REGIONE DEL VENETO

ACG tool for multiprofessional coordination to manage patients with multimorbidity and complex needs

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Regione del Veneto

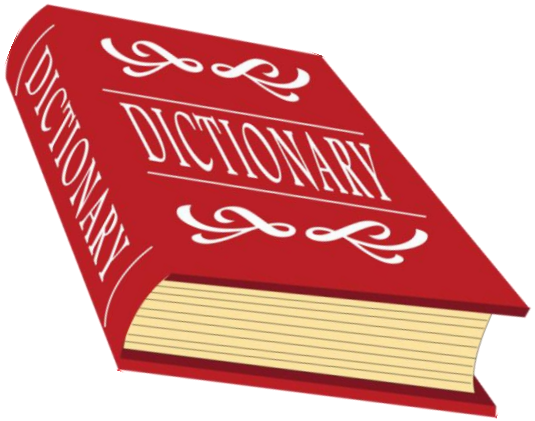
ACG tool for multiprofessional coordination to manage patients with multimorbidity and complex needs

Veneto Region "Case Study"

Design of the Project:
- Previous Experiences
- Aim of the Project
- Methods
- Design of the Care Pathway

Development of the Project:
- Tool Kit
- Enrollment
- Care management
- Preliminary Results

Introduction (1)



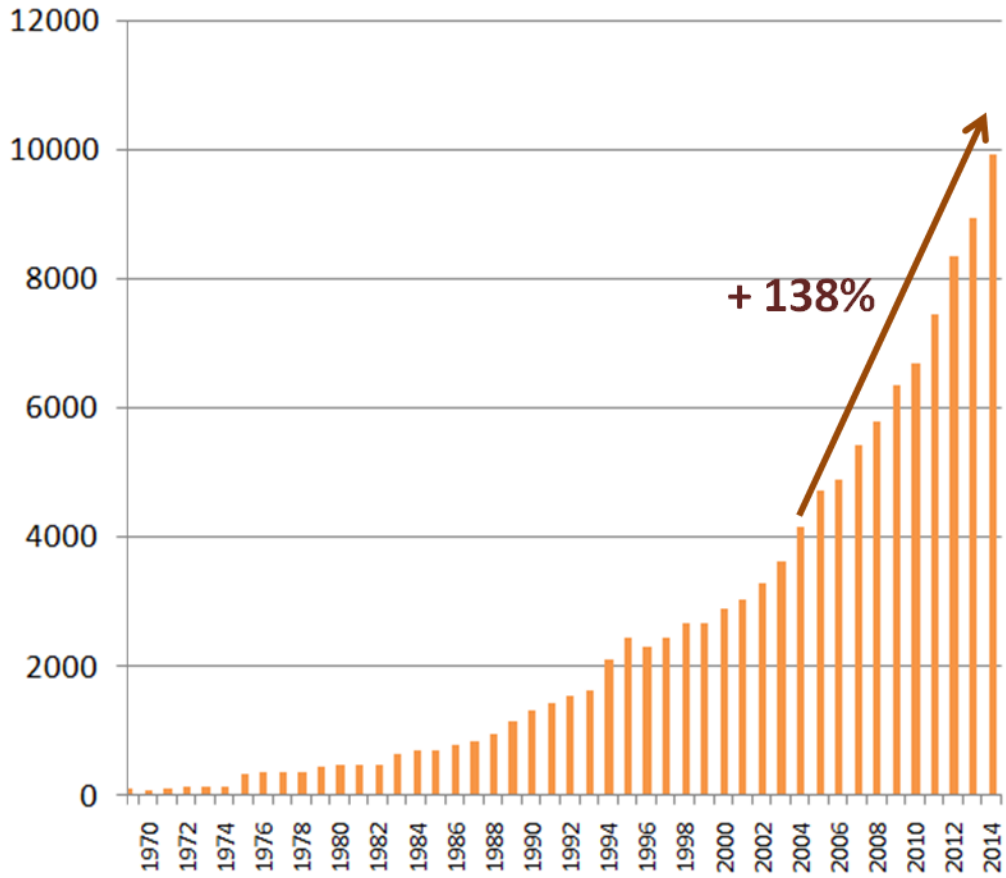
integration

[in-ti-**grey**-sh*uh* n]

