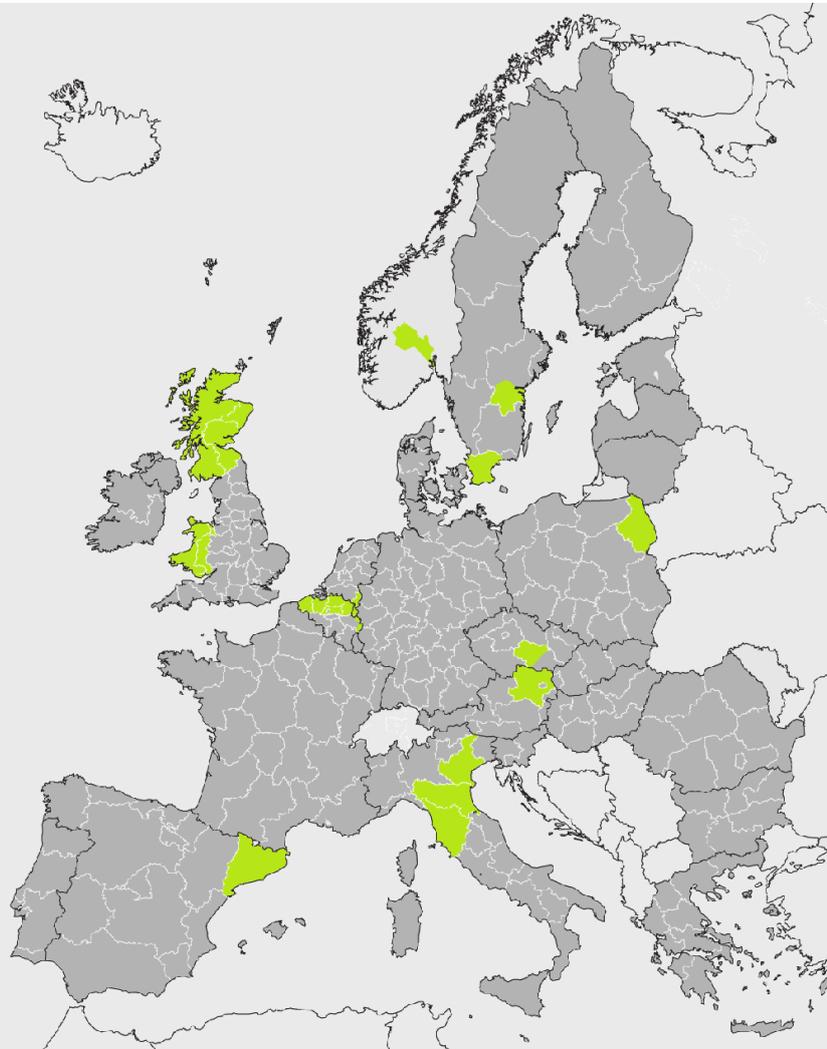


Primary Care

A SHOWCASE OF BEST PRACTICES FROM EUREGHA'S MEMBERS

Presented at the High-level Annual Conference on 6th December 2018



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INTRODUCTION

Primary care has played an outstanding role in health systems transformation, especially in health service delivery since the WHO Alma-Ata Declaration in 1978. This resulted in that many countries adopted primary care and in a majority of countries it represents the entry point and cornerstone of many health systems. In four decades primary care has achieved many successes and generated high expectations. A key element to the primary health care movement has been to improve what Barbara Starfield termed the 'four C's' of primary care: accessible contact; service coordination; comprehensiveness, and continuity of care. In addition to that, primary care has played a key role in promoting the delivery of more integrated care to people living in local communities and responds to a wide range of persons' needs.



Primary care has proven to play a fundamental role in improving not only population health but also population well-being. This has been sustained to the present day. However, Europe is facing high challenges such as the shift in global demographics that has seen age-related and long-term conditions replace communicable disease. The expectations and promises that primary care can become more responsive to changing needs, along with that primary care offers more integrated care delivery and increases the efficiency of the system are starting to be proved. Furthermore, there is evidence that strong primary care can contribute to strengthening the overall health system's performance.

However, international comparative information about primary care at regional level is still needed. This showcase of best practices of EUREGHA members is a relevant example to illustrate different strategies implemented at regional level; nevertheless, the core characteristics of primary care are present at all the examples in this compilation.

Primary care is evolving as it is reflected in the WHO Astana Declaration on Primary Care endorsed in autumn 2018. Some statements in the Declaration are already in place in several EUREGHA member regions, and in this showcase of good practices you will find that many regions envisioned the key points in the Astana Declaration. Finally, and quoting the Astana Declaration, there is need to take deliberate actions to reinforce the three components of primary health care, emphasizing greater equity, quality and efficiency, and one of the most efficient ways to achieve these components is at regional level.

Dr Toni Dedeu

Former Chair and Vice-chair

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the bottom.

BEST PRACTICES

Catalonia Region (ES)

Organisation name: Agency for Healthcare Quality and Evaluation of Catalonia

Region: Catalonia

Country: Spain

Total Region Population: 7.4 million

Operation partners: World Health Organisation European Centre for Primary Health

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA

The main focus area to provide primary health care in Catalonia is the proper development of multiprofile teams. Implemented and operationalized across the autonomous communities at different paces, the reform aimed to increase the responsive capacity of primary care services, ensure equal access and improve the efficiency of the entire health system by expanding the scope of services provided by new multidisciplinary teams.

SUMMARY

Multiprofile teams provide primary health care services in Spain. This model of care was designed in the 1985 Primary Health Care Reform Act which was inspired by the principles of the WHO Declaration of Alma-Ata. Implemented and operationalized across the autonomous communities at different paces, the reform aimed to increase the responsive capacity of primary care services, ensure equal access and improve the efficiency of the entire health system by expanding the scope of services provided by new multidisciplinary teams. Since 1985, new primary care models have emerged capitalizing on the role of nurses and information systems, as well as improving integration with community hospitals and other health services providers.

DESCRIPTION

There are multiple key components of multiprofile primary care teams, all of which are necessary to provide the most efficient system of primary care. The key components include: population orientation, multidisciplinary teams, service package, attention to working conditions, health services contracting, health information systems, and evidence-based practice and quality improvement.

METHODOLOGY AND PROCESSES

Population Orientation: It is important to develop a new geographical distribution based on natural aggregates of people. These catchment areas helped to deploy the primary care reform emphasizing community orientation and holding primary care accountable to designated populations. An average basic health area covers around 20,000 people. Each citizen is automatically assigned to a primary care team with a family doctor and nurse as referent professionals.

Multidisciplinary Teams: Primary care teams consist of family doctors, pediatricians, dentists, primary care nurses, nurse aides, social workers and health administrative staff to serve collaboratively in a basic health area. Teamwork is fostered by sharing care between doctors and nurses and by reserving one hour a day for team activities such as clinicals, training, or coordination sessions. Team members share roles and responsibilities, where nurses have a key role in disease prevention, health promotion and education.

Services Package: The new family medicine specialty and the role of nurses helped to expand the scope of services towards a preventative approach. Comprehensiveness and responsive capacity have significantly increased in the last decades with the adoption of techniques and technologies which once were performed only at hospital level. These services include: anticoagulant treatment, echography, spirometry/skin-prick tests are now offered closer to home in primary care centers.

Working Conditions: Accessibility was a key driver for changing the effectiveness of primary care services delivery. With the reform, family doctors and nurses increased their hours to work full-time (36 hours a week). This adjustment allowed them to service communities from 08:00 to 20:00 in two working shifts. A strategic overlap of one hour a day- from 14:00-15:00- between shifts secures time to schedule team activities that bring team building and group cohesion. In parallel, doctors' compensation shifted from a capita-based salary to a basic salary with complements to acknowledged population characteristics like rurality or socioeconomic level.

Health Services Contracting: CatSalut (Catalan Health Service Commissioner) is responsible for contracting health services and primary care teams based on per capita, which has evolved, adjusting from demographic, socioeconomic and geographic variables to a morbidity and equity index aiming to redistribute resources, reduce health inequities and acknowledge care complexity measured with a health risk stratification tool which amounts to 30% of the total per capita funding.

