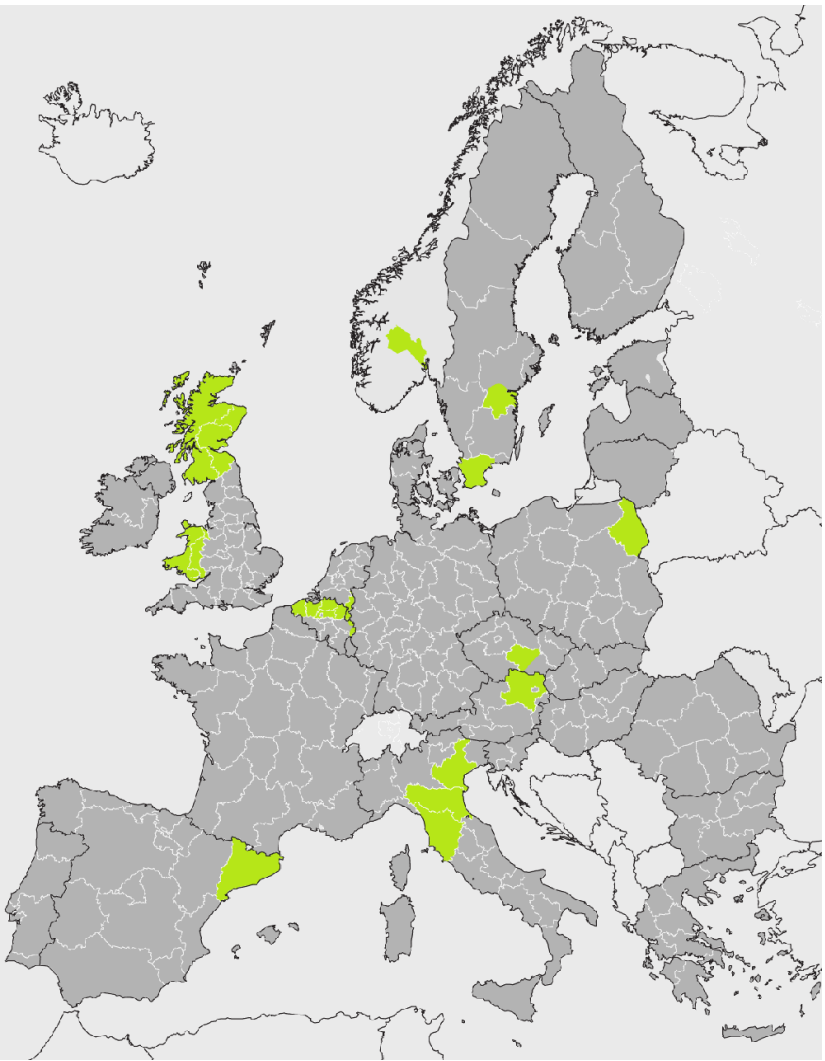
Chronic Diseases & Frailty

A SHOWCASE OF BEST PRACTICES FROM EUREGHA'S MEMBERS



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European Regional and Local Health Authorities

BEST PRACTICES

COMPLEX CARE IN CATALONIA

Organisation name: Department of Health

Region: Catalonia

Country: Spain

Total Region Population: 7.5 million people

Main characteristics of the good practice

☒ My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☐ My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Focus area: Complex chronic patients

Summary

The Chronicity Prevention and Care Programme set up by the Health Plan for Catalonia 2011-2015 has been an outstanding and excellent opportunity to create a new integrated care model in Catalonia.

People with chronic conditions require major changes and transformation within the current health and social system. The Chronicity Prevention and Care Programme aimed to implement actions which drive the current system towards a new scenario where organisations and professionals have been working collaboratively. New tools have been facilitating this work, such as integrated health information systems and an integrative financing and commissioning scheme, providing a new approach to virtual care by substituting traditional face-to-face care with transfer and shared responsibilities between patients, citizens and health care professionals.

This integrated care approach is incorporating social care to create a real and challenging integrated health and social vision. Some initial results related to better health outcomes and a decrease in avoidable hospital admissions are confirmed.

