La gestione integrata nei Paesi Europei

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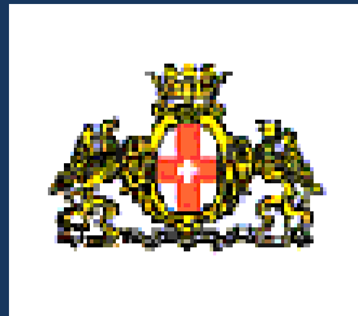
GENOVA



2006 : The European Parliament,

- Calls on the Commission and Council to:
  - prioritise diabetes in the EU's new health strategy as a major disease demonstrating a significant burden across the EU;
  - encourage Member States to establish national diabetes plans;
  - develop an EU diabetes strategy and draft an EU Council Recommendation for Diabetes Prevention, Diagnosis and Control;
  - develop a strategy to encourage consumption and production of healthy food;

SHETLAND ISLANDS
Mainland
Lerwick
North Sea
NORTH ATLANTIC OCEAN

United Kingdom
International boundary
National capital
Railroad
Road
0 50 100 Kilometers
0 50 100 Miles
ORKNEY ISLANDS
Mainland
Kirkwall
Thurso
Stornoway
Lewis with Harris
North Uist
South Uist
Skye
HEBRIDES
Inverness
Loch Ness
Aberdeen
Fort William
Scotland
Dundee
Perth
Saint Andrews
Kirkcaldy
Edinburgh
Glasgow
Mull
Islay
Arran
Ayr
Tweed
NORTH ATLANTIC OCEAN
North Sea
Newcastle upon Tyne
Sunderland
Carlisle
Stranraer
Londonderry
Northern Ireland
Belfast
North Channel
Isle of Man (U.K.)
Douglas
Middlesbrough
Scarborough
Barrow-in-Furness
Sligo
Westport
Dundalk
York
Kingston upon Hull
Leeds
Bradford
Blackpool
Preston
Grimsby
Irish Sea
Manchester
Liverpool
Sheffield
Galway
Dublin
Holyhead
Anglesey
Chester
Stoke-on-Trent
IRELAND
Derby
Nottingham
King's Lynn
Norwich
Shrewsbury
England
Leicester
Peterborough
Limerick
Wolverhampton
Birmingham
Tralee
Aberystwyth
Coventry
Cambridge
Wexford
Waterford
Wales
Hereford
Stratford-upon-Avon
Northampton
Ipswich
Cork
Saint George's Channel
Fishguard
Gloucester
Luton
Oxford
Southend-on-Sea
Swansea
Newport
Cardiff
London
Bristol
Bath
Reading
Canterbury
Dover
Bristol Channel
Southampton
Brighton
Hastings
Exeter
Bournemouth
Portsmouth
Weymouth
Plymouth
Torbay
Penzance
English Channel

NHS Diabetes

- The publication of the Diabetes National Service Framework (DNSF) in 2001 established for the first time what standards diabetes services in England should be meeting. They were developed against a background of increasing prevalence of diabetes and an awareness of unacceptable divergences in treatment and outcomes. Establishing the standards was one thing however but devising effective strategies for implementing them was another and this took a further two years, with the DNSF Delivery Strategy being released in 2003.

Department of Health

Delivery Strategy

Foreword

Executive summary

1 Introduction

2 Building Capacity: Organisational Steps in the First Year
Diabetes networks
Local leadership
Supporting frontline staff: workforce skills profile

3 Delivering the Targets: The Next Three Years
Systematic retinopathy screening programme
Diabetes registers and systematic treatment regimens

4 Delivering the Standards: The Next Ten Years
Agreeing local priorities
Evidence and information

5 Ensuring Progress
Accountability for delivery
Continuous quality improvement
Performance indicators

6 National Support for Local Action
Leadership and organisational change
Finance
Workforce planning and development
Information strategy
Research and development
Clinical and practice decision support and audit
Patient and public involvement
Prevention strategies

12 standards

- **Standard 1 : Identification of people with diabetes**
- **Standard 2** : **Empowering people with diabetes**
- **Standard 3** : **Clinical care of adults with diabetes**
- **Standard 4** : **Clinical care of children and young people with diabetes**
- **Standard 5** and **Standard 6: Management of diabetic emergencies**
- **Standard 7** : **Care of people with diabetes during admission to hospital**
- **Standard 8** : **Diabetes and pregnancy**
- **Standard 9** : **Detection and management of long-term complications**
- **Standard 10, 11 and 12**
  - regular surveillance for the long-term complications of diabetes.
  - effective investigation and treatment to reduce their risk of disability and premature death.
  - integrated health and social care.

