ISTITUTO SUPERIORE DI STUDI SANITARI
Giuseppe Cannarella

CARD

Associazione Direttori e Dirigenti Sanitari dei Distretti del Lazio

IL PNRR E LE CASE DELLA COMUNITÀ

La proposta della Card Lazio

18 giugno 2021

ore 14.30/17.00

''La Casa della Comunità quale fulcro dell'assistenza distrettuale''

METODOLOGIA DELLO STUDIO A SCOPING REVIEW

a cura di: Paola Arcaro, Ambrogio Cerri*, Ludovica D'Agostino, Alessio Perilli, Alessandra Romano, Giorgio Sessa, Elena Veneziano.

*presenting author

SCOPING REVIEW

- Population: popolazione di primary care;
- Context: tutti i modelli internazionali di “case della salute” o strutture di co-location in primary care;
- Concept: Co-location e Integrazione dell’assistenza primaria, come previsto in tutte le declinazioni di Pim P. Valentijn.

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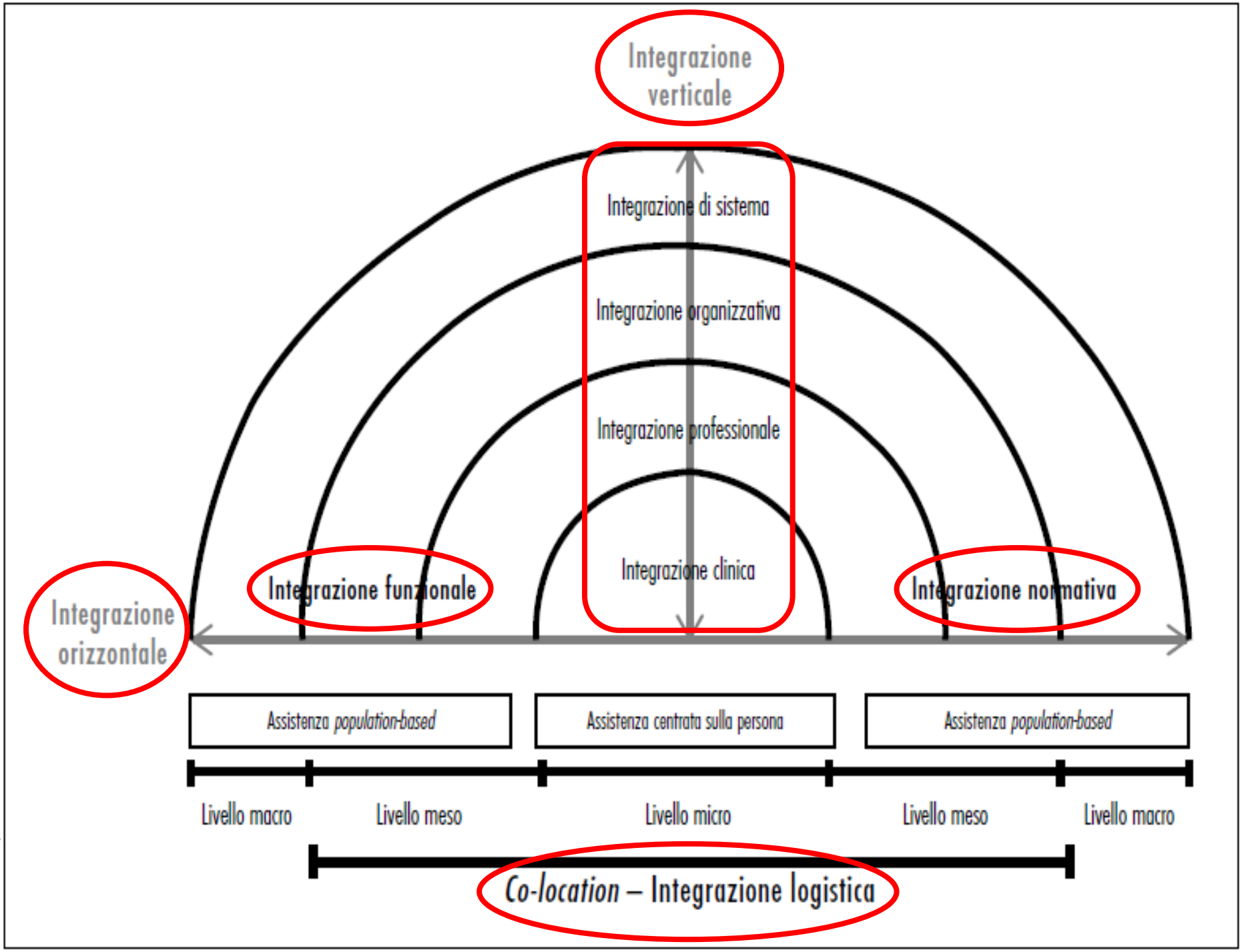
E LE CASE DELLA COMUNITÀ
La proposta della Card Lazio

FRAMEWORK CONCETTUALE



Valentijn PP, Schepman SM, Opheij W, Bruijnzeels MA. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. Int J Integr Care. 2013 Mar 22;13:e010. doi: 10.5334/ijic.886. PMID: 23687482; PMCID: PMC3653278.

