

The Managerial and Organizational Impact of Therapeutic Adherence in the National Health System: A Regional Social Welfare Comparison in the Perspective of Planning PNRR Funding and Social Welfare Regulation

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ABSTRACT

This article analyses therapeutic adherence to the national health system from a multidimensional perspective, through a comparative analysis of regulation and planning at different levels of European, national, regional and corporate governance. This analytical path is oriented to identify the critical issues and possible strategies aimed not only to overcome them, but also to implement the current management through organizational tools and alternative management models. In this evolution, an important role is played by the funding deriving from the PNRR intended to implement both territorial medicine and digital innovation, as main axes of the path to improving therapeutic adhesion. The conclusions concern the application of organizational models (one health, change management, value based health) able to channel these resources towards this area of therapeutic adherence.

In the current phase of planning and financing from PNRR mission 6, Italian institutions such as AGENAS and the Ministry of Health have initiated the reform of the D.M. n. 70/2015 through outline the lines of development of social protection to support social assistance adherence therapeutic. This programming path is accompanied by the regulation of local health care characterized by a greater continuity of care between hospital and home and multidisciplinary coordination for a wider take-up.

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In the Multilevel Balance of Therapeutic Adhesion: The European and National Context

Therapeutic adherence, beyond the debate of over thirty years, is currently a challenge for the national health service. The "compliance" of the 90s, as observance in the intake of a drug, in the dosages and in the frequency prescribed, has evolved in the empowerment characterized by the proactive role to the patient compared to the therapeutic plan in the therapeutic path to follow. This definition is referred to in the definition of the WHO, as "level of compliance with the recommendations relating to doses, time and frequency of intake and treatment methods to be followed for the entire therapy".

By therapeutic adherence we mean the degree of correlation between a patient's behavior in the management of a given pathology and the prescription for that pathology. The term adherence indicates "compliance", adherence to the methods of taking a drug in terms of dosage and frequency prescribed and "persistence", as a period of continuous drug intake. On the basis of the case studies in the sector, therapeutic adherence includes situations of imperfect implementation of what is prescribed; an unjustified interruption that lead to the failure of the therapeutic program.

The document of the World Health Organization dating back to 2003 analyzes the problem of adherence to chronic diseases, such as asthma and diabetes. In this regard, a correlation emerged according to which the more chronic the chronicity is, due to fragility and multiple pathologies, the more critical the therapeutic adherence becomes, as well as the increased impact of poor adherence to the increase in chronicity.

From the foregoing it emerges the complexity of the concept of therapeutic adhesion, in understanding different behaviours and factors of social healthcare, in addition to the intake of the prescribed drugs, attributable to a path characterized by continuity of care and a growing importance to multidisciplinary integration between the professionals involved. The following will indicate the different connotations of therapeutic adhesion, in a multidimensional perspective.

Clinical Value of Adhesion: Causes, Criticality and Consequences

The need for proper therapeutic adherence in achieving the objectives and clinical results related to each individual therapeutic path, can be compromised by endogenous and exogenous factors of different nature and entities, exposed below.

At exogenous level, the main causes of poor therapeutic adherence are related to the clinical condition of chronicity and multimorbidity. In chronic diseases, the majority suspend

treatments due to therapeutic complexity. In this context, the causes of the lack or poor adherence to the treatments while being able to be of various nature are mainly attributable to the relationship between doctor patient that causes a lack of motivation and 'unawareness of the disease, inadequate follow-up, fear of adverse reactions, the lack of information in the therapeutic path. The other exogenous factor is related to the coexistence of pathologies in the same patient, that makes more complex the therapeutic path from the administration of drugs belonging to several families to the extra-pharmacological assistance that requires a growing professional multidisciplinary.

The critical issues related to therapeutic adherence related to the care cycle occur when every assistance act meets resistance in the short and long term in chronic patients. In such cases, the negative impact of poor or absent therapeutic adherence is extended to various aspects of care, from the monitoring of risk factors to the continuity of care.

