



# Dedalus

HEALTHCARE SYSTEMS GROUP

## PCS

**Primary Care  
management  
system**

[www.dedalus.eu](http://www.dedalus.eu)



# The context

The progressive ageing of the population, the growth of chronic degenerative diseases, the increasing number of fragile patients, the reduction in expenditure and the significant decrease in investment cause major changes in the organization of Healthcare:

- De-hospitalization processes
- Shift of the focus of care onto Primary Care setting
- Implementation of intensity care hospital models
- The need for a real hospital - Primary Care setting care continuity according to predetermined clinical pathways

This context requires the seamless sharing of information among heterogeneous actors distributed across different healthcare delivery points: hospital doctors, general practitioners, local aggregations of primary care, caregivers, pharmacies, etc.



**PCS**  
PRIMARY CARE SYSTEM



# Functional areas

The Primary Care System of Dedalus includes a powerful tool for recording and documenting the clinical activities of the healthcare staff. The Primary Care Organizations can include healthcare teams specialized on different health domains: the Dedalus proposal aims to support the need to collect all the relevant data by doctors belonging to different specialties and branches.

To this goal, the system includes a tool for the customization of the clinical forms; in this regard, the Clients can take advantage of the consolidated knowledge of Dedalus, developed throughout several years in collaboration with clinical partners.

The entire Primary Care pathway can be supported:

- Work lists are automatically created on the basis of appointments made by the patient at the Front Office. All demographic information is collected at the Front Office, leaving the doctor free to focus on his own activity
- The specialist can consult the clinical pathway anytime, view the patient's history and access information collected by nurses and other practitioners
- Every action of the clinician is tracked and shared within the Care Team assigned to the patient
- Doctors can use assessment tools to define the patient's needs and evaluate his progresses
- Medical reports are archived and shared with the entire care staff
- Where necessary, the system feeds automatically the Billing tools, while the patient advances within his own care plan
- Devices management to support the diagnostic monitoring and evaluation
- Generation of key performance indicators to facilitate the Governance processes

The need to have the clinical tool always available, led to the creation of a solution than can be used on mobile devices, in either online or offline mode. In both cases, the system is able to synchronize data and to make them available to the entire care team. Clinical information become automatically accessible from the entire healthcare ecosystem, thanks to efficient cooperation services.



# Goals



Become problem solvers for the needs rising when starting new organizational forms such as Primary Care Units and Home Care settings



Provide a useful tool for receiving any type of contact from potential users



Encourage cooperation between actors involved in the process



Allow the full traceability of the patient within the care pathways



Give continuity to the care processes between hospital and the Primary Care setting



Support organisations in promoting a new vision of healthcare for citizens, which sees both the proximity and availability of services as an alternative to hospital access

# Advantages

Support for a development based on an integrated and multi-disciplinary network logic between hospitals, Primary Care settings, general practitioners, pediatricians and caregivers

A new approach to citizen care, in accordance with national guidelines and international standards, which perceives the need for solutions that look at the patient as an individual with a path and a story instead of as a single healthcare episode

Measurability of the quality and performance of the change process in Healthcare

A better knowledge of the health of the population, thanks to the possibility of replacing the care episode with a complete path managed by different professionals



# Scenarios

PCS is proposed as a hub for the collection of needs for a Primary Care setting, in view to establish collaborations between the different professionals involved in caregiving and to satisfy welfare needs.

PCS is targeted at healthcare institutions that are looking for tools to manage Primary Care Centers and the care planning within them, covering all aspects, from the provision of individual services to the complex care planning for chronic patients.

PCS can meet the needs of private centres and private healthcare facilities authorized to deliver healthcare services within NHS (National Health System setting) targeting their offer to the provision of services in the context of primary care, residential and semi-residential care, home care and chronic care.

PCS represents the natural evolution for cooperative entities composed of general practitioners and support staff, in support of multi-functional facilities with organizational, clinical, diagnostic and reporting needs.







# Care Plan

The Care Plan is the cornerstone of the patient's care. Its function is to create a coordinated workflow aimed at simplifying the delivery of services in complex contexts, which may see the involvement of different healthcare professionals.

