







USING THE SCIROCCO TOOL PUGLIA - ITALY

- Francesca Avolio
- Agenzia Regionale Sanitaria della Puglia Italy





Puglia Region

- 4,1 millions population
- 40% Chronic patients
- 21% over 65yrs





1. COMPREHENSIVE HOSPITAL NETWORK

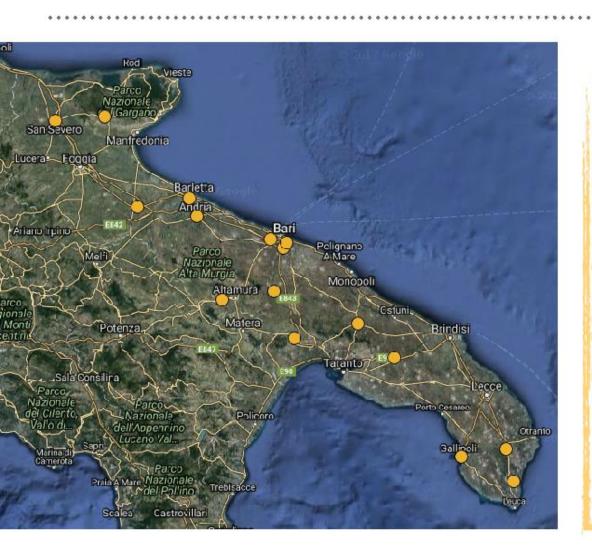


5 Second Level Hospitals

> average 825 beds



1. COMPREHENSIVE HOSPITAL NETWORK

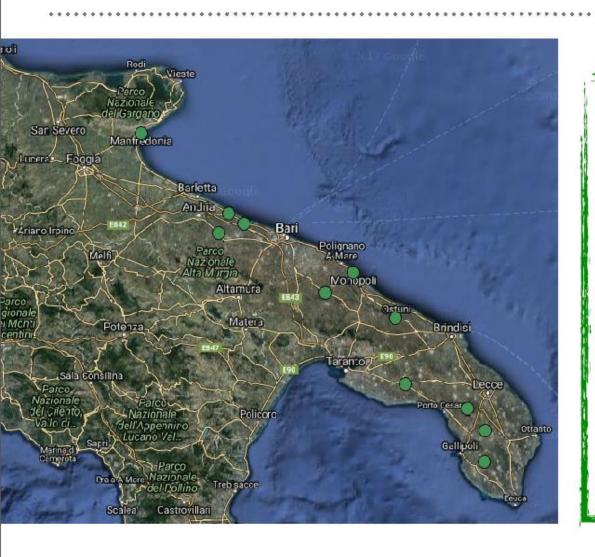


16 First Level Hospitals

> average 299 beds



1. COMPREHENSIVE HOSPITAL NETWORK

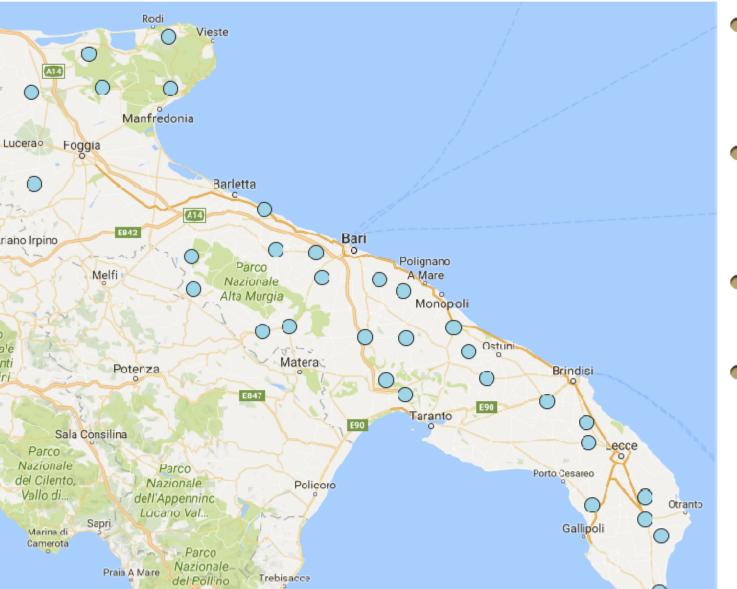


12 Basic Hospitals

> average 127 beds



2. INTEGRATED HEALTH COMMUNITY CENTERS (PTA)



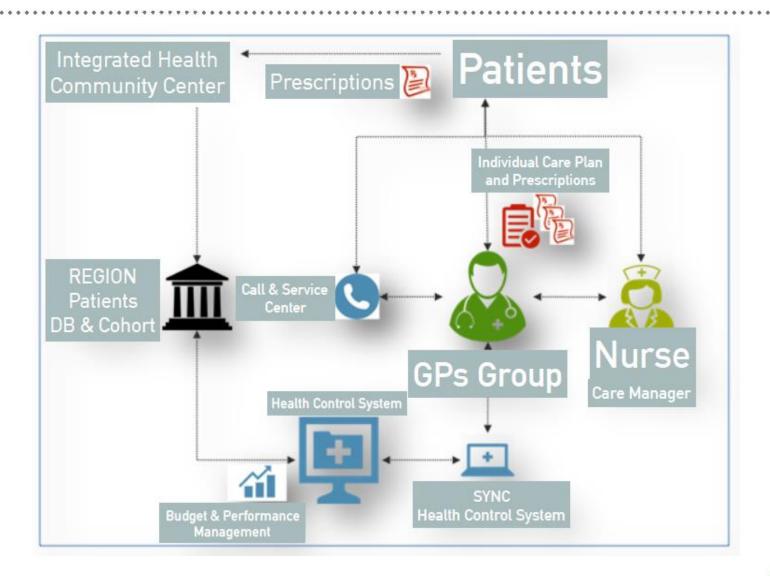
- 31 PTA (Presidi Territoriali di Assistenza)
- Most of them once (2010 e 2016)
 were hospitals
- PTA is not a "box full of things"
- ...but a center of integrated healthcare service