18 giugno 2021

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La proposta della Card Lazio

COMPOSIZIONE DELLA STRINGA

RISULTATI 2,053 su PubMed 05/05/2021 16h00

(("Primary health care" OR "Primary Health Care"[Mesh] OR "Primary care" OR "community care") AND ("community health centers" OR "integrated primary health care centers" OR "Patient-centered Medical Homes" OR "general practitioner led health centres" OR "Centre d'Atencio Primaria" OR "Centro de salud" OR "Centro de saude" OR "Maison de sante" OR "Case della Salute") AND ("integrated care" OR "Delivery of Health Care, Integrated"[Mesh] OR "collaborative care" OR "coordinated care" OR "co-located care" OR "family centered care" OR "shared care") AND (barrier OR inhibitor OR facilitator OR enable OR management OR organization OR "Organization and administration"[Mesh]))

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La proposta della Card Lazio

COMPOSIZIONE DELLA STRINGA

RISULTATI 2,053 su PubMed 05/05/2021 16h00

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CRITERI DI SELEZIONE

CRITERI INCLUSIONE:

- Presenza di un contesto di primary care;
- Presenza di strutture analoghe alle case della salute, ovvero strutture che presentino co-location di servizi e professionisti;
- Presenza di un livello di integrazione dell'assistenza.

CRITERI DI ESCLUSIONE:

- Lingua diversa da quella inglese e italiana;
- Articoli ritirati, duplicati o non disponibili in full-text;
- Tipologia di studi non significativa, in quanto non descrittiva di un modello che rispetti il concept stabilito.

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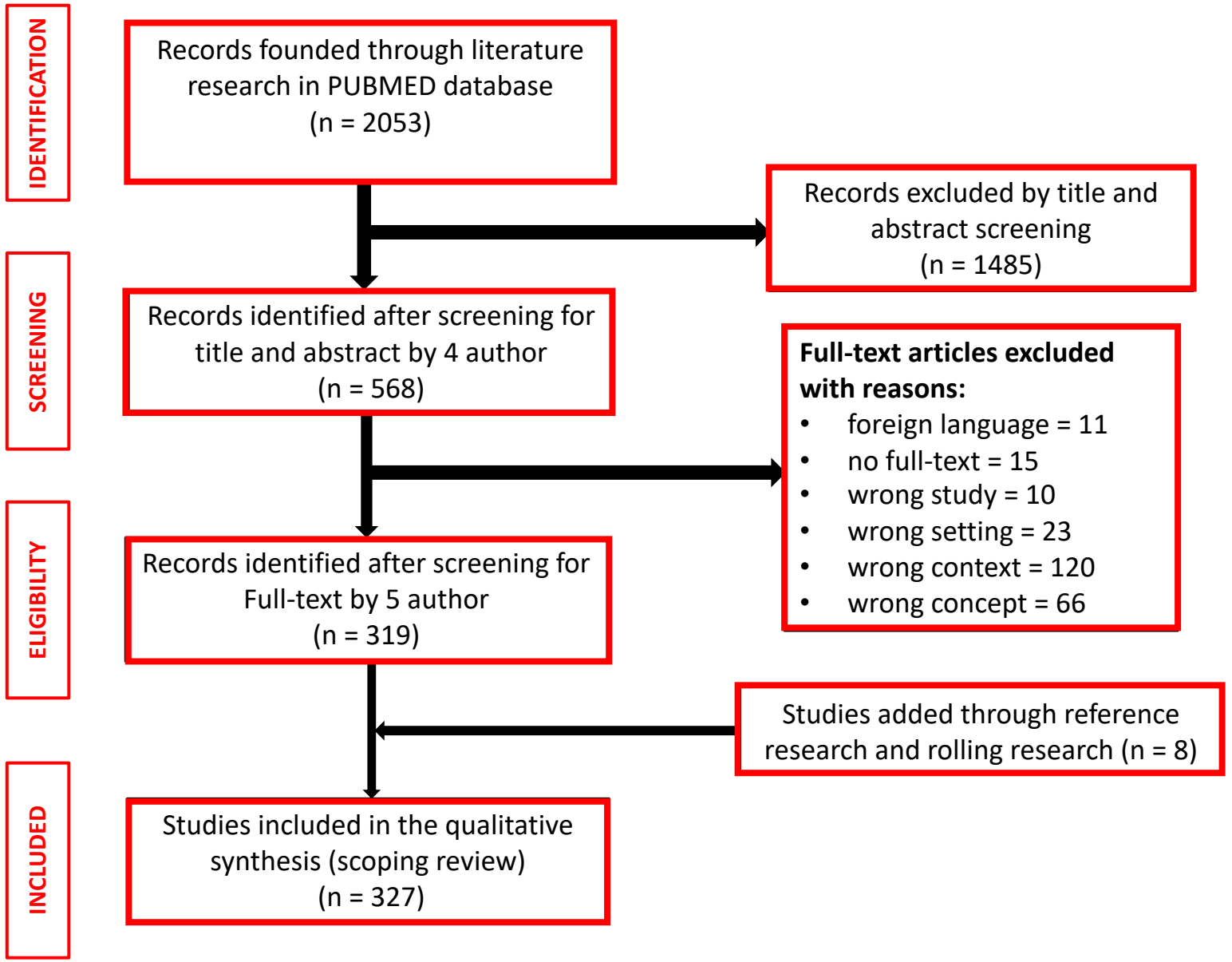
La proposta della Card Lazio