Primary care trusts

- Primary care trusts (PCTs) are at the centre of the modernisation of the NHS and are responsible for 80 percent of the total NHS budget. They are free-standing NHS organisation with their own boards, staff and budgets. PCTs are monitored by their local SHA and are ultimately accountable to the Secretary of State for Health.

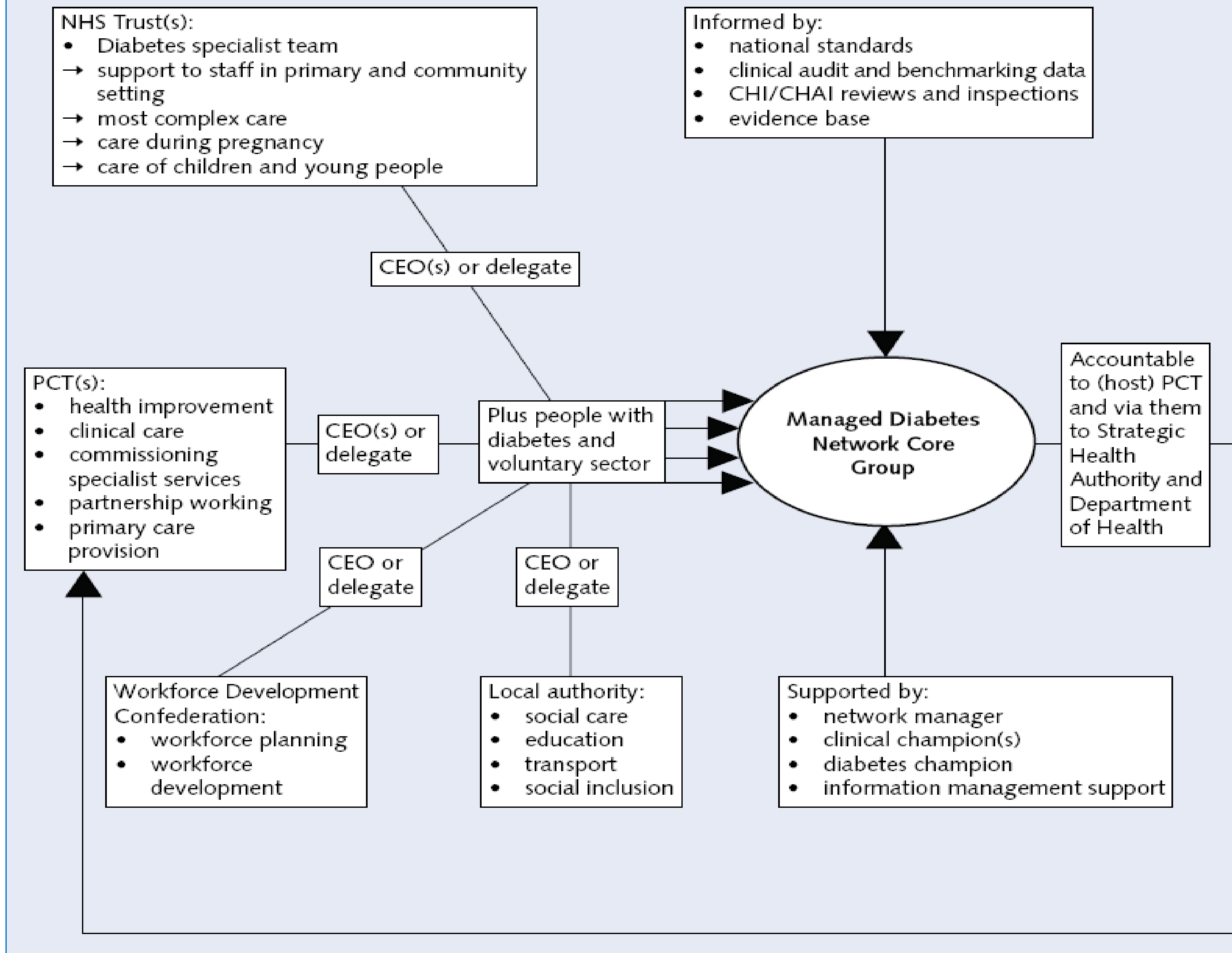


Figure 1: An example of a diabetes network
NHS Trust(s):
• Diabetes specialist team
→ support to staff in primary and community setting
→ most complex care
→ care during pregnancy
→ care of children and young people
Informed by:
• national standards
• clinical audit and benchmarking data
• CHI/CHAI reviews and inspections
• evidence base
CEO(s) or delegate
PCT(s):
• health improvement
• clinical care
• commissioning specialist services
• partnership working
• primary care provision
CEO(s) or delegate
Plus people with diabetes and voluntary sector
Managed Diabetes Network Core Group
Accountable to (host) PCT and via them to Strategic Health Authority and Department of Health
CEO or delegate
CEO or delegate
Workforce Development Confederation:
• workforce planning
• workforce development
Local authority:
• social care
• education
• transport
• social inclusion
Supported by:
• network manager
• clinical champion(s)
• diabetes champion
• information management support