1. an act or instance of combining into an integral whole.
2. an act or instance of integrating a racial, religious, or ethnic group.
3. an act or instance of integrating an organization, place of business, school, etc.
4. *Mathematics.* the operation of finding the integral of a function or equation, especially solving a differential equation.
5. behavior, as of an individual, that is in harmony with the environment.
6. *Psychology.* the organization of the constituent elements of the personality into a coordinated, harmonious whole.
7. *Genetics.* coadaptation (def 2).

Introduction (2)

Paper about "Integration" found in Pubmed (Results by Year)



Introduction (3)

Patient-Centred Care

Integration of IT and Data management

Multiprofessional **Integration**

Integration of Structures / Providers

Integration of whole health System

Source: Premier Healthcare Alliance
ACO = Accountable care Organization

Integrated care Models

- ☑ … are “patient centred”
- ☑ … are focused on health needs (and not on single diseases)
- ☑ …need High multiprofessional integration processes
- ☑ …need Patient and Care-giver empowerment

EXAMPLES

CHRONIC CARE MODEL

- Developed in California by Wagner and coll.

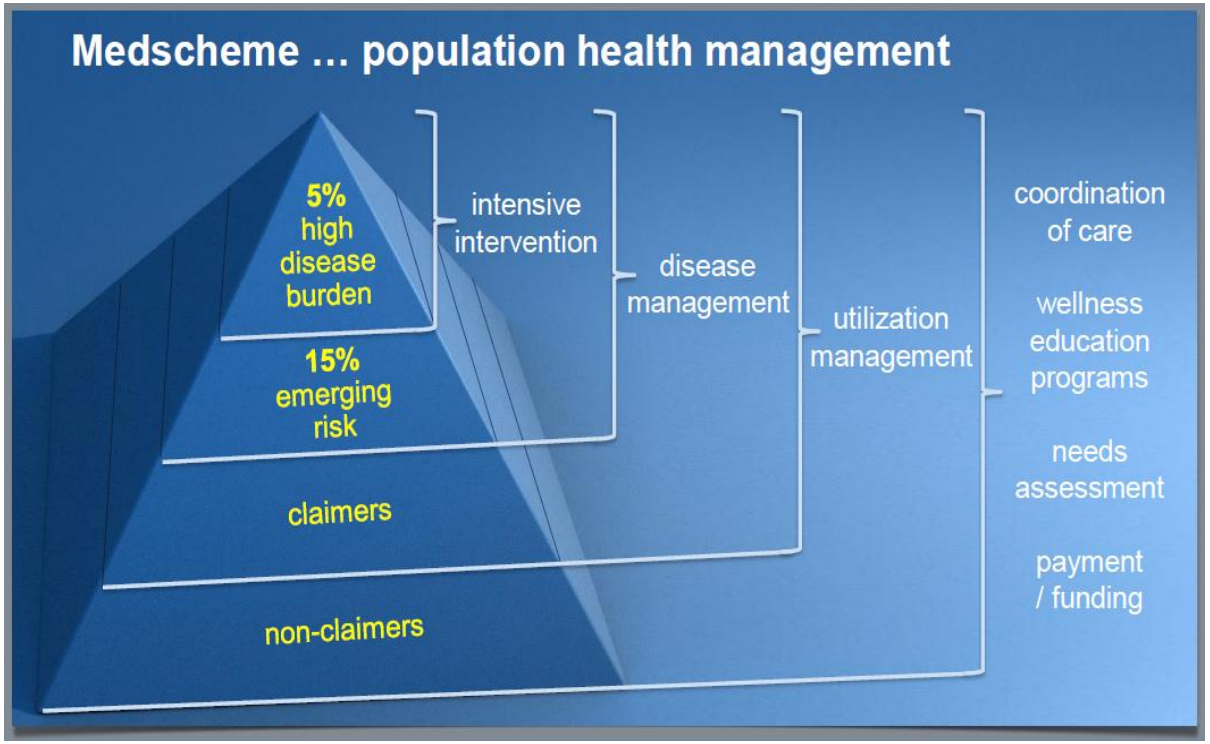
GUIDED CARE

- Developed in Maryland by John Hopkins University

Previous Experiences

Population Health Management

Medscheme is South Africa's **largest health risk management services provider** and second largest medical aid administrator