PRISMA DIAGRAM



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La proposta della Card Lazio

STRUTTURA TASSONOMICA

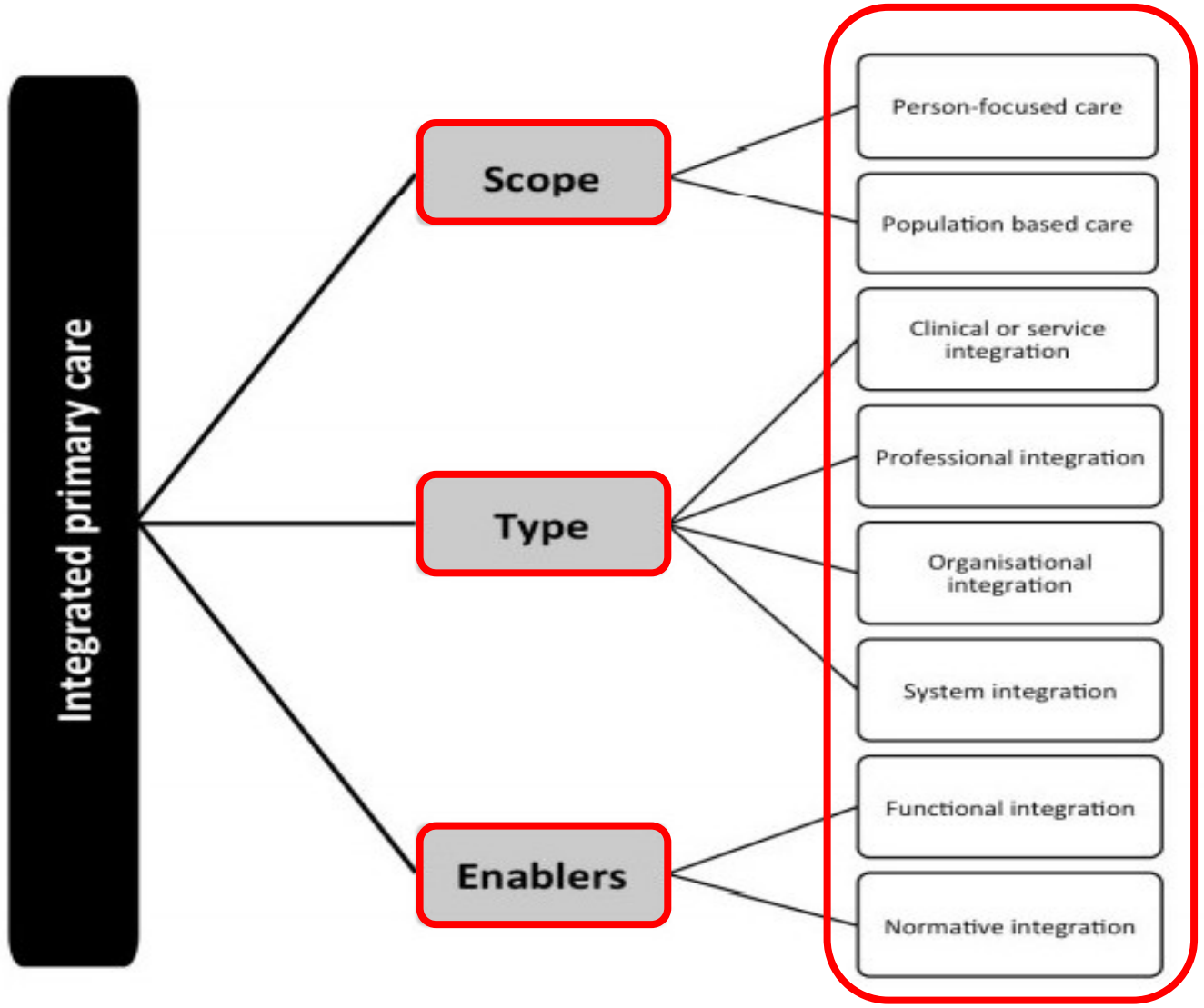

Figure 3: Final taxonomic structure of integrated primary care

Valentijn PP, Vrijhoef HJ, Ruwaard D, Boesveld I, Arends RY, Bruijnzeels MA. Towards an international taxonomy of integrated primary care: a Delphi consensus approach. BMC Fam Pract. 2015 May 22;16:64. doi: 10.1186/s12875-015-0278-x. PMID: 25998142; PMCID: PMC4446832.