The consequences of therapeutic adherence deficiencies are a 40% increase in mortality and 20% in hospitalization. Statistics from the sector showed that over 70% of patients stopped treatment in the first 6 months, as for other diseases, there was a constant reduction in therapeutic adherence.

Specifically, according to the Osmed Report, 55.1% of patients with high blood pressure need continuity in treatment, while among chronic patients it is estimated that half of them take drugs correctly and that among the elderly exceeds 70%. 52-55% for osteoporosis patients, 60% for rheumatoid arthritis, 40-45% for Type II diabetes therapy, 36-40% for heart failure and only 13-18% for asthma and COPD.

In the coming years, a more careful measurement of areas with a high welfare impact such as HIV, HCV and other chronic diseases will be necessary in order to be able to make predictions of the impact of therapeutic adherence deficiencies in terms of care deficits.

The Welfare Value of Therapeutic Adherence: The Organisational Management Impact

The impact of therapeutic adherence on the national health system is not only welfare, but also organizational and managerial. The endogenous criticalities are of a managerial nature related to the insufficient ability of the national health system to support the entire therapeutic distance as a result of deficiencies of the sanitary staff, organizational dysfunctions in the supplied services, elevated bureaucratic load, regulatory gaps and implementation and management deficiencies.

A health care system, when it guarantees greater adherence, is able to implement the benefits for the safety and effectiveness of treatments and consequently to reduce the pathological complications and the risk of hospitalization. Another consideration is the adherence-safety interaction, to be evaluated through clinical risk. Poor adherence to treatments can have effects on safety, and the risk of error increases if the person takes a large number of drugs. The national health system includes clinical risk management units, capable of dealing with the safety of drug use in order to prevent errors in taking / prescribing and improving patient adherence to the treatment path.

The above points out that adherence is a key factor for the governance of the National Health System. This implies the identification and implementation of new welfare models, aimed

at optimising resources, implementing efficiency and ensuring economic sustainability. The current trend of management oriented to deospitalization is oriented to the creation of macro areas able to ensure widespread assistance through the implementation of regional networks.

The value of adherence before it is implemented therefore implies different organizational levers. The first is that of communication aimed at improving the relationship in the path of care, as the first indicator of the sharing of any pact of care between doctor and patient. Failure to adhere to the treatment plan is an expression of gaps related to the communication relationship, especially the medical patient information circuit, not of cultural and educational limits of patients.

In addition, therapeutic adhesion is a component of health approaches based on the value of safety, able to convey innovative measures. In this context, therapeutic adhesion has an impact on safety in terms of risk management, such as control of therapy errors, prevention.

The Economic Value of Adhesion

Conversely, a lack of therapeutic adherence leads to a waste of resources with increased direct and indirect costs in managing chronic diseases and polypathologies. In the US, failure to adhere results in a waste of 100 billion dollars. In Europe, the Pharmaceutical Group report estimated the cost of admissions at €125 billion per year.

These data indicate that the economic impact of non-adherence is to represent the waste of financial resources linked to the purchase of drugs and the management and social costs of worsening and complications of diseases. In contrast, greater adherence to therapies can reduce health costs in the long term and ensure more sustainability of the SSN.

In this regard, according to the WHO 'Greater adherence means less risk of hospitalization, fewer complications associated with the disease, more safety and effectiveness of treatments and reduced costs. Adherence to therapies is fundamental to the sustainability of the SSN".

The implementation of the Qanto exposed, needs a shared vision in which each actor in the management care circuit from decision making to health care to entrepreneurs, Stakeholders have a role in assessing and addressing the impact of demographic and epidemiological evolution on the health system's ability to ensure therapeutic adherence. Just as the involvement of patients' associations in decision-making can facilitate the identification of therapeutic circuits in the patient's misdiagnosis, able to ensure a reduction in health costs related to the care circuit.

The Regional Regulatory Framework and Policy Areas

The regional regulatory framework is fragmented, as some Regions have regulated specific aspects of assistance related to therapeutic adherence, while others are without regulation.