Description

General and specific objectives

- ✓ All territories have developed and implemented an integrated care pathway related to complex care.
- ✓ To develop comprehensive clinical processes redesign for the chronic conditions with the greatest impact in all areas by building integrated care pathways in each geographical area which comprises a hospital, primary care centres, nursing home facilities and a mental health network.
- ✓ To promote self-care and personal responsibility of citizens concerning their health, risk factors or diseases. The successful Expert Patient Programme Catalonia (EPP) has been implemented with over 5000 patients included in the programme to date.
- ✓ To deploy social services and healthcare facilities working in a more integrated care approach, and adequate comprehensive systems for providing care for chronic and dependent patients. As a consequence, a new integrated health and social care plan was launched in Catalonia in March 2014 where it is expected that real integrated care will be implemented between health and social services, especially for people with complex health and social care needs.
- ✓ To provide comprehensive and proactive care of patients with complex chronic conditions and advanced chronic diseases that ensures a 24/7 coverage model with a good response to potential exacerbations of this patient group.
- ✓ To rationalise the use of medications, especially with people with polypharmacy and improvement of adherence in chronic patients.
- ✓ To promote an alternative remote care model substituting face-to-face visits with virtual contacts like telephone and electronic messaging.
- ✓ To replace acute conventional hospitalisations with other alternatives: sub-acute facilities, day care facilities, a more proactive home care programming in primary health care.
- ✓ To stratify the entire Catalan population, giving support to identify complex care patients.

Methodology and processes

To develop a strategy to transform the care management approach at microsystem level in each territory to guarantee good care for these specific complex situations.

Involvement of other organisations/actors

Health Commissioners (CatSalut), health provision, social services and patients.

Funding source(s) of the initiative

No extra funding. Implementation has been implemented under budgets constraints and cuts at the first stage of the health plan.

How do you plan to sustain the initiative?

We are upgrading the model from a chronic care programme to a new updated integrated health and social care model.

Innovation, Impact and Outcomes

Key innovative elements include

- ✓ Overall system transformation: primary care, hospital care etc.
- ✓ Engagement of clinical and professional leaders.
- ✓ Involvement of Commissioners.
- ✓ Support of ICT solutions for integrated care: Key information summary available to all providers and professionals.

Evidence on impact and outcomes

- ✓ The number of emergency admissions related to chronic conditions (COPD, heart failure, asthma, diabetes complications etc.) has decreased by 8% in five years.
- ✓ We have reduced the number of emergency admissions related to COPD by 14% in 3 years.
- ✓ We have reduced the number of emergency admissions related to heart failure by 2% in 3 years. Up until 2011 it has been an increasing tendency with an increase of 27% from 2006 until 2011 with a turning point since then.
- ✓ The 30-day readmission rate has decreased by 8.5% during the same three-year period.
- ✓ Introduction of an increasing number of subacute service beds with less intense care such that it enables offering a very good alternative to acute conventional hospital care for complex chronic patients. These facilities are directly accessible from primary care teams.
- ✓ All population is stratified.

Success criteria

- ✓ Outcomes presented earlier in services utilisation
- ✓ Commitment of some professional leaders

Ethical issues

Some ethical issues related to complex care patient labelling have been exposed. The Catalan Committee of Ethics has positioned themselves to support this initiative.

Transferability to other regions

- ✓ Showcasing best practices.
- ✓ Participation in the Congress of Integrated Care organised by the International Foundation for Integrated Care (IFIC).
- ✓ Participating in other showcase events at international level (if funding is available to travel and participate in different forums).

Key learning points

- ✓ Clinical leadership involvement.
- ✓ Collaboration between clinical leaders and managers.
- ✓ Change in the commissioning: joint objectives and indicators for primary care and hospitals.
- ✓ Good deployment of shared clinical records and central rules to incorporate minimum datasets from all providers.

Further information

The Catalan Chronic Care Programme:

http://salutweb.gencat.cat/ca/ambits_tematics/linies_dactuacio/model_assistencial/atencio_al_malalt_cronic

The Catalan Integrated Care and Social Care Plan:

http://presidencia.gencat.cat/ca/el_departament/plans_sectorials_i_interdepartamentals/PIAISS/

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PREDICTING RISK OF HOSPITALISATION: EMILIA-ROMAGNA RETROSPECTIVE POPULATION-BASED ANALYSIS

Organisation name: Regional Health Authority

Region: Emilia-Romagna

Country: Italy

Total Region Population: 4.5 million people

Main characteristics of the good practice

☐ My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒ My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Summary

The Emilia-Romagna regional health service has developed a population-based model that identifies the risk of hospitalisation for residents, using a longitudinal administrative database. The model has a level of performance as high as, or higher than, similar models.

The results of this model, along with profiles of patients identified as high risk, are provided to the physicians and other healthcare professionals associated with the Patient Centred Medical Homes to help planning care management and interventions that may reduce their patients' likelihood of a preventable high-cost hospitalisation.

