CONFERENCE ABSTRACT

The strategy role of transitional care units to support Integrated Care and Personalised pathways for frail persons

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The paper presents a comparative analysis of three models of transitional care units that have been set up in Italy in the last three years within the processes of Regional Healthcare Services and healthcare organisations’ reforms. The comparative analysis is worth of providing interesting insights and generalizable lessons learnt from integrated care in practice. The three cases of transitional care units belong to a similar background wherein greater needs for care coordination across the supply chain have risen, but the implementation has brought to different organizational solutions to meet the contextual features. The common base-line scenario can be described by four fundamentals: 1) the merge and establishment of larger Local Health Authorities, serving a population of 1.2mLn inhabitants on average; 2) the set-up of integrated care models between hospital care and primary care (as intermediate care, rehab., residential care, palliative care, home care or hospital at home); 3) the use of clinical governance tools and methods (as Integrated care pathways (ICPs), clinical networks), exploiting approaches deriving from the population health management (PHM); 4) the efforts to strengthen the integration between health and social care, foremost by using tools and targeted case management models for the most fragile persons. From this scenario, three different models of transitional care units rose, in Veneto Region, in Tuscany and in Lombardy, to build up integrated care by streamline ICPs across the supply chain of services and professionals within the newly established LHAs. The paper discusses comparatively the three cases of transitional care units. It analyses in depth three cases, one from each Region, based on different healthcare organization unit. The case study analysis allows to tackle out the organizational, professional and operational tools applied distinctively, based on the data collection of their initial activities and interviews with the key players. From the comparisons, lesson learnt can be drawn for generalization, detangling the contextual organizational features and service design’s needs (the path and resources dependency of each model) from more general observations and tips that could foster the sustainability and efficacy of similar services.
Keywords: population health management; transitional care units; risk stratification and segmentation; frailty; integrated care pathways