IAGG-ER 8th International Congress
"UNLOCKING THE DEMOGRAPHIC DIVIDEND"

Symposium: Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)

Caring For People With Multiple Chronic Conditions In Italy: Policy And Practices

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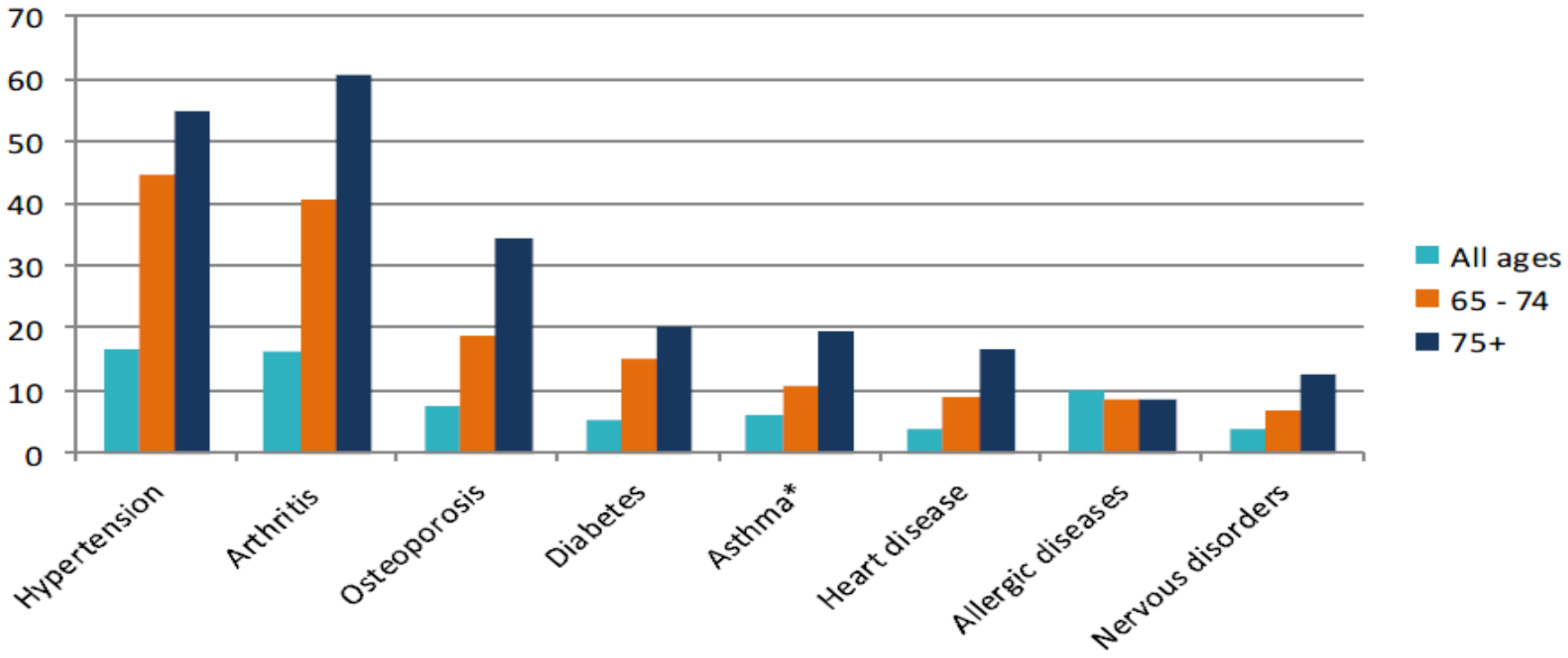
1. Challenges of multimorbidity in Italy

- In Italy, among a total population of around 59 million inhabitants, over 20% of people are aged 65 years and older, and 6% are 80 years and older, higher than European averages.

- Of the Italian population aged 16 to 64 years, an estimated 26.6% reported to have at least one long-standing illness or health problem. Prevalence rates are much higher for people aged 75+.

- Based on the occurrence of 14 self-reported chronic conditions, it has been estimated that approximately 46% of the population aged 50 years and older suffer from multimorbidity, i.e. have been diagnosed with at least two of these 14 conditions.