Description

✓ **Objectives**

To develop a predictive model using an administrative healthcare database that provides information to Patient-Centred Medical Homes (Case della Salute) to proactively identify patients at risk of hospitalisation for conditions that may be impacted through improved patient care.

✓ **Outcome measures**

In 2012, a model was designed and evaluated to predict the risk of hospitalisation or death for preventable medical problems. The model uses the area under the receiver operating curve C-statistic, in terms of sensitivity, specificity and positive predictive value and for calibration to assess performance across levels of predicted risk.

✓ **Methodology and processes**

Retrospective healthcare utilisation analysis with multivariate logistic regression models. A population-based longitudinal database of residents served by the Emilia-Romagna health service in the years 2004–2012 including demographic information and utilisation of health services by 3 726 380 people aged ≥18 years.

✓ **Involvement of other organisations/actors**

Regional Agency for Health and Social Care of Emilia-Romagna (ASSR).

✓ **Funding source(s) of the initiative**

Regional funds.

✓ **How do you plan to sustain the initiative**

Development of Patient-Centred Medical Homes.

Innovation, Impact and Outcomes

With the belief that a strong primary care system is conducive to improving population health, the Italian National Health Service (NHS) initiated reforms that encouraged primary care physicians to organise into collaborative arrangements. To this end, Emilia-Romagna Region (RER) has recently launched a plan in its 11 Local Health Authorities to establish Patient-Centred Medical Homes to better coordinate patient care and help patients avoid unnecessary hospitalisations.

The identification of those patients who would benefit the most from outreach efforts is fundamental to achieving these goals of promoting and practising population health in Patient-Centred Medical Homes.

The RER has established three objectives for this project:

1. Develop predictive models to identify patients at high risk of hospitalisation or death.
2. Create “risk of hospitalisation” patient profiles that provide information about their high-risk patients to the general practitioners in the newly formed Patient-Centred Medical Homes.

3. Assess the extent to which these models and reports provide additional information useful in the identification of patients who may benefit from case management or disease management.

Ethical Issues

The ability to spread the results of the project to all Patient-Centred Medical Homes in the Region to ensure equity of access.

Transferability to other regions

The risk predictions, in conjunction with the risk profile, show promise as a useful organisational tool for the regional Patient-Centred Medical Homes to develop and implement proactive case management and disease management programmes.

If similar data is available, these models can be applied in other Italian regions and other countries investing in organisations similar to the Patient-Centred Medical Home.

Key learning points

- ✓ The study included the entire adult population of the Emilia-Romagna Region of Italy, over 3.7 million people.
- ✓ The study used an existing longitudinal administrative healthcare database with the advantage of much lower cost than new data collection but the disadvantage of potential errors in administrative data.
- ✓ The results of the study are being used to assist in the development of newly formed Patient-Centred Medical Homes.

Further information

A specific web link is not available at the moment – please refer to the Patient-Centred Medical Home page*:* http://salute.regione.emilia-romagna.it/cure-primarie/case-della-salute

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FLANDERS' VISION: "EVOLUTION FROM ACUTE AND AD-HOC CARE TO INTEGRATED CARE AND SUPPORT"

Organisation name: Flanders Agency for Care and Health

Region: Flanders

Country: Belgium

Total Region Population: 6.4 million people

Main characteristics of the good practice

☐My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Focus area: Multi-level governance can work - strengthening of cooperation and framework setting at macro- and meso-level.

Summary

Integrated care is a multi-level governance issue as well as a whole-of-society approach to care. Flanders cooperated with the other Belgian regions and the federal (national) level to set up a National Integrated Care Plan on Chronic Diseases and recently developed a vision around the future of care: 'Evolution from Acute and Ad-hoc Care to Integrated Care and Support', which is developed under the re-organisation of primary healthcare in the region.

Description

Flanders' vision embeds the same approach as the Belgian national plan through the creation of a framework for cooperation and implementation at the relevant levels.

A whole-of-government approach implies respect of each other's competences as well as an agreement on definitions and approaches. It also implies finding elements for cooperation and identifying communalities amongst the needs and requirements to tackle the integrated health care of chronic diseases. Both the Belgian national plan and Flanders' vision prepare the ground for further implementation.

The national plan aims to develop a common action plan and communal actions around chronic care. The regions will be able to adapt this to their specific contexts. In the context of this plan, a collective appeal will be launched for pilot projects in chronic care. Also, with regard to the reforms of the hospital financing and the pilot projects in the context of the reduction of the length of stay, this shall be worked out in very close collaboration.