Incentives

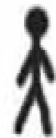
- Practices would have the opportunity to receive additional funding through the achievement of a range of quality standards.
- The new quality framework would reward practices for delivering quality care with extra incentives to encourage high standards.
- The contract would be practice-based and recognise the full range of professionals in primary care engaged in delivering high-quality, integrated care, appropriate to the patient’s needs.

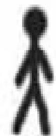
The ‘Year of Care’ Project

- A care plan is at the heart of a partnership approach to care and a central part of effective care management. The process of agreeing a care plan offers people active involvement in deciding, agreeing and owning how their diabetes will be managed.
- Each ‘Year of Care’ will be designed by a person with diabetes and a healthcare professional via the care planning process. The person’s individual needs should form the basis of each ‘Year of Care’.

Commissioning at micro and macro levels

Individual patient choices via the care planning process = micro-level commissioning



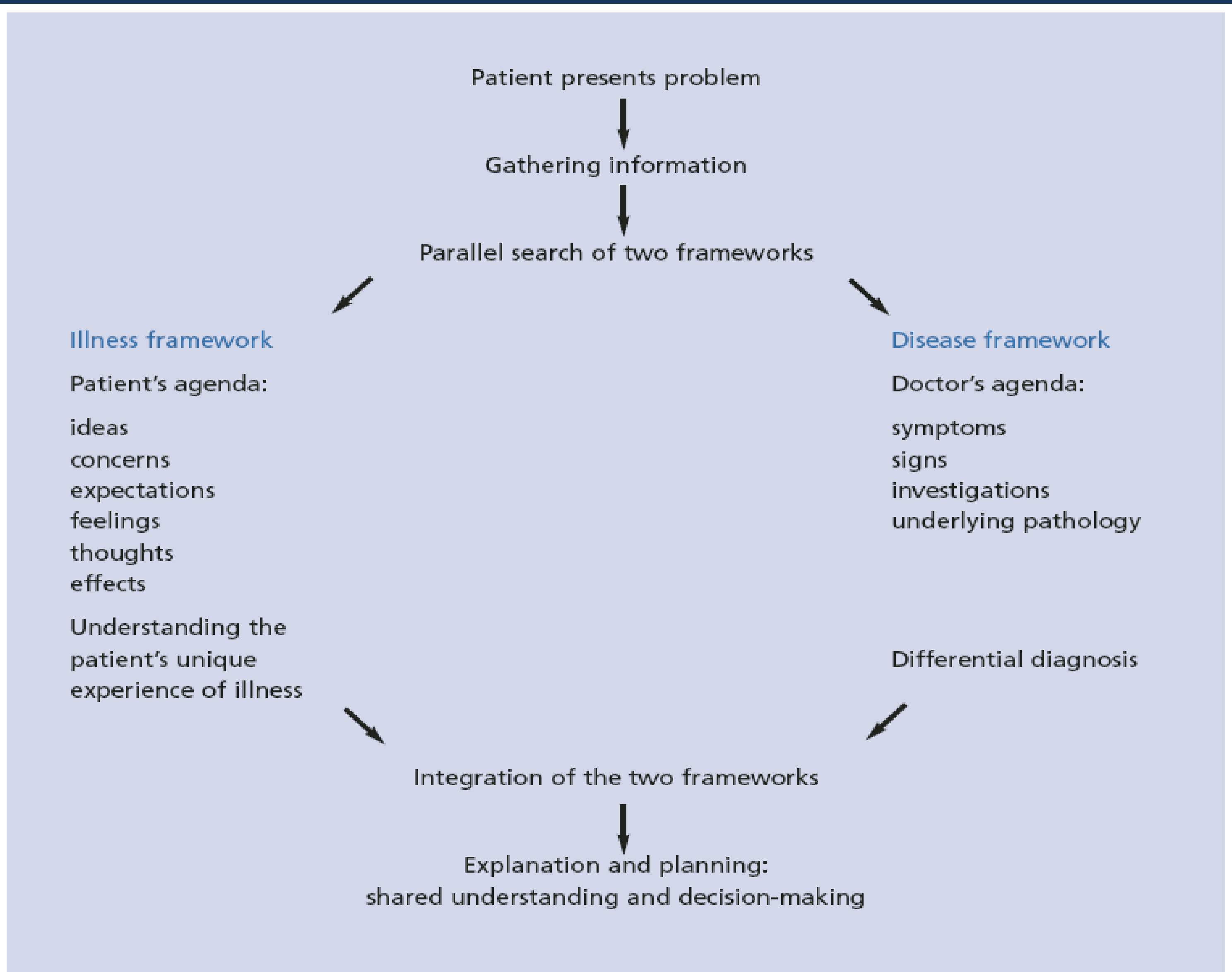


MENU OF OPTIONS
(menu set by commissioner in collaboration with diabetes network)

