



Population Health Management as a Driver of Primary Care Transformation

Thursday, 1 October 2026 - 13:00–14:00 CET

*#primarycare #populationmanagement #transformation
#primarycarenetworks*

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Dr. Paolo Parente, MD, PhD, MSc is the Director of the Office for Primary Health Care and Intermediate Care of the Lazio Regional Health System, Rome.



This session focuses on the Italian primary care system, taking a deeper dive into the primary care system, which covers 6 million people in the Lazio Region in Italy. The session will focus on the changes which are underway in the region and will include insights from initiatives to transform services across the whole system. Including current epidemiological and demographic status, population health management, building systems to improve the use of data for risk stratification and understanding the new and changing needs of the population.

What you will gain

- Gain a practical understanding of how population health management can support the transformation of primary care.
- Explore strategies for shifting from reactive, disease-focused care to proactive, person-centred and preventive approaches.
- Take away practical lessons and recommendations that can help accelerate the adoption, implementation, and scaling of innovative primary healthcare models in your own organisation or region.



JTC 2025 | The Call

Third THCS Joint Transnational Call for R&I proposals · launched November 2024 · co-funded by the European Commission

CALL TOPIC

Better care closer to home: Enhancing primary and community care

Europe relies too heavily on costly hospital and institutional care. The Call funds collaborative transnational projects that develop scalable, people-centred care models, improve coordination across care settings and shift services towards primary and community care.

1

Strengthening primary & community care

Organisational, operational and workforce innovations moving care from institutions to integrated, community-based services.

2

Systemic approaches to modernisation

Practical, evidence-based knowledge that policy and decision makers can apply across European contexts.

€ 36M

initial funding commitment by the participating national/regional Funding Agencies, plus EC top-up

34

Funding Agencies

22

Countries

Two-stage process

Pre-proposals → Full proposals, with the new **widening measure**



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JTC 2025 | Call Results

28

projects selected for funding

from 149 eligible pre-proposals

€ 38.7M

total Call budget expenditure

incl. ≈ €6.9M EC top-up generated

179

research teams funded

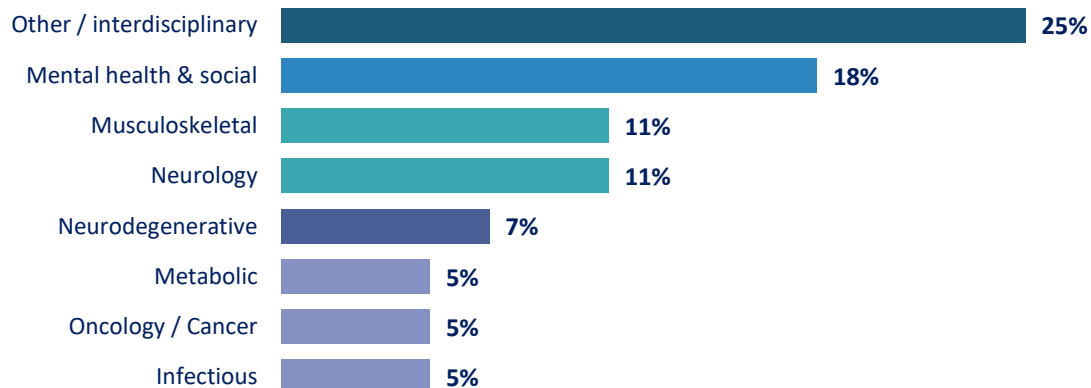
22 countries · 34 Funding Agencies

19.5%

overall success rate

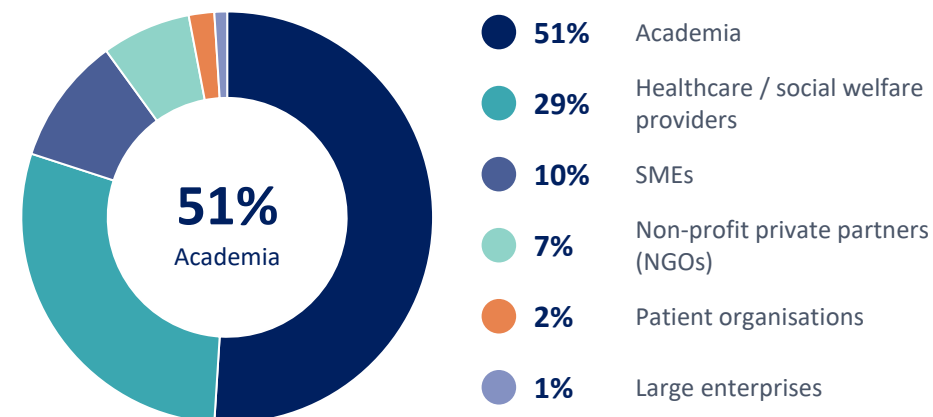
from pre-proposal to award

Medical domains of awarded projects



Also 2% each: cardiovascular, paediatrics, rheumatology, gastro, dermatology, ENT · multiple domains allowed

Type of entities selected for award



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JTC 2025 | Projects Selected for Award

28 transnational consortia bringing care closer to home, from digital tools and AI to rehabilitation, mental health and chronic disease management