The vision on integrated care and support developed in Flanders, and the path that has already been taken, identifies how the primary care meso-level should function and which support it offers. By extension, the support of the regional policy level will also be redefined.

Impact and Outcomes

The national plan tackles the macro-level. The plan provides a basis of coordination and support to the different authorities. In parallel, the plan embeds the agreement on common aspects and actions, such as the implementation and the communication of regional pilot actions on a larger scale. The national plan identifies 18 components of integrated care such as home care, prevention, regulatory exceptions for the pilot projects, dialogue with other policy areas etc. Although these components will be taken into account in different ways, they require close co-operation between the regional and federal levels.

In order to restructure the meso-level in a well-founded way, it was vital for Flanders to clearly formulate how we want to organise integrated care, and how to place the patient/citizen at the centre of the care process. At the same time the data will have to be determined in order to achieve this in a qualitative way, in a specific area, and which cross-compliance is necessary to mobilise the care providers. Six working groups have been set up and operate in parallel: *Targets and Structure Integration*, *Geographic demarcation of the care regions, Models for Integrated care, Focus on the Patient, Data sharing and Quality of care* and *Innovation and Entrepreneurship in Care*.

Ethical Issues

- ✓ Cooperation amongst different primary care providers.
- ✓ Re-formulation of the roles of primary care.
- ✓ Including the preventative role of primary care professionals (health and social).
- ✓ Common files with data from different care providers, including issues such as: reluctance of health and social care professionals, professional secrecy, the discussion around the informed consent and the consent on the therapeutic relationship for every file.

Transferability to other regions

Multi-level governance is a common issue in health policies. The Flanders experience and ways of cooperation may interest other regions and countries.

Key learning points

- ✓ Respect of each other's competences are key factors to set up frameworks and strategies.

- ✓ Identify and strengthen connecting factors such as methodological, scientific support, evaluation and financing.
- ✓ Clear goals, governance structure and coordination.

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RESHAPING CARE FOR OLDER PEOPLE (RCOP) IN SCOTLAND

Organisation name: Joint Improvement Team

Region: Scotland

Country: United Kingdom

Total Region Population: 5.4 million people

Main characteristics of the good practice

☐ My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒ My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Summary

Reshaping Care for Older People (RCOP): A Programme for Change 2011 – 2021 describes the vision for future care and support for older people in Scotland. Between 2011 and 2015, a national improvement programme and a £300 million Change Fund supported health and social care partnerships to enable older people to live well at home or in the community through preventative, anticipatory and coordinated care and support, intermediate care to improve outcomes at times of transition, and technology to empower greater choice and control.

An improvement network supported partnerships to test new approaches, spread good practices, understand variation and use joint commissioning and resourcing to improve outcomes for older people and their carers. As we enter year five of the programme, older people spent around 2 million more days at home in 2013/14 than predicted based on the previous balance of care and the impact of ageing.

Description

Each partnership developed a Change Plan that described how local health, social care, housing, third sector and independent sector partners would work together to test and spread four 'bundles' of interventions aligned to the four pillars of the RCOP pathway. These interventions were designed to collectively deliver improved outcomes for older people and agreed reductions in the rate of

emergency admission bed days. Partnerships were expected to develop strategic commissioning plans, using integrated budgets to sustain their new models of care beyond the conclusion of their Change Fund in 2015.

Innovation, Impact and Outcomes

The approach used disruptive innovation from the introduction of a new financial incentive with simple rules to lever cross sector partnership working. Adapted breakthrough collaborative and improvement methodology was used to systematically test and spread evidence based interventions and approaches to improve outcomes for older people with complex care and support needs:

- ✓ Empowering older people and their carers to remain active, independent and connected with families, friends and social networks.
- ✓ Building community capacity for preventative supports.
- ✓ Applying a national risk prediction tool to target high resource users.
- ✓ Scaling up anticipatory care planning.
- ✓ GP and community pharmacy led polypharmacy reviews
- ✓ Community rehabilitation and reablement.
- ✓ Proactive, coordinated and integrated care management for people with complex support needs.
- ✓ Frailty pathways for community CGA.
- ✓ Hospital at Home and intermediate care alternatives to emergency admission.

