INNOVATING THE MANAGEMENT OF CHRONIC CONDITIONS

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OUTLINE

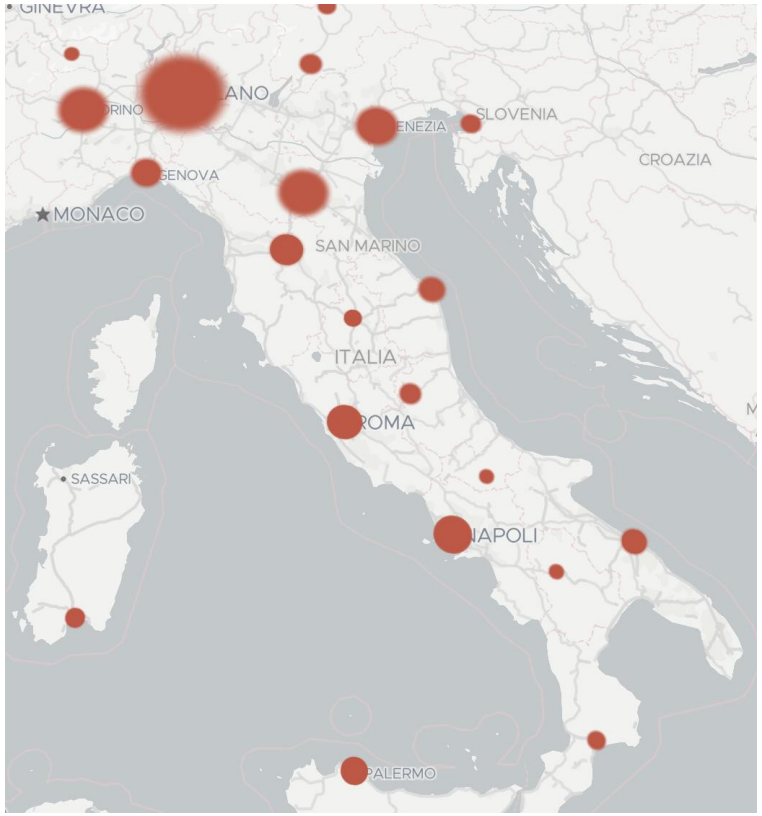
- Introduction: Italy and Covid-19
- Aim and methodology
- What happened during the emergency to the management of chronic patients in outpatient settings
- Identify and discuss some implication to innovate the management of chronic patients

THE PANDEMIC IN ITALY

- **COVID-19 in Italy**
  - First Western country to suffer a major Covid-19 emergency
  - Feb 21: identification of first cases
  - Within 2 weeks: massive rise, reaching > 15,000 cases and > 1,000 deaths

- **Consequences to the National Health System**
  - Massive access to emergency departments, saturation of ICUs and inpatient wards
  - Many hospitals, especially in Northern Italy, had to completely restructure their services in order to accommodate the demand

Total number of cases in Italy
(21st feb-27th oct)



538,324	39,578	51 years	49.1% | 50.9%	37,406 (6.9%)
Cases	Cases among healthcare workers*	Median age of cases	Males (%) | Females (%)	Deaths (Case-Fatality Rate)

Source: COVID-19 integrated surveillance data in Italy

THE MANAGEMENT OF CHRONIC PATIENTS DURING COVID-19

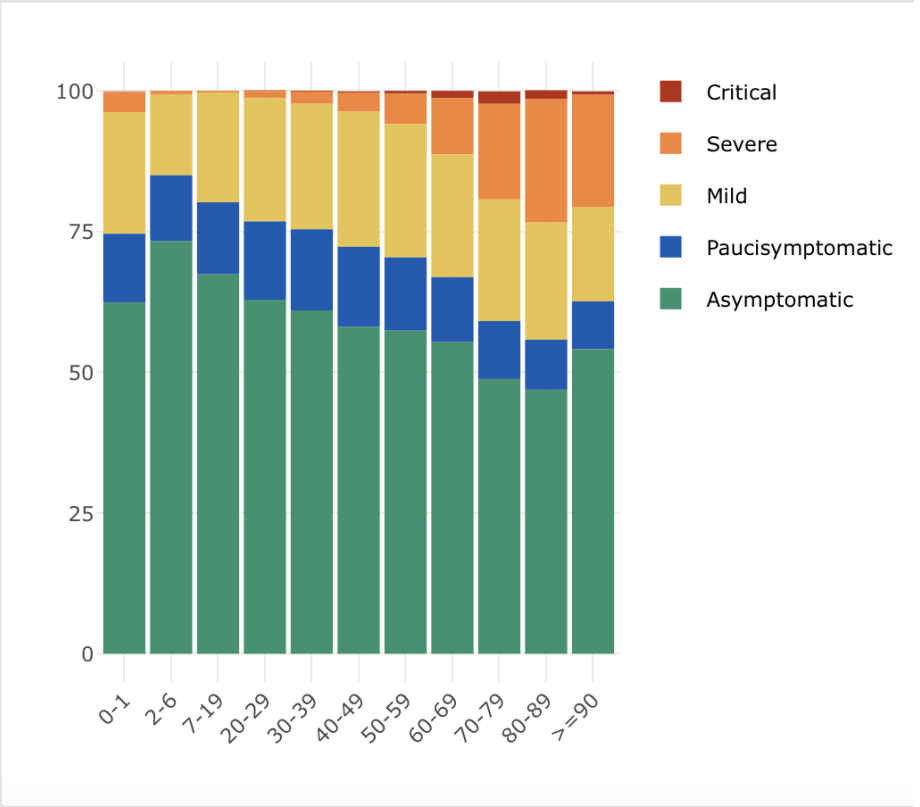
Managing chronic conditions amid a pandemic has proven to not be easy for several reasons:

1. Elderly and patients with chronic illnesses were among the most vulnerable populations at **increased risk of severe illness** from COVID-19,
2. health care organisations have had to **balance the need to protect patients** and those who live with them from getting COVID-19, with the need to **maintain continuity of care** to avoid the risk of decompensated patients requiring emergency hospital care.

Adjustment to daily routines, developing new care models and dealing with new obstacles.

Lack of adjustments → negative effects (medium/long term) on Chronic patients (no Covid)

Proportion (%) of Covid-19 cases of Covid-19 notified in Italy by current clinical status and age group (data available for 194,927 cases)



Source: COVID-19 integrated surveillance data in Italy

QUESTIONS AND AIMS

- What strategies and organisational models healthcare organizations developed in the different phases of the COVID-19 pandemic to drive chronic disease management within the outpatient ambulatory setting?
- What can be learnt from the emergency to innovate the health system and the management of chronic patients?

Aims:

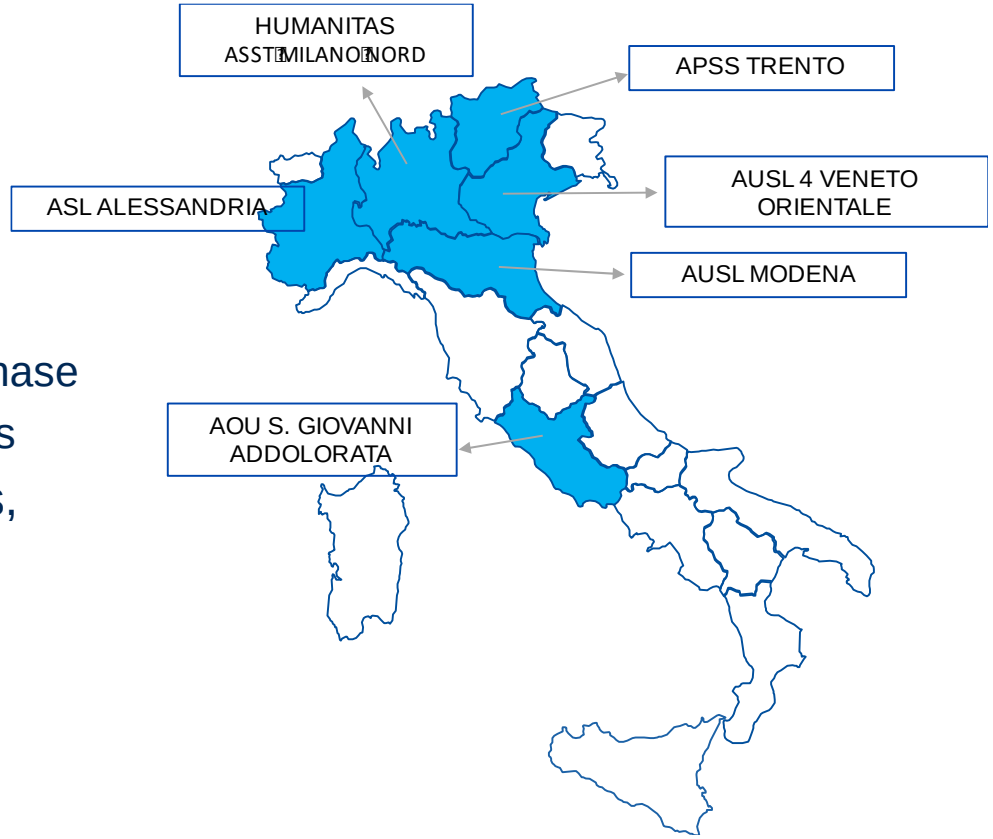
1. to present and discuss the choices made by several hospital trusts and local health authorities in Italy to maintain the continuity of care in outpatient ambulatory settings
2. To consider what is needed in the immediate future.