IL PNRR
E LE CASE DELLA COMUNITÀ
La proposta della Card Lazio

KEY FEATURES

Valentijn PP, Vrijhoef HJ, Ruwaard D, Boesveld I, Arends RY, Bruijnzeels MA. Towards an international taxonomy of integrated primary care: a Delphi consensus approach. BMC Fam Pract. 2015 May 22;16:64. doi: 10.1186/s12875-015-0278-x. PMID: 25998142; PMCID: PMC4446832.

18 giugno 2021

Table 5: Final taxonomy of key features

Main categories and domains	Description
Scope of integrated care	
Person-focused care	
Centrality of client needs	The principle of integrated service delivery is to address the needs of individual clients in terms of medical, psychological and social aspects of health
Population based care	
Centrality of population needs [b]	The principle of integrated service delivery is to address the dominant needs of well-defined populations
Type of integration processes	
Clinical integration	
Case management	Coordination of care for clients with a high risk profile (e.g. identifying risks, developing policies and guidance)
Continuity	Integrated service delivery aims to provide fluid the processes of care delivery for an individual client
Interaction between professional and client	Attitude and behavioural characteristics between professional and client regarding all health needs of the client
Individual multidisciplinary care plan	Implementation and application of a multidisciplinary care plan at the individual client level
Professional integration	
Inter-professional education	Inter-professional education for professionals focused on interdisciplinary service delivery and collaboration
Agreements on interdisciplinary collaboration	Agreements on the establishment of interdisciplinary service delivery and collaboration between the professionals
Value creation for the professional	The value added by the integrated service delivery approach for the individual professional
Organisational integration	
Inter-organisational governance [b]	The governance of the integrated service model is focused on openness, integrity and accountability between the involved organisations and professionals (e.g. joint accountability, appeal on pursued policies and responsibilities)
Inter-organisational strategy	Collective elaborated strategy between the organisations involved in the integrated service model
Trust	The extent to which those involved in the integrated service model trust each other
System integration	
Alignment of regulatory frameworks [a]	Alignment of regulatory frameworks for teamwork, coordination and continuity of care
Environmental climate [a]	Political, economic and social climate in the environment of the integrated service model (e.g. market characteristics, regulatory framework, and competition)
Enablers for integration	
Functional integration	
Learning organisations	Collective learning power between the organisations involved in the integrated service model (e.g. joint research and development programs)
Information management	Aligned information management systems within the integrated service model (e.g. monitoring and benchmarking systems)
Regular feedback of performance indicators	Regular feedback of performance indicators for quality improvement and self-reflection
Normative integration	
Shared vision [b]	Collectively shared long-term vision among the people who are involved in the integrated service model
Reliable behaviour	The extent to which the agreements and promises within the integrated service model are fulfilled
Visionary leadership	Leadership based on a vision that inspires and mobilizes people within the integrated service model
Linking cultures	Linking cultures (e.g. values and norms) with different ideological values within the integrated service model

IL PNRR
E LE CASE DELLA COMUNITÀ
La proposta della Card Lazio

18 giugno 2021

TABELLA IDENTIFICATIVA DEGLI ARTICOLI

ID	#
TITLE	#
AUTHOR	#
YEAR OF PUBBLICATION	#
JOURNAL	#
COUNTRY	#
STUDY DESIGN	#
PROFESSIONAL TEAM	#
POPULATION TARGET	#
AIM	#
ARTICLE TYPE	#
OUTCOME	#
COMPARISON	#
MODEL TYPE	#

TABELLA SINOTTICA

ID			#
TITLE			#
SCOPE	Person focused care	Centrality of clients needs	#
	Population based care	Centrality of population needs	#
TYPE	Clinical integration	Case management	#
		Continuity	#
		Interaction between professional and client	#
		Individual multidisciplinary care plan	#
	Professional integration	Inter-professionl education	#
		Agreements on interdisciplinary collaboration	#
		Value creation	#
	Organisational integration	Inter-organisational governance	#
		Inter-organisational strategy	#
		Trust	#
	System integration	Alignment of regulatory frameworks	#
		Enviromental climate	#
ENABLES	Functional integration	Learning organisations	#
		Information management	#
		Regular feedback of performance indicators	#
	Normative integration	Shared vision	#
		Reliable behaviour	#
		Visionary leadership	#
		Linking cultures	#

