II Conferenza Nazionale sull'ASSISTENZA PRIMARIA 2017

UNIVERSITÀ CATTOLICA del Sacro Cuore

Prospettive di sviluppo dell'Assistenza Primaria

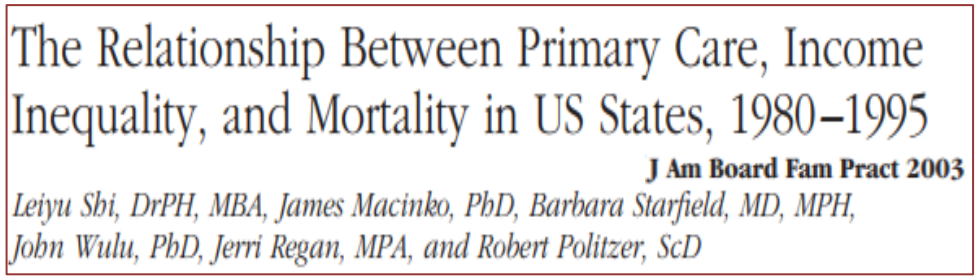
Gianfranco Damiani

Dal 2000 al 2014 **l'età di insorgenza** delle **malattie croniche è diminuita mediamente di 3 anni** (da 56.5 a 53.5 anni)

Il numero di **anni non in buona salute è aumentato** per due cause: **aumento dell'aspettativa di vita** e **anticipo dell'insorgenza di malattie**.

Fonte: Meridiano Sanità, Le coordinate della Salute Rapporto 2016. The European House – Ambrosetti su dati Eurostat, 2016

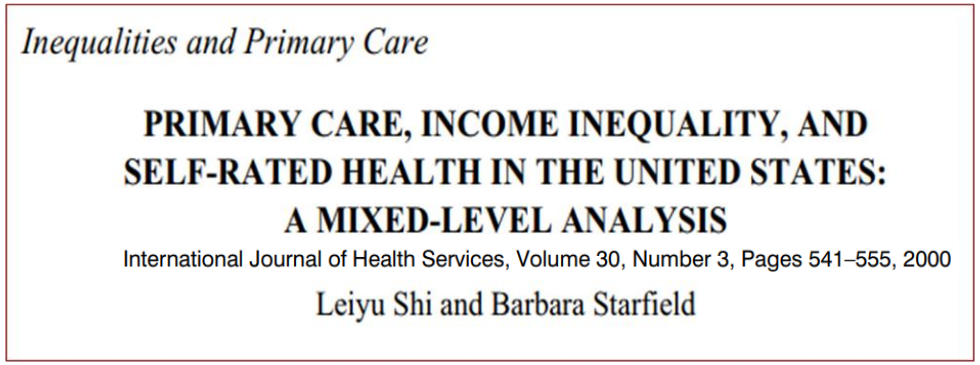
The "Double Expansion of Morbidity" Hypothesis: Evidence from Italy. CEIS Tor Vergata. Research Paper Series Vol. 15, Issue 1, No. 396 pag 15-16– February 2017


The Relationship Between Primary Care, Income Inequality, and Mortality in US States, 1980–1995

J Am Board Fam Pract 2003

Leiyu Shi, DrPH, MBA, James Macinko, PhD, Barbara Starfield, MD, MPH, John Wulu, PhD, Jerri Regan, MPA, and Robert Politzer, ScD

Primary care was found to be associated with better health outcome therefore improving the ratio of primary care to population could improve health outcomes

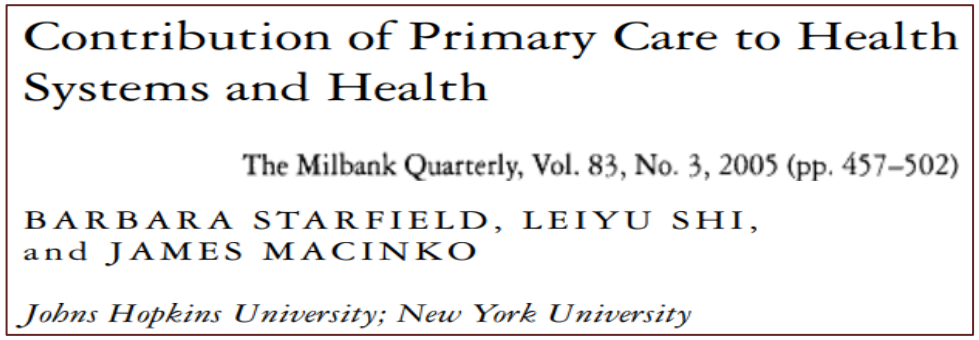

Inequalities and Primary Care

PRIMARY CARE, INCOME INEQUALITY, AND SELF-RATED HEALTH IN THE UNITED STATES: A MIXED-LEVEL ANALYSIS

International Journal of Health Services, Volume 30, Number 3, Pages 541–555, 2000

Leiyu Shi and Barbara Starfield

…the supply of primary care physicians significantly reduced the effects of income inequality on self-reported health status

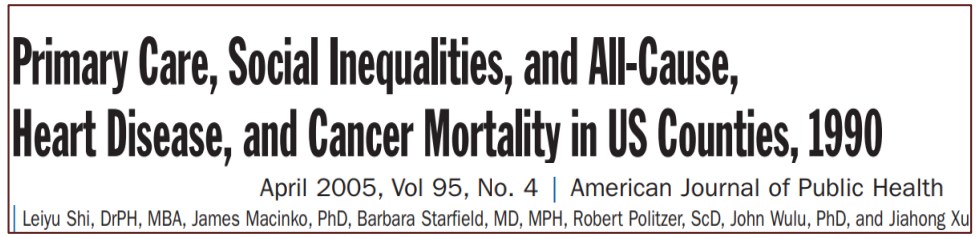

Contribution of Primary Care to Health Systems and Health

The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)

BARBARA STARFIELD, LEIYU SHI, and JAMES MACINKO

Johns Hopkins University; New York University

Primary care reduces disparities in health across major population subgroups (including racial and ethnic minorities) as well as socially deprived adults and children


Primary Care, Social Inequalities, and All-Cause, Heart Disease, and Cancer Mortality in US Counties, 1990

April 2005, Vol 95, No. 4 | American Journal of Public Health

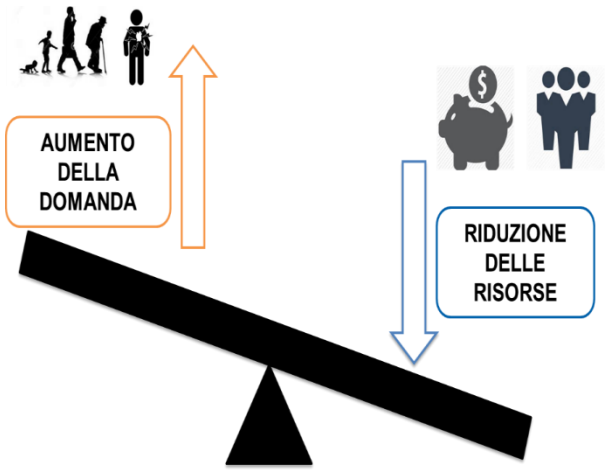
Leiyu Shi, DrPH, MBA, James Macinko, PhD, Barbara Starfield, MD, MPH, Robert Politzer, ScD, John Wulu, PhD, and Jiahong Xu

Counties with high income inequality experienced between 11% and 13% higher mortality than counties with less inequality

Nano Level

Concerne le decisioni che riguardano il rapporto diretto tra paziente/caregiver e professionisti e organizzazione sanitaria

Patient engagement: una possibile risposta



Il **paziente** è una risorsa **poco valorizzata ma essenziale** per migliorare **l'efficacia e la sostenibilità dei processi di cura.**

Evidence of success:

Engaged patient

Evidence	Authors
Patients who are more active and engaged in their care more frequently reports better clinical outcomes	Hibbard & Greene, 2013
Higher satisfaction with their care relationships	Becker & Roblin, 2008 Alegría et al., 2009
Higher quality of life	Barello & Graffigna, 2014a
Healthier behaviours	Hibbard et al., 2007
More effective self-management skills	Skolasky et al., 2008
Treatment adherence	Green & Hibbard, 2012
Reduction of healthcare costs and to better economically sustainable organizational processes	Coulter & Ellins, 2007 Berwick et al., 2008 Hibbard et al., 2013

Engaged caregiver

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	*Evidence rating*	*References*
Family caregivers should be offered a caregiver assessment to identify high levels of burden.	C	1, 2, 6
Encouraging caregivers to take a break, take care of their own health, maintain a healthy diet, exercise, seek preventive health care, join a support group, and seek respite care when needed are key ways to provide direct caregiver support.	C	2
Caregivers identified as having unmet educational and informational needs should be directed to appropriate resources.	C	1, 7
Psychoeducational, skills-training, and therapeutic counseling interventions have small to moderate success in decreasing burden and increasing quality of life for caregivers of patients with chronic conditions such as dementia, cancer, stroke, and heart failure.	B	25-28, 32-34, 37, 38, 51-53