AT-HOME study

Home antimicrobial therapy

CARE@HOME

AI for ageing at home

CARE-CDS

Nursing practice & decision support

CARE-HOME

Connected home-based recovery

CARING-AI

Social assistive robots

CC4C

Paediatric rehab closer to home

CLARITY

Health literacy for migrants

CO-ACT

Adaptive care for ageing communities

CoCare

Co-care learning ecosystems

DISA-LNT

AI-powered schizophrenia assessment

ENABLED

Near-home AMR diagnostics

ENCOURAGE-ME

Coaching & empowerment for ME/CFS

ENHANCE-SVD

Small vessel disease in primary care

eRECOVER

Digital care for mental disorders

GlaukomaiCare

Glaucoma care in the community

GOAL-MM

Multimorbidity management

IBD-CARE

Digital primary care for IBD

INTEGRA

Telerehab for persons with disabilities

LIZZ-TRANSCARE

Hospital-to-home rehab companion

MOMENT

Midwifery-led perinatal care

MUSCLE

Lean care for MSK disorders

PRIME

Community mental health pathways

PRIME-OncoTBC

Breast cancer care transition 65+

SHIFT-EU

Digital self-management

SONETTO

Sarcopenic obesity prevention

SPACES

Telerehab & telemonitoring

STRIDE-COM

Diabetic foot ulcer prevention

WISH

Hormonal health in breast cancer

28 projects · 179 teams · 22 countries



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Learning Week 2026

- Thank you for joining this session.
- The session recordings will be hosted on the Knowledge Hub:

<https://knowledgehub.thcspartnership.eu/>



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POPULATION HEALTH MANAGEMENT AS A DRIVER OF PRIMARY CARE TRANSFORMATION

Paolo Parente
Director of the PHC Office – Lazio Regional Health Directorate



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Proximity epidemiology

Between classical epidemiology, social epidemiology, community epidemiology and citizenship epidemiology. An approach of investigating the closest territorial reality, collecting and analyzing micro, relational data in order to understand the territory, its complexity and the interaction of the many networks involved in the illness and health of the people and communities that inhabit and pass through it.

The Blue Book for Primary Care Reform in Italy.



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Territory and Territorialization

- **TERRITORY:** physical or virtual space, dynamic, delimited by fluid boundaries and profiles, in continuous construction and transformation, belonging not only to a geographical dimension but also to demographic, epidemiological, administrative, technological, political, social, cultural (Mendes, 1993), etc. Territory is a process that is (re)constructed by the actions of the people who pass through it, it is the place of (interaction of social groups and it is a place of construction and exercise of power (Gondim et al, 2008).

Territory and Territorialization

- **TERRITORIALIZATION:** a permanent process of recognition and induction of the territory, thus understood both as a process of knowledge of the territory-subject and, above all, as a process of recognition and identity co-construction of the territory-subject (territory that is created and transformed in the interaction with health services). Territorialization is a fundamental tool for implementing the founding principles of the Blue Book (health as a right, person- and community-centered approach to health, and oriented to the principles of Comprehensive PHC). It is also a means capable of producing changes in the model of care and health practices (Teixeira et al, 1998) and enables the planning of health actions aimed at people's everyday realities.

THE BLUE BOOK FOR PRIMARY CARE REFORM IN ITALY.



The Italian National Healthcare System



The **central government** has a stewardship role: it determines **the core health benefits** to be uniformly granted across Italy.



The **regional governments** oversee, organize and deliver **primary, secondary and tertiary healthcare services, as well as preventive and health promotion services**. They define their own **regional health plans**, coordinate the strategies of the regions, **allocate the budget within their systems** and **monitor quality, appropriateness and efficiency of the services provided**.



The **local level** ensures the **provision of primary, secondary and tertiary healthcare services, as well as the preventive and health promotion services** through:

- ✓ **local health authorities 'LHAs'** (geographically based organizations, responsible for delivering public health services, community healthcare services and primary care directly, while secondary and specialist care through directly managed facilities or by outsourcing to public hospital institutions or private accredited providers);
- ✓ **public hospital institutions** (which often cooperate with Medical Schools and work as Teaching Hospitals);
- ✓ **private accredited providers**.



Demographic & Epidemiological Profile

A large, highly urbanised population with ageing, demographic decline and a growing chronic-care burden

5.71 M

residents

73.9% live in the Province of Rome



46.7 yrs

mean age (2024)

199.5

ageing index
≥65 per 100 <15

11.4%

foreign residents

33,699

births in 2024

DEMOGRAPHIC DYNAMICS

- Population change** −0.1% vs 2023
- Women** 51.5%
- Mortality rate** 10.7 per 1,000
- Territorial gradient** Rieti/Viterbo older;
Rome/Latina younger

EPIDEMIOLOGICAL PROFILE

42%

of adults aged 18–69 are overweight or obese

Ageing + multimorbidity

increase demand for proactive, integrated chronic care and population health management.

Marked urban–rural heterogeneity

requires local stratification of needs and tailored primary care planning.