ID	#1	#2	#3
TITLE	General practitioners: Between integration and co-location. The case of primary care centers in Tuscany, Italy	Appreciative inquiry in evaluating integrated primary oral health services in Quebec Cree communities: a qualitative multiple case study	Community-based integrated care versus hospital outpatient care for managing patients with complex type 2 diabetes: costing analysis
AUTHOR	Sara Barsanti and Manila Bonciani	Richa Shrivastava, Yves Couturier, Felix Girard, Christophe Bedos, Mary Ellen Macdonald, Jill Torrie, Elham Emami.	Maria Donald, Claire L. Jackson, Joshua Byrnes, Bharat Phani Vaikuntam, Anthony W. Russell, Samantha A. Hollingworth.
YEAR OF PUBBLICATION	2019	2020	2021
JOURNAL	Health Services Management Research	BMJ Open	Australian Health Review
COUNTRY	Italy	Canada	Australia
STUDY DESIGN	Observational study via web survey	observational study (qualitative multiple case study)	costing analysis in a non-inferiority randomised control trial
PROFESSIONAL TEAM	202 GPs of 2700 in Tuscany Region, 7 nurses on averege per PCC, averege 2 social workers per PCC and averege 7 specialists per PCC. Involved in web survey: 178 GPs in PCC and 2958 GPs not in PCC. The survey's response rate was about 41%, out of a total of 1136 GPs.	Selected four Cree communities for involving administrator and care providers in an interview program (Dentist, Dental hygienist, Clinical nurse, Dental specialist on referral, Doctor, Nutritionist, School nurse, Home care nurse, community health representative).	Two OPDs and three GP-based Beacon (GPs, endocrinologist and diabetes nurse educator) practices participated
POPULATION TARGET	Around 9000 patients in Tuscany Region.	Selected four Cree communities for involving patients in an interview program (all age, student, pregnant woman, children, elderly)	Patients with complex type 2 diabetes (T2D).
AIM	To investigate the experiences and points of view of Tuscan GPs involved and not in PCC (primary care center). They use the perspective of GPs as proxy to measure the integration dimensions.	Integrating oral health service within primary healthcare in Quebec Cree communities.	This study compared the cost of an integrated primary–secondary care general practitioner (GP)-based Beacon model with usual care at hospital outpatient departments (OPDs) for patients with complex type 2 diabetes.
ARTICLE TYPE	Primary research	Original Research	narrative review
OUTCOME	Positive impact of co-location on the integration of professionals, especially with nurses and social workers, and on organizational integration, in terms of frequency of meeting to discuss about quality of care. Conversely, no significant differences were found in terms of either clinical or system integration. Furthermore, the collaboration with specialists is still weak.	Our results suggest that the CBHSSJB has developed a grassroots innovation in integrating POHC.	"The Beacon model of integrated primary–secondary care for patients with complex T2D has delivered non-inferior clinical outcomes with greater patient satisfaction and, as we have now demonstrated, in a more cost-efficient manner.….the total cost per patient course of treatment for the Beacon model was, on average, lower than usual care ($2622 vs $2987). The incremental cost saving of the Beacon model was $365 per patient course of treatment."
COMPARISON	Perceptions of different aspects of integration between GPs involved and those GPs not involved in a PCC.	Different comparisons between four purposefully selected Cree communities or CMCs (Community miyupimaatisiiun Centre, Â Mâshkûpimâtsît Awash, Elementary school-based programmes, Daycare and homecare programmes).	3 Beacon clinics and 2 hospitals outpatient departments
MODEL TYPE	Italian model of primary care centres "case della Salute"	The Cree Board of Health and Social Services of James Bay (CBHSSJB), as a pioneer in the Canadian province of Quebec, implemented a model for the integrated delivery of health and social services that includes primary oral healthcare. Each of the nine Cree communities has a Community Miyupimaatisiiun (wellness) Centre (CMC).	Beacon model

ID	#4	#5	#6
TITLE	The Montana Model: Integrated Primary Care and Behavioral Health in a Family Practice Residency Program	Measuring Perceived Level of Integration During the Process of Primary Care Behavioral Health Implementation	When colocation is not enough: a case study of General Practitioner Super Clinics in Australia
AUTHOR	Claire Oakley, Douglas Moore, Duncan Burford Roxanne Fahrenwald and Kathryn Woodward	Staab et al.	Riki Lane, Grant Russell, Elizabeth A. Bardoel, Jenny Advocat, Nicholas Zwar.
YEAR OF PUBBLICATION	2005	2017	2017
JOURNAL	Education for Rural Practice	American Journal of Medical Quality	Australian Journal of Primary Health
COUNTRY	USA	USA	Australia, New south Wales and Victoria
STUDY DESIGN	observational study	Before-after (Survey administered at time 0 and after QI efforts)	Observational study, case study.
PROFESSIONAL TEAM	the Montana Family Medicine Residency (MFMR), an integrated primary care and behavioral health family practice clinic, works cooperatively with the Deering Community Health Center (DCHC), staffed primarily by resident physicians	1st survey: PCPs (N = 36), BHPs (N = 3), and clinical staff (N = 19) 2nd survey: PCPs (N = 38), BHPs (N = 3), and clinical staff (N = 22)	Outertown GOSC: FTE GPs, practice nurses, physiotherapy, psychiatry, community mental health nursing, psychology. Hillside GPSC-Hub Practice: FTE GPs, practice nurses, physiotherapy, osteopathy, chiropractic, dietician. Hillside GPSC-Spoke Practices: small general practice, exercise physiology practice, phisiotherapy practice, chiropratic practice, specialist eye practice, psychology practice.
POPULATION TARGET	Rural patients in Montana	patients in need of BH services	Population in Primary Care.
AIM	In this paper we describe our experience with integrating mental health and substance abuse services into a primary care setting (a community health center) while simultaneously teaching family practice physicians to take the lead in providing these services.	To describe the quality improvement (QI) efforts toward achieving BH integration, which used a data-driven approach generated by first surveying the study institution's PCPs, BHPs, and staff on their perceived level of integration, and then using these data to target areas for improvement and evaluation.	To illustrate how the process of transitioning into a GPSC influences the development of organisational and clinical routines, particularly relating to the collaborative care of persons living with chronic illness.
ARTICLE TYPE	Narrative review	Original Article	Original Research
OUTCOME	Within this context, the Montana Model has been developed to equip the family practice physician with the capability and, it is hoped, the willingness to meet mental health challenges in rural and frontier communities.	Overall, LIM score increased from 64.5 to 70.1, P = .001. The lowest scoring domains at baseline were targeted for quality improvement and increased significantly: integrated clinical practice, 60.0 versus 68.4, P < .001; systems integration, 57.0 versus 63.8, P = .001; and training, 56.7 versus 65.3, P = .001.	The constraints inherent within the GPSC program, and the lack of effective incentives for collaborative care in fee-for-service MBS items, meant that program objectives for integrated multi-disciplinary care were largely unattainable.
COMPARISON	No comparison	No comparison	No comparison
MODEL TYPE	Montana model	primary care behavioral health (PCBH) model.	General Practice Super Clinic (GPSC) model.