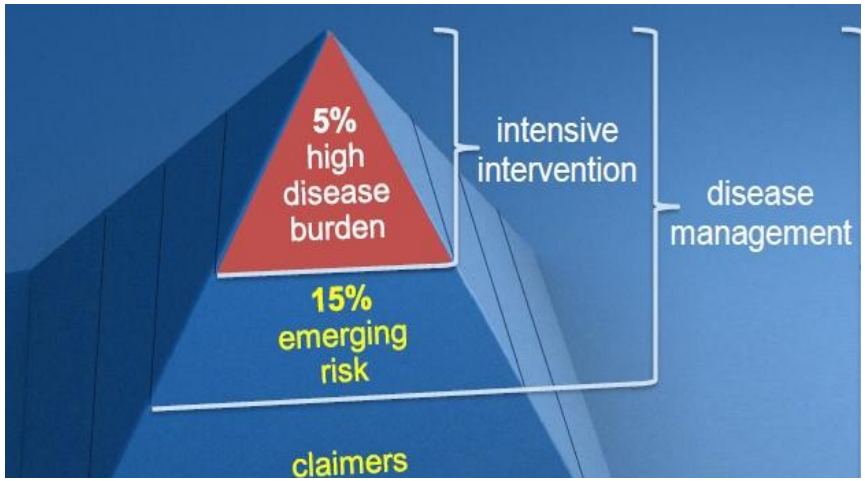


- Scan entire medical aid population
- identify potential high risk / emerging risk
- implement health care management well ahead of time
- improve cost, access and quality of care
- measure outcomes

Walters & al; 2014

Previous Experiences

Population Health Management



2006 novel approach to care management

telephone based individual centered *(instead of disease)* multiple co-morbidities *(rather than single disease)*

sophisticated predictive modelling identifies individuals with higher than expected healthcare resource utilization

- Care of high risk patients with intensive intervention.
- <u>Decrease</u> Specialist visits, ER admissions, medical admissions, hospital LOS
- approximately 2 months contributions per member saved!!!

medical admissions	ER admissions	hospital ALOS
per 1000 selected lives	per 1000 selected lives	
35	42	0.3

more GP visits
… less specialist visits
… appropriate care at right time

Walters & al; 2014

Aim of the Project

- To Develop a comprehensive primary care pathway , with multi-professional integrated approach, in Veneto Region Context

Integrated Primary Care
"Medical Homes"