Prevalence of some major chronic diseases in Italy in 2013, estimations of the total population (all ages, 65-74, 75+) (% of 100 units in same age group)



*Chronic bronchitis, bronchial asthma

2. Organisation of chronic care and policy response

- The organisation and continuity of long-term care for patients with multimorbidity is far to be optimal. Main risks: the **care process is fragmented**; **limited view** of each specialised care provider of other disease-based treatments and related effects.

- Italy outlined a first attempt of policy on chronic care in 2005 when the National Institute of Health (ISS) and the Italian Centre for Disease Prevention and Control developed the "**IGEA" project**, which aimed to improve the quality of **diabetes management** by implementing integrated care.

- A following step was the promotion by the Italian Ministry of Health in 2009 of the **Global Alliance against chronic respiratory diseases**.

- Moreover, the **Single Point of Access** (PUA) started being implemented by regions from 2007 in order to allow patients in the community to access more easily to health and social services by a more integrated collaboration between professionals (in 84% of the health districts PUAs are currently implemented).

3. Selected programmes: experiences and results

- Out of 175 programmes identified in the ICARE4EU project by means of expert information and snowballing approach, 101 were finally verified as addressing all the inclusion criteria set. Within this corpus, **4 programmes** were found in the first half of 2014 in Italy.

- We considered care programmes, projects and interventions that have been developed or adapted for **addressing patients with multimorbidity** in Italy and were still running in 2014 (as a pilot or as on systematic basis), started in 2014 or finished in 2013.

- From these four programmes, we collected information about their **objectives**, **characteristics** and **results** (as reported by either the country expert or the programme managers through dedicated structured questionnaires).

ARIA PROJECT (ongoing)

AREA: Emilia-Romagna region
FOCUS: Lung and Neuromuscular Diseases
AIM: to avoid hospital admissions for respiratory exacerbations of patients suffering of neuromuscular/neurological diseases and/or largely tracheotomy/ mechanically ventilated at home.

MATRICE PROJECT (ongoing)

AREA: various Italian regions
FOCUS: Diabetes, Hypertension, Heart Diseases, Dementia,
AIM: to collect data related to chronic conditions through the integrated use of existing information flows in order to monitor and improve management of some chronic diseases.

CHRONIC CARE MODEL(ongoing)

AREA: Tuscany region
FOCUS: people with cognitive impairment
AIM: to review the integrated care system by implementing a CCM for the access and continuity of care in the Primary Care, the governance of user demands, the network of health, social and specialized care in the process.

RENEWING HEALTH (ended in Dec. 2013)

AREA: Multicentre European project: IT, DK, NO, FI, SE, ES, GR, AT, DE
FOCUS: Diabetes, Cardiovascular, Pulmonary Diseases
AIM: to validate the use of Personal Health Systems for innovative Telemedicine services used to monitor chronic patients and prepare for their wider deployment.

4. Experiences and results

Objectives and target groups	ARIA	CCM	MATRICE	RENEWING HEALTH
Objectives	Preventing misuse of services, improving patient involvement, decreasing morbidity and mortality	Quality of care, reducing access inequalities	Quality of care, preventing misuse of services, improving patient involvement, monitoring adherence	Quality of care, preventing misuse of services, improving patient involvement, decreasing mortality, reducing access inequalities
Target groups	Patients, informal carers	Patients, health and other care providers	Health and other care providers	Patients, informal carers
Focus on older people	No	Yes	No	Yes

4. Experiences and results

Organisation	ARIA	CCM	MATRICE	RENEWING HEALTH
Organisations involved	University and general hospital, patient organisation	General hospital, primary care, nursing home, social care, community care	University hospital, primary care, health district, region, ministry of health, government	University and general hospitals, primary care, nursing home, community care, patient organisation, region, ICT department
Professional competences for multimorbidity	Diagnostics, care delivery	Diagnostics, care delivery	Diagnostics, care delivery, collaboration, change management, ICT & eHealth	Self-management support, collaboration, ICT & eHealth

4. Experiences and results

Patient centredness	**ARIA**	**CCM**	**MATRICE**	**RENEWING HEALTH**
Involvement of patients	Yes: informed, consulted	No	No	Yes: informed, consulted
Decision-making tools for patient involvement	Personal care plan	No	No	Motivational interviewing, informational leaflets, active participation in care choices
Educational materials	No	Yes, not adapted	No	Yes, adapted