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

Collins, Lauren G., and Kristine Swartz. (2011)

CCIPE
2017 – Conferenza di Consenso Italiana sul *Patient Engagement*

The 8 basic priority for self-management

1. Know how and when to seek medical advice

2. Learn about the disease and setting goals

3. Take medication properly

4. Perform examinations and recommended controls

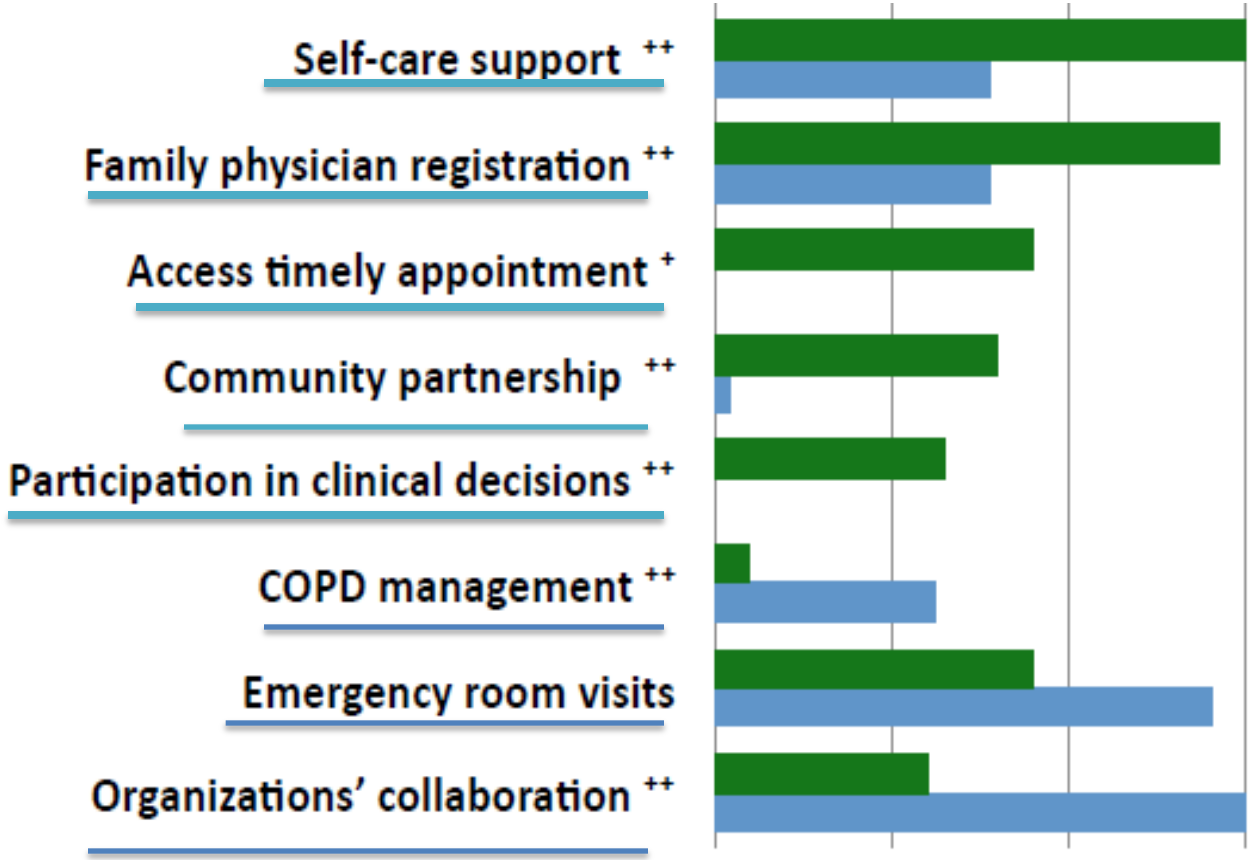
5. Know how to keep the jumping control disease

6.Changing lifestyles in order to reduce the risks

7. Changing lifestyles in order to reduce the risks

8. Carry out specialist visits and follow-up

AN ALTERNATIVE VISION FOR PRIMARY HEALTHCARE AGREEING ON COMMON IMPROVEMENT PRIORITIES WITH PATIENTS AND PROFESSIONALS



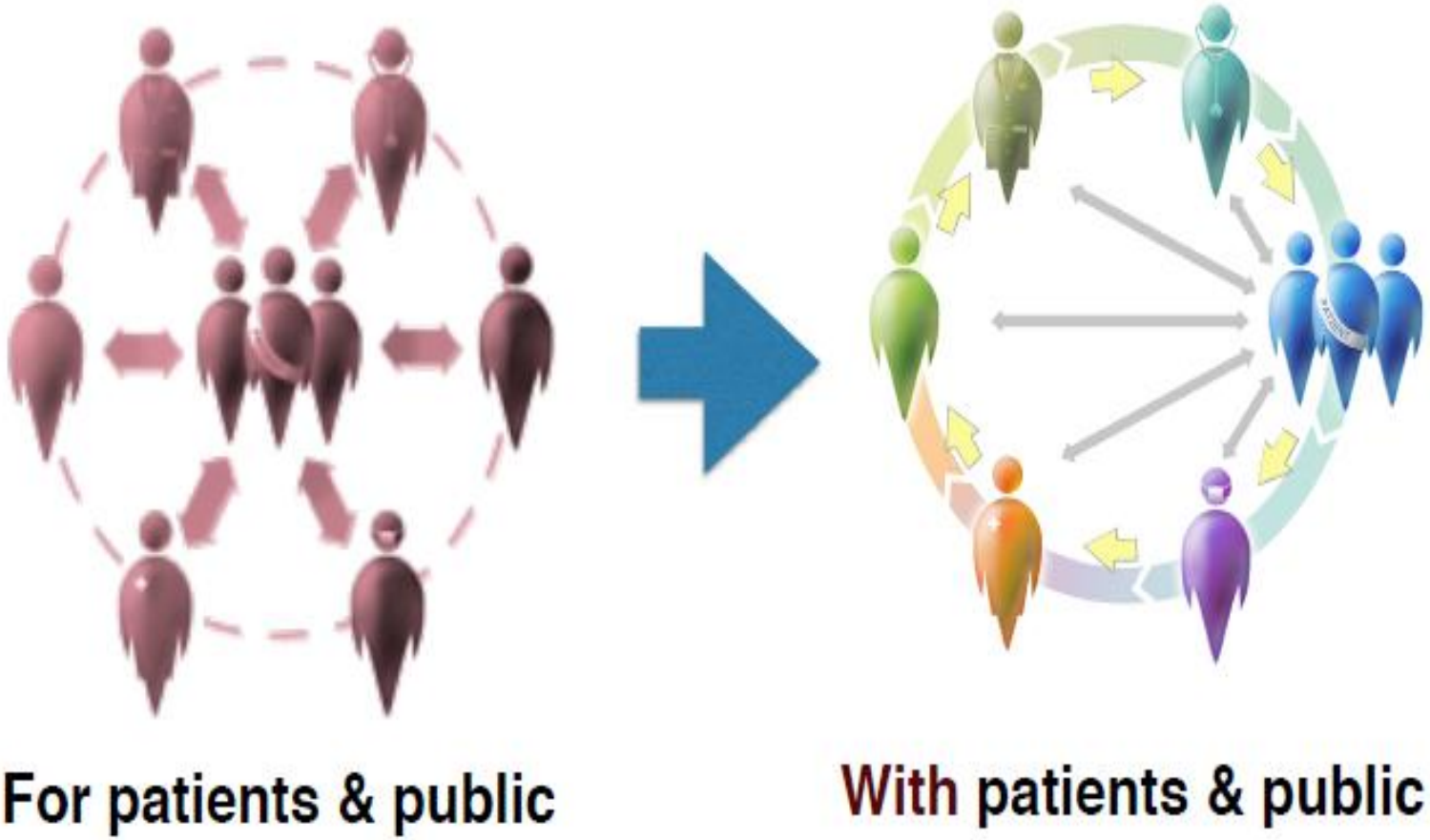
Intervention (Patients and professionals)
Control (professionals only)

++ p<0,01

Boivin, 2014

WHAT IS THE ROLE OF PATIENTS AND THE PUBLIC?

Improving primary healthcare...



Collins, Lauren G., and Kristine Swartz. "Caregiver care." *American family physician* 83.11 (2011): 1309.

Micro Level

Concerne le decisioni che riguardano i professionisti e gli operatori socio-sanitari

Interprofessional Education

WHO defines IPE as "students from two or more professions learn[ing] about, from, and with each other to enable effective collaboration and improve health outcomes"

Interprofessional Collaborative Practice

The World Health Organization (2010) defines interprofessional collaborative practice CP as "multiple health workers from different professional backgrounds working together with patients, families, caregivers and communities to deliver the highest quality of care"

Organization (2010). Framework for action on interprofessional education and collaborative practice. Geneva, Switzerland: World Health Organization.