ID			#1
TITLE			General practitioners: Between integration and co-location. The case of primary care centers in Tuscany, Italy
SCOPE	Person focused care	Centrality of clients needs	N/A
	Population based care	Centrality of population needs	N/A
TYPE	Clinical integration	Case management	N/A
		Continuity	N/A
		Interaction between professional and client	Empowerment of patients and Relationship with patients.
		Individual multidisciplinary care plan	N/A
	Professional integration	Inter-professionl education	N/A
		Agreements on interdisciplinary collaboration	Relationship and collaboration among GPs and nurses. Less collaboration among GPs and specialists (approximately 15% of GPs met other professionals only to discuss complex cases, and 16% did not organise any kind of meeting) and social workers.
		Value creation	Positive impact on dealing with chronic and complex patients.
	Organisational integration	Inter-organisational governance	N/A
		Inter-organisational strategy	N/A
		Trust	N/A
	System integration	Alignment of regulatory frameworks	"The PCC model (in Italian: Case della Salute) was first implemented in 2007 (Italian National Law 27 December 2006 No. 296)". • Meetings for clinical audit • Meetings to share guidelines
		Enviromental climate	N/A
ENABLES	Functional integration	Learning organisations	N/A
		Information management	N/A
		Regular feedback of performance indicators	N/A
	Normative integration	Shared vision	N/A
		Reliable behaviour	N/A
		Visionary leadership	N/A
		Linking cultures	N/A

ID			#2
TITLE			Appreciative inquiry in evaluating integrated primary oral health services in Quebec Cree communities: a qualitative multiple case study
SCOPE	Person focused care	Centrality of clients needs	N/A
	Population based care	Centrality of population needs	Cree community members participated during the planning phase of the project. Patients were involved in the recruitment and conduct of the study. Organisation's efforts to provide services adapted to the population's local needs.
TYPE	Clinical integration	Case management	shared physical medical and dental records facilitate care coordination and referral services.
		Continuity	N/A
		Interaction between professional and client	They recognised strong team working and effective coordination among professionals as the strength of this organisation. It creates a pleasant environment not only for care professionals but also for patients.
		Individual multidisciplinary care plan	development of strategies for incorporating oral health into service delivery within CMCs and public health programmes.
	Professional integration	Inter-professionl education	N/A
		Agreements on interdisciplinary collaboration	guidelines for multidisciplinary team working. It is comfortable to deal with nurses and physicians; strong team working and effective coordination among professionals.
		Value creation	N/A
	Organisational integration	Inter-organisational governance	The CBHSSJB organisation works for integrating oral health by facilitating interprofessional teamwork and oral health promotion during health promotion activities.
		Inter-organisational strategy	The CBHSSJB has developed an infrastructure facilitating the co-location of the dental clinic with other primary care services.
		Trust	"The key success of your clinic is the interaction between everybody when it works well. Here it does. […] First of all, it's much more pleasant for me because it's a good environment to work in, but it's good for the patient as well, he can feel that things are going well, that it's pleasant." (Dental health care provider 3, Interview)
	System integration	Alignment of regulatory frameworks	Regular meetings and evaluations
		Enviromental climate	"Community Miyupimaatisiiun (wellness) Centre" (Co-location)
ENABLES	Functional integration	Learning organisations	N/A
		Information management	Shared physical medical and dental records
		Regular feedback of performance indicators	Evaluation and quality improvement.
	Normative integration	Shared vision	The Cree people are very interdependent, they believe that in order to move forward, we need each other.
		Reliable behaviour	The concept of integration is embedded in the Cree culture, which promotes working and moving forward interdependently. Working together helped them to claim their rights and sign their land claim agreement 'the James Bay and Northern Quebec Agreement'. Consequently, from a vision of integration, the CBHSSJB developed its first strategic regional plan in 2004 as a tool for integrating health and social services in the Cree communities.
		Visionary leadership	Multilevel organizational structure under the strong leadership of the board of directors and executive directors.
		Linking cultures	Reducing social disparities between indigenous communities; Employment and training of Local health workers (dental assistants, dental secretaries and Community health workers); Integration of traditional practices into health services by creating a specific department that works on integrating traditional knowledge and culture for their health and well-being; Culturally competence training (done for nurses); Use of Cree language in service delivery