Health Information Systems: At the time of the reform, nobody was able to foresee the transformative power health information systems would bring. Since 1999, the primary care information system (ECAP) equips primary care teams to ensure the principles of primary care: accessibility, continuity, longitudinally, quality and efficiency. ECAP allows family doctors and nurses to maintain patient records, prescribe diagnostic tests and medicines, follow clinical guidelines and communicate with patients in a secure e-consultation system. A bespoke risk stratification system (GMA) classifies patients according to risk and makes this information available to healthcare providers to facilitate proactive care of chronic patients. A business intelligence system (SISAP) built upon ECAP provides doctors and managers with information to track quality of care indicators and benchmark with peers and other territories. A Catalan e-health infrastructure complements ECAP and SISAP with a e-prescription service; a shared electronic health record to access records from hospitals and other health care providers, and a personal health record which allows patients to have access to their own health data and use services like e-consultation.

Evidence-Based Practice & Quality Improvement: Collaborative work between medical scientific societies and the Department of Health has contributed to develop an evidence -based clinical practice

and quality improvement system. This is based on the adoption of clinical guidelines and quality monitoring tools deployed by clinical decision support systems accessible through ECAP such as clinical recommendation reminders. Additionally, the Agency for Healthcare Quality and Evaluation of Catalonia has developed the essential programme to improve clinical practice and reduce overdiagnosis, overtreatment, as well as addressing de-prescription. Using benchmarking tools allow health managers to monitor quality improvement and incentivize individual and team performance. This practice also promotes transparency based on health outcomes. This structure has allowed primary care teams to identify and improve care of complex chronic patients, deploy preventative campaigns for the most prevalent conditions and risk factors.

FUNDING SOURCE(S) OF THE INITIATIVE

In terms of efficiency, primary health care costs have remained stable accounting for approximately 15% of the total health expenditure while process and outcome indicators have improved due to quality monitoring tools and payment-by-results. In the last ten years, this linkage has also contributed to control prescription costs while the quality of prescription has not declined.

INNOVATION, IMPACT AND OUTCOMES

The development of primary care multiprofile teams has progressively improved the satisfaction, quality and efficiency of primary care services in Catalonia. From 2003 to 2015, global satisfaction and fidelity scores have steadily increased with outstanding marks, respectively 7.94 out of 10 and 88.9%. However, improvements in telephone access, punctuality of visits and waiting time for diagnostic tests are needed. Both patients and doctors positively perceive the continuity and care coordination between primary and secondary care in terms of information transfer, consistency and accessibility to secondary care. Preventative activities foster quality of care when primary care professionals work effectively in teams. This is shown in the significant decline in chronic obstructive pulmonary disease and diabetes mellitus.

KEY LEARNING POINTS

- **Implementing an ambitious, nation-wide primary health care reform can be a long and arduous process** taking Catalonia 22 years to complete the implementation of the reform. This required sustained social and political consensus.
- A solid scientific background developed in the family and community medicine specialty have advanced the scope of primary care.
- **The social reputation of primary care services, family doctors and nurses** have positively evolved thanks to a continuous investment in physical and information infrastructures as well as health campaigns based on primary care.
- **The multidisciplinary nature of primary care teams has led to improved responsiveness and health outcomes.** Family doctors benefitted from the contribution of primary care nurses to increase the accessibility, comprehensiveness, continuity and coordination of services.
- Innovations in information technologies in primary care services are the cornerstone for both clinical practices and health services governance. ECAP and Primary Care Electronic Health Record are the information backbone for Catalonia's primary care system.

- Linking contracts and pay for performance schemes to quality improvement allow health planners and managers to effectively implement health policy goals. Behaviors of organizations, teams and individuals are aligned towards common goals which are easy to measure, monitor and act upon through existing information systems.

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Emilia-Romagna Region (IT)

Organisation name: RER-ASSR

Region: Emilia-Romagna

Country: Italy

Total Region Population: 4.461.612

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA:

A comprehensive approach to primary health care: the Emilia-Romagna model

KEY WORDS:

- Universal and equity-oriented health system
- Health and social care integration
- Patient centered organization and delivery of services
- Proximity and proactive care
- Risk stratification of general population
- Comprehensive management of chronic conditions

SUMMARY

The Emilia-Romagna Region is historically characterized by a strong system of public, territorial and community welfare: an “engine of development”.

Health and social integration, prevention, promotion and equity, participation, quality and proximity of care are the driving forces planned through the 2015-2018 Regional Plan for prevention and the 2017-2019 Regional Social and Health Plan.

The Community Health Centres and the Community Hospitals are the main structures ensuring continuity between primary and hospital care, acting as a filter to avoid inappropriate hospitalization and to facilitate hospital discharge. The activities implemented reflect the integration between health and social services and the participation of patients and voluntary associations.

The Emilia-Romagna Region has developed an innovative population-based model, Risk-ER, using longitudinal administrative databases (health and social care), that estimates the risk of potentially preventable hospitalization and death for the resident adult population and creates 'patient risk profiles', allowing proactive case management within Primary Health and Social Care services network.

The overall outcomes of the new organizational model are reduced hospital and emergency admissions for ambulatory sensitive conditions. The ICT regional system allows the complete sharing of health information within services and for the citizen's use.

DESCRIPTION

Background

Several on-going socio-demographic patterns are challenging European welfare policies, such as i) the ageing of the population, ii) the increasing burden of non-communicable diseases (NCDs) and iii) the impact of the recent economic crisis [1], [2].

In this context, the new European health policy framework – Health 2020 – identifies a primary health care approach as the main key to address these challenges [3].

In line with that, the "Community Health Centre" (CHC) primary care organizational model has emerged in recent years as a potentially successful model to improve equity, efficiency, effectiveness, and responsiveness of health systems.

In 2007 the Italian Ministry of Health identified the implementation of the CHC model as a priority objective to strengthen the Italian primary care system, allocating a €10-million fund to support Regions in the implementation of experimental projects [1],[4].

The Italian National Health Service is statutorily required to guarantee the uniform provision of comprehensive care throughout the country, covering all citizens and legal foreign residents. It is regionally based and organized at the national, regional and local levels. Under the Italian Constitution, the central Government controls the distribution of tax revenue for publicly financed health care and has defined a national statutory health-benefits package – LEA ("livelli essenziali di assistenza" (essential levels of care)) – to be offered to all residents in every region.

The Italian regions are responsible for organizing and delivering health services, through local health units (LHUs), and enjoy a significant degree of independence in determining the macro structure of their health systems. [5],[6], [7].

The Emilia-Romagna Region

The Emilia-Romagna Region is historically characterized by a strong system of public, territorial and community welfare.

The Health Service comprises:

- 8 Local Health Units
- 4 university hospitals

- 4 research hospitals
- 38 health districts

LHUs deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care. They operate through their health districts, at which level local councils and health services determine requirements, plan health and social services, and assess results [5],[6], [7].

METHODOLOGY AND PROCESSES

The Emilia-Romagna Region Primary Care Services

With the 2015-2018 Regional Plan for prevention and the 2017-2019 Regional Social and Health Plan, the Region is renewing its efforts to support the development of territorial and community health-care services, strengthening the role of primary health care facilities as a strategic hub for health and social integration, fostering prevention, promotion and equity, participation, quality and proximity of care.

Since 2010 in the Emilia-Romagna Region, primary care services are provided through Community Health Centres (Case della Salute) and a range of territorial services/facilities.

The number of operating Community Health Centres has increased since 2011 (from 42 to 105) as well as the range and availability of health care and social services provided, the share of health care and non-health care personnel involved, the supply of health education programs, training activities and communication campaigns.

Key features of the services provided by the regional regulation [8],[9] include:

- single point of access for citizens;
- access to care 24 hours a day, 7 days a week;
- coordination of responses for citizens;
- integration among hospitals, social and health services and community care;
- provision of diagnostic pathways;
- management of chronic conditions;
- promotion of citizens and patients' empowerment;
- health prevention and promotion;
- ongoing education and training for healthcare workers.