There is now sufficient evidence to conclude that effective interprofessional education (IPE) enables effective CP (Blackwell et al. 2011; Frenk et al. 2010; Reeves et al. 2009; Yan et al. 2007).

Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes (Review)

Zwarenstein M, Goldman J, Reeves S

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2009, Issue 3

http://www.thecochranelibrary.com

WILEY
Publishers Since 1807

EUROPEAN COMMISSION

Definizione di Primary Care (European Commission Expert Panel)

Erogazione di servizi sanitari e comunitari, universalmente accessibili, integrati, esaustivi ed orientati alla persona, forniti da un team di professionisti responsabili nel dare risposte a gran parte dei bisogni di salute delle persone.

Questi servizi sono erogati attraverso una **partnership con pazienti e caregiver informali**, nel contesto familiare e comunitario, e giocano un ruolo centrale nel generale coordinamento e continuità dell'assistenza alle persone.

De Maeseneer, Jan. "European Expert Panel on effective ways of investing in Health: opinion on primary care." *Primary*

Skill mix definizione

The term ‘‘skill mix’’ is usually used to describe the mix of posts, grades or occupations in an organization (strictly speaking, this is more accurately referred to as ‘‘grade mix’’).

It may also refer to the combinations of activities or skills needed for each job within the organization

Skill mix caratteristiche

Table 1. **Skill mix: determinants, requirements and possible interventions**[a]

Determinant	Requirement	Possible interventions
Skill shortages	Response to shortages of staff in particular occupations or professions	Undertake skill substitution; improve use of available skills
Cost containment	Improved management of organizational costs, specifically labour costs	Reduce unit labour costs or improve productivity by altering staff mix or level
Quality improvement	Improved quality of care	Improve use and deployment of staff skills to achieve best mix
Technological innovation; new medical interventions	Cost-effective use of new medical technology and interventions	Re-train staff in new skills; introduce different mix or new types of worker
New health sector programmes or initiatives (e.g. Roll Back Malaria)	Maximum health benefits of programme implementation, by having appropriately skilled workers in place	Determine the cost-effective mix of staff required; enhance skills of current staff; introduce new types of worker
Health sector reform	Cost containment, improvements in quality of care and performance, and responsiveness of health sector organizations	Adjust staff roles; introduce new roles and new types of worker
Changes in the legislative/regulatory environment (note: this is also a possible intervention)	Scope for changes in (or constraints on) role for different occupations, professions	Adjust staff roles; introduce new skills and new types of worker

[a] For further discussion of these issues see Buchan et al. (*3*).

Buchan, James, and Mario R. Dal Poz. (2002): 575-580.

UNSW THE UNIVERSITY OF NEW SOUTH WALES
AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE
ANU THE AUSTRALIAN NATIONAL UNIVERSITY

OPTIMISING SKILL MIX IN THE PRIMARY HEALTH CARE WORKFORCE FOR THE CARE OF OLDER AUSTRALIANS: A SYSTEMATIC REVIEW

THE UNIVERSITY OF NEW SOUTH WALES
THE UNIVERSITY OF WESTERN SYDNEY
UNIVERSITY DEPARTMENT OF RURAL HEALTH
THE UNVERSITY OF NEWCASTLE
THE UNIVERSITY OF MANCHESTER

Zwar N
Dennis S
Griffiths R
Perkins D
May J
Hasan I
Sibbald B
Caplan G
Harris M

KEY FINDINGS

- Task substitution between doctors and nurses in primary health care improves health professionals' adherence to guidelines and patients' physiological measures of disease. Roles nurses can adopt include case-management using guidelines, proactive patient follow-up, general patient consultation and support, care planning and goal setting and patient self-management education
- Task substitution between doctors and pharmacists improves health professionals' adherence to guidelines, patients' adherence to treatment, physiological measures of disease, patients' health status and patient satisfaction. Pharmacists could do medication reviews and management as per published therapeutic algorithms, medication compliance check and medication counselling, proactive patient management, patient monitoring and goal settings, proactive patient screening and referral, and patient self-management education
- Nursing role enhancement improves patients' adherence to treatment, quality of life and functional status. The enhanced nursing roles that produce positive patient health outcomes include general patient consultations, patient home visits and support, care planning and goal settings, and patient self-management education
- Skill mix interventions for the care of older people in the community may not reduce health service use so may not be effective in reducing cost

Meso Level

Concerne le decisioni che riguardano i modelli di organizzazione dell’erogazione dell'assistenza

The Chronic Care Model (CCM)

It is an organizational approach to caring for people with chronic disease in a primary care setting.

The system is population-based and creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive practice team.

Davy et al. BMC Health Services Research (2015) 15:194
DOI 10.1186/s12913-015-0854-8

BMC
Health Services Research

RESEARCH ARTICLE Open Access

Effectiveness of chronic care models: opportunities for improving healthcare practice and health outcomes: a systematic review

Carol Davy[1*], Jonathan Bleasel[2], Hueiming Liu[2], Maria Tchan[2], Sharon Ponniah[2] and Alex Brown[1]

Abstract

Background: The increasing prevalence of chronic disease and even multiple chronic diseases faced by both developed and developing countries is of considerable concern. Many of the interventions to address this within primary healthcare settings are based on a chronic care model first developed by MacColl Institute for Healthcare Innovation at Group Health Cooperative.

Methods: This systematic literature review aimed to identify and synthesise international evidence on the effectiveness of elements that have been included in a chronic care model for improving healthcare practices and health outcomes within primary healthcare settings. The review broadens the work of other similar reviews by focusing on effectiveness of healthcare practice as well as health outcomes associated with implementing a chronic care model. In addition, relevant case series and case studies were also included.

Results: Of the 77 papers which met the inclusion criteria, all but two reported improvements to healthcare practice or health outcomes for people living with chronic disease. While the most commonly used elements of a chronic care model were self-management support and delivery system design, there were considerable variations between studies regarding what combination of elements were included as well as the way in which chronic care model elements were implemented. This meant that it was impossible to clearly identify any optimal combination of chronic care model elements that led to the reported improvements.

Conclusions: While the main argument for excluding papers reporting case studies and case series in systematic literature reviews is that they are not of sufficient quality or generalizability, we found that they provided a more detailed account of how various chronic care models were developed and implemented. In particular, these papers suggested that several factors including supporting reflective healthcare practice, sending clear messages about the importance of chronic disease care and ensuring that leaders support the implementation and sustainability of interventions may have been just as important as a chronic care model's elements in contributing to the improvements in healthcare practice or health outcomes for people living with chronic disease.

Keywords: Chronic care model, Integrated care, Chronic disease, Primary healthcare

Evidence-Based Psychiatric Treatment

Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis

Emily Woltmann, Ph.D.

Andrew Grogan-Kaylor, Ph.D.

Brian Perron, Ph.D.

Hebert Georges, M.D.

Amy M. Kilbourne, Ph.D.

Mark S. Bauer, M.D.

Objective: Collaborative chronic care models (CCMs) improve outcome in chronic medical illnesses and depression treated in primary care settings. The effect of such models across other treatment settings and mental health conditions has not been comprehensively assessed. The authors performed a systematic review and meta-analysis to assess the comparative effectiveness of CCMs for mental health conditions across disorders and treatment settings.

Method: Randomized controlled trials comparing CCMs with other care conditions, published or in press by August 15, 2011, were identified in a literature search and through contact with investigators. CCMs were defined a priori as interventions with at least three of the six components of the Improving Chronic Illness Care initiative (patient self-management support, clinical information systems, delivery system redesign, decision support, organizational support, and community resource linkages). Articles were included if the CCM effect on mental health symptoms or mental quality of life was reported. Data extraction included analyses of these outcomes plus social role function, physical and overall quality of life, and costs. Meta-analyses included comparisons using unadjusted continuous measures.

Results: Seventy-eight articles yielded 161 analyses from 57 trials (depression, N=40; bipolar disorder, N=4; anxiety disorders, N=3; multiple/other disorders, N=10). The meta-analysis indicated significant effects across disorders and care settings for depression as well as for mental and physical quality of life and social role function (Cohen's d values, 0.20–0.33). Total health care costs did not differ between CCMs and comparison models. A systematic review largely confirmed and extended these findings across conditions and outcome domains.

Conclusions: CCMs can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.