The analysis of the individual regulations shows a lack of uniformity even in the "overall" strategy, for the divergent interventions and priorities pursued. Indeed, some regions deal with adherence to therapies at a general level; in other cases for specific diseases (oncology, chronic intestinal inflammation, chronic renal, rheumatic, COPD, stroke) and within specific Therapeutic Diagnostic Treatment Routes - PDTA (Campania, Friuli Venezia Giulia, Molise, Lombardy). Adherence to therapies

has been addressed in the profile of prescriptive appropriateness (e.g. Lazio: appropriateness indicators; Marche: identification of corporate target for appropriateness; Valle d'Aosta: "Approval of the update of the Guideline Lines for the promotion of prescriptive appropriateness and for the achievement of the objectives of saving"; Molise: Dementia National Plan - strategies for the promotion and improvement of the quality and appropriateness of assistance interventions in dementias).

Some regional regulations pay attention to the impact of adherence on the organization, as in the Marche, the "Extension of the authorization to prescription of medicines for the treatment of respiratory diseases (ASTHMA and COPD) to pneumologists operating outside hospital facilities, "Schemes of agreements relating to distribution on behalf of (...)", the "Operational Technical Specifications for Direct Distribution and Other Performance Detected with F File Tracing", "Class CNN Drugs". There are rules on adherence, since they are intended to facilitate access to medicines for patients, by increasing the number of prescription doctors or the dual distribution of medicines, which may be withdrawn in the place nearest to the person's domicile, in the interior areas.

In Lombardy, determinations relating to "Integrated Programme for the Improvement of the Organisation (PRIMO)", an act of guidance for the evaluation and continuous improvement of health organisations, through a checklist to be returned to the regional portal.

In Veneto, the organizational impact of adhesion has been addressed with respect to the profile of hospital continuity - territory, providing "Regional guidelines for the continuity of the prescription between Hospital and Territory". Safety, prevention and management of errors and clinical risk have been the subject of some provisions (Liguria, Lombardia: Del.n. X/3652 del 5.6.2016 - Programma integrato di miglioramento dell'organizzazione (PIMO), where they are identified "international objectives for patient safety with specific reference to high risk drugs"; Umbria: the Racc. Min.n. 12 on the prevention of errors in therapy with drugs LOOKALIKE-SOUNDALIKE (LASA)" and "Implementation of Racc. min.n.14 on the prevention of errors with antineoplastic drugs"; Implementation of Racc. Min. n. 7 for the prevention of death, coma or serious damage derived from errors in pharmacological therapy"; Veneto: Clinical risk and pharmacological therapy, as strategies for the correct pharmacological management in prison.

In other regions, paths oriented towards centralization in the management of the different care segments have been undertaken, concentrating the different applications towards a single one, think of the multidisciplinary platform ASL 1 Rome or the fseTosaco best app from a good local practice implemented at company and regional level. As well as in relation to the use of anticoagulants, a centralized regional registry was installed with integrated data.

Further interventions concern interventions in favor of pharmacological reconciliation (Liguria and Umbria: Transposition of the Min. Rec. N. 17) and polypharmacy (Campania and Friuli Venezia Giulia).

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This highlights the silo approach in implementing the Ministerial Recommendations, where adherence and ppropriateness are on the same track. The main problems concern the knowledge of these measures by the operators themselves. In view of the picture that emerged from the responses of the Regions/Pas, about one in two professionals (52%) states that there are provisions/projects/regulations/recommendations in the field of therapeutic adherence; 24% report the non-existence of provisions on the subject; 24% say they do not know.

The Role of the Regions: A Comparison Between North and South

The regional frameworks for improving therapeutic adherence are varied. A consequence of the exposed regional variety is that therapeutic adherence has been addressed in a way that is not only fragmentary but also deficient in the different dimensions that distinguish it. This leads to the existence of areas related to the therapeutic adhesion not put to system.

Each region has initiated several process controls, using the data made available by the AIFA, which have revealed divergences in the extent to which therapeutic adherence is related. This has led to the identification of different routes set out below.