As we enter year five of the programme, o**lder people spent around 2 million more days at home in 2013/14 than predicted based on the previous balance of care and the impact of ageing. Other** outcomes delivered include:

- ✓ 39% of the Fund provided support for carers including assessments, opportunities for short breaks, information, advice, training, income maximisation and advocacy.
- ✓ Around 16% of the Change Fund was invested in the Third Sector.
- ✓ 83% of older people receiving support at home now benefit from telecare.
- ✓ **Bed days in hospital for people aged 75+ following an emergency admission are down by 11.4% from 2009/10 to 2014/15.**
- ✓ Each day in 2013/14, people aged 65+ used around 1300 fewer emergency hospital beds than 'expected' had the age related rate at 2008/09 continued in line with the ageing profile of Scotland's population.
- ✓ **In 2014, there were around 4,000 fewer older people in care homes than projected based on the 2009 rate and demographic trends.**

Ethical Issues

The approach adopted promoted social inclusion and values based on personalised care and support.

Transferability to other regions

The principles adopted are highly transferable levers that implement the chronic care model which has a strong international evidence base.

Key learning points

- ✓ Transformation requires local and national implementation support to create the right conditions for sustainable change.
- ✓ RCOP and the Change Fund helped to reinvigorate partnership working, including the contribution of the housing, third and independent sectors in working with statutory services to redesign and transform care and support.
- ✓ The relationships forged and the behaviours nurtured are part of the critical path towards formal health and social care integration in Scotland.
- ✓ The new integration authorities in Scotland will build on this learning to make best use of their collective resources from April 2016.
- ✓ Scotland is now ready to scale up and mainstream new models of care and support for those who are frail or live with complex multiple conditions.

Further information

http://www.jitscotland.org.uk/resource/reshaping-care-for-older-people-change-fund-building-on-progress-june-2015/

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THE CERTIFICATION OF ALLERGY-, ASTHMA- AND COPD-CLINICS IN PRIMARY CARE IN REGION SKÅNE

Organisation name: Allergy Competence Centre

Region: Skåne

Country: Sweden

Total Region Population: 1.2 million people

Main characteristics of the good practice

☐My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Focus area: An initiative to improve the structure and care of patients with Asthma/allergy and COPD in primary care in Region Skåne.

Summary

In primary health care asthma, allergies and COPD are common diseases with increasing prevalence, causing both human suffering and huge costs for society. A structured treatment with well-functioning asthma/COPD-clinics has been found to improve the care of these patients.

In 2013, Region Skåne made a decision to certify the asthma/COPD-clinics in primary health care according to the Swedish national criteria for asthma/COPD clinics. The aim of the certification process was to ensure the quality of care regarding the patients with asthma, allergy and COPD in primary health care in Region Skåne, Sweden. The mission of certification was assigned to the Allergy Competence Centre at the University Hospital in Lund.

Today the quality of care has improved significantly. The level of education has increased, more members of the staff have been trained in spirometry, the dedicated patient time for nurses has been extended and more clinics have connected to “The Swedish Airway Registry”.

Description

General objective

- ✓ Structuring the treatment in well-functioning asthma/COPD-clinics to improve patient care.

Specific objectives

Requirements that clinics must meet before certification:

- ✓ Asthma/ COPD-nurse with university education in asthma/COPD >15 credits Bologna.
- ✓ **Disposable time for the nurse's** ≥ 2 hours a week/1000 listed patients.
- ✓ General Practitioner medically responsible.
- ✓ "Spirometry driving license" (a Swedish national education programme) for the team.
- ✓ Smoking cessation programme.
- ✓ Necessary equipment includes spirometer, pulse oximetry, oxygen and devise for nebulisation.
- ✓ Connection to "The Swedish Airway Registry".

Methodology and processes

To achieve the objectives, knowledge about the skills and approaches in the centres, online questionnaires were sent to all primary health care centres in Region Skåne. All primary health care centres were then instructed how to achieve the requirements for certification.

Involvement of other organisations/actors

Region Skåne's primary care management and healthcare committee have approved and supported continuous development of the initiative.

Funding source(s) of the initiative

The project is funded by the Regional budget.

How do you plan to sustain the initiative?

We plan to sustain the project through an education programme and the primary health care centres will have regular contact and feedback. Since January 1st 2014, only certified asthma/COPD clinics could be listed on the Swedish health care guide (www.1177.se).