(Am J Psychiatry 2012; 169:790–804)

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas Holtz-Eakin, Director

October 13, 2004

Honorable Don Nickles
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

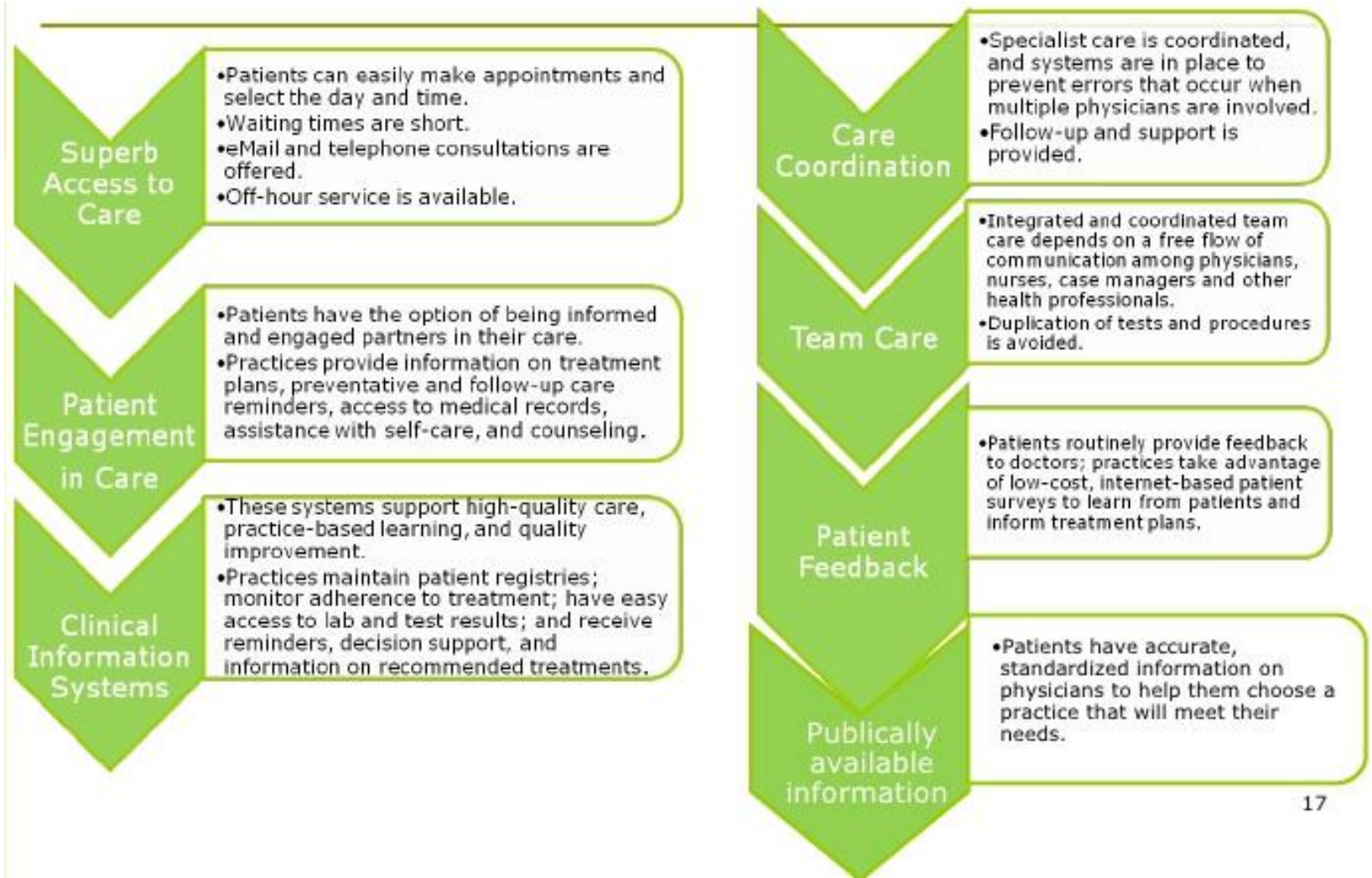
Dear Mr. Chairman:

In response to inquiries by you and your staff about whether disease management programs can reduce the overall cost of health care and how such programs might apply to Medicare, the Congressional Budget Office (CBO) has prepared the attached analysis. It examines peer-reviewed studies of disease management programs for specific conditions—congestive heart failure, coronary artery disease, and diabetes (selected in part because they are highly prevalent among Medicare beneficiaries)—and broader reviews of the relevant literature published in major medical journals.

According to CBO's analysis, there is insufficient evidence to conclude that disease management programs can generally reduce overall health spending. It is important to note that such programs could be worthwhile even if they did not reduce costs, but CBO's analysis focused on the question of whether those programs could pay for themselves. The proposition that decreased use of acute care services might offset the costs of the screening, monitoring, and educational services in disease management programs is clearly appealing, but, unfortunately, much of the literature on those programs does not directly address health care costs. Instead, the focus is often on the processes of care or on intermediate measures of health, from which an overall impact on spending cannot reasonably be inferred. The few studies that report cost savings do so for controlled settings and generally fail to account for all health care costs, including the cost of the intervention itself. Furthermore, if disease management programs were applied to broader populations, the reported savings might not be attainable, and the programs could even raise costs. So while a few studies indicate that disease management programs could be designed to reduce overall health costs for select groups of patients (at least in the short term), little research directly addresses the issues that would arise in applying disease management to the older and sicker Medicare population.

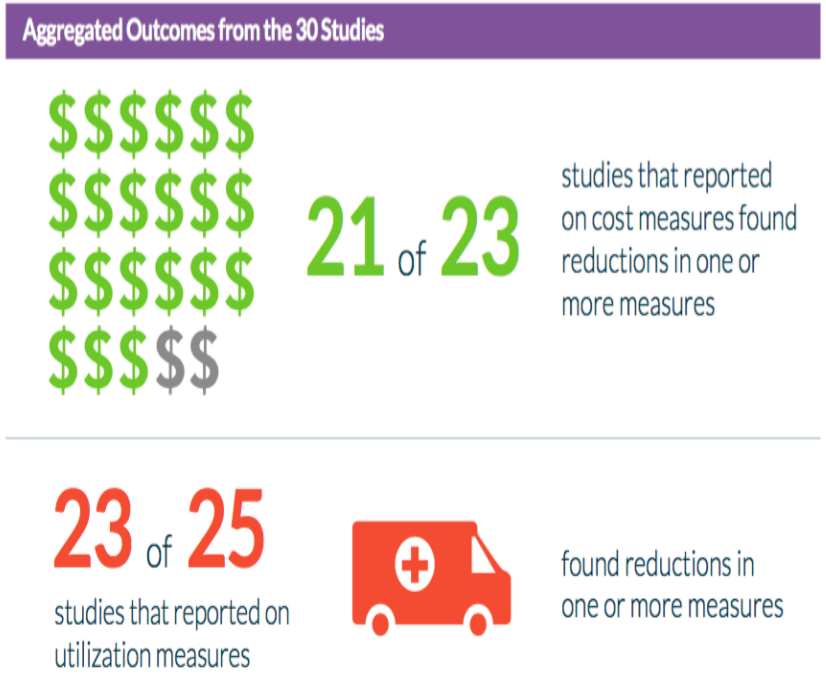
Patient Centered Medical Home (PCMH)

A model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and long-term healing relationship



Impatto Patient-Centered Medical Home

Riassunto delle pubblicazioni 2014-2015



Nielsen, M., Buelt, L., Patel, K, & Nichols, L.(2016). The Patient-Centered Medical Home's Impact on Cost and Quality, Review of Evidence, 2014-15

Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care

Mark W. Friedberg, MD, MPP; Eric C. Schneider, MD, MSc; Meredith B. Rosenthal, PhD; Kevin G. Volpp, MD, PhD; Rachel M. Werner, MD, PhD

JAMA. 2014; 311(8):815-825.

IMPORTANCE Interventions to transform primary care practices into medical homes are increasingly common, but their effectiveness in improving quality and containing costs is unclear.

MAIN OUTCOMES AND MEASURES Practice structural capabilities; performance on 11 quality measures for diabetes, asthma, and preventive care; utilization of hospital, emergency department, and ambulatory care; standardized costs of care.

RESULTS Pilot practices successfully achieved NCQA recognition and adopted new structural capabilities such as registries to identify patients overdue for chronic disease services. Pilot participation was associated with statistically significantly greater performance improvement, relative to comparison practices, on 1 of 11 investigated quality measures: nephropathy screening in diabetes (adjusted performance of 82.7% vs 71.7% by year 3, $P < .001$). Pilot participation was not associated with statistically significant changes in utilization or costs of care. Pilot practices accumulated average bonuses of $92 000 per primary care physician during the 3-year intervention.

CONCLUSIONS AND RELEVANCE A multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA certification, was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years. These findings suggest that medical home interventions may need further refinement.

By Michael E. Porter, Erika A. Pabo, and Thomas H. Lee

DOI: 10.1377/hlthaff.2012.0961
HEALTH AFFAIRS 32,
NO. 3 (2013): 516–525

ANALYSIS & COMMENTARY

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs

Michael E. Porter is the Bishop William Lawrence University Professor at the Harvard Business School, in Cambridge, Massachusetts.

Erika A. Pabo is a resident in internal medicine and primary care at Brigham and Women's Hospital, in Boston, Massachusetts.

Thomas H. Lee (thlee@partners.org) is network president at Partners HealthCare and a professor at the Harvard School of Public Health and Harvard Medical School, in Boston.