Other innovative territorial facilities are the Community Hospitals, managed by nurses (under the clinical responsibility of GPs or LHUs physicians), and with the involvement of physiotherapists and care workers. These facilities have a limited number of beds (usually less than 30), and provide mainly rehabilitation services (physical, respiratory and cognitive), patient empowerment, self-management and care giver training. At present, in the Emilia-Romagna Region there are 19 Community Hospitals. Community Health Centres and Community Hospitals are the main facilities ensuring the continuity of care, acting as filter between primary and hospital care, to avoid inappropriate hospitalization and to facilitate hospital discharge [9].

Concerning human resources, in 2018, 45% of total regional general practitioners (GPs, n. = 2919) and 43% of total regional family paediatricians (n. = 603) worked in the catchment area of the Community Health Centres [10].

The more largely available specialist services were Cardiology (in the 70% of Houses of Health), Ophthalmology (53%), Orthopaedics (34%) and Otolaryngology (43%).

Between one and five nurses were exclusively working in 64% of the Community Health Centres. Overall in the Region, 93 midwives and other 1398 non-medical professionals worked exclusively in the Houses of Health [1].

In 2017 social workers were available in over 70% of the Community Health Centres, and 78% of the Houses of Health had active collaborations with voluntaries associations.

Emilia-Romagna Region ICT services

The ICT regional system is based on integrated and interoperable technologies (SOLE network, Personal Health Electronic Record, Telemedicine) allowing the complete sharing of health information within services and for the citizen's use.

Since 2006 the Emilia-Romagna Region designed the "SOLE Network", to permit communication between GPs, paediatricians and specialists of the local health authorities and hospitals, contributing to the ICT regional system with the following features:

- electronic prescriptions of pharmaceuticals and specialist care visits, laboratory and radiology
- examinations by GPs, paediatricians and hospital physicians, and automatic return of the results in the patient's health record;
- management of updated patients' personal and administrative data;
- notification to the GPs/paediatricians of patients' admission and hospital discharge;
- first aid reports, from the hospital to the GPs/paediatricians;
- patients' vaccinations records.

To guarantee the respect of privacy law and of the General data protection regulation, explicit consent of the patient is required.

Citizens' data, provided by the "SOLE Network", are available through the Personal Health Electronic Record, accessible online in a protected and confidential environment.

In the last decade the Emilia-Romagna Region participated to several projects on Telemedicine, focusing on specific conditions and targeting population with limited access to services. From 2016, according to a Regional Decision, a comprehensive programme has been adopted to ensure equity and appropriateness of access to all citizens with chronic conditions living in remote areas, in close cooperation with the Community Health Centres.

The Regional Risk Stratification Model

The Emilia-Romagna Region, in close collaboration with the Regional Health and Social Agency (ASSR) and with the support of the Jefferson University of Philadelphia (US), has developed an innovative population-based model on risk stratification for the resident adult population, using longitudinal administrative databases (health and social care).

Its objectives are (i) to apply a predictive model to identify patients at risk of hospitalization and death; (ii) to create 'patient risk profiles' that provide information about high-risk patients to GPs and nurses in the Community Health Centres; (iii) to assess whether this model provides additional information to identify patients for case or disease management purposes; and (iv) to analyse the quality of care through investigations on professionals and patients experiences (PACIC and ACIC).

The model has been implemented since 2004 through the Community Health Centres. The risk-profiles are distributed to GPs, along with data on demography and morbidity, health care resources, and a number of quality indicators, thus allowing the assessment of services performance.

The Sunfrail Tool

A tool aimed to detect frailty in elderly over 65 by generating alerts on functionality, especially in social-community dwelling settings (Sunfrail Tool), has been identified as part of an EU funded project coordinated by the Emilia Romagna Region between 2015-2018. By focusing on people at low to medium risk, the tool complements the regional risk stratification model for this target population [11].

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The activities implemented in the Community Health Centres reflect the integration between health and social services and the collaboration and support of patients and voluntary associations from the community. According to the Emilia-Romagna Social and Health Plan, activities conducted at primary care level are developed through an intersectoral approach, in collaboration with local authorities, local associations, educational institutions, and other relevant stakeholders.

FUNDING SOURCE(S) OF THE INITIATIVE

The Regional Health Service is mainly founded by general taxation, gathered both at national and regional level. Specific population categories and interventions can also be supported by additional dedicated resources.

The total expenditure of the Emilia-Romagna Regional Health Service in 2015 amounted to 8.847 billion euros.

Concerning the allocation through levels of care, the highest percentage of the total expenditure is absorbed by Primary Health Care (54,9%).

KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

Preliminary results suggest that the Community Health Centres are a successful and innovative model to provide evidence-based care, to foster primary care quality and efficiency and to reduce health care direct and indirect costs. The change management approach is based on multi-professional and proactive care of "at risk" patients, identified through Risk-ER.

Integration is enhanced through the activation of the regional services network, supported by ICT regional system. The involvement of family/carers and formal caregivers in the personalized care plan boosts empowerment and participation. Community Health Centres and Community Hospitals are the main structures ensuring continuity of care between the primary care and hospital levels.

EVIDENCE ON THE IMPACT AND OUTCOMES

The overall outcomes of the new organizational model are reduced hospital and emergency admissions for ambulatory sensitive conditions due to improved pathways for the management of chronic conditions within Primary Health and Social Care services network.

In 2017 a pilot study compared 488 people identified with Risk-ER Model with 488 controls, and analysed the following outcomes: emergency departments visits, hospital admissions, ambulatory care sensitive conditions admissions and mortality. An overall trend of reduction has been observed for all outcomes. For emergency departments visits and hospital admissions, a statistically significant reduction has been proved.

The assessment and analysis of the economic impact of the risk stratification model is ongoing.

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

The overall output indicators are the increase of the appropriateness of health care delivery in community setting; the reduction of unnecessary hospital admissions, and the increase of citizens' satisfaction regarding the quality of care.

Specific process and outcome indicators are under implementation.

Given the positive results obtained on the experimentation of the Sunfrail Tool, the Emilia-Romagna Region decided to conduct an additional study to test its Criterion and Construct validity in two Community Health Centers.

LEGAL AND/OR ETHICAL ISSUES

The system is based on the collection and management of administrative and health related patient's data, that are subject to national and European regulation mechanisms.

During the implementation of the model, these aspects have been taken into account, and the analysis of some sensitive issues is under revision.

As part of the 2015-2018 Regional Plan for prevention, the Emilia-Romagna Region has undertaken a Health Equity Assessment to identify population's vulnerability due to socio-economic conditions potentially affecting health status and access to care. The resulting equity profiles are important tools to inform health planning.

TRANSFERABILITY TO OTHER REGIONS

The organization of the Emilia Romagna Primary Care Service is based on the most recent national and European directives emphasizing the role of Community Health Centres in detecting and managing chronic conditions. Other Italian and European countries have undertaken a similar process.

The essential components of the change management approach are the intersectoral planning, a multidisciplinary and participative approach and the availability of ICT based information systems. Within these key principles, the Emilia-Romagna model can be transferred and adapted to fit within other organizational contexts.

The request of adoption and replication of these elements and tools by other Italian Regions witnesses the success obtained.

At the same time, the requests for adoption of the Sunfrail Tool from professionals (GPs, nurses), local authorities, Italian and European regions, the commitment for further funding and the creation of permanent stake-holders groups confirm the success of this easy to use complementary tool, especially in social and community settings.

KEY LEARNING POINTS

An integrated and intersectoral approach by local health and social authorities is a necessary condition for efficient and effective planning and implementation of primary care services;

Community Health Centres are essential primary care facilities acting as a filter for population health needs, to avoid inappropriate hospitalization through a preventive and proactive approach;

Risk stratification model allows to predict the risk of hospitalization and death, to identify patients at risk and to manage their conditions in primary care settings;

The availability of Regional ICT systems is a precondition for the implementation of the risk stratification model;

The Sunfrail tool complements this by allowing to detect low to medium risk in elderly over 65 especially in social-community dwelling settings.