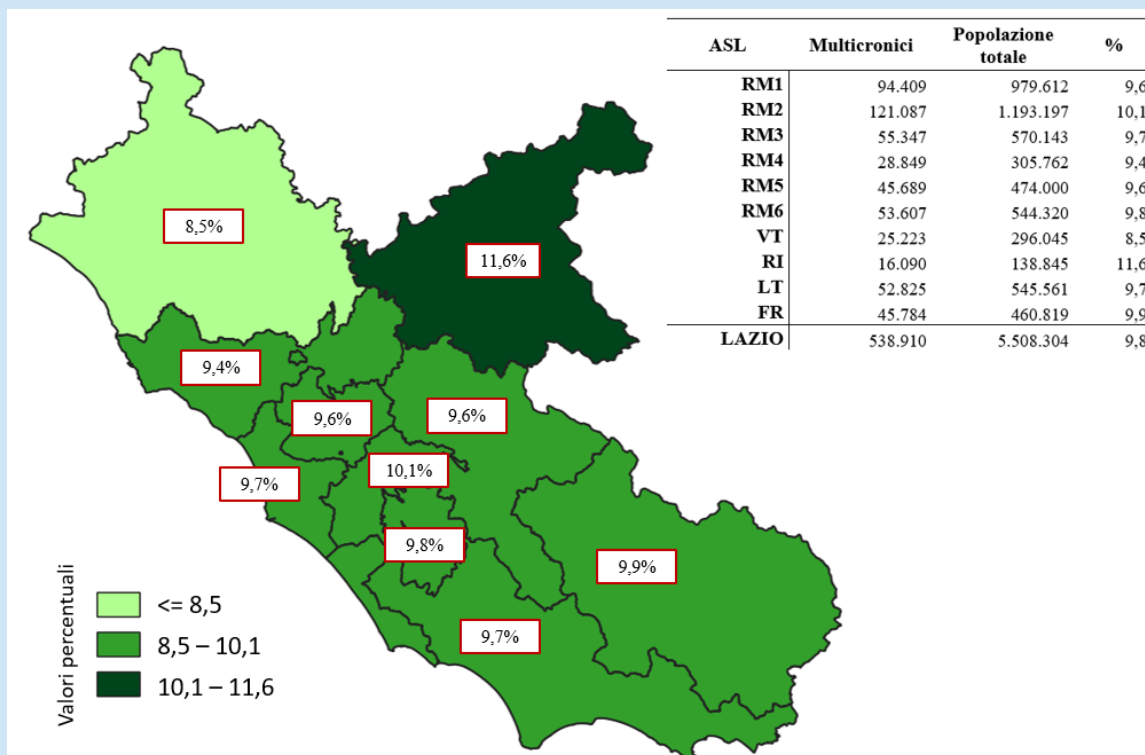
Planning implication | Shift from a “one-size-fits-all” model to population stratification by age, chronicity, social vulnerability and geography.



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Understanding the characteristics of the Lazio Region population is critical to ensuring effective, patient-centered health care services.



Multi-chronic population (2 or more diseases) by ASL of care. Latium, 01/01/2022



ELDERLY INDEX

Over the past decade, there has been a significant increase in the percentage of elderly residents, with more than 23 percent of the population over the age of 65.



MULTICRONICITY

The increase in the elderly population has been accompanied by an increase in patients with more than one chronic disease at the same time (a complex target that needs individualized approaches and coordinated interventions).



SOCIO-ECONOMIC VULNERABILITY

There are more than 192,000 chronic patients with "concurrent" socio-economic vulnerability factors considered (12.8 percent of the population with chronic diseases and 3.5 percent of the entire regional population).



RISK FACTORS

More than 18% of the adult population is exposed to at least 2 behavioral risk factors (smoking, obesity, alcohol, and sedentary lifestyle). About 500,000 caregivers have cardiovascular risk factors, (hypertension and/or hypercholesterolemia).

Paradigm shift. Now or never

The changing epidemiological context in Lazio, characterized by an aging population and an increase in chronic diseases, has highlighted the importance of addressing this challenge through innovative approaches.

Ministerial Decree 77/2022 defines national quality, structural, technological and quantitative standards of facilities dedicated to territorial care and the prevention system in the health, environmental and climate fields under the NRP.

We developed a PHC Plan taking considering:



Population health needs;



Criteria for eligibility, access, and user intake;



Transitional Care procedures and interconnection between different care settings;



Systems of remuneration and reimbursability of benefits;



Criteria and timing of provider engagement in a social and health integration perspective.



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Objectives of the PHC REGIONAL PLAN

- a) **Strengthening district governance:** Aims to strengthen capacity and expertise at the local level to ensure community-based interventions through networking of community resources and functional coordination of district structures.
- b) **Proactivity, Listening and Proximity:** Proactive action focuses on the identification and delivery of health services needed by the most at-risk segments of the population, implementing new professional figures such as the Family and Community Nurse and activating Prevention Teams to promote integrated prevention and care interventions in the territory. Focus on domiciliarity and development of processes that lead to making the Home a true place of care
- c) **Access to services and caretaking:** Aims to ensure equity of access to health services and reduce fragmentation of care with the activation of the Harmonized European Number (NEA) 116117, the strengthening of Single Points of Access (PUAs) and the establishment of Territorial Operations Centers (TOCs)
- d) **Great attention to Mental Health:** Mental Health again at the center of Latium Health's planning agenda, especially in complex settings such as Prisons .



The implementation of the Plan includes the adoption of a participatory working model, through the establishment of special Working Groups representing the various companies, so as to strengthen coordination at the regional level between the various actors of territorial services.



**REGIONE
LAZIO**

**PIANO DI PROGRAMMAZIONE
DELL'ASSISTENZA TERRITORIALE
2024 - 2026**

**COMPANIES
HOSPITALIST**



**LOCAL HEALTH
COMPANIES**

**REGIONAL
TECHNOSTRUCTURE**

**DEPARTMENT OF
EPIDEMIOLOGY (DEP)**

DELIBERA

per le motivazioni espresse in narrativa, che si intendono integralmente richiamate:

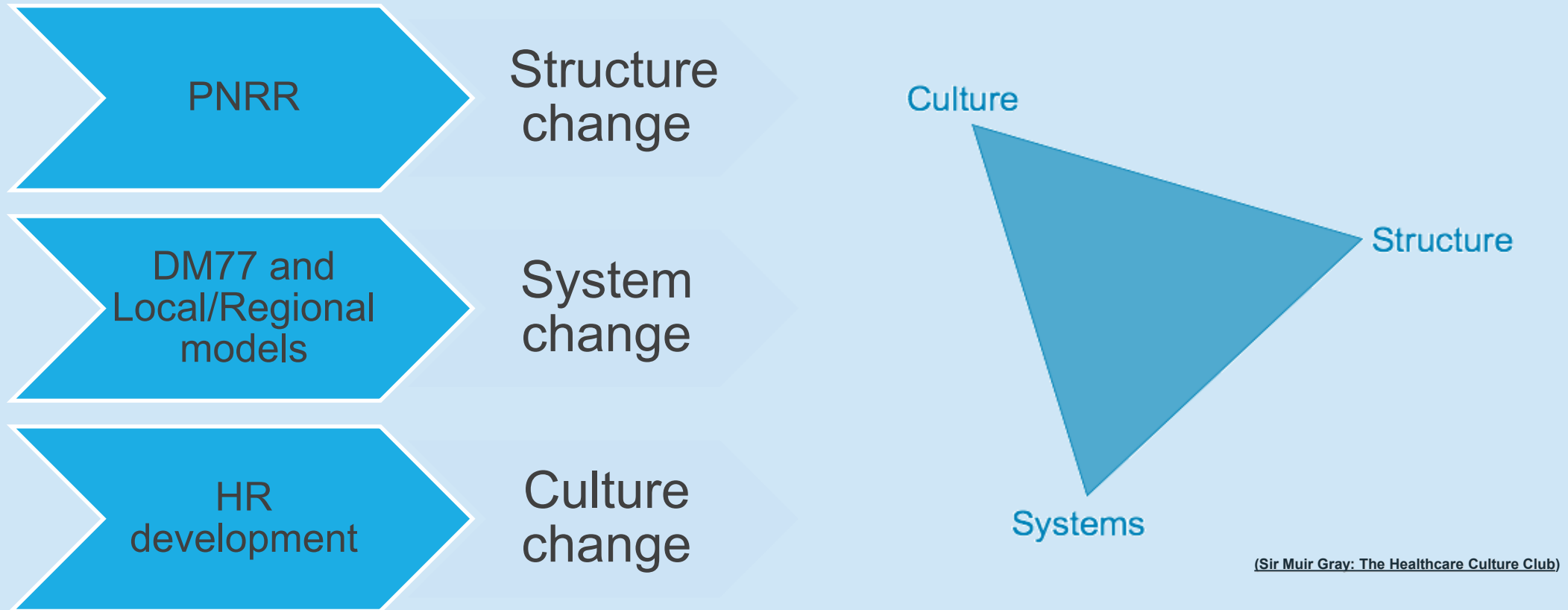
di approvare il "Piano di programmazione dell'Assistenza territoriale 2024 - 2026", allegato alla presente deliberazione quale parte integrante e sostanziale;

di sospendere i nuovi accreditamenti di strutture residenziali socioriabilitative dedicate all'assistenza delle persone con disabilità fino al termine massimo del 30 giugno 2024, nelle more della puntuale definizione del fabbisogno per livello assistenziale secondo quanto disciplinato dall'art. 34, comma 1, lettera c) del DPCM 12 gennaio 2017 concernente "Definizione ed Aggiornamento dei Livelli Essenziali di Assistenza";

Il Direttore regionale della Direzione Salute e Integrazione Sociosanitaria provvederà a tutti gli adempimenti necessari all'attuazione del Piano.

Avverso il presente provvedimento è ammesso ricorso giurisdizionale innanzi al Tribunale Amministrativo Regionale del Lazio nel termine di giorni 60 (sessanta) dalla pubblicazione ovvero ricorso straordinario al Capo dello Stato entro il termine di giorni 120 (centoventi).

La presente deliberazione sarà pubblicata sul Bollettino Ufficiale della Regione Lazio e sul sito istituzionale www.regione.lazio.it.



1) Evidence-based planning approach

Use of a **planning approach based on epidemiological analysis of population health needs and assessment of local contexts**, to ensure that organisational decisions are driven by **data and evidence rather than abstract models**.

2) Co-design of regional policies

Adoption of **participatory methods in the development of regional policies and guidance**, through the systematic involvement of **Local Health Authorities, professional bodies and other institutional stakeholders**, to ensure the **appropriateness, sustainability and shared ownership** of policy decisions.

3) Redefining key professional roles

Redefinition of key professional roles, including the **Family and Community Nurse** and the **General Practitioner under the new unified professional role**, to align them with the new models of **community-based care and integrated patient management**.

4) Coherence and progressive implementation of regional policies

Regional resolutions have been designed as **progressive and mutually consistent policy measures**, each addressing a specific component of the new community-based care model.

Implemented to date: Regional guidance on **Community Health Centres (CdC)**, **Community Hospitals (OdC)**, **Family and Community Nurses (IFeC)**, **Functional Territorial Aggregations of GPs (AFT)**, **Territorial Operations Centres (COT)**, **Palliative Care**, **Regional Collective Agreement for General Practice (AIR)**; etc.

Currently under development: **Operating Procedures (SOPs) for multidisciplinary teams; SOPs for community participation.**



Population Health Management requires a perceptual shift.

1. The Lens of Time (Demographics)

Preparing for the 2040 demographic winter.



2. The Lens of Risk (Stratification)

Visualizing vulnerability beyond clinical diagnosis.