ABSTRACT Primary care in the United States currently struggles to attract new physicians and to garner investments in infrastructure required to meet patients' needs. We believe that the absence of a robust overall strategy for the entire spectrum of primary care is a fundamental cause of these struggles. To address the absence of an overall strategy and vision for primary care, we offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be organized around subgroups of patients with similar needs. Second, team-based services should be provided to each patient subgroup over its full care cycle. Third, each patient's outcomes and true costs should be measured by subgroup as a routine part of care. Fourth, payment should be modified to bundle reimbursement for each subgroup and reward value improvement. Finally, primary care patient subgroup teams should be integrated with relevant specialty providers. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system.

…We must deconstruct **primary care**, which is **not a single set of services but a group of services** delivered to meet **the different needs of multiple subgroups of patients**…primary care **teams** should be **organized around serving distinct subgroups** of patients with similar primary care needs…

Am J Manag Care. 2013 Sep;19(9):725-32.

Risk-stratification methods for identifying patients for care coordination.

Haas LR[1], Takahashi PY, Shah ND, Stroebel RJ, Bernard ME, Finnie DM, Naessens JM.

Author information

Abstract

BACKGROUND: Care coordination is a key component of the patient-centered medical home. However, the mechanism for identifying primary care patients who may benefit the most from this model of care is unclear.

OBJECTIVES: To evaluate the performance of several risk-adjustment/stratification instruments in predicting healthcare utilization.

STUDY DESIGN: Retrospective cohort analysis.

METHODS: All adults empaneled in 2009 and 2010 (n = 83,187) in a primary care practice were studied. We evaluated 6 models: Adjusted Clinical Groups (ACGs), Hierarchical Condition Categories (HCCs), Elder Risk Assessment, Chronic Comorbidity Count, Charlson Comorbidity Index, and Minnesota Health Care Home Tiering. A seventh model combining Minnesota Tiering with ERA score was also assessed. Logistic regression models using demographic characteristics and diagnoses from 2009 were used to predict healthcare utilization and costs for 2010 with binary outcomes (emergency department [ED] visits, hospitalizations, 30-day readmissions, and highcost users in the top 10%), using the C statistic and goodness of fit among the top decile.

RESULTS: The ACG model outperformed the others in predicting hospitalizations with a C statistic range of 0.67 (CMS-HCC) to 0.73. In predicting ED visits, the C statistic ranged from 0.58 (CMSHCC) to 0.67 (ACG). When predicting the top 10% highest cost users, the performance of the ACG model was good (area under the curve = 0.81) and superior to the others.

CONCLUSIONS: Although ACG models generally performed better in predicting utilization, use of any of these models will help practices implement care coordination more efficiently.

Kaiser Permanente's risk stratification model

Deciding the right approach

It is important to have the information and knowledge to be able to carry out a risk-stratification on local populations to identify those who are most at-risk.

Level 3

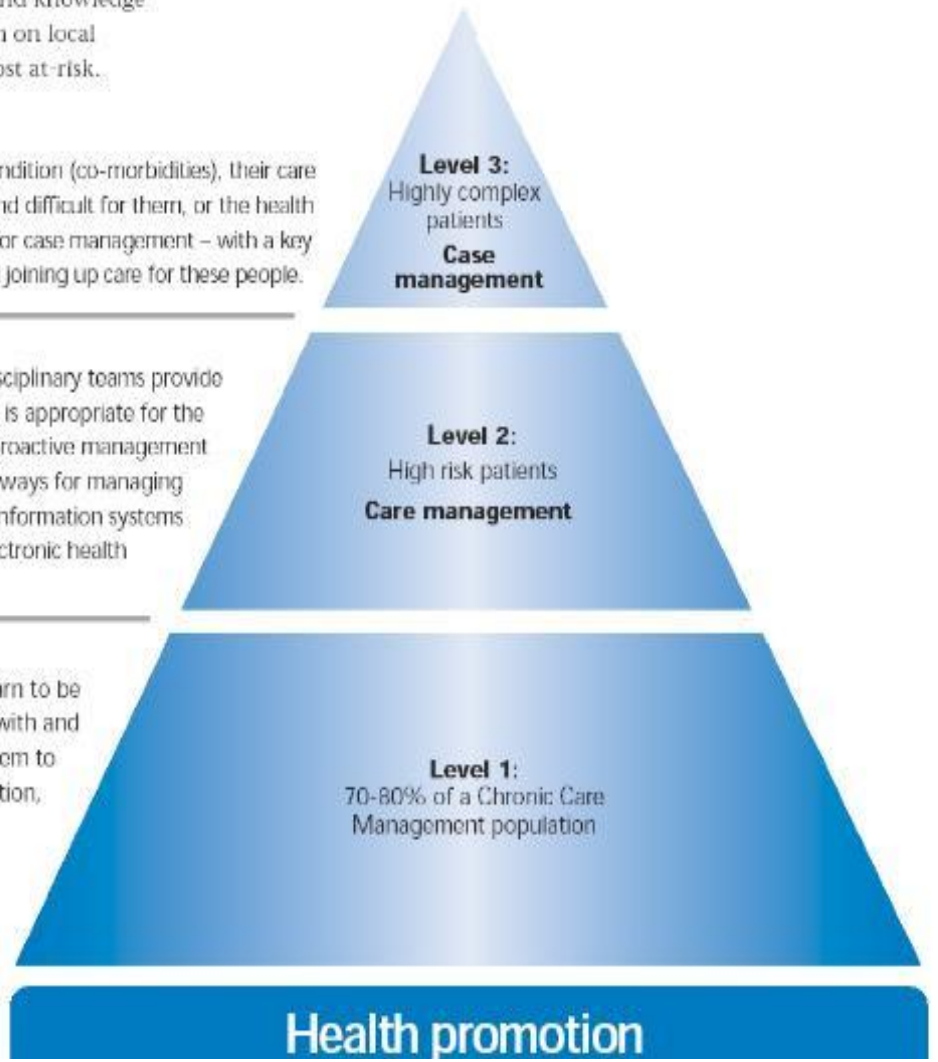
As people develop more than one chronic condition (co-morbidities), their care becomes disproportionately more complex and difficult for them, or the health and social care system, to manage. This calls for case management – with a key worker (often a nurse) actively managing and joining up care for these people.

Level 2

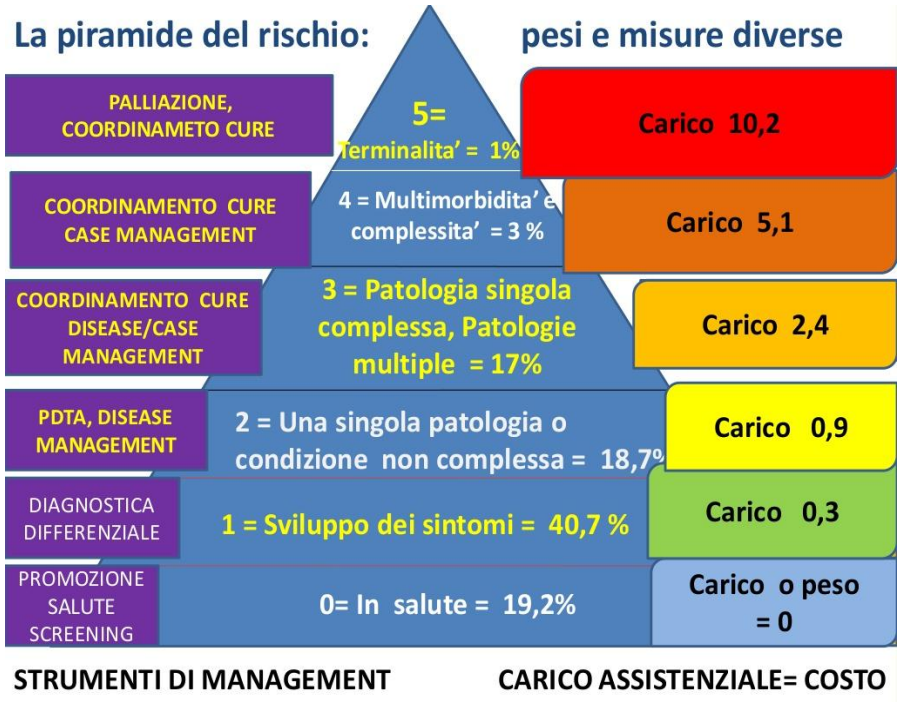
Disease/care management, in which multidisciplinary teams provide high quality evidence based care to patients, is appropriate for the majority of people at this level. This means proactive management of care, following agreed protocols and pathways for managing specific diseases. It is underpinned by good information systems – patient registries, care planning, shared electronic health records.

Level 1

With the right support many people can learn to be active participants in their own care, living with and managing their conditions. This can help them to prevent complications, slow down deterioration, and avoid getting further conditions. The majority of people with chronic conditions fall into this category – so even small improvements can have a huge impact.