Innovation, Impact and Outcomes

- ✓ Acknowledgment to the health centre to guarantee the care of patients with asthma/allergy/COPD in a quality assured manner by qualified staff.
- ✓ Increased number of patients receive proper diagnosis, are better informed about their disease and thus have reduced risk of insufficient treatment that could lead to future complications.
- ✓ Continuous improvement where the clinics' competence is ensured through education, monitoring and evaluation.
- ✓ In the beginning, in January 2014, only nine health care centres met the criteria. In September 2015, approximately 50% of primary health care units (out of 65) now have a certified asthma/allergy and COPD clinic.

- ✓ An ongoing study of COPD exacerbations in Emergency Department at Skåne's University Hospital in Malmö shows a reduced number of patients with COPD exacerbations from the certified clinics compared to the uncertified clinics. This indicates better care in the certified asthma/ COPD clinics.

Ethical Issues

The good practice leads to equal care for patients with asthma, allergy or COPD in the region.

Transferability to other regions

Awareness of the certification process will be spread to other regions and organisations in Sweden through an information programme.

Key learning points

By certifying asthma and COPD clinics the following points can be increased:

- ✓ The education level on the staff
- ✓ The allocated time for patients
- ✓ The quality of care
- ✓ Better diagnosed patients
- ✓ Improved medical treatment

Further information

http://www.akcsyd.se/sites/default/files/files/uploaded/certifgrund-AstAllKOLmott-RS2014.pdf

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Regione Toscana

TUSCANY ADAPTED PHYSICAL ACTIVITY (APA) PROGRAMME

Organisation name: Regione Toscana, Citizens' Rights and Social Cohesion Directorate, Organization of treatments and paths for chronic illnesses sector
Region: Tuscany
Country: Italy
To: 3.8 million people
Best Practice Target Population: >65 years

Main characteristics of the good practice

☐My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒ My region is **in the process of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Focus area: Physical activity for senior citizens

Summary

Adapted Physical Activity (APA) was developed in Tuscany Region in 2005 to provide a community-based, progressive and supervised group exercise for elderly sedentary citizens with chronic disabilities, as an alternative to over-subscribed clinic-based rehabilitation programmes. After 10 years, approximately 30,000 senior citizens (3.5% of the Tuscany population aged 65 and over) have exercised in 1891 classes in 773 gyms scattered throughout 81% of the Tuscan municipalities.

APA is safe, effective and economically sustainable. It provides exercise opportunities to citizens previously excluded from the benefits of exercise, increases appropriateness and correct timing of rehabilitation treatment, and may be integrated in a global strategy for the management of chronic disease conditions. The number of classes continue to increase every year, demonstrating consumer satisfaction.

Description

General and specific objectives

Although only a small proportion of older adults in Europe engage in recommended amounts of physical exercise, the health benefits of exercise to this population and the potential for lowering health care costs are substantial. However, access to regular exercise programmes for the frail elderly

remains limited. In this context, the experience in Tuscany in implementing a community-based exercise programme for frail elderly with chronic disabilities may be of interest. APA was developed in 2005 by the Tuscany Region as an alternative to over-subscribed clinic-based rehabilitation programmes.

Methodology and processes

General practitioners (GPs) are the primary referral source. They are encouraged to refer all elderly patients with chronic musculoskeletal complaints who they deem to be adequately medically stable to participate in exercise. Local Health Authority (LHA) staff coordinates patient assignment to participating local gymnasiums.

The key features of APA are:

- ✓ Inclusion of participants by functional status rather than diagnosis
- ✓ Screening and referral by GPs
- ✓ Exercise supervised by exercise trainers
- ✓ Use of private and public gyms
- ✓ Training of trainers
- ✓ Quality assurance, monitoring, and coordination by LHA professionals

The LHAs are also encouraged to develop APA programmes for individuals with chronic neurological deficits (e.g. stroke, Parkinson's disease, multiple sclerosis). The latter patients have significantly impaired function, and thus require a different programme of exercises and smaller classes than those in the original programme.

The APA programme has been well-received in the community. After 10 years, approximately 30,000 senior citizens (3.5% of the Tuscany population aged 65 and over) exercised in 1891 classes in 773 gyms scattered throughout 81% of the Tuscan municipalities. The number of classes continues to increase every year, demonstrating consumer satisfaction. This led the Tuscany Region, in 2009, to adopt a new resolution which establishes APA as one of the cornerstones of health policy in Tuscany for the prevention and management of chronic diseases. In addition, it established benchmarks for APA enrolment for all of the twelve LHAs in Tuscany and incorporated these benchmarks into the performance plans for the senior executive managers of the LHAs.