ID			#3
TITLE			Community-based integrated care versus hospital outpatient care for managing patients with complex type 2 diabetes: costing analysis
SCOPE	Person focused care	Centrality of clients needs	N/A
	Population based care	Centrality of population needs	N/A
TYPE	Clinical integration	Case management	nurses are specifically skilled in case coordination
		Continuity	N/A
		Interaction between professional and client	N/A
		Individual multidisciplinary care plan	The endocrinologist reviews and endorses a management plan
	Professional integration	Inter-professionl education	"GPwSIs undertake a 23-h online advanced diabetes care course, attend a 1-day workshop and complete a competency assessment. The DNE is specifically skilled in case coordination and comfortable working independently."
		Agreements on interdisciplinary collaboration	N/A
		Value creation	N/A
	Organisational integration	Inter-organisational governance	"appropriate administration staff (e.g. clinic manager, reception staff)"
		Inter-organisational strategy	"A multidisciplinary team, made up of two GPs with a special interest (GPwSIs) and advanced training in diabetes, an endocrinologist and a diabetes nurse educator (DNE), is colocated in a community-based general practice that hosts 4-h weekly or fortnightly Beacon clinics for its neighbourhood."
		Trust	N/A
	System integration	Alignment of regulatory frameworks	N/A
		Enviromental climate	"The Beacon model is a fully integrated primary–secondary care model providing a comprehensive service for patients with complex type 2 diabetes (T2D)"
ENABLES	Functional integration	Learning organisations	N/A
		Information management	N/A
		Regular feedback of performance indicators	"In a non-randomised pilot study, the Beacon model achieved significant improvement in HbA1c and fewer potentially preventable diabetes-related hospitalisations"
	Normative integration	Shared vision	N/A
		Reliable behaviour	N/A
		Visionary leadership	N/A
		Linking cultures	N/A

ID			#4
TITLE			The Montana Model: Integrated Primary Care and Behavioral Health in a Family Practice Residency Program
SCOPE	Person focused care	Centrality of clients needs	patients with mental health problems who live in rural area of Montana
	Population based care	Centrality of population needs	Accordingly, studies have demonstrated the value of providing patients access to health care, and specifically to mental health care, in their local communities
TYPE	Clinical integration	Case management	N/A
		Continuity	Through the Montana Model, mental health problems are incorporated into the spectrum of chronic diseases that residency graduates are capable of, and, it is hoped, interested in managing
		Interaction between professional and client	Depending on the individual resident and/or patient, faculty members may also observe the resident-patient interaction to help the resident with interviewing, history-taking, and developing her or his relationship with the patient
		Individual multidisciplinary care plan	Systems-based practice is modeled using interdisciplinary teams to manage complex patients with multiple comorbidities
	Professional integration	Inter-professionl education	The enhanced longitudinal curriculum incorporates mental health across the 3 years of the family practice residency. Unique characteristics of this model include staffing and the concurrent delivery of a high volume mental health service while teaching family practice resident physicians and the faculty to integrate this competency into their primary care practices.
		Agreements on interdisciplinary collaboration	Systems-based practice is modeled using interdisciplinary teams to manage complex patients
		Value creation	Montana Model has been designed to combine clinical faculty, behavioral approaches, and skills in such a manner as to acculturate the resident physician to mental health care as an integral aspect of medicine.
	Organisational integration	Inter-organisational governance	N/A
		Inter-organisational strategy	Five full-time and 2 half-time family physician faculty members, 5 midlevel providers, and several part-time physicians practice in DCHC alongside 16 residents.
		Trust	N/A
	System integration	Alignment of regulatory frameworks	The enhancement model is characterized by specialized clinical training that enables primary care physicians to ‘‘recognize, diagnose, and treat mental health problems independently.’’
		Enviromental climate	The evolving curriculum stems from a philosophy that if the resident physicians study and practice in an atmosphere where mental health is always considered an essential part of family medicine, better patient care will result in the rural and frontier areas where the residents will eventually reside.
ENABLES	Functional integration	Learning organisations	N/A
		Information management	The MFMR is led by a physician who began practice in a remote village of Alaska and who has maintained her career interest in the rural/frontier delivery of care.
		Regular feedback of performance indicators	Conversations with faculty allow immediate feedback and support for the resident physicians in their clinical management plans
	Normative integration	Shared vision	N/A
		Reliable behaviour	N/A
		Visionary leadership	N/A
		Linking cultures	N/A

