A pilot experience of HTA institutionalization

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ABSTRACT

The regional Health Authority of Sicily has promoted the introduction of Health Technology Assessment as tool for quality assurance in regional healthcare services. From 2007 to 2013 Agenas has supported the regional initiative helping to identify the organizational model that could better fit in the specific context. The process allowed to the regional health authority to define the role of the regional HTA body, its interactions both with other regional offices responsible of investments’ decisions and local health authorities. A network of local representatives for HTA was formally created. Shared prioritization criteria, submission templates, Check lists for mini HTA at local level and for regional HTA and rules for workload distribution were also officially adopted through “regional guideline on HTA”. A training program targeted to regional network and the monitoring of the model efficiency/efficacy are ongoing.

METHODS

Sicily has a population of about 5 million of inhabitants and the regional health system is organized in 9 provincial health authorities, 5 autonomous Hospitals and 3 teaching Hospitals.

The regional authority set up an office for Health Technology Assessment in 2007 that needed to organise the HTA activities both for regional and local decision makers. The Authors carried on the project of setting up the regional network for HTA.

1) A context analysis was carried out to map decisional and organisational processes linked to the regional investments and to the adoption of health technologies at local level. All the health organisations were asked to fill a questionnaire made available on the regional web-site (a help desk service was set up to facilitate). The questionnaire included the following sections:
   1. Identification of technologies’ needs, including organisational and clinical pathways;
   2. Prioritization methods, if adopted

2) The answers were analysed and the synthesis was presented to all general managers and health directors of the local health authorities in a face to face meeting for final validation.

3) According to the context analysis it was decided to invite each of general managers to identify a HTA representative to participate in the network, with the duty of coordinating internal activities and interactions with the regional office for HTA. Regional offices in charge of investments decisions regarding health technologies were also invited to participate.

4) A cycle of seminars on HTA was organised by the regional education center (CEFPAS) for professionals involved.

5) Network participants from local health authorities and regional representative were actively engaged in defining and testing various methodological tools for collaboration, taking into account international and national best practices.
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RESULTS

The Sicilian network for HTA has been set up on the basis of the context analysis. It was created an organizational model composed of different actors, with different competencies, at regional and local level. The model has been developed sharing intermediate and final results with people involved (health professionals and managers) in a step by step process (Fig.3).

The regional office for HTA formally adopted the “Regional guidelines on HTA activities”, identifying the criteria for local and regional activities. All professionals involved in the network, at different level, were involved in continuous training to share methods of HTA.

The regional authority’s choice was to share methods to allow autonomous, but coherent HTA activities at different levels of the regional health system. Each local Authority created a HTA multidisciplinary team composed of professionals formally identified by its general manager. At regional level was set up the Regional Multidisciplinary Technical Body (NTHTA), composed by professionals from different healthcare organizations.

The network activity includes the following phases: notification of technologies (by local level), prioritization (through the application, at local level, of pre-defined criteria) and assessment (at local or regional level according to the result of prioritization). Prioritization criteria were adopted both to identify technologies to be assessed and to draw up the boundaries between local and regional level competences of assessing them were defined by NTHTA and regional authority (Fig.4).

Methods and templates were defined for official communications across the network and between regional offices involved (Fig.5).

RESULTS (continues)

CONCLUSIONS

The process allowed the regional health authority to define the role of the regional HTA body, its interactions both with other regional offices responsible of investments’ decisions and local health authorities. The network of local representatives for HTA was formally created. Shared prioritization criteria, submission templates, Check lists for mini HTA at local level and for regional HTA and rules for workload distribution were also officially adopted through “regional guideline on HTA”. A training program targeted to regional network and the monitoring of the model efficiency/efficacy are ongoing.

The organizational model based on shared methods and strong interactions among professionals involved in HTA activities at different levels can allow the spreading of a HTA culture in the regional healthcare system.

In addition the formal adoption of specific indications on HTA by the regional government and the active monitoring of the network should improve the use of HTA results in local and regional decision making.

More results of the model will be available after the first two years of application.

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