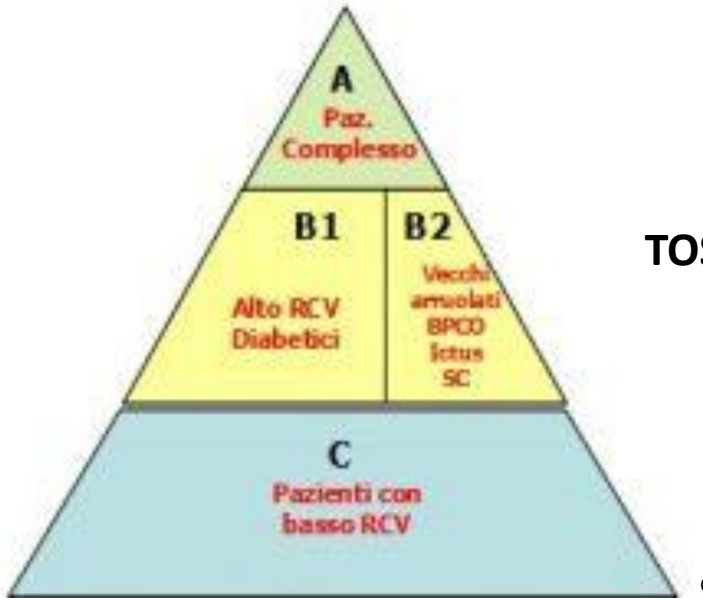
Department of Health. Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration. London: Department of Health; 2005.



VENETO

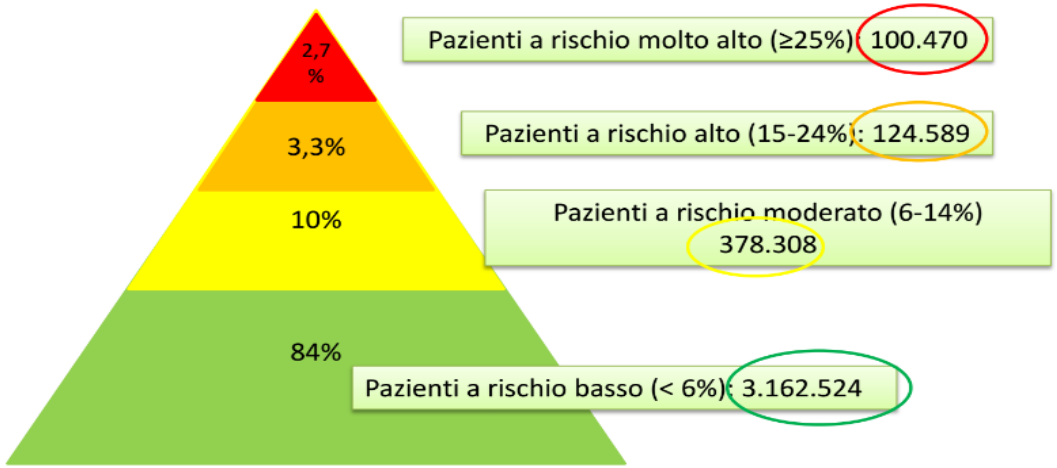
LOMBARDIA

	N° Pazienti/ Utenti	DOMANDA	BISOGNI	PERTINENZA PREVALENTE
Livello 1	**150.000**	Fragilità clinica e/o funzionale con bisogni prevalenti di tipo ospedaliero, residenziale, assistenziale a domicilio	Integrazione dei percorsi ospedale/domicilio/ riabilitazione/ sociosanitario	Struttura di erogazione Strutture sanitarie e socio sanitarie pubbliche e private accreditate
Livello 2	**1.300.000**	Cronicità poli-patologica con prevalenti bisogni extra-ospedalieri, ad alta richiesta di accessi ambulatoriali integrati/ *frequent users* e fragilità sociosanitarie di grado moderato	Coordinamento e promozione del percorso di terapia (prevalentemente farmacologica e di supporto psicologico - educativo) e gestione proattiva del *follow-up* (più visite ed esami all'anno)	Struttura di erogazione e MMG Strutture sanitarie e socio sanitarie pubbliche e private accreditate MMG in associazione
Livello 3	**1.900.000**	Cronicità in fase iniziale, prevalentemente mono-patologica e fragilità sociosanitarie in fase iniziale, a richiesta medio- bassa di accessi ambulatoriali integrati e/o domiciliari / *frequent users*	Garanzia di percorsi ambulatoriali riservati/di favore e controllo e promozione dell'aderenza terapeutica	Territorio (MMG proattivo)
Livello 4	**3.000.000**	Soggetti 'non cronici' che usano i servizi in modo sporadico (prime visite/accessi ambulatoriali veri)	Accessibilità a tutte le Agende ambulatoriali disponibili sul territorio	Territorio (MMG)
Livello 5	**3.500.000**	Soggetti che non usano i servizi, ma sono comunque potenziali utenti sporadici	Sono solo 'potenziali utenti'	Territorio (MMG)