The first path concerns the territorial extension and the destination of funding with respect to adherence, selecting the most strategic care areas. The second path of improving adherence is no longer aimed at circumscribing individual local projects and initiatives, but at integrating them in order to systematize and disseminate the best measures and specific experiences implemented. The different regional experiences of the national health system will be compared below.

Veneto Regional Project to Improve Therapeutic Adherence for Chronic Diseases and Diabetological Screening

The Veneto, with DGR n. 279 of 14.03.2017 subject: "self-control and self-management of diabetes from 1 April 2017. Experimentation activities related to the Pharmacy of Services", redefined the prices of reimbursement of devices for self-control and self-management of diabetes: Also funded a regional project within the Pharmacy of Services, to improve adherence to chronic therapies. The initial project is structured in two parts.

- A preliminary part concerned the training of pharmacists in approved pharmacies (with residential events and distance training on issues related to adhesion, the switch between different products containing the same active ingredient, the fragility of chronic patients and their taking charge, pharmacovigilance)
- A second part concerned the recruitment of patients with diabetes and/or COPD who are poorly treated or who do not follow their chronic treatment. On such patients, the trained pharmacist has put in place a series of activities and actions aimed at improving adherence, through individual counselling and structured communication.

The collaboration of pharmacists has favored the initiation of actions aimed at improving adherence to therapy in patients suffering from diabetes and/ or COPD , strategic in view of a return of the emergency from COVID-19.

In continuity with the activities proposed, the project has entered a new phase with the transposition of the document "Guidelines for testing new services in the pharmacy Community" part of the Agreement State Conference Regions approved on 17. 10.2019 Rep. Acts No. 167/CSR, DGR No. 1658 of 12-11.2019.

The New Phase Defined by Decree no. 47 of 28 September 2020[AMM1], In which both Participating and Interested Pharmacies will be Able to Participate, Provides For

The extension of the initial project on therapeutic adherence in patients with diabetes and/or COPD; the activation of a diabetological screening program, based on the possibility of administering to the patient a structured questionnaire on the assessment of the risk of developing diabetes in the coming years and on the determination of blood sugar. All these activities are in line with what is defined in the Membership Plan-Regional Health which recalls the importance of the proximity relationships of the pharmacist and his professional role that allow him to establish a relationship of confidence with regular users and to play a potentially active role in education, information and personalized assistance. In particular, pharmacies can achieve significant objectives in terms of primary and secondary prevention in compliance with protocols shared with Districts, MMG and the PLS, including regarding adherence to long-term treatments and pharmacovigilance.

Puglia

The Puglia Region has a guaranteed therapeutic adherence through services for BPCO, asma and sleep-related diseases. This organization allows in a single access to manage more diseases and avoid hospitalization through the implementation of therapeutic adherence. The exposed virtuous circuit has favored a remarkable reduction of the inappropriate hospitalizations and the overall improvement of the clinical condition of such patients, to be extended also to other pathologies that require the therapeutic adhesion, as assistential priority.

Calabria

The most recent OSMED data show a higher per capita territorial expenditure than the national average, such as the gross per capita weighted agreement, being the third Region with the highest pharmaceutical expenditure in A-SSN class (deviation of +14,6% compared to average gross expenditure per capita Italian weighted). The Calabria Region has a gross expenditure per capita weighing € 190.72 14.6% higher than the gross average per capita Italian weighed € 166.46. The Italian Drug Agency has supported Calabria in defining strategies that aim to act on consumption per 1000 ab. /die) and the alignment of prices to the national average. On this basis, the savings in pharmaceutical expenditure expected in the 2019-2021 programme, estimated by Alfa, compared to the 2018 expenditure, was calculated at €43 million.

Sicily

In Sicily there is an increase in chronicities, combined with social inequalities, in access to care and quality of care, linked to the increase in the proportion of the elderly population that requires more assistance.

In Sicily was created a dedicated technical table, in collaboration with the Department of Health, from which was born a D. A. on

the Letter of resignation, first example on the territory and a project of PSN for its implementation.