Funding source(s) of the initiative

The cost of each session is low, about € 2.30 per participant (equivalent to the cost of a cappuccino and a pastry, the popular Italian breakfast). Participants cover the entire cost of the programme, except coordination, which is provided by LHAs. The low cost of APA is obtained by encouraging all local gymnasiums to hold classes during the day at "off hours". This strategy not only helps to keep prices low but also to obtain a wide geographic dispersion for gymnasiums (thereby reducing travel time and costs), which facilitates adherence to the community exercise programme.

Involvement of other organisations/actors

Support of the medical community (physicians and physical therapists) was obtained through an extensive series of meetings that assured that the APA programmes would not divert patients from medical care, and that patients participating in the APA programmes would be promptly referred back to their medical providers for treatment of intervening problems.

Municipalities provided an effective liaison between LHAs and community gyms. Non-profit service organisations were involved to provide transportation for the most disabled individuals. Research collaborations were established with national (Italian National Institute of Health, University of Florence, Regional Health Agency, Don Gnocchi Foundation Research Hospital) and international (U.S. National Institutes of Health, University of Delaware, University of Maryland Baltimore County) teams of investigators.

The published studies provided evidence of the effectiveness and safety of the programme, increasing the trust of APA among clinicians. Finally, private companies (e.g. banks, department stores, and other private enterprises) sponsored initiatives to spread the knowledge of the APA programmes in the community.

How do you plan to sustain the initiative?

The growth of the APA programme is sustained by the interest and continuity of the administrative and medical leadership of LHAs with financial incentives for change, ongoing data collection and analysis for decision support, and the establishment of clear benchmarks to measure performance. Ongoing support from GPs and LHA clinicians allows new participants to be recruited and adherence to be maintained high, which in turn allows geographic distribution to be extended and low costs to be maintained. Ongoing communication is pursued with residents in the community on the fundamental role of APA for a better quality of life (e.g. APA Day).

Innovation, Impact and Outcomes

Key innovative elements of your good practice

The most important innovative element of the APA programme is its integration in a global strategy for the management of chronic disease conditions as envisioned by the Regional Health Plan and the Regional Plan for Prevention. APA activities create a new scenario to foster productive interactions between patients who take an active part in their care and LHAs providers backed up by resources and expertise.

In particular, the APA project, according to the principles of the chronic care model, has the potential to contribute to empowering and preparing patients to manage their health and health care, assure the delivery of effective, efficient clinical care and self-management support, promote clinical care that is consistent with scientific evidence and patient preferences, and mobilize community resources to meet the needs of patients.

Impact and outcomes

- ✓ A reduction of waiting lists for community rehabilitation services and more appropriate and timely service delivery was observed.
- ✓ Published studies prove the effectiveness and safety of APA programmes for individuals with chronic musculoskeletal pain (Clin J Pain. 2012;28:195-203; Eur J Phys Rehabil Med. 2011;47:543-9; J Neuroeng Rehabil. 2008;25:32-8) and chronic stroke survivors (Neurorehabil Neural Repair. 2009;23:726-34. J Rehabil Res Dev. 2008; 45:323-8. Eur J Phys Rehabil Med. 2015 Jul 27).
- ✓ We do not yet know whether implementation of APA programmes will result in measurable long-term improvements in community health or in reductions in health care utilisation.

Success criteria

- ✓ Increase of number of classes and gyms, and their geographic distribution, reduction of sedentary behaviour in the population aged 65 and over.
- ✓ High customer satisfaction (telephone interview).

Ethical Issues

The low cost and the variety of APA programmes, as well as the opportunity for transportation provided by voluntary service associations, give safe and effective opportunities to exercise to the entire eligible population regardless of their economic income status and functional conditions.

The widespread geographic distribution of gyms allows exercise needs to be met in both high- and low-density population areas.

Transferability to other regions

Given the positive experience of Tuscany, in 2011 the Italian Ministry of Health included APA in the National Guidelines for Rehabilitation (Piano di Indirizzo per la Riabilitazione). Presently, to our knowledge, APA programmes have been successfully started in 15 out of the 20 Tuscany regions.

Researchers and policy makers from European Countries and the US have visited Tuscany APA programmes in the last 10 years. The APA programmes of APA stroke survivors have been replicated in Howard County (Maryland, USA).

Key learning points

- ✓ APA is safe and effective.
- ✓ APA is economically sustainable.
- ✓ APA provides exercise opportunities to citizens previously excluded from the benefits of exercise.
- ✓ APA increases the appropriateness and correct timing of rehabilitation treatment.
- ✓ APA may be integrated in a global strategy for the management of chronic disease conditions.