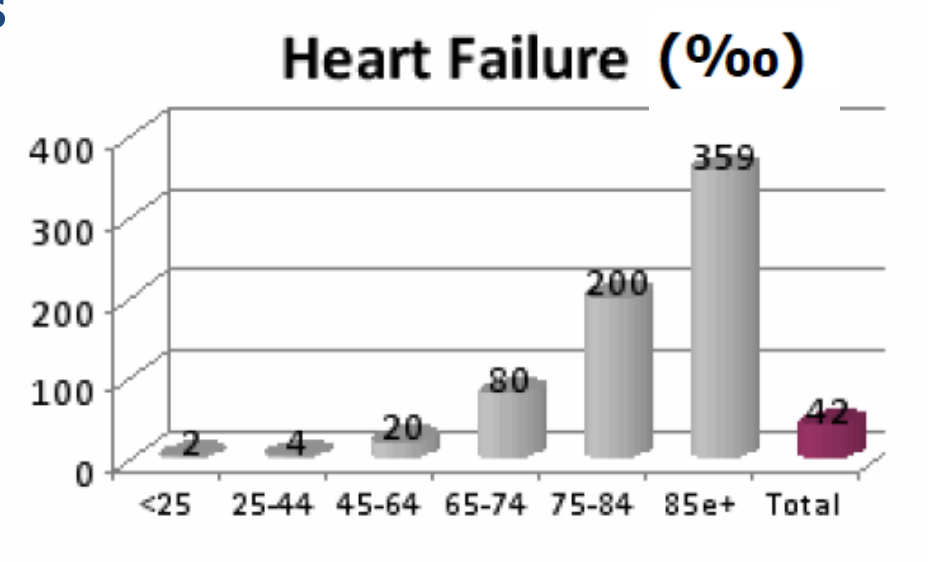
Material and Methods

- Identification of a sub-population to enroll in the project
- Identification of professionals to involve in the project (selecting Services/Providers)
- Development of pathways, clinical tools and IT support.
- Identification of Outcomes (indicators)

PATIENTS WITH MULTIMORBIDITY AND COMPLEX NEEDS

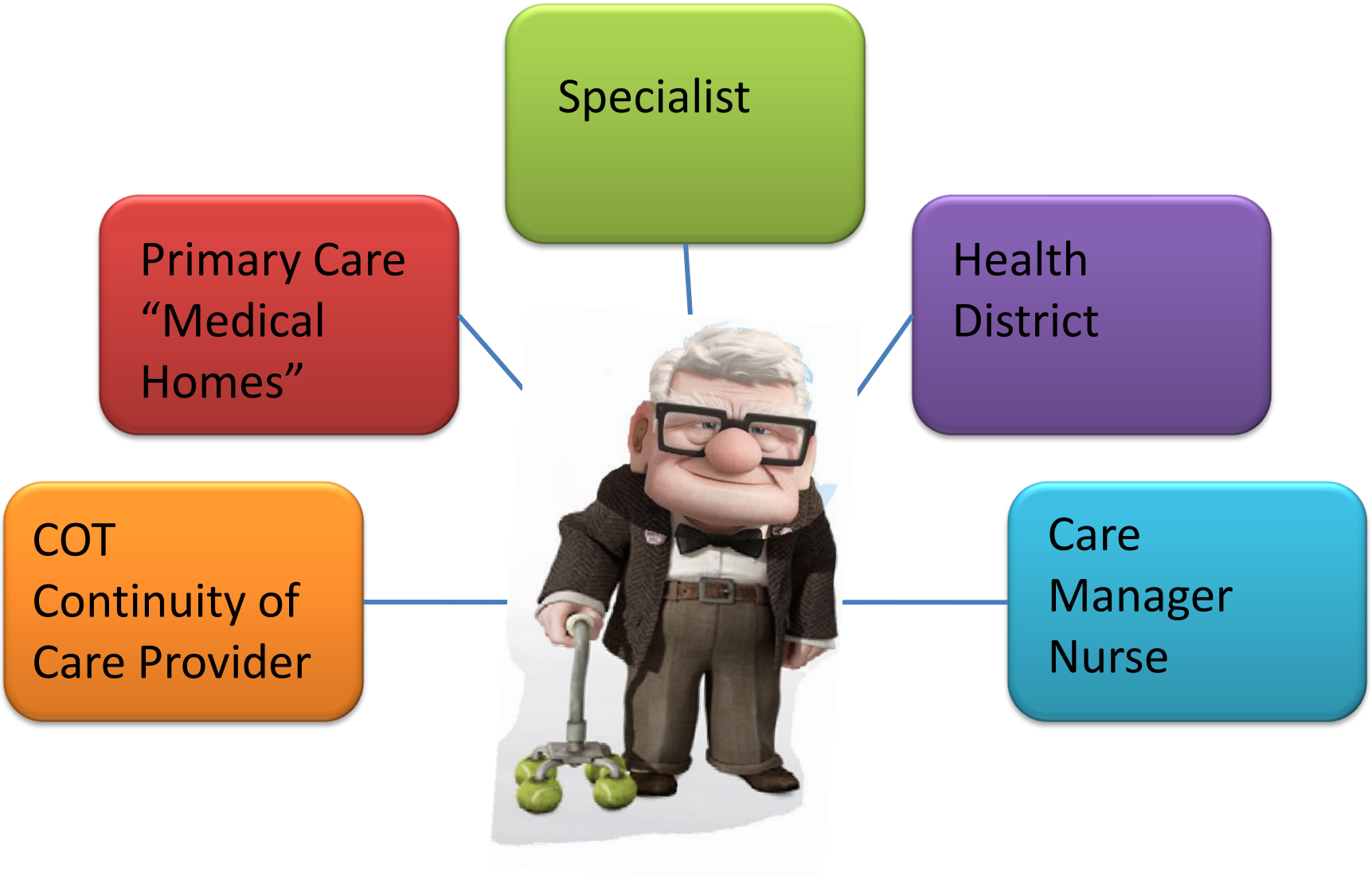
Identification of a sub-population to enroll in the project