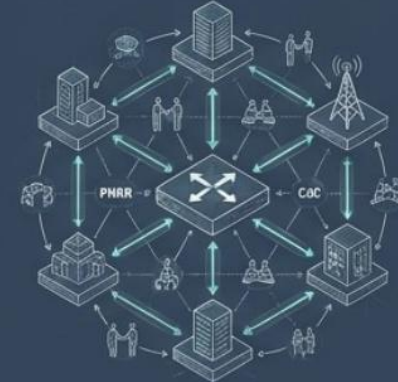
3. The Lens of Geography (Isochrones)

Redefining access by time, not distance.

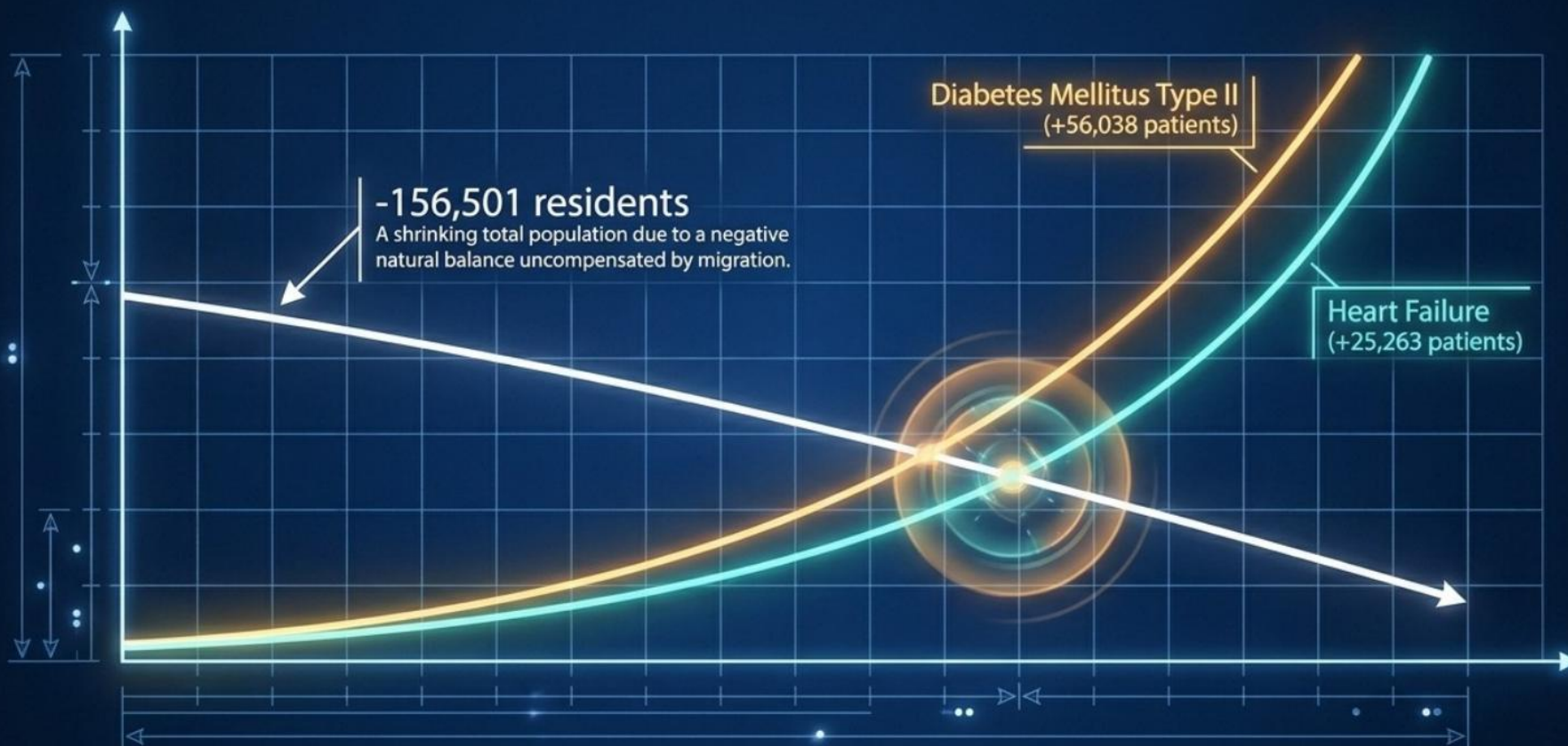


4. The Lens of Teamwork (Infrastructure)

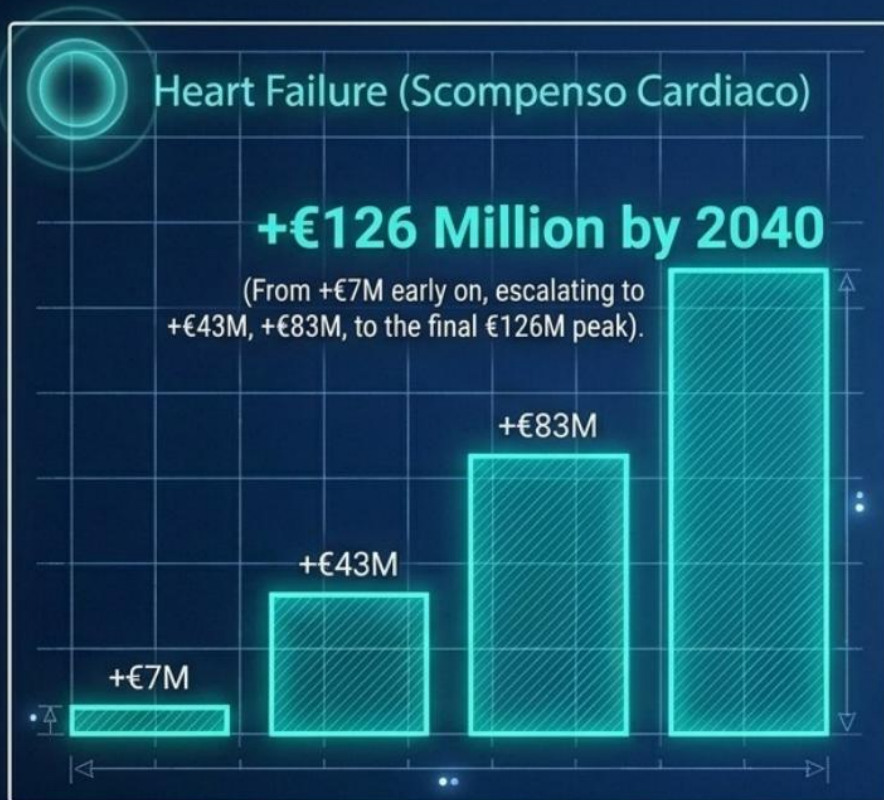
Operationalizing PNRR, CdC, and AFT networks.