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Flanders Region (BE)

Organisation name: Flanders Agency for Care and Health

Region: Flanders

Country: Belgium

Total Region Population: 6.400.000

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA:

The implementation of the reform of Primary care in Flanders 2015 - 2019: the creation of multi-disciplinary primary care zones

SUMMARY

Flanders is one of the federated states of Belgium. After the Sixth State Reform of 2014 Flanders started the reform of primary care towards integrated and personalised care.

The starting point is not to reinvent but to focus on the strengths of the primary care offer in its different forms.

The Reform Trajectory of the Primary Care and the Vision on a Reform 2015-2019 in Flanders was endorsed in 2017 by the Flanders Parliament.

The Flanders Agency is since 2015 speeding up the implementation and created a frame for cooperation at the level of the practitioner while avoiding to take the lead in stakeholder discussions. The Agency is the instrument for dialogue and a keeper of the Flanders interests.

DESCRIPTION

The next step of the reform is implementation by concrete actions shaped into 13 research projects and 2 initiatives concerning regulations: 1. Development of the primary care zones (geographical areas); 2. Development of regional care zones; 3. Development of the Flemish Institute of primary care; 4. More capacity in primary care and financial incentives for general practitioner, e.g. administrative assistance, facilitation of establishment of practice location in areas with low levels of

coverage of practitioners; 5. Coordination of care and case management for persons with a complex needs of care and financing of the reformed mechanisms; 6. Digital primary care, e.g. development of a digital care plan; 7. Quality of care and management of complaints; 8. Community care; 9. Care provided by the family (informal care); 10. Basic training and continuous education; 11. Communication on the primary care reform; 12. Patient-centered / person-centered care; 13. Social mapping: inventory of all health professionals and organizations

Each project has its goals linked to timelines, budget, set-up of legislation and includes cooperation with multi-disciplinary working groups. Key is multi-disciplinary patient-centeredness coordination amongst social and health care professionals!

Additionally, 2 initiatives pertaining to reviewing the regulations are ongoing: (1) the revision of the regulations on primary health care, under the direct responsibility of the Flanders Agency for Care and Health, and (2) the revision of other regulations e.g. on home care and elderly care.

Key is multi-disciplinary patient-centeredness coordination amongst social and health care professionals.

METHODOLOGY AND PROCESSES

Here we focus on Project 1: development of the Primary care Zones. With a population in Flanders of 6 million, around 60 primary care zones should cover a catchment population of 75.000 to 125.000 persons.

The care areas are demarcated by local stakeholders under the supervision of the Flanders Agency for Care and Health. They will be spread all over Flanders without blind spots. Local stakeholders are care providers, authorities and care- and wellbeing organisations and associations.

The programme management for the reform trajectory and for the 13 projects is supported by different structures composed by the Minister's Kabinet and Administration on Wellbeing, Health and Family, the local authorities and the field and scientific experts.

The Flanders Agency keeps the overview of the development.

The call was launched in September to all the stakeholders and was followed by provincial information sessions.

The applications for the zones are evaluated beginning of 2018.

The roll out of the primary care zones is facilitated by:

1. 8 Transition Coaches who assist in finding consensus for the demarcation of the zones and will as of 2018 deepen content and guidance.
2. The experience of two pilot projects Dender and South-East Limburg who started in spring 2017.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The Flanders Agency has sped up the implementation and created a frame for cooperation at the level of the practitioner while avoiding to take the lead in stakeholder discussions since 2015. The Agency is the instrument for dialogue and a keeper of the Flanders interests.

INNOVATION, IMPACT AND OUTCOMES

- Set up a coordination mechanism and finding consensus amongst stakeholders of different disciplines (social and health care)
- The setup of the primary care zones is part of a process for change in the care culture for every care professional.
- Expected results for 2019: 60 formed and accredited Zones; Care Council per Care Zone; Care Zones formulated their goals, plans for execution and have the necessary resources.

LEGAL AND/OR ETHICAL ISSUES

Issues will be communicated to the Agency during the pilot projects and the start-up of the zones.

TRANSFERABILITY TO OTHER REGIONS

The short time frame of four years (2015 – 2019) forces to focus on genuine cooperation. The Agency learned from the international community and early adopters of integrated care. Reciprocally, we expect that the Flanders experience can be considered by others in a similar process.

KEY LEARNING POINTS

Main challenges to start-ups:

- Time, energy and dialogue to make teams learn to know and understand one another.
- Process and steps may be clear, the expected results are not necessarily clear.
- Professionals in Flanders are used to top-down structures and arrangements.
- Doubts about bottom-up working creates a loss of focus on opportunities.

Points for attention

- Every zone is different
- Look in a holistic way to care and wellbeing and try to fit this into people's own role.
- Mapping of stakeholders before networking.
- Common language.

Lessons learned

- Don't regulate the daily work; identify the tasks at hand and start from there to organise the work.
- Invest time to get actors out of the normal legislative and organisational context.
- Include the citizen, the person with a need of care and the caregivers.

2018 Challenges:

- Financing and governance
- Accreditation procedure

- New Primary Care Decree and tune existing decrees in prevention, home, elderly, and specialised care
- Identify socioeconomic data to determine local needs of the population together with the available care offer.

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German Speaking Community (BE)

Organisation name: Ministry of the German Speaking Community of Belgium

Region: German Speaking Community of Belgium

Country: Belgium

Total Region Population: 77.000

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

SUMMARY

Description DSL (Dienststelle für selbstbestimmtes Leben); Case management; Care management;

DESCRIPTION

In the German speaking Community there is one central office which is in charge of the consultation of people in need of assistance (Example: Senior citizens, disabled people). This central office is called “Dienststelle für selbstbestimmtes Leben” (=Office for self-determined life)¹. The office for self-determined life (Dienststelle für selbstbestimmtes Leben) is the central partner in the matter of case management for senior citizens and disabled people.

This office fulfills the following tasks:

1. Information, orientation and consultation of the beneficiary about the existing services.
2. Assessment of personal needs. Doing this the office respects the wishes and the freedom of choice of the beneficiary.
3. Establishing individual support plans in consultation with the beneficiary.
4. Coordinating the actions and different steps which are included in the support plan. In case that the plan is deviated or rejected, the Office supports the beneficiary to implement other measures, actions and steps.

5. Simulation of the beneficiary's financial contribution; Giving Information about the existing financial support to the beneficiary.
6. Consultation of the beneficiary during the hole time he/she makes use of supporting services; care continuity until the person moves in a home for senior citizens.
7. Consultation in the field of prevention of violence and support in case of violent experience.

Attention: There is only the possibility to be placed in home care or home for elderly as the counselling by the DSL has been realized. By this way it will be guaranteed that older people and their family will be completed informed about possibilities to stay home.

METHODOLOGY AND PROCESSES

A) Case management

Case management is the management of an individual case situation. Case management connects the three levels: individual case, organization and network.

An implemented case management concept provides the beneficiary with a coordinated consultation and advices from a single source.

B) Care Management

Care management is the care and initiation of the network of all the existing services, independent of individual cases.

C) Care and Case Manager

The care manager is responsible for the care of the network and for the external contacts and organizes the cooperation.

The case manager is active in the field of the individual cases and coordinates the network with regard to the individual cases.

The scientific tool of the case and care management which is used by the Dienststelle für selbstbestimmtes Leben is the case and care management process which has been defined by Mennemann.

Our plan for the future is the implementation of BelRai, an assessment tool, from 2019.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

All actors in the network of care and help working in the German speaking community are involved.

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

It is implemented apart from BelRai (see above)

KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

- Obligation to be consulted by DSL
- Self-determination of choices
- Improved practice of case- and care management
- The DSL consults the beneficiary independently from the financial possibilities of the government.
- Only one central office
- Continuous consultation and support of the beneficiary by the same case manager

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

Reaching the number of 1800 beneficiaries which are consulted by DSL = 10% of the senior citizens in the German speaking community. → Statistically speaking they are 10% of the senior citizens which take advantage of professional assistance.