- **Congestive Heart Failure**
  - Great economic and organisational impact in health care
  - A proactive approach can improve outcomes (Renewing Health Project)
  - ACG can identifies congestive heart failure patients to support disease management and care management programs



Gallina et al. 2014 JHU International ACG User Conference; Seattle

Identification of professionals to involve in the project



Development of pathways

Integration of GPs and Case –manager nurse in management of patients with CHF and multimorbidity in 21 LHUs

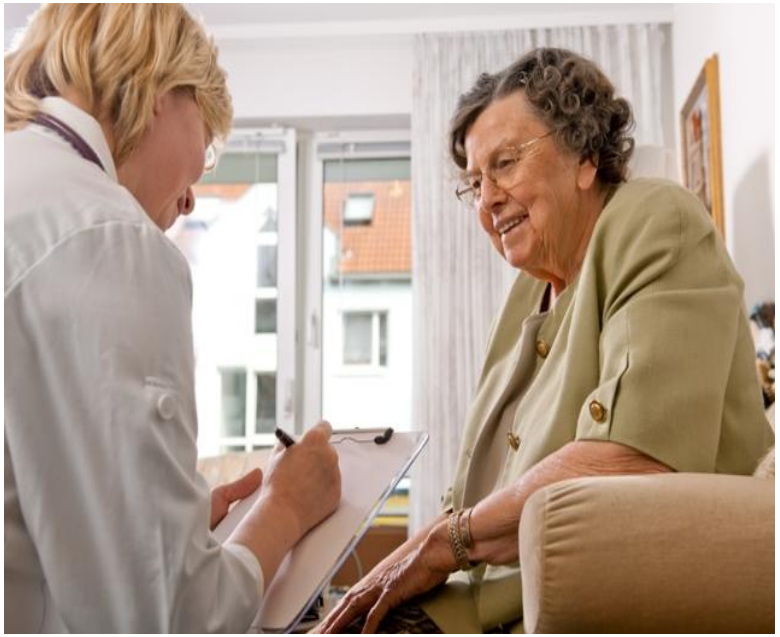
care management based on team work.

- The nurse follows a limited number of patients
- 20-30 patients from care management lists
- Scaling up to 70 patients followed with continuity

Invitation and consent (enrollment by GP)

Home visits by the case manager nurse

Integrated Care Planning



- Care plan shared by GP and Case-manager Nurse
- Action Plan for patient and care-giver .
- Active monitoring with calls, home visits and outpatient visits.
- Team meeting and follow-ups
- No deadline.

Identification of Outcomes (Indicators)

Increase Satisfaction	Patient Satisfaction Professionals Satisfaction
Decrease Unplanned Events	Outpatients visits, ER admissions, Hospital admissions, Hospital LOS

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http://acg.regione.veneto.it




Observatory Venice Summer School 2015
"Integrated care: moving beyond the rhetoric"
26 July- 01 August 2015, Isola di San Servolo, Italy

Photo by Pietro Gallina