The 2040 Demographic Winter in Lazio

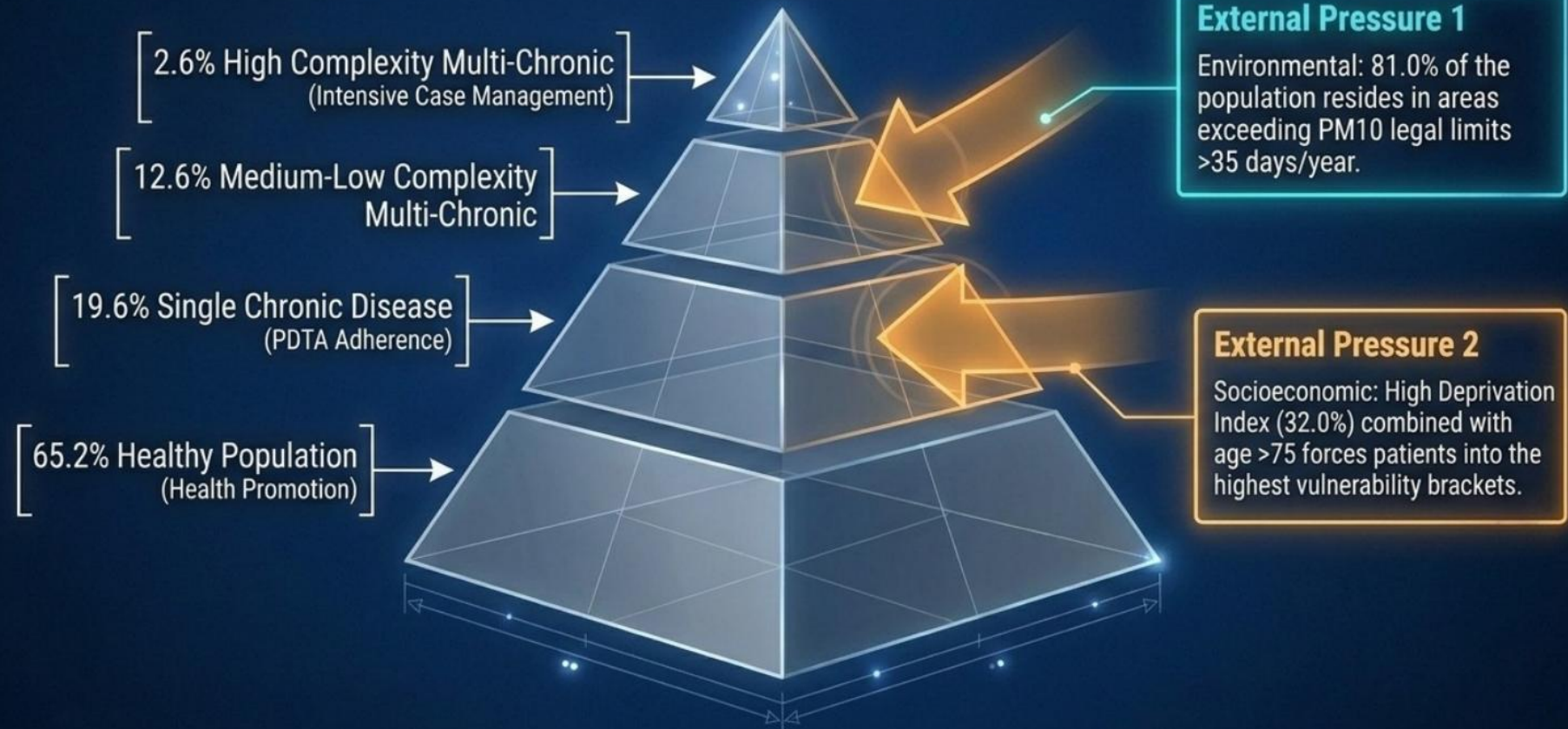


The financial burden of reactive care will become insurmountable.



Insight: Currently, Lazio holds a 35.9% prevalence rate for chronic diseases overall. A proactive shift is mandatory.

Mapping vulnerability beyond the clinical diagnosis.



Shifting from reactive treatment to population-based anticipation.

	The Legacy Model	<u>The PHM 2026 Model</u>
View of Patient	Sick individuals in a waiting room.	At-risk populations within a territory.
Care Trigger	Reactive / Acute episodes.	Proactive / Sanità d'Iniziativa (Initiative Medicine).
Primary Care Role	Isolated Solo Practitioner.	AFT Node within a multiprofessional network.
Infrastructure	Fragmented, siloed clinics.	Hub & Spoke Community Houses (CdC) integrated with COTs.