2. INTEGRATED HEALTH COMMUNITY CENTERS (PTA)

- Patient Information and Orientation
- Primary Care and GPs associated
- Ambulatory Care and Outpatient Surgery
- Bioimaging and Diagnostics
- Dyalisis Center
- Prevention and Vaccination Services
- Rehabilitation Services and Accommodation
- Health Community Housing (hospice, disability, senior)
- Family Counselling and Maternal Services
- Psychiatric services and housing



3. CARE PUGLIA FOR CHRONIC PATIENTS: THE MODEL







GOOD PRACTICES: CKD INTEGRATED CARE

Key Innovative Elements

- CKD integrated-care is a platform with an e-learning environment, with edu-games for the empowerment of the general population
- a business intelligence tool on board for the early identification of CKD patients through the analysis of clinical pathology data
- efficient clinical information management infrastructure inspired by home living design and fully equipped with telemonitoring system audio-video connection between patients, nurses and nephrologists
- empowerment of the patient and caregiver through a social network and e-learning system: patient trained to self perform dialysis treatment.





Challenges Addressed

- ► Ageing of population and the related increased prevalence of chronic degenerative diseases (empowerment and ICT support System).
- ► Early detection (rate of progression of CKD reduced by 10% costs, leads to savings in health spending of 2.5 bilion euros in 5 ys).
- **►** De-hospitalization.
- Marginalization of the most vulnerable people.
- ► Improve access to healthcare: better care, less costs, care training (professionals), client empowerment.
- ► Social and healthcare integration.





Transferability

- Adequately equipped control room (PCs, monitors, network, etc..).
- Specialized physicians (Case manager).
- Specialized Nurses (Care manager).
- ICT specialist (software maintenance and improvement).
- Home telemedicine kits (sofà + medical devices + HD camera).
- Smart devices (tablet, PC, smartphone, etc..).
- ICT regional structure, with privacy and security systems.
- Training facility.





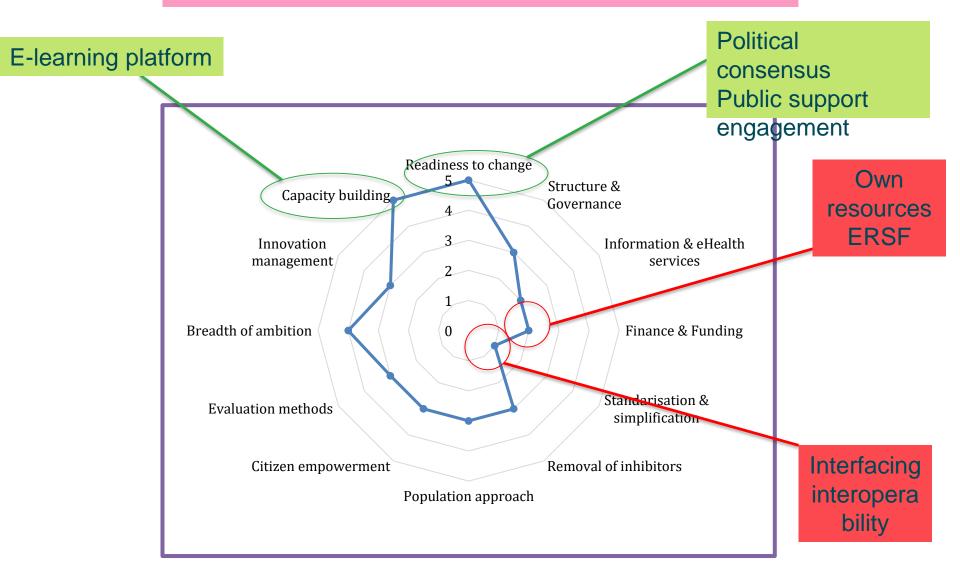
Transferability

- Commitment of Political Government in introducing telemonitoring systems in daily clinical practice.
- Specific requirements like ICT infrastructure at Patient Home and Control Room (multiconnection audio-video platform).
- Technical interfacing problem with the existing ICT structure.
- Difficulties in the use of devices by older patients.
- Privacy Policies.





CKD Integrated Care





Conclusions



- The online tool was easy to use and to access.
- Dimensions seems appropriate to assess the maturity of the context.
- Refinement on some of the scales is needed, and some language issue should be analyzed.
- The use of the maturity model was accepted by stakeholders as a very "precious" support for the development of feasibility studies prior to activation of scaling up processes.
- The outcome of the good practice assessment was coherent to context, regional framework, points of weakness and strengths of GP, but mainly to the "context" and "policies":
 - 🔷 to do list
 - agenda priorities







Innovation Initiative

EHTEL Innovation Initiative Meeting @ EHTEL 2017 Symposium