The analysis presented and discussed is one of the chapters published in the Annual Report of the **Observatory on Healthcare Organizations and Policies in Italy** (*OASI*) of CERGAS-SDA Bocconi https://cergas.unibocconi.eu

OASI 2020
Osservatorio sulle Aziende e sul Sistema sanitario Italiano

METHODS

- **Multiple Case studies** (7 case studies in 6 Italian Regions)
- **Selection criteria**: Cases were selected in order to maximize the differences
  - HTs, LHAs, Research hospitals
  - Regions that have had the most impact of Covid-19 in the first phase
  - Regions with different models of care delivery for chronic patients
- **Data** were collected through interviews with Hospital directors, organizational unit directors, HCPs, operations head
- **Focus**:
  - Chronic patients
  - Outpatient ambulatory care
- **Timeframe**



Before emergency	1st phase	2nd phase	Nowadays
February 21st (1° case of Covid-19) – March 9th	Lockdown (Between March 9th – May 4th)	Mitigation of restrictions → new cases From May 4th to September	Raising of numbers and new restrictions (October – up to date)

EVIDENCES: FIRST PHASE

Period: 9th of march – 4th of may

Context:

1) general lockdown
2) on March 8th the Prime minister ordered a block on all but urgent outpatient services (e.g. chemotherapy, radiotherapy, or dialysis)
3) Definition of the Regional network of coronavirus testing Centers
4) Involvement of private (accredited) providers to manage the increasing numbers of patients with Covid
5) Definition of Special Continuity Care Units (USCA) to monitor patients at home or in nursing home for elderly

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Strategy and aim of Healthcare organizations:

Maintain the continuity of care «at zero risks» for chronic patients

EVIDENCES: FIRST PHASE

Actions

1. Block of not urgent outpatient services and timely contact with patients
2. Specialization of hospital network (Covid/Covid free) and decentralization of outpatient services in other settings (outside the hospital premises)
3. Transformation of the internal logistics (separation of patient flows)
4. Development of digital solutions (telemonitoring, teleconsultation, tele visit, virtual visits) – *often domestic solutions*
5. Provision of services “at home”
6. Development of task forces to improve the coordination between levels of care (hospital and primary care)

Facilitating factors

- Previous experiences of collaboration and connection between levels of care
- Availability of platforms and previous experiences (digitalization)
- Expertise: previous experiences of “itinerant teams”
- Availability of operation management functions

EVIDENCE: SECOND PHASE

Period: 4th of may – September
Context: mitigation of restrictions, low number of cases, outpatient services opened also to non urgent patients

Strategy and aim of Healthcare organizations:
Maintain the continuity of care «minimizing the risks» while increasing the capacity

Actions

1. 1) Increase the capacity: Opening times, Spaces, Human resources, Flexible layout, Partnership with private (accredited) providers
2. 2) Development of several strategies to recall patients and decentralization of outpatient care
3. 3) Digitalization: definition of new models of tele visit, of regional rules/guidelines and framework to sustain, reimburse and further develop the use of digital solutions

CONCLUSIONS

1) Similar strategies but different level of development and implementation

2) What happened in the first phase of the pandemic accelerated some transformative processes that were already under the radar of healthcare organizations

3) Learning process: important to facilitate knowledge sharing
   the Italian Regions who didn't experience the major pressure during the first phase of Covid-19
   are now experiencing the same major difficulties experienced by Northern regions in march
   1) Slowing / closing outpatient services
   2) Difficulty to do contact tracing
   3) Difficulty to provide swab

4) We need to imagine a future were we "fight two battles"
   Covid-19 + Chronic care conditions and other conditions

CONCLUSION: LEARNING LESSONS

- The management of the pandemic forces us to reflect on the implications to **innovate the management of chronic care patients:**
  1. Challenges the traditional care model and forces to rethink the integrated care pathways for chronic patients
     - The boundaries of outpatient services are becoming more flexible: *what do we mean by outpatient services? setting? activities?*
     - Development of multichannel model (mix of in-person and tele visit): *which target can benefit the most? When? How often? How to organize it?*
     - «The discovery» of the phone both in the relationship with patients and with other HCPs: *how we can transform what was developed during the emergency into routine practice and recognize it?*
     - Development of new roles and competences (i.e. operation manager)
  2. Proliferation of digital solutions: → move from multiple fragmented platforms to a unified vision and ensure interoperability
  3. Improve the coordination with territorial actors (i.e. GPs, USCA)
  4. Hypothesis of a new mix of person-centred services and community centred-services (prevention, public health)
  5. Internal debate: how to evaluate the performance of healthcare systems

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