prioritize targeted interventions; provide high quality services and foster partnering amongst and across service providers, patients, care-takers and communities in the wider sense.

Community nursing plays a key role in integrated care systems by forming the interface between community and people's needs, coordinating and informing service providers, participatory services planning for patients in need (case-management) and helping patients and care-takers to self-manage their conditions. The Healthy Life project supports the development of a consistent community nursing concept and helps build staff capacity with regards to integrated care. Local authorities play a key role in prioritizing the health of their people and mobilizing expertise to reduce public health risk factors and establish healthy communities. Linking health, social and complementary services (e.g. palliative care, physical and social mobilization of chronically ill) in one planning framework improves responsiveness of services to people's needs (e.g. case management). The project supports the development of health and service profiles to identify priorities and needs in terms of information gasps, areas to promote health, but also the identification of relevant services at community and rayon levels, which will lead to health action plans guiding priority activities.

With regards to quality of care, basic equipment that is needed to implement the key clinical protocols at PHC level will be provided to the pilot rayon's. This will be accompanied by capacity building measures and the introduction of peer exchanges as well as facility-based continuous quality improvement "projects". Capacity building on updated NCD guidelines (e.g. WHO PEN protocols are another important pillar towards quality of care. The 2017 quality of care study shows that up to 28% of primary care facilities have not received any training on relevant guidelines during the last year with a clear geographic disadvantage of the north of the country. Main focus is to provide comprehensive services for the management of NCDs and to reduce the likelihood of unnecessary hospitalization [3].

The Viatasan project supports the newly created National Agency for Public Health and its substructures by building expertise in health promotion and risk reduction activities at national and rayon levels. This expertise will strengthen intersectoral planning (e.g. with health, social, community and other relevant services and together with people's representatives), coordination and implementation capacity of Rayon Health Councils based on jointly developed health action plans. Jointly with the National Agency for Public Health highly practical and skills based training activities in health promotion will be conducted to enable rayon and community level actors to plan, implement and evaluate their own health promotion activities. Community interventions such as local health promotion activities, interventions towards the development of "healthy communities" are also supported in form of small projects.

The Healthy Life Project supports the Moldovan Government to strengthen its primary care services to cope with the increasing burden of NCDs. Using the conceptual framework of "Integrated People centred Health Services (IPCHS)" promoted by WHO it facilitates the reform of services, and the empowerment of patients, care-takers, families and communities to be knowledgeable about health risk and individual risk behavior in order to form a care partnership, with the aim of improving quality of life. Local authorities play a strong role to organize and provide coordinate platforms for interventions from health, social and complementary services and create healthy communities. The primary health team in health centers and family doctor's offices are the health experts to manage NCDs, reduce the likelihood of hospitalization and coordinate expert services around patient's needs following a more patient centred and less professional group centred approach.

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## MANAGING CHRONIC DISEASES – A FRAMEWORK FOR INTEGRATED SERVICES

***Manfred ZAHORKA***[1,2], ***Natalia ZARBAILOV***[3,4],
[1]Swiss Tropical and Public Health Institute, Basel Switzerland,
[2]University of Basel, Switzerland,
[3]Viatasan project, Republic of Moldova
[4]State University of Medicine and Pharmacy *Nicolae Testemitanu*, Republic of Moldova

The management of chronic diseases has replaced acute care in today's work portfolio of ambulatory care providers. According to World Health

Organization (WHO) the burden of largely preventable Non-communicable diseases (NCDs) in the WHO European region is estimated at 80% [1]. The preference for hospital care, low quality of primary care services, out-dated clinical procedures and limitations in home based care generate a high number of unnecessary hospitalizations. The 2015 study report on *Ambulatory care sensitive conditions in the Republic of Moldova* [2] showed that 60% of hospitalization for hypertension and 40% for diabetes could be avoided by a better performing Primary Health Care system. Increasing disease focus advances in medical technology and specialization as well as the lack of patient information across provider systems leads to a fragmentation of care, duplication of services and possibly overmedication. In older populations, however, a single morbidity focus is not improving patients' quality of life. The contribution of a single disease to the mortality risk continuously decreases with age and factors like frailty and disability become stronger predictors of adverse health outcomes [3]. The management of chronic diseases in older people needs to shift from prolonging life towards extending disability-free life expectancy [4]. This shift requires an integrated approach to the provision of services with people at its centre.

WHO launched its Global Framework for *Integrated People centred Health Services* (IPCHS) during the 2016 World Health Assembly [5]. The approach requires the health system to think beyond disease and rather focus on the comprehensive needs of people and communities including empowering people to play a more active role in their own health. There are a variety of concepts on care integration in the literature but the common denominator of all is their focus on people, services, provider systems and change management. Conventional care systems mostly focus on vertical delivery of disease specific care. Service quality is evaluated by the quality of its inputs through professional mechanisms (guidelines, provider performance, audits). The focus on people and communities requires a broader range of services of different provider groups leading to a higher integration and coordination. In an integrated service approach the whole person with his complex needs is considered and services are provided through close collaboration of the entire provider system. Service performance and quality in this context are evaluated by considering the quality of patient outcomes, such as functional status, maintenance of independence and quality of life. People centred care includes by definition services closer to home through care networks, prevention of unnecessary hospitalization, offering choice and probably the use of new technologies, particularly for information sharing. Putting people in the centre of a service network requires support and coordination, which can be delivered by family physicians networks, (community) nurses, home based care and social work, like in Germany or Switzerland; through hospital networks like the Health Maintenance Organizations (HMO) of the United States or through Government systems like the National Health System (NHS) of Great Britain. There are a variety of innovative responses to patient needs in the framework of IPCHS. However, most systems use some of these innovations and there is little experience with countrywide coverage.

In Switzerland for example physicians operate within geographical networks sharing patient data, subscribing to joint quality standards and using peer review mechanisms (quality circles) for continuous quality improvement of their services. People centred care is quite common in rehabilitation work, particularly for brain injuries, where complex service interactions are required.

Estonia is probably one of the most advanced countries concerning the use of electronic platforms to securely sharing patient data across the entire country. An important part of the instrument is an online patient portal with access to personal health information including treatments, test results and prescriptions.

The Scotland NHS subscribes to a lead agency model under which health and social services are integrated to coordinate comprehensive services for adults and children, a model closely related to the WHO model of health through the life-course approach.

Current models of care integration provide useful examples for the organization of people centred care. Provider coordination of health, social and health education services are of key importance independent of who the coordination body finally is. Sharing patient information across provider networks and opening this information to patients themselves facilitates quality control and continuous improvement and keeps the patient in the driving seat. Service providers need to seamlessly connect and interact, focusing on people's outcomes rather than on professional inputs.

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