Further information

http://www.usl11.toscana.it/pagina_0.php?pag=afa|home

http://www.asf.toscana.it/index.php?option=com_content&view=article&id=696&Itemid=126

http://www.usl4.toscana.it/?act=f&fid=3210

http://www.usl5.toscana.it/index.php?option=com_content&view=article&id=12231:afa&catid=144:riabilitazione&Itemid=6502

http://www.usl6.toscana.it/usl6/index.php?option=com_content&view=category&id=72&Itemid=360

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VYSOČINA REGION CONCEPTION OF PALLIATIVE CARE

Organisation name: Kraj Vysočina

Region: Vysočina

Country: Czech Republic

Total Region Population: 510 000 people

Main characteristics of the good practice

☐My region has a **fully implemented** strategy/programme for the prevention and management of chronic diseases/frailty

☒My region is **in the progress of implementing** a strategy/programme for the prevention and management of chronic diseases/frailty

Summary

Vysočina region aims to create a system of accessible palliative care covering the whole region. The system shall be based primarily on a form of domestic care. Further on, it shall be supplemented by a form of ward block care provided mostly by institutions established by Vysočina region.

To provide the abovementioned care, it is necessary to create tight clinical as well as organisational contacts with other key institutions and actors in the region. Extensions of the suggested system is necessary to shape with regard to the demand of such service, and in the framework of existing disposable financial possibilities of the regional budget.

Currently, the situation does not allow for setting high quality measures of palliative care in the whole system, nor a fluent conversion among individual elements of the system. This good practice aims to change this present status, to a situation where patients in need of palliative care (and accepting such care) can choose where, within the region, they wish to be treated. Wherever care is provided, it will be provided to the patients with same quality.

Description

General and specific objectives

- ✓ High quality setting of palliative care which shall cover all the need in the region.
- ✓ Available, mobile, specialised palliative care.
- ✓ Available beds of palliative care at providers established by the region.
- ✓ Unified database connecting health and social services (needs and supply).

Methodology and processes

- ✓ Creation of mobile, specialised teams of palliative care in Vysočina region – providing care in the domestic or supplementary social environment of patients.
- ✓ Operation of mobile (in field) specialised palliative care in the region in close cooperation with existing groups of care providers, such as general practitioners, churches, public companies, organisations etc.
- ✓ Konziliary teams of palliative care in means of medical facilities (hospital or long term hospitalised patient care facilities) – creation of well-functioning interdisciplinary konziliary teams of palliative care.
- ✓ Ambulances of specialised palliative care available on district level in the region.
- ✓ Beds of palliative care – gradual selection of beds from the total amount of subsequent care beds, internal or surgical care – with regard to the needs of specific hospitals.
- ✓ Information support – creation of brochures about palliative care in the region targeted to both patients and their family members and providers of health and social services.
- ✓ Interconnection of databases from the area of health care and social services.
- ✓ Training and continuous education of personnel in social services and health care institutions and education of family members in relation to palliative approach to patients.

Involvement of other organisations/actors

Hospitals, social facilities and private providers.

Funding source(s) of the initiative

Public health insurance and public finance from social area.

Innovation, Impact and Outcomes

The Czech Republic is, in means of palliative care, notably leaping behind some economically developed countries, not only European countries. Various public research studies imply that a majority of the population would like to spend the end of their lives at home. The social and clinical reality is however different. In the Czech Republic only 20 % of deaths occur in the domestic environment. Most people die in hospital facilities of intensive, and further subsequent, care. In a long-term perspective, demand dominates over supply of palliative care.

Currently, there is only one facility of palliative care, in the regional hospital of Jihlava, complemented by several individual units of home care in various districts of the region, which mostly offer supportive services. The current situation unfortunately does not even provide 10 % of demanded specialised palliative care in the region and does not offer space for future development. Patients often stay at unspecialised beds in hospitals and often far away from their family/relatives and familiar environment, as they have no place to go or no person to take care of them. The good practice aims at ensuring adequate comfort for the patient and his/her relatives.

Ethical Issues

Dignity to patients with long term incurable diseases as well as dying patients with support of family/close relatives in known environment.

Transferability to other regions

The good practice should be transferable to other regions. In case of interest it is possible to provide current results and our experience with the implementation of the projects.

Key learning points

- ✓ Education of non-medical employees in palliative care.
- ✓ Education of medical doctors in palliative medicine – making the specialisation more popular
- ✓ Education of family members and close relatives

Contact Person

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