In conclusion, it should be noted that Ssrs have become efficient in treating the acute phase, but not the post-acute phase, which would require monitoring for the widespread trend of neglect of care. Among the possible explanations, the most concrete is the lack of awareness of the importance of maintaining the treatment assigned to discharge, not exhaustively explained for the persistence of different criticalities, which needs to be addressed through further measures and actions.

The Specific Open Issues in Chronic Diseases

As a result of the emergency situation, the criticalities encountered earlier in the management system of chronic patients have been amplified. To overcome them, we must learn from the crisis, combining the National Chronic Plan, approved in 2016, with the agenda dictated by the PNRR. care responses based on the needs of individual people, through innovative interactions between systems to listen to chronic patients.

In reducing the risk of regional and fragmented interventions and promoting a uniform policy on adherence to therapies, it is recommended to implement in all Regions/ PA the indications contained in the National Plan of Chronic Disease (PNC), with reference to the section "Therapies and therapeutic adherence". The National Plan of Chronicity draws attention to: promotion of applied research studies and technological and organizational solutions to improve adherence; dissemination of knowledge on increased risk of adverse drug reactions of people with chronic disease and in polytherapy; adoption of procedures to encourage adherence to medical prescriptions, in particular in the case of polytherapy; training and information for chroniclers and health professionals on the appropriate use of therapies and technologies.

Strategic Levels and Solutions to Improve Prescriptive Appropriateness and Adherence to Therapy

The more complex the chronicity, due to fragility and multi-pathologies, the more critical it becomes. Appropriateness and adherence are made up of several indicators and steps to monitor it. The management of COVID19 has highlighted the need for informative completeness, interoperability of systems and change management.

Action Points

From the debates it emerges the need for an integrated path between programming and regulation able to foresee and implement a set of concrete measures and actions capable of improving the situation as exposed to adherence to diagnostic and therapeutic pathways. From representatives of institutions from clinicians and citizens' associations came up with the proposal to develop tools to assess adherence to monitor and correct poor adherence behavior and the implementation of technologies that facilitate patients to follow the path of care. The proposal to include a synthetic adhesion indicator in the system may represent an opportunity for value and guidance for key actors.

The Role of Monitoring

During the recent pandemic, the relevance of implementing tools to support/simplify adherence was understood. The possible interventions imply to combine cost-effective: use of poly pills. educational interventions aimed at patients and health professionals, involvement of pharmacies and health care staff, adhesion monitoring systems (Devices and telemedicine).

Adherence to pharmacological care in the available studies is not unique, the indicators of therapeutic adherence in Italy are collected from databases from flows that do not measure discontinuity due to change of therapy or adverse events.

The Role of Welfare Networks

The need to redesign care pathways implies giving greater importance to continuity oriented to therapeutic adhesion. The implementation involves redefining the continuity of the hospital-territory, ensuring access, appropriateness and unitary direction. Therefore, it is necessary to think about the transversal medical record between different health professionals (MMG, caregiver, territorial specialist and hospital specialist). In this circuit it is necessary to capitalize on the proximity to the citizen, to meet the fragility of the person, families and disadvantaged areas, such as internal areas .

The Role of Innovation

New telemonitoring and telemedicine technologies offer opportunities to measure adherence to therapies. In the same way, we need to invest in innovation in adherence, as investment in this area corresponds to savings in terms of expenditure. The estimated savings are: Hypertension: adherence 80% annual savings of € 462 per capita (IQR € 414-1.020); Dislipidemia: adherence 80% annual savings of € 659 (IQR).

Use of Digital as a Strategic Lever for Therapeutic Adhesion

Digital Health has been an objective of the National Plan of Chronicity, in promoting the management of chronic pathology compared to the improvement of therapeutic adhesion. The Electronic Health Record (FSE) was created as an information tool through which citizens can trace and consult health history, sharing it with health professionals. This function of therapeutic monitoring favors the improvement of therapeutic adhesion.

At regional level, the ESF has been implemented in Campania and Lazio, other Campania, Friuli Venezia Giulia, Lombardy, Marche, Molise, P.A. di Trento, Valle d'Aosta use telemedicine; teleassistance (Friuli Venezia Giulia, Marche, Molise, Valle d'Aosta, Veneto); the tele-monitoring Molise, Valle d'Aosta, Veneto); Umbria has implemented a management to take charge of the protected resignations, while none has adopted the pharmaceutical dossier.