EVIDENCE OF THE IMPACT AND OUTCOMES

Reducing the number of seniors who are on waiting lists for different homes for senior citizens
Improving the ascertainment of demand for assistance and help in our region.

TRANSFERABILITY TO OTHER REGIONS

Possible

KEY LEARNING POINTS

- Case management
- Care management
- Self determination
- One central office
- Continuous consultation and support

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Lower Austria Region (AT)

Organisation name: Health and Social Fund of Lower Austria

Region: Lower Austria

Country: Austria

Total Region Population: 1.653.000

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA:

The main objective of the EU co-founded project "Healthacross for future" between Lower Austria and South Bohemia is to set further steps to improve the quality and conditions of life for the population in the border region, and to guarantee and expand access to high-calibre health care close to where they live.

SUMMARY

The project aimed to provide optimum usability of health services and equal access to health care by all people living in the border region of Lower Austria and South Bohemia (Czech Republic), especially in the "divided" City Gmünd - České Velenice through close cooperation among health service providers. Especially this region makes evident how cross-border cooperation makes people's everyday lives easier – after all, the hospital in Gmünd is situated directly on the border – and on the Czech side the nearest emergency doctor's vehicle is over 30 km away; indeed, the nearest hospital is 60 km away. The former project "Healthacross" was the first large-scale project on cross-border cooperation in health care between an old and a new EU member state and acts as a model for other border regions and the current EU enlargement. The follow-up project, "Healthacross in practice", enabled Czech patients from the border region of Lower Austria and South Bohemia to have simple and uncomplicated access to medical treatment at the hospital Gmünd in Austria. In the pilot period from 25 February 2013 to 30 June 2013, around 100 Czech patients received outpatient treatment in Austria. The pilot project was institutionalized and now about 4000 Czech patients have received outpatient treatment at hospital Gmünd. The new project "Healthacross for future" will use this already good foundation and will set further step in the field of cross-border health care.

The project "Healthacross for future" is co-funded through the INTERREG V-A Austria – Czech Republic program and it includes all relevant stakeholders from the health sector in the border regions. Regular meetings and events between the project partners guarantee the implementation of the project. The main objective is to extend cross-border health care provision from inpatient care also to outpatient

care and to plan and prepare a common cross-border health care center. To build this cross-border health center another funding program is used.

DESCRIPTION

The project focuses on two main pillars.

1. Cross-border health care provision

Bring the benefits of the respective health systems in line with the needs of the local population to allow equal access to medical care on both sides of the border. This is to be achieved by the mutual and optimal use of health infrastructure and resources by focusing on. Main objective is to ensure inpatient cross-border healthcare and expand it to inpatient care for CZ patients.

2. Cross-border health center

Numerous international scientific studies show a stronger orientation of the health care system towards a decentralized, comprehensive primary health care for Europe. This primary care covers not only the general medical field, but also areas such as physiotherapy, logo therapy as well as the social component. In order to achieve this, a repositioning of the health professions as well as the establishment of corresponding structural and organizational framework conditions in the extramural care area is necessary. Therefore, the project will plan and prepare a "cross-border health centre" for the border region.

METHODOLOGY AND PROCESSES

The project is divided in four major parts. The first one "preparation" is dealing with all the work before the project officially starts. The second part "management" includes all the events, the project monitoring, controlling and the common project management. The third part "implementation" involves the two main work packages about the outpatient treatment and the cross-border health center. The final part "communication" includes a common corporate identity and publications for the project.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The project involves many organizations and actors operating in the field of health care in the border region. The major partner is the regional government of South Bohemia. Moreover, the hospitals in the project region, the social insurance companies, the local authorities and many other actors in the field of primary health care are involved.

FUNDING SOURCE(S) OF THE INITIATIVE

The project is co-funded through the INTERREG V-A Austria – Czech Republic program 2014-2020

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

The major aim of the project is the long-term cooperation; therefore "Hhealthacross for future" develops strategies for sustainability to guarantee the outpatient treatment after the project. In addition to this, the analysis and all the preparation work of the "cross-border health center" is used to hand in in another funding program, which offers the opportunity to build the planned "cross-

border health center". Furthermore, the project partners ensure all project outcomes through internal budget.

INNOVATION, IMPACT AND OUTCOMES

The major key innovative element is that the project is setting up the first cross-border health care center of Europe and it also combines different funding programs for the implementation.

The main work packages of the project are

- Ensuring inpatient cross-border healthcare and expand to inpatient care for CZ patients
- Analyse possibilities of the exchange of medical treatments between AT and CZ
- Organise study visits between the participating hospitals for different professional groups
- Analyse opportunities for a long-term cooperation
- Planning and prepare a "cross-border health cube" (= cross-border health / primary health care centre)
- Analyse of performance spectrum, personnel and financial situation for a "cross-border health cube"

Each work package has a specific output factor and success criteria like the number of patients are treated or the number of organized study visits to guarantee the evidence.

LEGAL AND/OR ETHICAL ISSUES

The project deals with different legal and also ethical issues. First of all, the financing of the outpatient treatment of CZ patients in Austria is a critical factor. Finding new ways and solution is one of the major parts in the project. In that case, working in a cross-border region is always going along with ethical issues, because the project is dealing with different cultures, languages and also with a different economic situation of the two-border region.

TRANSFERABILITY TO OTHER REGIONS

The project serves as a best practice in cross-border healthcare for other regions within Europe. The project partners will share their experiences within their own networks (both nationally and internationally). The lead partner is a member of various European networks and ensures a transfer of knowledge to other regions of Europe. The procedures for medical treatment are available and can be transferred to other hospitals as an example for the transfer of knowledge, as well as the experience gained in in-and outpatient cross-border health care, as well as the planning and preparation of a cross-border health cube.

KEY LEARNING POINTS

Since the fall of the Iron Curtain, Lower Austria has moved closely to its neighbors, the Czech Republic and Slovakia. Unfortunately, health care is one of the few aspects of daily life that does not work well in cross-border aspects. Therefore cross-border cooperation is gaining in significance in the health sector. Cooperation arrangements between hospitals can help balance out regional demands and guarantee a better provision of health care to the population to reduce health and social inequalities.

It can also help in optimizing costs due to the shared use of resources and a better return on resource investment. By leading and carrying out EU-co-founded projects, Lower Austria, through the Health and Social Fund of Lower Austria (NÖGUS) has not only taken responsibility for its own population but also for the population of the neighboring regions: It's not about moving borders, but about reducing their separating character.

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Scotland (UK)

Organisation name: TEC and Digital Healthcare Innovation Division, Scottish Government

Region: Scotland

Country: United Kingdom

Total Region Population: 5.3 million

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA:

Primary Care implementation

SUMMARY

Primary care is the first point of contact within the NHS. This includes contact with community-based services such as General Practitioners (GPs) or Community Nurses. It can also be with Allied Health Professionals such as Physiotherapists and Occupational Therapists, Midwives and Pharmacists.

The Scottish Government's vision for the future of primary care services is for multi-disciplinary teams, made up of a variety of health professionals, to work together to support people in the community and free up GPs to spend more time with patients in specific need of their expertise.

The Scottish Government is already working to transform primary care in order to develop new ways of working that will help to put in place long-term, sustainable change within primary care services that can better meet changing needs and demands:

- Putting general practice and primary care at the heart of the healthcare system.
- Ensuring people who need care are more informed and empowered than ever, with access to the right person at the right time and remaining at or near home wherever possible.
- Developing multi-disciplinary teams in every locality, both in and out of hours, involved in the strategic planning and delivery of services.

There are five main areas of work to transform the primary care services:

- Strategy for Primary Care
- The GP Contract
- National review of Primary Care Out-of-Hours Services
- Eyecare
- Sponsorship and Performance Management of NHS 24 and the Scottish Ambulance Service.