PHM context analysis

Overall Objective

To conduct a **systematic assessment of the regional territory** to support the development of a **territorial model for the organisation of health and social care services**, in line with the principles of **Ministerial Decree 77/2022 (DM 77/2022)**.

Specific Objectives

Understand the actual needs of local communities through the integrated analysis of **demographic, epidemiological and social data**.

Identify the most vulnerable areas and the **determinants of health** that should guide priorities for action.

Provide Local Health Authorities with practical methods and tools to plan community-based services according to the principles of **equity, proximity and appropriateness**.

Support resource allocation decisions regarding the **location of new community-based services**, the rationalisation of existing services, and the **elimination of organisational overlaps and redundancies**.

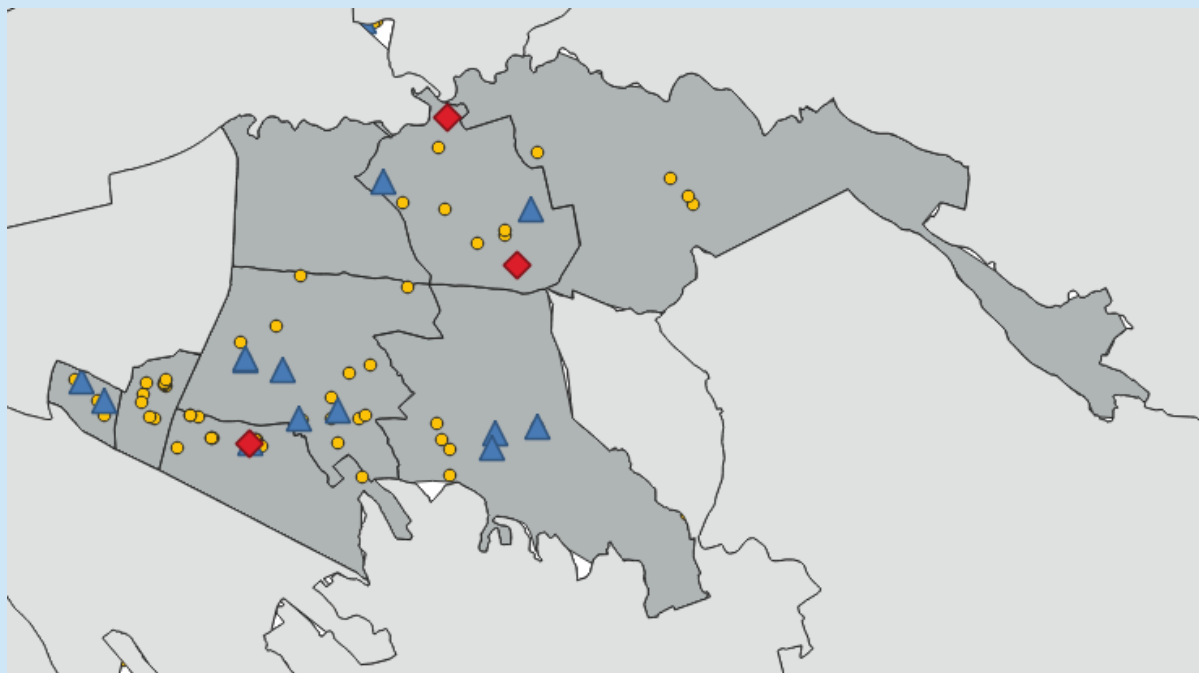


Urbanistic context analysis



Distretto 6, ASL Roma 2 – Zone urbanistiche «Acqua Vergine» e «S. Vittorino»

- **Geospatial mapping of healthcare providers:** Mapping the distribution of existing healthcare service networks in relation to the location of **Community Health Centres (CdC)**, **Community Hospitals (OdC)**, **General Practice clinics**, **Primary Care Units (UCP)** and **Functional Territorial Aggregations (AFT)**.



This approach makes it possible to **identify geographical gaps in service provision and highlight where healthcare capacity needs to be strengthened or expanded.**

D/EP/Lazio

Redefining access through the Isochrone model

Distance is a flawed metric for access. We map healthcare proximity using '**Isochrones**'—irregular geographic zones defined by travel time.

The "Tenuta di Torrenova" proximity ring represents a precise **10-minute** walking radius from the Community House.

This guarantees that infrastructure is placed where communities can actually reach it without systemic friction.



The Proximity Intersection: Putting care where the risk lives.

- The glowing dots represent mapped multi-chronic patients with high socioeconomic vulnerability (deprivation index) and polypharmacy needs.

Insight: By mapping Population Health Management “by district,” we ensure our physical brick-and-mortar investments match the exact geospatial footprint of our most vulnerable citizens.



The Patient Orbit: A cohesive, multiprofessional ecosystem.

Aggregazioni Funzionali Territoriali (AFT).

The GP network serving as
the primary clinical anchor.

**Outer Hubs: Case della Comunità
(CdC) for physical integration;
Ospedali di Comunità (OdC) for
step-up/step-down intermediate care.**

The Home
(First place of care).

**Infermiere di Famiglia e
Comunità (IFeC).**
Activated by the District,
AFT, or COT for proactive
stratifications.

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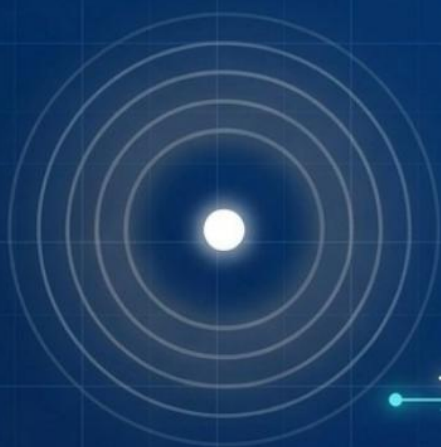
DGR 416/2024: Matching the intervention setting to the risk tier.