4. Experiences and results

eHealth	ARIA	CCM	MATRICE	RENEWING HEALTH
Types of eHealth tools:			None	
Digital health care communication		e-referral system		e-visits, e-prescriptions
Electronic systems for registering/monitoring care processes	registration monitoring, health status parameters			registration monitoring, health status parameters
Electronic decision support systems	medication and non medication treatments	non medication treatment and registration of patient data		patients safety and registration of patient data
Systems for patients' self-management	self monitoring health parameters			self monitoring and behavioural change
Electronic Patient Records (EPRs)		yes		yes
Training to patients and professionals	yes			yes

4. Experiences and results

Financing	ARIA	CCM	MATRICE	RENEWING HEALTH
Source of funding	Statutory health financing system, private sources	Public sources	Public sources	Statutory health financing system, public sources, EC structural funds
Same payments as usual care	Yes	yes	yes	No
Results in cost savings	Yes (lower recourse to hospital for acute events)	no	no	no

4. Experiences and results

Evaluation	ARIA	CCM	MATRICE	RENEWING HEALTH
Assessment conducted	Yes	Yes	Yes	Yes
Structure level	Organisational aspects	Organisational aspects, accessibility, continuity, health care provider	Continuity	Organisational aspects, enrolment of patients
Process level	Care management	Care management	Decision-making	Care management
Outcome level	Clinical outcomes, hospital admission, patient satisfaction, cost effectiveness, quality of life	Hospital admission	Staff and management responsiveness, competencies of staff	Clinical outcomes, hospital admission, patient satisfaction, staff and management responsiveness, cost effectiveness, quality of life

3. Experiences and results: focus on older people

Chronic Care Model programme

- **Chronic Care Model programme** aims at reviewing the integrated care system dedicated to people with cognitive impairment for enhancing the access and continuity of care process in the Primary Care, the governance of the request for assistance, the Social and Health Services network, the Specialized Care Services.

- **STRENGTHS**: The re-organization of the diagnostic-therapeutic-assistance process of the person with dementia should represent, in Tuscany, a necessary evolution of the current integrated system of patient social and health management able to assure the **continuity** of care. An **effective integration** between the Primary Care system, the District (the PUA, the Multidisciplinary Assessment Unit) and the specialists is implemented. Furthermore, the model would benefit from enhancements made for **other chronic diseases**.

- **WEAKNESSES**: It is difficult to reorganise Alzheimer Assessment Units as specialised units integrated in the whole care process (proactive medicine), probably because specialists are afraid of losing their **professional autonomy**. Also quality and pertinence requirements of residential and semi-residential services dedicated for people with a cognitive impairment and behavioural disorders is not easy to define maybe because of the current **regional legislation** which appear to be too difficult to modify.

3. Experiences and results: focus on older people

RENEWING HEALTH programme

- **RENEWING HEALTH** aims at implementing large-scale real-life test beds for the validation and subsequent evaluation of innovative telemedicine services using a patient-centred approach and a common rigorous assessment methodology. It involves a Consortium of 9 of the most advanced European regions in the implementation of health-related ICT services.

- **STRENGTHS**: Main positive aspects concern: interdepartmental **cooperation** amongst health services providers and social welfare services via new technologies; **patient empowerment**; **cost-benefit gains**.

- **WEAKNESSES**: It has not been entirely **legally/institutionally adopted** in the context of an integrated health service system for patients with multiple co-morbidities. Furthermore, there is still no method of **funding** for its wider deployment in the National Health System. Finally, it is still difficult to deal with **interoperability** of technologies.

5. Final remarks and key points

- New **policies** and **care programmes** addressing multimorbidity have been introduced recently in Italy, with good/preliminary results in terms of integration/collaboration of care services/providers, changes in utilisation of resources, involvement of informal carers and transferability. Positive outcomes have thus been collected, although final assessments are needed for confirmation.

- Despite these developments, the Italian long-term care (LTC) system is characterised by **high fragmentation** in terms of sources of funding, governance, and management responsibilities.

- Moreover, the current **economic crisis**, **recession** and related **cuts** in public expenditures on health and social care sectors have an impact on the provision of care services.

- Also the wide provision of public **cash allowances** instead of in-kind services, as well as the reliance on **family carers** and privately-employed **care assistants**, contribute to limit the development of adequate, comprehensive policies and programmes towards multimorbidity of frail and older people.

Thank you for your attention

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