Support tools (apps, tutorials) are present in 3 Regions that have adopted specific measures (Friuli Venezia Giulia, Marche, Bolzano); Liguria eTrento present projects to promote these tools. 13. Toll-free numbers, operational centers, remote assistance: 4 Regions / Provinces (Friuli Venezia Giulia, Marche, Molise and P.A. of Bolzano); in Campania and Liguria there are business experiences.

The Role of Participation

In the governance of adherence it is necessary to implement both the multidisciplinary and participatory role of each subject involved in the various care segments (specialist doctors. Assoc. Patients) in achieving a balance between expected benefits with respect to the availability of the economic resources used.

This implies a dual sheep top down and button up. The first relates to the initiatives which arise from the highest levels and which are accompanied by the widest participation. In this regard have been presented Proposals for Civic Recommendations for therapeutic adherence At the Ministry of Health, the Regions,

the Asls, professionals, patient associations is recommended: 1.Implementation of the National Plan of Chronicity on the national territory In order to improve adherence, it is important to intervene also on polypharmaceutical therapy, simplification and pharmacological reconciliation, reduction of unnecessary drugs or combinations; on prescriptive appropriateness, as reflected in the regional framework.

The second is a button-up in ensuring a better relationship of care through the levers of communication and vocational training.

The first step is to consolidate the adherence to the therapeutic path, through a relationship between the person and the care team, enhancement of the professional skills involved and counseling, in supporting the care team and ensuring a "support for more useful behaviour

Finally, another step is the implementation of training aimed not only at health professionals in relation to safety and interaction between drugs in polypropylene therapy, but also in support of the family caregiver, in supporting and qualifying such assistance.

The Regional Strategic Areas

They can be distinguished in macro areas and interventions of a corporate nature. A trend noted is the growing attention to the person/family/caregiver.6 Regions (Campania, Friuli Venezia Giulia, Liguria, Marche, Umbria and Veneto) declare to adopt regional policies; the P.A. of Trento adopts such programs at company level.

- Appropriateness of requirements: 11 regions deal with appropriateness of requirements; Trento and the Valle d'Aosta have projects at company level.
- Prevention of adverse events from errors in drug therapy (LASA): 10 Regions implement regional policies (Campania, Friuli Venezia Giulia, Lazio Liguria, Marche, Molise, P.A. of Bolzano, Sardinia, 42 Do not respond: Campania, Lazio and Umbria). Umbria and Veneto); Lazio, Trento and Valle d'Aosta, have experiences at the company level.
- Pharmacy of the services: 9 Regions (Friuli Venezia Giulia, Liguria, Marche, Molise, P.A. of Bolzano and Trento, Sardinia, Umbria, Veneto) 43.
- Prevention of adverse events from errors in the prescription: 9 Regions/PA (Campania, Friuli Venezia Giulia, Liguria, Marche, Molise, P.A. of Bolzano, Sardinia, Umbria and Veneto); in Lazio, in the P.A. of Trento and in Valle d'Aosta there are company level projects44 .
- Training programmes for health workers: 8 Regions/Pas (Friuli Venezia Giulia, Liguria, Lombardy, Marche, Molise, P.A. of Bolzano); Campania and P.A. of Trento at the level of business projects.
- Pharmacological reconciliation: 7 Regions (Lazio, Liguria, Marche, P.A. of Bolzano, Sardinia, Umbria, Veneto); 3 Regions: FRIULI VENEZIA GIULIA, P.A. of Trento and Valle d'Aosta have experience in business projects .
- Regional simplification programmes: Regione Marche declares to have a regional policy of pharmacological simplification; Liguria and the P.A. of Trento declare the presence of business projects.
- Poly drug therapy 7 Regions declare to implement measures in this field (Friuli Venezia Giulia, Liguria, Marche, P.A. di Bolzano, Sardegna, Umbria and Non risponde: Campania, Lazio e Lombardia; Non risponde la Lombardia; Non risponde: Campania, Lombardia, Molise, Veneto); at company

level there are experiences in Campania, P.A. of Trento and Valle d'Aosta.