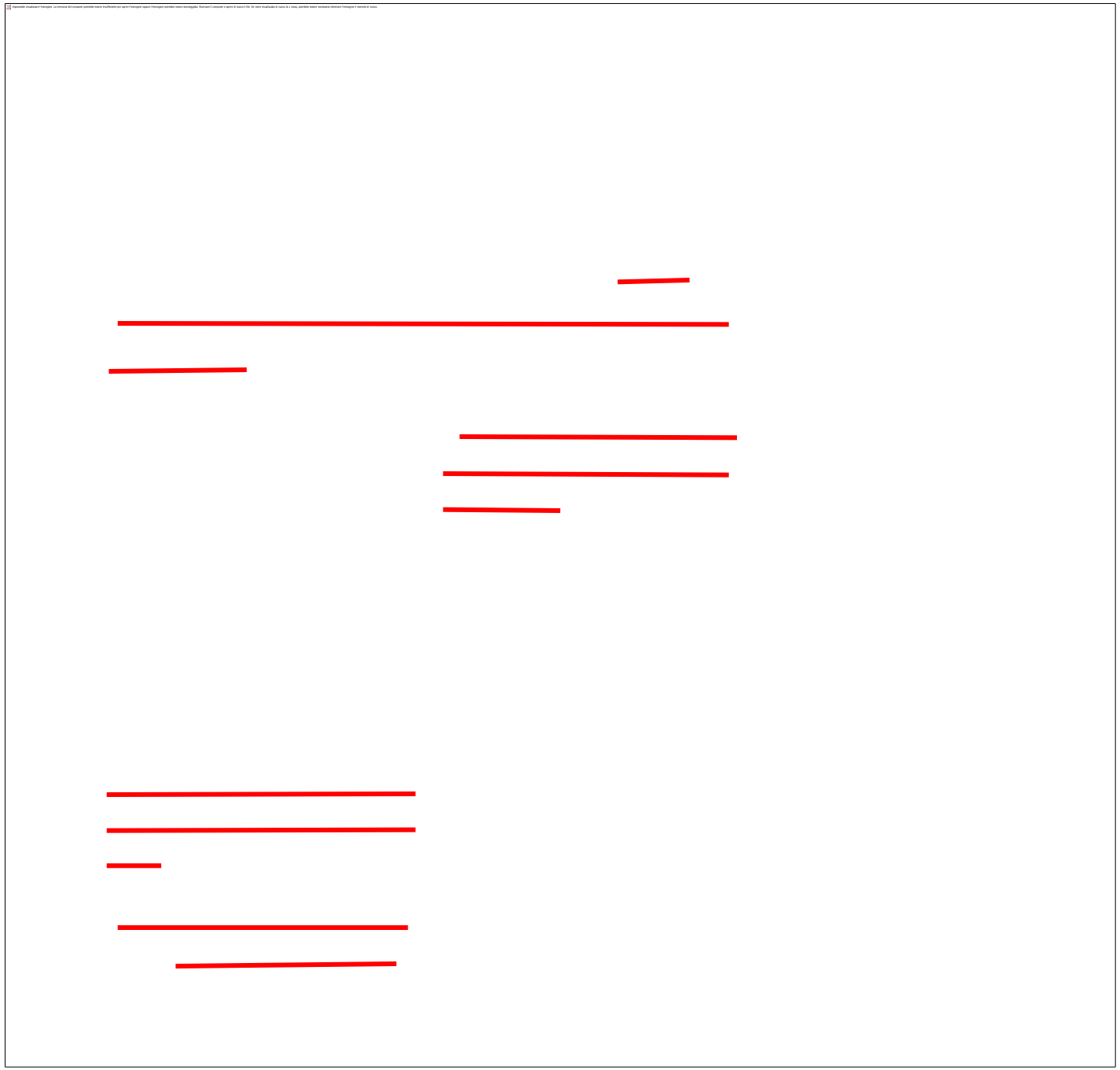


TOSCANA

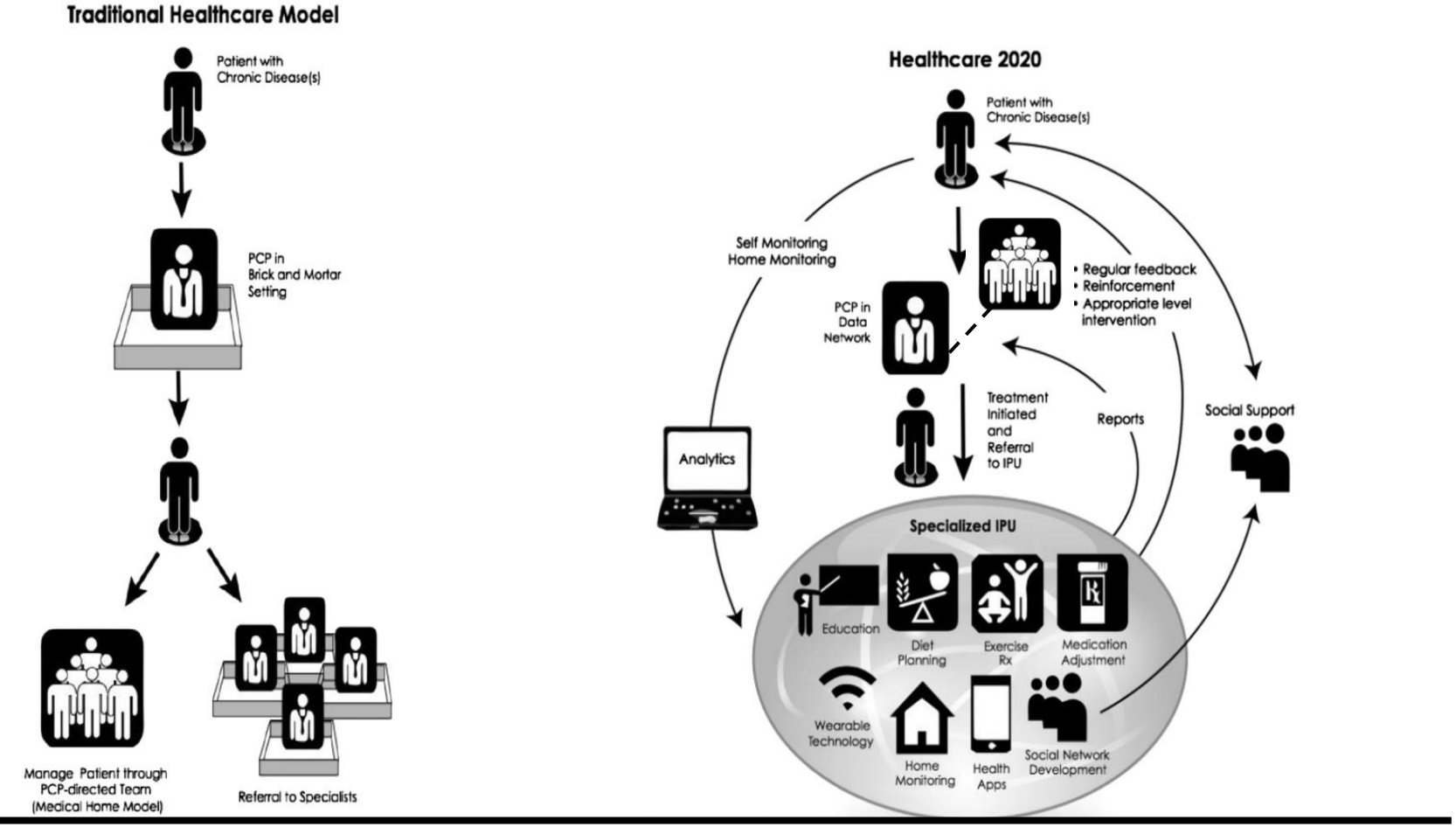
EMILIA ROMAGNA



Cacciapuoti. 2015; Lorenzo Roti 2017, Maria Chiara Corti 2014; Quotidiano Sanità 30.01.201



“gatekeeping di medici del territorio” con “referral” ad un team di assistenza di professionisti, che agisce con il patiente “coinvolto” nelle attività quotidiane, e che ingaggia l’assistito avvalendosi anche di tecnologie centrate sul paziente



Richard V. Milani· Carl J. Lavie. Health Care 2020: Reengineering Health Care Delivery to Combat Chronic Disease

Hoovering: Impatto

Reducing weight in an internal medicine outpatient clinic using a lifestyle medicine approach: A proof of concept☆

Daniela Lucini [a,b,*], Giovanna Cesana [c], Chiara Vigo [a,b], Mara Malacarne [a,b], Massimo Pagani [b]

[a] University of Milan, Department BIOMETRA, Milan, Italy
[b] Exercise Medicine Unit, Humanitas Clinical and Research Center, Rozzano, Milan, Italy
[c] ASL Monza e Brianza, Italy

Improving Hypertension Control and Patient Engagement Using Digital Tools

Richard V. Milani, MD, Carl J. Lavie, MD, Robert M. Bober, MD, Alexander R. Milani, Hector O. Ventura, MD

Department of Cardiovascular Diseases, John Ochsner Heart and Vascular Institute, Ochsner Clinical School – University of Queensland School of Medicine, New Orleans, La.

JAMA. 2013 Jul 3;310(1):46-56. doi: 10.1001/jama.2013.6549.

Effect of home blood pressure telemonitoring and pharmacist management on blood pressure control: a cluster randomized clinical trial.

Margolis KL[1], Asche SE, Bergdall AR, Dehmer SP, Groen SE, Kadrmas HM, Kerby TJ, Klotzle KJ, Maciosek MV, Michels RD, O'Connor PJ, Pritchard RA, Sekenski JL, Sperl-Hillen JM, Trower NK.

Self-Management of Patients with Long-Term Conditions: A Longitudinal Study

David Reeves[1]*, Christian Blickem[1], Ivaylo Vassilev[2], Helen Brooks[3], Anne Kennedy[2], Gerry Richardson[4], Anne Rogers[2]

1 National Institute for Health Research Collaboration for Leadership in Applied Health Research (NIHR CLAHRC) Greater Manchester, Centre for Primary Care, Institute of Population Health, University of Manchester, Manchester, United Kingdom, **2** National Institute for Health Research Collaboration for Leadership in Applied Health Research (NIHR CLAHRC) Wessex, Faculty of Health Sciences, University of Southampton, Southampton, United Kingdom, **3** School of Nursing, Midwifery and Social Work, University of Manchester, Manchester, United Kingdom, **4** Centre for Health Economics and NIHR Research Design Service for Yorkshire and the Humber, University of York, York, United Kingdom

Ann Intern Med. 2012 March 20; 156(6): 416–424. doi:10.1059/0003-4819-156-6-201203200-00004.

Peer Mentoring and Financial Incentives to Improve Glucose Control in African American Veterans: A Randomized, Controlled Trial

Judith A. Long, MD[1], Erica C. Jahnle, BA[2], Diane M. Richardson, PhD[1], George Loewenstein, PhD[3], and Kevin G. Volpp, MD, PhD[1]

[1]Philadelphia VA Center for Health Equity Research and Promotion, Philadelphia, PA

[2]University of Pennsylvania Leonard David Institute of Health Economics, Center for Health Incentives, Philadelphia, PA

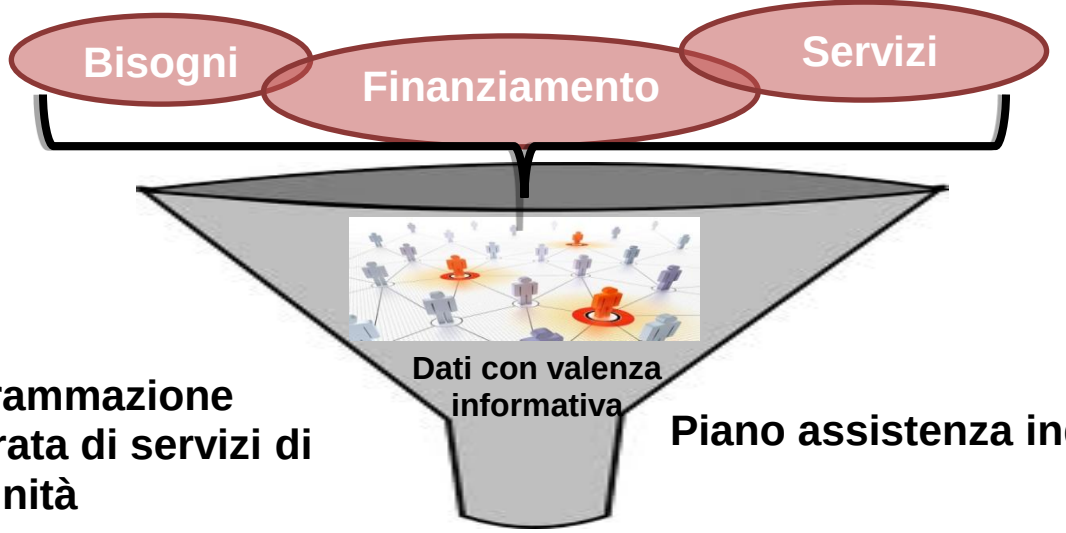
[3]Department of Social and Decision Sciences, Carnegie Mellon University, Pittsburgh, PA

J Manag Care Pharm. 2007 Jan-Feb;13(1):28-36.

Adherence to clinical practice guidelines for 7 chronic conditions in long-term-care patients who received pharmacist disease management services versus traditional drug regimen review.

Horning KK[1], Hoehns JD, Doucette WR.