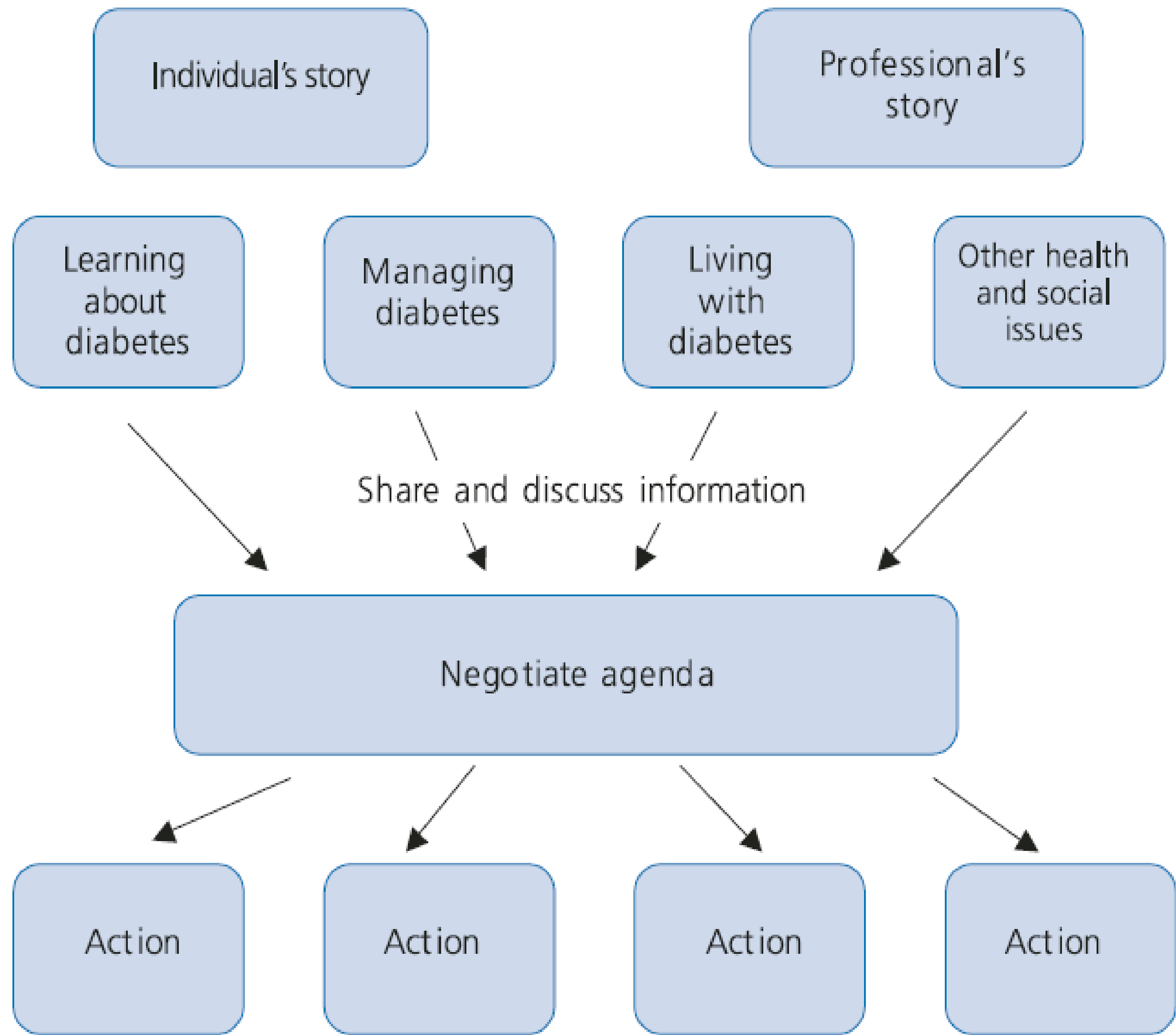
- Structured education
- Weight management
- Screening for complications
- Telephone review
- Smoking cessation advice
- Local authority exercise programme
- Specific problem solving
- Expert Patient Programme (EPP)
- etc…

Macro-level commissioning by the commissioner (PCT/practice/network) on behalf of the whole diabetes population

Aim of the Year of Care project: Establish the menu of options and a process for matching micro and macro level commissioning. Process will be dynamic and refined over time.