ID			#5
TITLE			Measuring Perceived Level of Integration During the Process of Primary Care Behavioral Health Implementation
SCOPE	Person focused care	Centrality of clients needs	N/A
	Population based care	Centrality of population needs	N/A
TYPE	Clinical integration	Case management	N/A
		Continuity	Warm handoffs (33%agree at baseline vs 58% at follow-up)
		Interaction between professional and client	N/A
		Individual multidisciplinary care plan	PCPs and BMED specialists collaborate in making decisions about mutual patients in the clinic (33% vs 58%)
	Professional integration	Inter-professionl education	Locally tailored algo- rithms were developed for depression screening, manage- ment, and referral; antidepressant medication initiation and titration; and panic management. One-page flow chart flyers were posted throughout the clinic. The team sent out weekly tips about behavioral treatments for physical and mental health conditions, guidance for navigating BMED and psychiatry services, and local referral resource lists. Interventions via flyers, emails, brochures describing BMED delivered to the clinic providers
		Agreements on interdisciplinary collaboration	PCPs and BMED specialists work comfortably together.(39% vs 71%)
		Value creation	PCPs and BMED specialists learn from each other. (43% vs 69%) PCPs and BMED specialists have regular, positive interactions in our clinic.(41% vs 62%)
	Organisational integration	Inter-organisational governance	PCPs and BMED specialists are treated as equals within the clinic. (37% vs 60%)
		Inter-organisational strategy	BHPs shared a common workspace with PCPs and were available for joint sessions, curbside consulta- tions, and brief same-day patient consultations via warm handoff. Between April and August 2015, BHPs were available 1 half day per week. Beginning in September 2015, BHPs were available 3 to 4 half days per week. BMED specialists take part in PCG clinic meetings. (4% baseline vs 40% follow-up)
		Trust	PCPs and BMED specialists trust each other. (48% vs 65%). PCPs and BMED specialists respect each other.(61% vs 75%)
	System integration	Alignment of regulatory frameworks	N/A
		Enviromental climate	N/A
ENABLES	Functional integration	Learning organisations	QI interventions on lowest scoring domains in 1st survey
		Information management	BMED specialists share access to the electronic medical record with primary care providers. (46% vs 63%) BH management and depression screening into the EHR
		Regular feedback of performance indicators	N/A
	Normative integration	Shared vision	Integrated care is a superior form of patient care.(100% vs 87%). Integrating care ensures that patients receive appropriate care. (87% vs 83%). Integrated care is a worthwhile investment of clinic time, energy, and resources.(96% vs 87%)
		Reliable behaviour	The clinic is committed to integrated care. (65% vs 71%). Delivering integrated care is a priority in our clinic. (59% vs 65%) Our clinic has at least one integrated care “champion.”(63% vs 75%)
		Visionary leadership	Clinic administrators value integrated care. (67% vs 69%). Clinic administrators "go to bat" for integrated care.(63% vs 60%)
		Linking cultures	N/A

ID			#6
TITLE			When colocation is not enough: a case study of General Practitioner Super Clinics in Australia
SCOPE	Person focused care	Centrality of clients needs	N/A
	Population based care	Centrality of population needs	N/A
TYPE	Clinical integration	Case management	N/A
		Continuity	N/A
		Interaction between professional and client	To some degree, patient self-management.
		Individual multidisciplinary care plan	N/A
	Professional integration	Inter-professionl education	N/A
		Agreements on interdisciplinary collaboration	Outertown GPSC: whereas GPs, nurses, practice management and reception worked cohesively, other professions on site usually worked in parallel. Hillside GPSC: well-established relationships between practitioners at the spoke clinic enabled collaborative care; in hub multidisciplinary collaboration was sporadic.
		Value creation	N/A
	Organisational integration	Inter-organisational governance	N/A
		Inter-organisational strategy	Outertown GPSC: space was offered to community groups for health-related meetings.Hillside GPSC: CEO active and visible in the practice; organized group meetings, social events and operations activities.
		Trust	N/A
	System integration	Alignment of regulatory frameworks	Outertown GPSC: GPSC–hospital organisational agreements for specialist clinics or the use of MBS Team Care Arrangement items for private allied health. Hillside GPSC: established relationships between organisations or individual practitioners, allowing efficient use of MBS items. Both GPSCs use evidence-based protocols.
		Enviromental climate	N/A
ENABLES	Functional integration	Learning organisations	N/A
		Information management	Each clinic had specific requirements regarding data collection, monitoring, patient reminder systems. Outertown GPSC: absence of shared information systems (clinical records remained separate between professions).
		Regular feedback of performance indicators	N/A
	Normative integration	Shared vision	N/A
		Reliable behaviour	N/A
		Visionary leadership	Hillside GPSC: lead GPs recruited from UK (perceived as being trained in routines of multidisciplinary teamwork).
		Linking cultures	N/A

IL PNRR
E LE CASE DELLA COMUNITÀ
La proposta della Card Lazio

Grazie dell'attenzione

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