- Correct ways of taking the drug: only 2 regions declare regional policies in this area (Friuli Venezia Giulia, Marche); there are business experiences in Liguria, P.A. of Trento, Umbria and Valle d'Aosta.

Motivation/Training of the Person with Chronic Condition

7 Regions have shown commitment in this area (Campania, Friuli Venezia Giulia, Liguria, Marche, Umbria, Valle d'Aosta and Veneto), while in others they are deficient as Lazio and Lombardy; "No": Molise Do not answer: Lazio, Lombardy, Umbria, Veneto.

Improvement programmes and communication with patients/ and with caregivers: 5 regions have launched macro initiatives (Campania, Friuli Venezia Giulia, Marche, P.A. of Trento and Umbria) while others 3 have started projects/ initiatives at company level, such as Liguria, Sardinia and Valle d'Aosta. Training programs for carers: there are regional policies in Molise and the P.A. of Trento; while in Liguria business experiences. This includes the activity of counseling in which specific projects have been launched in Friuli Venezia Giulia and Veneto, while individual business experiences in Liguria and P.A. Trento.

In this circuit of implementation of the level of communication between patients and professionals include health literacy programs provided in Friuli Venezia Giulia and Sardinia through regional policies, while company-level experiences have been implemented in the Marche, Trento and Valle d'Aosta. Another path of the above implementation concerns the start of surveys, studies and surveys to which Liguria, Marche and P.A. have responded positively, as well as business experiences in Friuli Venezia Giulia, in P.A. of Trento and in Valle d'Aosta.

Another area concerns the simplification and bureaucratic reduction to be implemented in the prescription (renewal treatment plan, transcription from white recipe to red tape) and therapeutic course (distances in reaching the Prescribing Center or withdrawal of the drug). With regard to the first profile, the aim is to improve the clarity of the prescriptive indications, avoiding acronyms, abbreviations and foreign words, in order to increase comprehensibility and reduce the risk of errors in recruitment.

In order the second profile is to ensure the full implementation in the regions of the RACC. Ministerial No. 17 on Pharmacological Reconciliation, through the unambiguous identification of the centre of responsibility for ensuring reconciliation.

Programmes to improve communication with patients/caregivers: 5 Regions/Provinces (Campania, Friuli Venezia Giulia, Marche, P.A. of Trento and Umbria); projects/initiatives at company level in Liguria, Sardinia and Valle d'Aosta.

- Counseling: only Friuli Venezia Giulia and Veneto work on counseling; there are company experiences in Liguria and P.A. in Trento.
- Health literacy programmes: Friuli Venezia Giulia and Sardinia have regional policies. There are experiences at the company level in the Marche Region, Trento and Valle d'Aosta
- Training programmes for carers: there are regional policies in Molise and the P.A. in Trento; while in Liguria business experiences.
- Surveys, studies and surveys: Liguria, Marche and P.A. of Bolzano have responded positively; business experience exists in Friuli Venezia Giulia, in P.A. of Trento and in Valle d'Aosta.

The Role of Simplification of Administration

Simplify and reduce unnecessary bureaucracy by reducing the bureaucratic burden on the prescription (renewal of the treatment plan, transcription from white recipe to red recipe) and the distances to reach the Prescribing Centre or withdraw the drug).

Full implementation in RACC regions. Ministerial N. 17 on Pharmacological Reconciliation, clearly identifying the centre of responsibility for ensuring reconciliation. To improve the clarity of the indications contained in the prescriptions avoiding the use of acronyms, abbreviations and of Latin or foreign words (eg. ½ cp die), in order to increase the comprehensibility and reduce the risk of errors in the assumption.