For the purpose of this Good Practice the primary focus is on the area of the Scottish Government's new Strategy for Primary Care.

DESCRIPTION

Primary Care Transformation is focusing on the modernisation of primary care to deliver a safe, effective and person-centred healthcare service in line with Scotland’s 2020 vision and the National Clinical Strategy. This new approach focuses on multidisciplinary team working, to reduce pressures on services and ensure improved outcomes for patients with access to the right professional, at the right time, as near to home as possible. The objective of this good practice is to address the challenge of workforce shortages and aim to recruit 800 more GPs by 2028.

METHODOLOGY AND PROCESSES

The primary care model in Scotland is moving towards a multidisciplinary team model. The expanded team should consist of GPs, pharmacists, advanced nurse practitioners, MSK (musculoskeletal) physiotherapists and a paramedic role in primary care as defined in Primary Care Workforce Plan published in April 2018. The new GP contract came into force in April 2018 and the primary focus is on GP cluster working, where GPs work as “expert medical generalist”. This new arrangement replaces the payment for performance approach.

GP Clusters

A GP cluster is a professional grouping of GP practices represented at periodic meetings by **Practice Quality Leads** (PQLs) either face to face or by video conferencing depending on their circumstances.

A **Practice Quality Lead** is one GP from each practice who has responsibility to link with their Cluster Quality Lead. Under the requirements of the GP contract, they spend around two hours per month preparing practice responses to data provided by the cluster.

A **Cluster Quality Lead** is a GP nominated by the cluster with responsibility to provide a quality improvement leadership role to other GPs in their cluster. The Cluster Quality Lead will liaise between practices and the NHS Board / Health and Social Care Partnership on quality improvement issues.

To carry out this work, there needs to be protected time for the GPs taking on these roles, and an infrastructure that supports leadership and assists with data provision and analysis.

Clusters may be of different sizes and be influenced by local circumstance and geography. They should be a small group, consisting of between five and eight GP practices. These clusters provide a mechanism whereby GPs may engage in peer-led quality improvement activity and contribute to the oversight and development of care within their healthcare system.

To help support GP clusters, the Scottish Government’s Deputy Chief Medical Officer produced *Improving Together: A National Framework for Quality and GP Clusters in Scotland* in association with a number of key stakeholders who sat on the GP Cluster Advisory Group. This Framework, published in January 2017, sets out the principles and values that NHS Boards and Health and Social Care Partnerships should be considering when delivering GP services in their areas, and helps GP clusters consider their role in supporting their local Boards or Partnerships. Please see below the overview of the principles and values in detail:

Intrinsic	Extrinsic
Learning network, local solutions, peer support	Collaboration and practice systems working with Community MDT and third sector partners

Consider clinical priorities for collective population	Participate in and influence priorities and strategic plans of Integrated Authorities
Transparent use of data, techniques and tools to drive quality improvement – will, ideas, execution	Provide clinical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Ensure relentless focus on improving clinical outcomes and addressing health inequalities

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The implementation of this good practice requires the collaboration of the following actors, often called as the Primary Care Collaborative:

- Scottish Government (Health and Social Care Analysis Division; Primary Care Division)
- NHS Health Scotland
- Scottish School of Primary Care
- The ALLIANCE
- Healthcare Improvement Scotland
- NHS Education for Scotland
- NHS National Services Scotland
- Person-centred Stakeholder Group
- NHS Boards and Integration Authorities

FUNDING SOURCE(S) OF THE INITIATIVE

The Primary Care Transformation Fund is a primary funding resource on testing of this new models of primary care. £72 million have been invested into primary care to deliver these changes. This includes funding to:

- NHS Boards and Integration Authorities to test new ways of delivering primary care services, both in and out-of-hours, and support mental health services in primary care
- Recruit 140 new pharmacists to work directly with practices and support the care of patients with long term conditions – freeing up GP time for other patients.
- Address issues around GP recruitment and retention through the GP Recruitment and Retention Fund to promote general practice in Scotland as a positive career choice.
- Develop digital services, including helping online appointment booking to improve patient access.
- Expanding the Local Intelligence Service Team (LIST) analysts to support GP clusters in developing their local intelligence to determine the services they need to support their local community.

HOW TO YOU PLAN TO SUSTAIN THE INITIATIVE?

Transformation of primary care services is not necessarily about a single strand of work or about commissioning a new project. Most of the transformation work in the provision of health and social care services has already been undertaken in Scotland since the Joint Bodies Public Act came into force in 2016. The transformation of primary care services is one element of the overarching vision of Scottish Government to shift the resources to community. By 2021, there is a commitment to increase spending on primary care services to 11% of the frontline NHS Scotland budget. The introduction of new primary care model is the enabler of this shift hence the Scottish Government has invested additional £20 million to test and evaluate the model in order to measure changes and improve the sustainable improvements in care.

This initiative is about making the different components of change work together to achieve the interlinked aims of better care, better health and better value at pace. Taken together, these changes in health and social care will bring long-term sustainability of new services and continuing improvement of the nation's health and wellbeing.

KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

- The following key innovative elements of this good practice can be highlighted:
- Expanded multidisciplinary primary care team model.
- Freeing up GP time by bringing other professionals to work directly with practices.
- Support for GP clusters to develop their local intelligence gathering and analytics to inform the services they need to deliver to support their communities.
- Value-based approach rather than financial incentives for the provision of primary care.
- Promotion of the role of GPs as a positive career choice.

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

The outcomes framework for primary care has been developed to map out the changes and success criteria that need to happen in order to deliver NHS Scotland's Vision for Primary Care to 2028. Over time, it will be tested for its continued relevance and revised as we work toward the Vision.

It consists of strategic level outcomes (or "logic model"), with three nested frameworks for:

(1) People (the public who use primary care); (2) the Workforce; and (3) the System.

It sets out: the Situation (why there needs to be change); the changes we need to realise in the Vision in the form of the six high-level Primary Care Outcomes; and the Inputs, Activities and Intermediate Outcomes that need to happen along the way. The Framework expresses the basic components of a theory of change for those responsible for primary care policy and delivery to map out and understand how activities and inputs should and do contribute to the Primary Care Outcomes, at different levels and at points in time. Please see below the graphic illustration of the monitoring framework:

NATIONAL OUTCOMES				
Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive	
We start well	We live well	We age well	We die well	
PRIMARY CARE VISION				
Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.				
HSCP OUTCOMES				
	People can look after own health	Live at home or homely setting	Positive Experience of Services	Services improve quality of life
Services mitigate inequalities	Carers supported to improve health	People using services safe from harm	Engaged Workforce Improving Care	Efficient Resource Use
PRIMARY CARE OUTCOMES				
We are more informed and empowered when using primary care		Our primary care services better contribute to improving population health		Our experience as patients in primary care is enhanced
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care		Our primary care infrastructure – physical and digital – is improved		Primary care better addresses health inequalities

The Scottish Government will publish a 10-year Monitoring and Evaluation Strategy for Primary Care in Scotland in summer 2018. The Outcomes Framework provides a foundation for identifying where we need indicators and other kinds of evidence to measure progress in delivering the Vision. It will help inform the prioritisation of evidence gaps which require new data, research or analysis to be taken

forward within the Monitoring and Evaluation Strategy. The Strategy aims to gather and share evidence on whether intended changes are being delivered and the reasons for this. This will help ensure evolving policy, practice and strategy continues to be informed by consistent and robust evidence.

EVIDENCE ON THE IMPACT AND OUTCOMES

The new GP contracts came into place on 1 April 2018 so it is too early to provide any evidence on the impact and outcomes.

LEGAL AND/OR ETHICAL ISSUES

There are no emerging ethical issues currently. In terms of legal issues, the new contracts for the expanded multidisciplinary teams may need to be negotiated at the level of Integrated Joint Boards rather than GP practices. Currently, the GPs are hired directly by GP practices.

TRANSFERABILITY TO OTHER REGIONS

The teaching of approaches to transform primary care services in Scotland can be transferred to other regions in Europe.

