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CONFERENCE ABSTRACT

The designing of an evaluation and monitoring system of the primary care services reorganization in Tuscany through the process of implementation of the "family and community nurse" (FCN) care model: the case of the AUSL Toscana Centro, Italy.

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Introduction:

The organization of Primary care services in Tuscany has remained unchanged through the years 1978 (establishment of the NHS) – 2000s as policies mainly dealt with hospital's issues. In this neglected sector no one had ever bothered to quantify the nature and extent of the existing inefficiencies until they came forward with the epidemic outbreak of chronicity and population's ageing, together with a substantial commitment to make serious progress in its improvement. Tuscany has gone from a provisional model that did not add much value either to patients or to professionals to the creation of the family and community nurse (FCN) model which will be effective throughout the Region by 2020, by virtue of Regional deliberation 597/2018.

Description of policy context and objective:

As stated in the aforementioned resolution, the goals to be reached are the early interception and effective population's health needs management through FCN's proximity and multi-professional patient's co-management and the and the collection of these data in order to monitor the phenomenon and set a standard . The temporal continuity and the capacity for responding to high variability in needs are the main features of a formally trained FCN, who is responsible for a geographically based share of 3300 people, of whom 300/400 are classified as chronic patients. Tuscan population is around 4 million people. In 2018, 89.221 cases were home treated for a total of 1.193.632 home care acts. In Florence the cases were 8811 for a total of 196.222 care acts, 1 person on 43. The mean of interventions on a singular patient is 2 (among the most frequent: care givers education, bladder catheterization management), meaning that people rarely have a single problem and the mean of home visits is 10,88, meaning that continuity is necessary.

Targeted population:

Each resident for whom the GP asks for home care or is identified by the FCN during a home visit.

Highlights:

This substantial phenomenon is to be monthly monitored even in this implementation stage through a set of indicators that focus on:

- Number of professionals completing the formal Regional training

- Multiprofessional integration through the number of cases shared between FCNs and GPs
- FNC's proximity to entire families through the number of cases identified by FCNs during home visits
- System sustainability through the reduction of emergency calls during the hours of FNC's availability.

Comments on transferability:

The IFC pool is not uniquely defined, but organized according to the demographic and epidemiological characteristics of the area concerned. On the other hand, the monitored indicators should be the same.

Conclusions:

The FCN not only is asked to be a gatekeeper that governs health's demand, but a resource of health and equity. The latter is guaranteed by orienting families and easing their access to the health services they need. A sustainable, value-based approach that imposes itself as necessary for the survival of the healthcare system and that is expected to be monitored and assessed by the Regional' set of indicator in order to be continuously improved.