The Next Pnrr-Oriented Approaches: Comparative Organisational Models in Healthcare

The current treatment models are oriented to the enhancement of the role of the person through patient engagement (active involvement of the patient), as an active and "expert" subject within the clinical process-A virtuous development of the therapeutic adhesion implies a growth of the current health systems in ensuring a balance between the different assistenziali segments, in the phases of the health path between the possible treatment options, the benefits and risks involved. The optimal level of adherence implies an improvement of the attainable results through the better use of the amounts of resources used and a positive fiscal impact. This involves structured interventions to increase adherence to therapies through initial investments and incentive systems, able to improve without wasting resources.

The National Recovery and Resilience Plan sent on April 30 to the European Commission and approved by the same provides for an allocation of 235.15 billion euros. Referring only to the resources that come from the National Recovery Plan and, therefore, net of the Supplementary Fund, 15.63 billion euros have been allocated for Mission 6 Health of the National Recovery Plan, divided between the two components of the Mission as follows: Proximity networks, intermediate facilities and telemedicine for territorial health care: 7 million appropriations Innovation, research and digitalization of the National Health Service: 8 million and 63 million euros.

The Investment Prospects of the Pnrr Imply a Specific Strategy Drawn in the Field of Health Able to Identify Challenging Objectives

The first step concerns the alignment of services to the needs of patients in each area through the improvement of infrastructure and technological equipment, promoting research and innovation and the development of technical skills professional, digital and managerial staff.

The digital innovation within the PNRR is to be oriented to the «cross channel», that is the combination of different delivery channels in managing the same patient up to the «omnicity», the synergy between different integrated channels able to share the information system.

The reforms and investments envisaged by Mission 6 Health of the PNRR included in the Plan imply innovative organizational and management paradigms set out below.

The management tools to be implemented in the implementation of what is described are the pharmacy services and community nurses who fit into a care circuit increasingly integrated in ensuring closer proximity to the patient in therapeutic adherence.

In reference to the first leverage of financing, there is also the need to increasingly ensure a more integrated and reinforced PDTA model in which the main feature will be multidisciplinary professional.

In addition to the above, it will be necessary to identify and implement an organized development methodology able to maintain the current organizational models as well as to implement new ones such as One Health, in the achievement of the objectives described above planned at the programmatic level.

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Finally, another necessary lever is that of the measurement in order to prevent the underestimation and the wrong prognosis that require complex interventions to restore the prescriptive path. This implies the need to identify more adhesion indicators than the current LEA indicators combined with a new regulation for regional indicators capable of achieving greater uniformity. The development of audits, which are able to monitor in order to standardize best practices, is always in this line.

The conclusions are aimed at identifying the best application of organisational models in health that can exploit the resources of the PNRR in the field of therapeutic adhesion. At this point it is necessary to understand how to adapt these models to the health system that will be decided with the PNRR. Every one health , change management, value based health organizational approach has the elements that if integrated can be the best support towards the best destination of such funds [1-9].

Lastly, a leading role is played by institutional bodies such as AGENAS in the planning of the use of these PNRR funds through the priority attention given to social protection

Assistance

In this regard, the first draft drawn up by Italian institution AGENAS and Ministry of Health “Models and standards for the development of Territorial Assistance in the National Health System” provides for the implementation of the allocation of EUR 2 billion of mission 6 of the PNRR to the centrality of Community Houses, in the dual organisational dimension of the HUB and SPOKE integrated with the structure of the HOSPICE, in order to improve the current global take-over for patients suffering from chronic neurodegenerative diseases, oncology (10 beds per 100,000 inhabitants), through the implementation of chronic monitoring and basic home care.

This program follows the regulation of territorial assistance reform of the Ministerial Decree n. 70/2015 “ Regulation defining the qualitative, structural, technological and quantitative standards relating to hospital care”, characterized by the desire to extend social protection through greater continuity of care between hospital and home, the implementation of intermediate care structures and pharmacies and the provision of specific professional figures such as community and family nurses as organizational and managerial segments functional to the effective taking care of chronicities

and fragility welfare.

Programming and Regulation

- D.M. 70/2015 - Regulation defining the qualitative, structural, technological and quantitative standards relating to hospital care.
- Draft AGENAS and Ministry of Health- Models and standards for the development of Territorial Assistance in the National Health System

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