities of practice</td>
</tr>
<tr>
<td>2) Each community of practice is encharged to prepare an integrated care implementation project</td>
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</tbody>
</table>

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

Describing **AS IS**
(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 teamwork
- 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

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

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

### Avoidable Mortality
2001-03 vs. 2009-2011

<table>
<thead>
<tr>
<th>of which with other n. pathologies</th>
<th>2</th>
<th>70.079</th>
<th>1.66%</th>
</tr>
</thead>
<tbody>
<tr>
<td>by Intensity of care</td>
<td>3</td>
<td>16.704</td>
<td>0.36%</td>
</tr>
<tr>
<td>by disease’s burden</td>
<td>4</td>
<td>3.141</td>
<td>0.07%</td>
</tr>
<tr>
<td>etc.</td>
<td>5</td>
<td>407</td>
<td>0.01%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>33</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

### Chronic patients
- Number: 501,539
- 10.95% on Piedmont Inhabitants’ total
- Example on 7 pathologies
- Ischemic heart disease
- Cerebral vasculopathy
- Heart failure
- Malignant tumor
- Chronic renal failure (in dialysis)
- COPD
- Diabetes

### Other patients
- Healthy exposed to risk factor
- Action: active prevention (GP, CN...)
- Predictive algorithm of probability of being exposed to risk factors
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

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