KEY LEARNING POINTS

The following learning points can be highlighted:

- There needs to be a recognition of the compelling need to address the shortages of workforce in Scotland, GPs in particular, across the wide spectrum of stakeholders.
- There needs to be a very active communication and engagement with all stakeholders involved.
- The proposed solution for new model of primary care is accepted by GPs and the GPs' demands are aligned with the Scottish Government's Vision for primary care. GPs do not feel threatened by the new primary care arrangements, most likely as a result of the extensive consultation process throughout the development of the new arrangements.
- Support mechanisms need to be in place to enable the transformation of the primary care services.
- The expansion of primary care teams may require the expansion of practices depending on the location of practice; some of the GP practice buildings in Scotland are too small to accommodate larger multidisciplinary teams.

CONTACTS

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Regione Toscana

Tuscany Region (IT)

Organisation name: Tuscany Region

Region: Tuscany

Country: Italy

Total Region Population: 3.742.437

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

FOCUS AREA:

Prevention and management of chronic diseases

SUMMARY

The aging of the population, which is associated with an increasing burden of chronic non-communicable diseases on the health systems, led Tuscany Region to redesign its strategy to prevent evitable morbidity, mortality and disability at community level. This strategy, named “Sanità d’iniziativa” (SdI) (Proactive Medicine), was launched in 2010 as one of the main priorities of the 2008-2010 Regional Health Plan. It is based on the principles of the Expanded Chronic Care Model aimed at creating productive interaction among a prepared proactive practice team of community clinicians (general practitioners [GPs] and nurses), and informed and activated (empowered) patients to manage their health and clinical care. The SdI model has been implemented progressively all over the Region, reaching in 5 year a coverage of 1,620,000 (55%) citizens aged 16+. In the initial phase, SdI was based on the active identification of citizens with at least one of the following four chronic conditions with high prevalence in the population: chronic heart failure, type II diabetes, stroke and chronic obstructive pulmonary disease. This disease-oriented approach, although effective, turned out sometimes difficult to be implement, given the characteristics of multi-morbidity of the aged frail population. Thus, SdI model is currently under revision to better meet the epidemiological characteristics of the population. The revision process started in 2016.

DESCRIPTION

The SdI model aims at creating productive interaction among a prepared proactive practice team of community clinicians and empowered patients to manage their health and clinical care through a number of synergistic actions:

- a) assure the delivery of effective, efficient clinical care and self-management support;
- b) promote clinical care that is consistent with scientific evidence and patient preferences;
- c) facilitate transmission of patient data to facilitate efficient and effective care;
- d) create culture, organization, and mechanisms that promote safe and quality care for chronic patients;
- e) mobilize community resources to meet the needs of patients.

METHODOLOGY AND PROCESSES

In each Local Health Authority (LHA), diagnostic and therapeutic pathways were developed according to care pathways established at regional level (based on international guidelines) for four chronic conditions as a reference for the LHAs to implement the model in local contexts, taking into account the available resources.

The constitution of Community teams of 5-10 GPs and at least a nurse per 10,000 assisted patients was encouraged. GPs were requested to enroll patients and to produce a list of them. Regular follow-up visits have been proactively scheduled for each patient according to the diagnostic and therapeutic pathways; recalls have been set up for patients who were not compliant. Nurses were made responsible for updating the lists patients with chronic conditions, planning routine assessments, scheduling specialist visits, managing patient counseling, providing self-management support and recording weight and blood pressure.

In addition, self-management support initiatives for people with chronic diseases have been implemented, based on the programs developed by Patient Education Research Center of the Stanford University (CA, USA). These programs aim specifically at improving adherence to correct lifestyle and medication regimens.

Clinical governance programs targeted to GPs' practices, mainly based on periodic audits, are adopted with the goal to systematically evaluate and improve patients' care by using data extracted from regional health system databases. The results are shared by means of structured periodic reports.

A coordination group participated by Regional Authority and professionals of LHAs was also established to lead and monitor the process.

An evaluation system aimed to assess the impact of the interventions has also been set up by the Regional Health Agency (Agenzia Regionale di Sanità).

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The GPs' participation to SdI has been voluntary. However, a pay for performance scheme has been set up to encourage GPs' participation on the basis of the following indicators: percentage of enrolled patients treated with ACE inhibitor/ARBs and beta-blockers, had creatinine and electrolyte blood tests each year, attended individual or group counseling, and had their weight measured.

FUNDING SOURCE(S) OF THE INITIATIVE

No holistic analysis of economic and market impact of the model has been performed. However, the following items should be considered: GP's performance annual payment (4.5 euros max per assisted person), primary care team coordinators annual payment (1,500 euros per year), economic contribution for nurses and assistant nurses' appointments (depending on the size of assisted population), economic support for informatics implementation/update, and educational programs for clinicians (200 euros per year per GP). Globally, 21,500,000 euros were invested from 2010 to 2014 (health regional fund). The estimated total amount of resources invested per person assisted by GPs adherent to SdI is 13.20 euros, in addition to the resources regularly provided for the delivery of usual care. In addition, the cost of human resources provided by the LHAs and assigned to the primary care teams should be considered (1 nurse and 1 assistant nurse every 10,000 assisted persons). Finally, 10 million euros have been allocated for the evolution of the model started in 2016.

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

The SdI model is due to be further implemented in order to cover the entire regional population. An annual investment to support the scale-up has been taken into account by regional government, especially for the involvement of GP's and communication actions, while the costs of personnel involved at local health authorities' level are considered as running costs.

KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

integrated care team, proactive care, care pathways, performance and impact evaluation, self-management support.

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

After 5 years 1,271 (48%) GPs were involved in SdI with a coverage of 1,620,000 (55%) citizens aged 16+. From this population the adherent GPs screened individuals with one or more chronic conditions to be inserted in the SdI care pathways. SdI proved to be effective in improving the patients' adherence to ongoing monitoring and therapeutic regimens and reducing mortality (see regional Government decision 1152/2015 which approved the results of the impact assessment). A survey conducted on patients' and SdI clinicians' satisfaction indicated overall preference for the new approach as compared to the usual care.

LEGAL AND/OR ETHICAL ISSUES

Particular effort has been made in assuring the respect of personal data protection. The enrollment in the SdI and the subsequent monitoring activity is based on the collection and management of data which is fully described and authorized through a specific informed consent.

TRANSFERABILITY TO OTHER REGIONS

The SdI system can be transferred to other region, both in Italy and abroad, since is based on an organizational model which is recognized as effective at international level (Expanded Chronic Care Model).

KEY LEARNING POINTS

All the actors involved in the proactive care system should be involved in the design and implementation since the first stage. A strong commitment and coordination effort is necessary at central level.

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REGIONE DEL VENETO

Veneto Region (IT)

Organisation name: Veneto Regional Government- Primary Care Office

Region: Veneto

Country: Italy

Total Region Population: 4.907.529

MAIN CHARACTERISTICS OF THE BEST PRACTICE

- My region has a **fully implemented** strategy/programme for primary care
- My region is **in the process of implementing** a primary care policy/strategy/programme

SUMMARY

Achieving integrated management and continuity of care are the two main aims of the Veneto Region's health planning legislation for 2012-2016. Under this framework, and to meet new emerging population needs, it has become necessary to adopt a new primary care model that embraces multi-professional teams. In response the Veneto Region has developed the Integrated Medical Group (IMG), launched in 2016. The Integrated Medical Group is an innovative model at both the regional and national level and represents a key element of the health care system. It targets several goals: it provides more effective care than in the past; guarantees services within the region while optimizing the use of resources, through integrated patient care and its accompanying care pathways; it builds dialogue between hospitals and community based primary care services; develops relationships of trust between doctors and patients, pursuing shared team goals and enhances the different skills and roles of their constituent members.