The definition of a Care Plan, therefore, has a twofold objective:

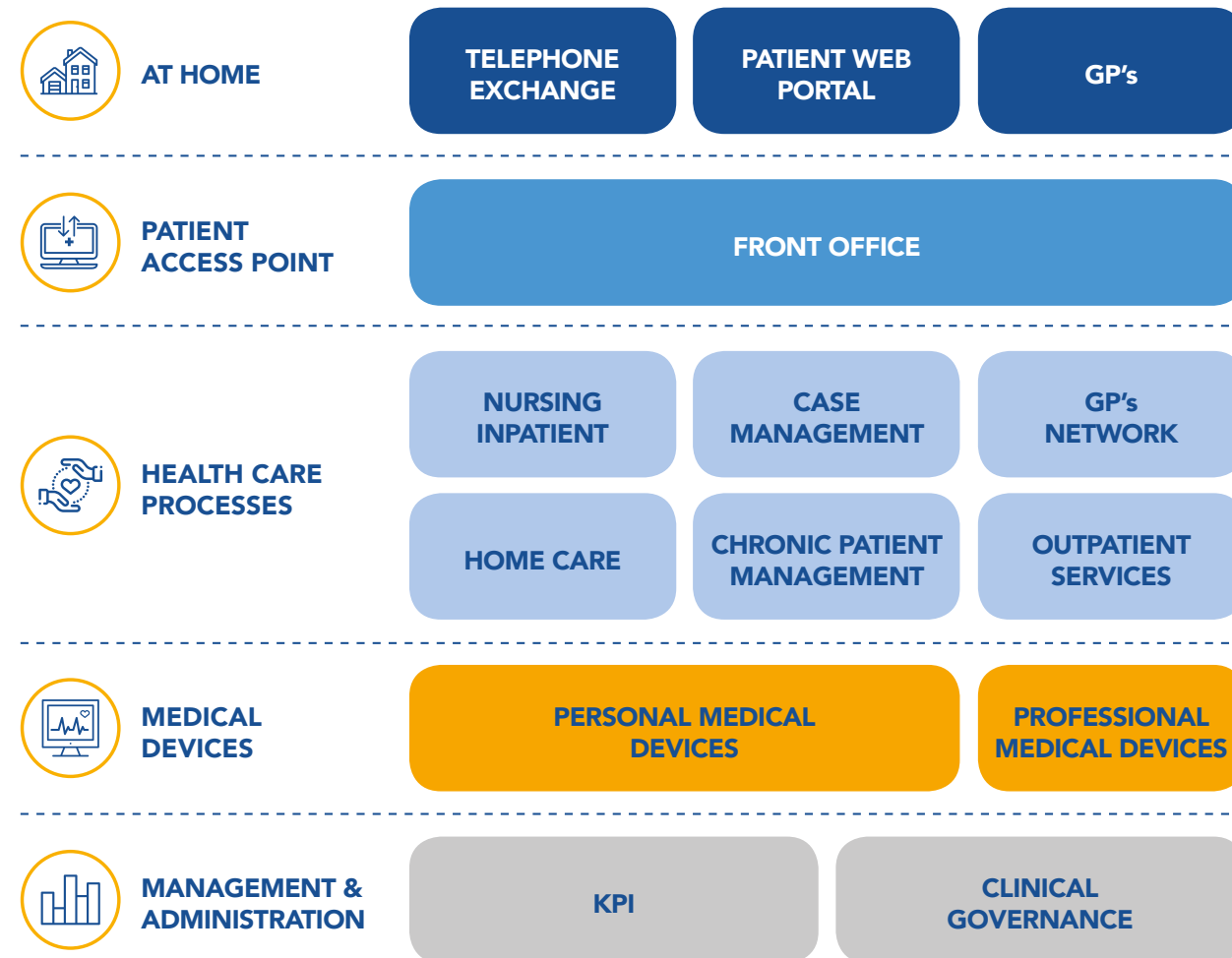
- On one side it simplifies the contribution of each involved specialist to the definition of a plan fully responsive to the patient's needs
- On the other side it supports the creation of a structured document that can be easily shared among regional and national systems, as well as among the different health professionals who participate in the care process.

The creation of a Care Plan is closely linked to both the health pathway of the patient and the complexity of the study case, and it may be subject to change over time; the system that generates the Care Plan must therefore be extremely flexible and versatile in its use and configurability.

The basic elements of a Care Plan creation at the ICT level, that are available in our solution, are:

- The possibility to identify professionals as case and clinical manager within simple or complex Care Teams
- The definition of the whole Care Team
- Management of the patient's acceptance
- An internal repository of national and/or regional guidelines and best practices related to the treatment of certain pathologies or specific needs/problems
- A set of tools that simplify the needs assessment and the identification of the services actually required for the specific study case

# Functional overview



# A new multi-professional approach





# Supporting the entire patient's pathway



## ENROLMENT PROPOSAL

The GP provides the Primary Care Centre with the patient's information and generates a proposal for enrolment

## ACCEPTANCE AND ENROLMENT

Assessment of the patient's data collected and evaluation of the eligibility of the patient to the proposed pathway



## PATHWAY ASSIGNMENT

Care pathway personalization and assignment

## INFORMATION SHARING

Information about treatment performance and prescriptions is exchanged among the involved experts



## MONITORING AND MANAGEMENT

Continuous monitoring of the care pathway, and extraction of relevant KPIs



**PCS**  
PRIMARY CARE SYSTEM

**A complete Primary Care management system**





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