	IFeC	CdC	116117	OdC	COT	ADI	UCA
Healthy Population							
Stable Chronic	Proactive care, self-care training, home delivery.						
High Complexity Chronic		Health/Social integration, therapeutic specialist care, follow-up.					
Post-Acute Discharge				Functional recovery, step-down transit.			

Redefining Primary Care: The AIR Lazio 2026 Framework.

The Shift: Moving away from isolated solo practices toward Aggregazioni Funzionali Territoriali (AFTs).

Isolated Solo Practices (Before)



Innovations Introduced:

- Shared organizational models written collaboratively with system actors.
- Reactivation of the Regional Committee for General Medicine.

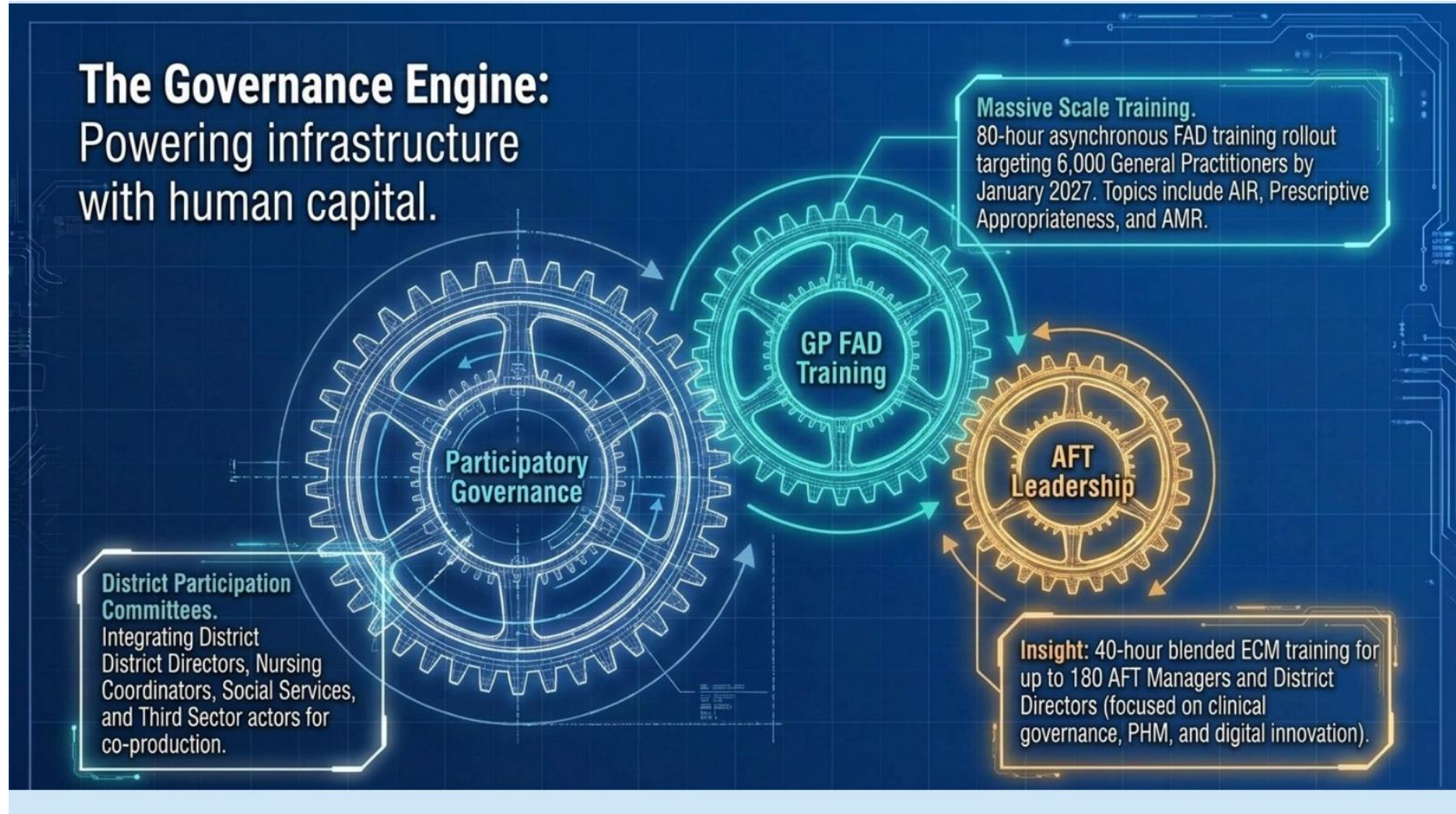


Aggregazioni Funzionali Territoriali (AFTs) (After)

Expected Outcomes:

- AFTs become the territorial reference unit.
- Shared goals between GPs, Community Houses, Home Care (ADI), and the District.
- Reduced territorial variability and heightened efficiency.

The Governance Engine: Powering infrastructure with human capital.



A system guided by data, driven by proximity.

- We are building based on epidemiological realities, not abstract models.
- We are placing infrastructure exactly where demographic vulnerability dictates.
- We are equipping 6,000 clinicians with the training to lead this new paradigm.



**The implementation of DM 77 is not a regulatory fulfillment;
it is the comprehensive redesign of territorial equity.**

One goal

***"Tearing down walls,
building bridges..."***

Giorgio La Pira

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