DESCRIPTION

The regional planning framework identifies, as a strategic objective, the diffusion of IMGs. These multi-professional teams composed of various health and social care professionals are structured according to a clear division of labor, based on activity planning and follow up. They:

- deliver a comprehensive array of peoplecentred services;
- operate within a designated headquarters (guaranteeing 12 hours of medical and nursing care), while also safeguarding peripheral clinics in particular geographical areas;
- ensure the effective management of chronic care patients in light of the PDTA (DiagnosticTherapeutic Pathways) defined at regional level and tailored within each individual Local Health Authority;

- take responsibility for community health by addressing the determinants of illness and collaborating with local actors.

These elements of IMGs are governed by the Implementation Agreement (Contratto di Esercizio - CdE), defined at the regional level by a joint board (made up of members of the public and the unions) that sets objectives, indicators and resources, and which acts as the planning instrument for the IMG team's work.

Generally, an IMG serves a group of 10.000-15.000 patients.

Currently 74 IMG are active, employing 623 GPs and taking care of 890.055 patients on the whole (corresponding to the 21% of the regional population).

METHODOLOGY AND PROCESSES

The Implementation Agreement consists of three basic parts:

- **Management and production factors:** these factors relate to managing the location of the group practice. IMGs are expected to have a main clinic/facility that adheres to specific structural standards and which is open 12 hours a day (together with out-of-hours services - that operate every day of the week from 8 pm to 8 am, and at weekends from 10 am on Saturdays to 8 am on Mondays, plus bank holidays- ensure 24 hours of medical care). Access should be guaranteed through booking systems (such as telephone or internet booking, or "face to face"). Nursing staff standards are also outlined with regard to their ability to provide information and self-care support to patients, and in terms of monitoring chronic patients, medications, samples, etc. Clinic assistants are also required to manage appointments and doctors' schedules, provide administrative support and to book specialist services for patients. One of the GPs within an IMG should be designated as its coordinator, responsible for managing relations with the Health District and to coordinate the IMG's activities.
- **GPs' professional commitments:** this element is related to prevention activities, chronic care, training and maintenance of computerized individual health records. Prevention activities (e.g. Screening and vaccination campaigns, promotion of healthy life styles) are an integral part of primary care. These activities are detailed within PDTAs with the aim of promoting more patient engagement in their care pathway and their interaction with the health system, enabling them to take action at the first signs of symptoms, to contact a GP promptly and to make use of the most appropriate health services available. Specifically, the Implementation Agreement focuses on chronic diseases with the highest prevalence (diabetes, COPD, congestive heart failure), defining measurable management objectives. The PDTA application is monitored through well-defined process and outcome indicators, taken from the existing literature. The adoption of audit methodologies, both clinical and organizational, is central to guaranteeing multi-professional comparisons to support continuous improvement of services. It is also expected that GPs working within IMGs will make use of interoperable software to allow the implementation, development and the transmission of patient summaries and supporting documents under the agreed PDTA. In this regard an Accuracy and Quality Evaluation Index (IVAQ index) has been developed for computerized individual health record data. This represents an initial assessment of GPs' ability to record information in a structured way. The Index takes values between 0 and 1 and is composed of four "sub-indices", which measure a specific aspect of the Agreement, such as: recording general population information; the registration of problems and diseases, diagnostic referrals and prescription of medicines; registration of major chronic diseases (such as diabetes, heart failure, COPD, hypertension, tumors) and the provision of certain healthcare services linked to the PDTA (e.g. testing glycosylated haemoglobin levels for diabetes patients).

- **Participation in governance:** this relates to contributing to Local Health Unit's annual strategic objectives for effective resource utilization. IMGs are called upon to contribute to the regional health system's good governance and economic sustainability through clinical appropriateness and prescribing practices to meet patient needs while promoting efficiency (e.g. reduction or maintenance of annual cost for pharmaceuticals sold under agreements, reduction or maintenance of hospitalization rate).

The evaluation of the CdE outcomes, after one year of IMGs activity, is still in progress and shows that satisfactory results have been achieved where GPs and nurses are fully integrated, and the assistance can be properly organized, with the help of the administrative staff.

Moreover, recently has emerged the need to "review and re-adapt" the model in order to find the right solution for some needs related to:

- the maintenance of the capillarity of GPs' main clinics in mountainous or low-density areas, especially to guarantee medical assistance to elderly people with reduced mobility.
- the need to combine the centralization of the headquarters' service, opening for 12h, with the capillarity of peripheral clinics,
- the need to reconcile the guarantee of free access with a successful organization of access to the GPs (access by appointment, follow-up management), avoiding waiting lists in primary care
- strengthening of primary care skills: it is necessary to strengthen the competences of the GPs and the team through transversal training courses, by providing the co-presence of GPs, nurses and specialists.

Finally, the availability of economic resources must be taken into account by assessing the real sustainability of the model, since the achieved outcome, including prevention interventions rather than chronic ones, have not visible effects in the short term, but in the medium-long term.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The Implementation Agreement was formulated by a Technical Group and is the subject of a formal agreement between the General Medicine unions and the Regional Committee for General Medicine

IMGs are not isolated structures but are integral parts of Health Districts. In the Veneto Region, primary care services are delivered by Health Districts, the operative branches of Local Health Units (LHU). Each Health District is expected to plan and deliver health and social care based on population needs. Therefore, they are included in a system that promotes the integration between health and social care and between hospitals and other medical services. The IMG model, in fact, promotes collective responsibility towards personalised care services through multi-professional team work.

Municipal authorities have a preeminent role in the IMG development. More in details, they promote social initiatives, provide the premises, promote IMG programs for good health practices, foster the cooperation among different professionalisms (social workers and other care professionals).

FUNDING SOURCE(S) OF THE INITIATIVE

To incentivize the uptake of IMGs, the Veneto Region has provided specific regional funding for Local Health Units to finance the start-up phase of the process. These funds are paid when the objectives

outlined the Agreement (CdE) are met (Veneto Region, verify the IMGs results achieved, through specific annual report).

On the whole, each GP who reaches all the CdE objectives, is funded with € 14,55 per patient per year, in addition to the primary care model benefit, which amounts to € 10,10 per patient per year.

The activation of each IMG is authorized by an appointed regional board, after the presentation of a detailed project.

KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

- promotion of the nurse role
- greater accessibility to services
- trust between doctors and patients
- shared team goals
- valorisation of the different skills and roles of their constituent members,
- contribute to the sustainability of the health system through clinical appropriateness,
- enhancement of skills and integration among professionals.

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

As mentioned, Veneto Region, verify the IMGs results achieved, through specific annual report. ²

EVIDENCE ON THE IMPACT AND OUTCOMES

According to early evidence, it has been observed that the IMG model, where the team is cohesive and well organized, can provide adequate responses to the current population health needs, especially in managing chronic care patients. Integrated management is not only important at an organizational level and in terms of appropriateness but becomes an element of improvement in the quality of life for the patient and for the family members.

However, the high cost of the model and the different performances that characterize the IMG are bringing out the need for a review of the model, also proposing different contractual profiles (as in the case of Catalonia GPs employees of the National Healthcare System - private GPs), in order to make it sustainable and effectively extendable to the entire Veneto Region population.

LEGAL AND/OR ETHICAL ISSUES

It should be considered that currently national regulatory constraints (ACN) foresee only one type of contract for the GP, unlike what happens in other European contexts (e.g.: Catalonia), in fact is defined to respond to the logic of the relationship with the single GP and not for the team.

In addition, on the basis of the current legislation, it is difficult to identify the operating methods of acquisition and management of administrative and nursing staff since they are not always employees

of the National Healthcare System, but most often they are services guaranteed from third parties (especially Cooperatives), making it difficult to identify the specific legal institutions applicable.

TRANSFERABILITY TO OTHER REGIONS

With regard to the national context, many Italian regions are implementing projects or initiating pilot programs in primary care. Some of them refer to the Veneto Region Implementation Agreement in order to define their own primary care teams.

KEY LEARNING POINTS

- Need to define different primary care models, according to the local contexts (e.g. urban or mountainous areas.)
- Need of team-working training for the professionals;
- Need to determine alternative agreement for the constitution of primary care teams, with respect to the current national health system (e.g. with National Health Service employees)
- Need to set economically sustainable models

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