Concerne le decisioni riguardanti le policy da intraprendere



Programmazione integrata di servizi di comunità

Piano assistenza individuale

Appropriatezza (clinica ed organizzativa),
Esiti clinici, Esperienza dell'assistito

"...*good governance and public policy implication with the maximum achievable effectiveness and efficiency (not to be confused with mere savings), and the same standards of transparency, accountability and responsibility required from health professionals*.."

Ortún Vicente Primary care at the crossroads. Gac Sanit. 2013;27(3):193–195.

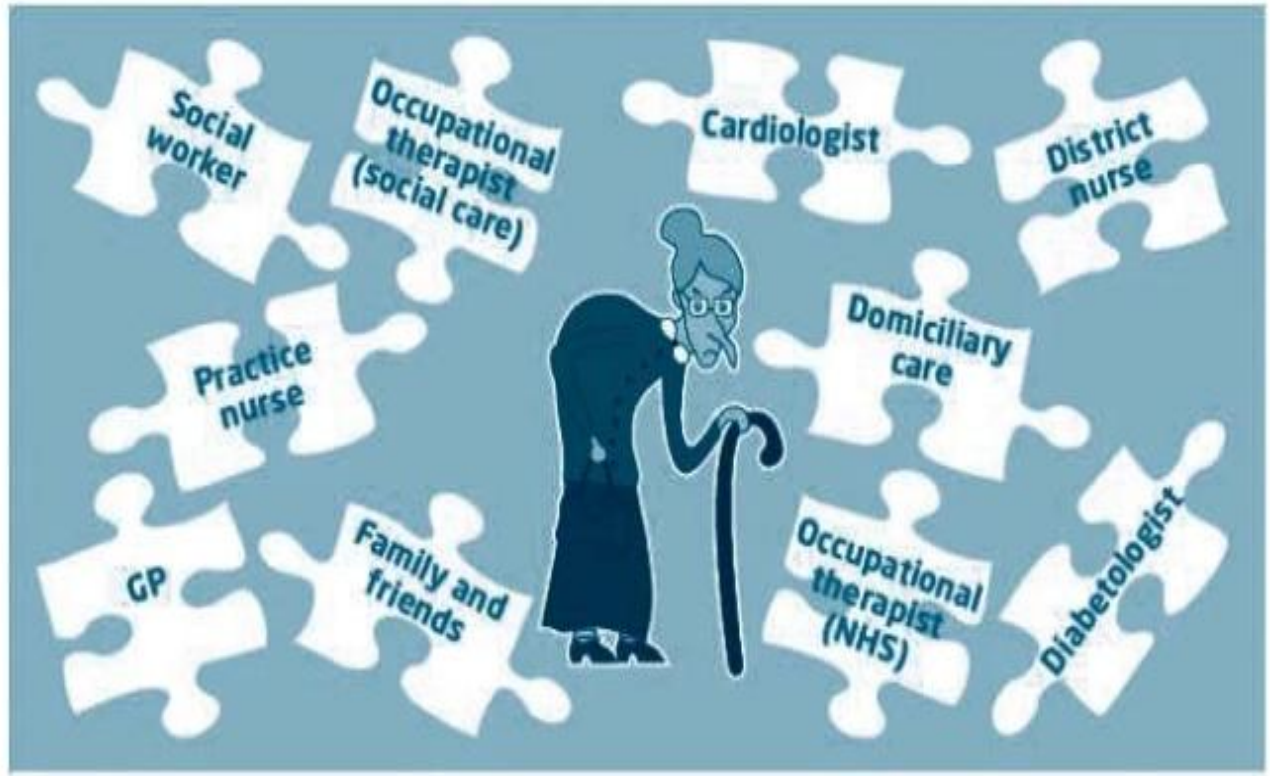
Necessità di **programmazione e monitoraggio** di comunità (programmi di comunità)



Necessità di **programmazione e monitoraggio** a livello individuale (piani di assistenza individuali)

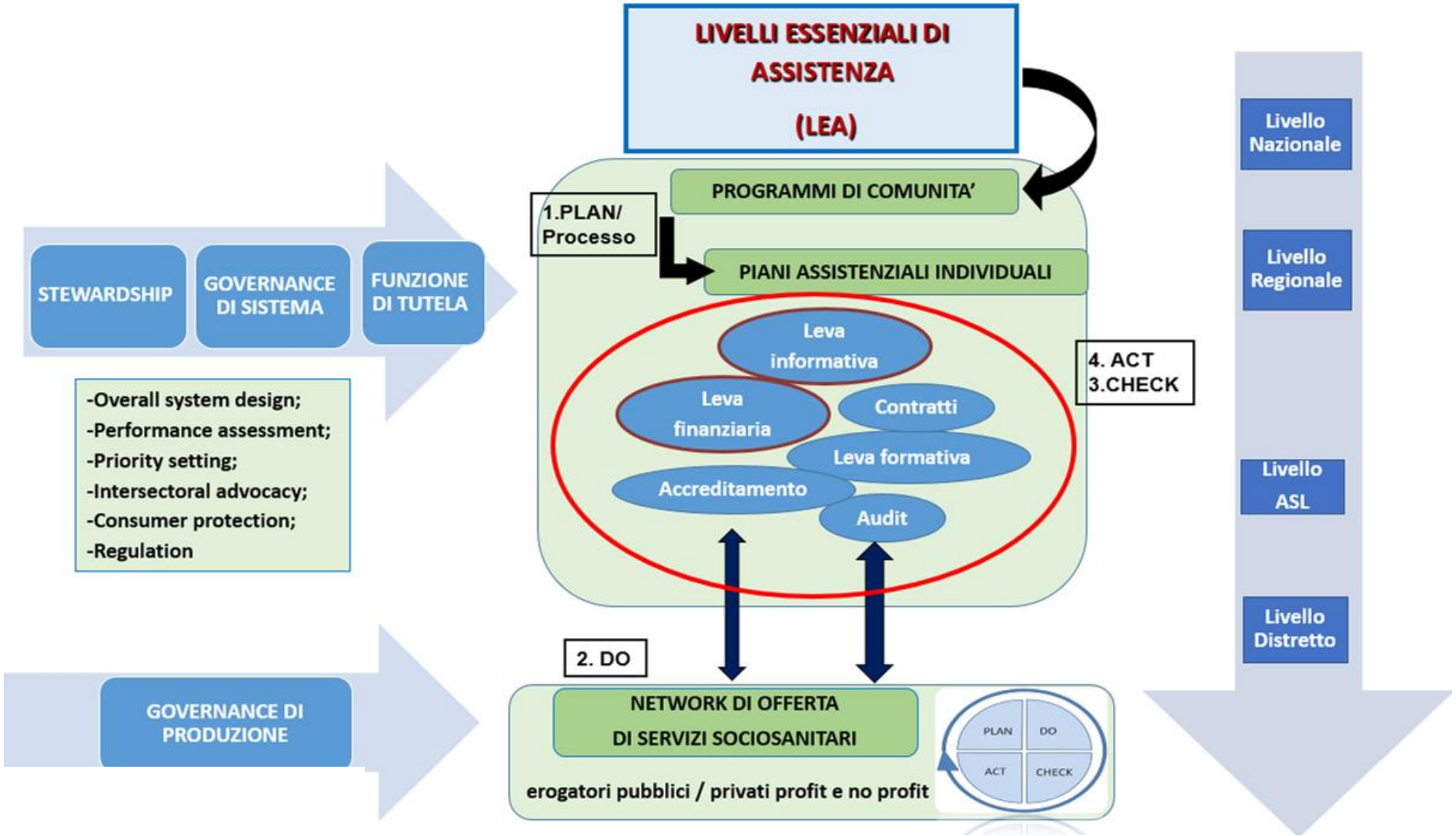


From a fragmented set of health and social care services …



The King's Fund
Ideas that change health care

nuffield trust
evidence for better health care



Governare l'Assistenza Primaria. Manuale per operatori sanitari. Gruppo di Lavoro S.It.I. (2016)
https://www.aprirenetwork.it/2016/11/10/che-cosa-e-la-assistenza-primaria/

“QUADRUPLE AIM” PER LA POPOLAZIONE

Bodenheimer, Thomas, and Christine Sinsky. "From triple to quadruple aim: care of the patient requires care of the provider." *The Annals of Family Medicine* 12.6 (2014): 573-576.

PRIMARY HEALTH CARE: DAGLI “ESPERIMENTI” ALLA ROUTINE

- **Sviluppare policy ed investimenti** per consentire le innovazione suddette (**forte commitment**)
- Fornire risorse adeguate e creare **sistemi di incentivi che incoraggino il coordinamento** tra di diversi fornitori e settori
- **Bilanciare rapporti** tra governo centrale e autonomia locale e **fornendo messaggi coerenti** tra riforme e prassi assistenziale
- **Coinvolgere tutti gli stakeholder**
- **Imparare dall'esperienza: policy informate sulla base evidenza scientifica** (modelli di organizzazione e finanziamento,barriere e elementi di facilitazione nel contesto locale)