The "Disease-Illness model" as described by Stewart and Roter, 1989


Individual's story
Professional's story
Learning about diabetes
Managing diabetes
Living with diabetes
Other health and social issues
Share and discuss information
Negotiate agenda
Action
Action
Action
Action

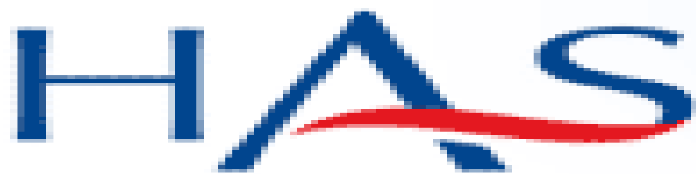
Finance

- 6.7 Some elements of the Diabetes NSF require additional resources across primary, community and specialist care.
- 6.8 Extra resources for the NHS were announced in the 2002 Budget, with an annual average increase of 7.4% above inflation over the five years from 2003–4 to 2007
- 6.10 PCTs will be given control of 75% of the growing NHS budget, with freedom to purchase care from the most appropriate providers and moving towards a hospital payment system based on results, using a case-mix adjusted national tariff with regional variations.

Prevention strategies

- **Five-a-day Programme** to increase the consumption of fruit and vegetables, particularly in deprived groups
- **PE and Sport Programme** – £581 million of NOF funding for a PE and Sports programme, launched in November 2001
- **Community Pilots for Increasing Physical Activity**

France
International boundary
National capital
Railroad
Expressway
Road
0 50 100 Kilometers
0 50 100 Miles
Lambert Conformal Conic Projection SP 36N /48 30 N
UNITED KINGDOM
London
Fishguard
Cardiff
Bristol
Reading
Ipswich
Thames
Dover
Southampton
Brighton
Portsmouth
Weymouth
Plymouth
Penzance
English Channel
Strait of Dover
Sea
The Hague
Utrecht
Rotterdam
NETHERLANDS
Oostende
Dunkerque
Calais
Gent
Antwerp
Brussels
Liège
Lille
BELGIUM
Valenciennes
Charleroi
LUX.
Luxembourg
Mannheim
Saarbrücken
Karlsruhe
GERMANY
Stuttgart
Ulm
Metz
Nancy
Strasbourg
Freiburg
Bodensee
Mulhouse
Basel
Zürich
Vaduz
LIECH.
Bern
SWITZERLAND
Lausanne
Lake Geneva
Geneva
Rhône
Milan
ITALY
Turin
Po
Piacenza
Alessandria
Genoa
Ligurian Sea
MONACO
Nice
Cannes
Toulon
Corsica
Ajaccio
Bonifacio
CHANNEL ISLANDS
Alderney
Sark
Guernsey (U.K.)
Jersey (U.K.)
Cherbourg
Le Havre
Amiens
Rouen
Caen
Seine
Paris
Reims
Châlons-sur-Marne
Troyes
Marne
Meuse
Moselle
Brest
Rennes
Lorient
Le Mans
Orléans
Belle-Île
Angers
Tours
Loire
Saint-Nazaire
Nantes
Île d'Yeu
Bourges
Dijon
Besançon
Saône
Doubs
Poitiers
Île de Ré
La Rochelle
Île d'Oléron
Limoges
Clermont-Ferrand
Lyon
Chambéry
Saint-Étienne
Grenoble
Valence
Bay of Biscay
Gironde
Bordeaux
Dordogne
Lot
Avignon
Nîmes
Montpellier
Marseille
Gulf of Lion
Toulouse
Garonne
Bayonne
Pau
San Sebastián
Santander
Bilbao
Vitoria
Pamplona
Burgos
Rio Ebro
Andorra la Vella
ANDORRA
Perpignan
Port-Bou
Gerona
SPAIN
Zaragoza
Rio Duero
Mediterranean Sea



- **ALD n°8 - Prise en charge du diabète de type 2**

- **L’objectif du guide médecin** est d’expliciter pour les professionnels de santé la prise en charge optimale et le parcours de soins d’un malade admis en ALD au titre de l’ALD 8 : diabète.

- **L'objectif du guide patient** est d'expliquer au malade admis en ALD, au titre d'un diabète, les principaux éléments du traitement et du suivi. Il contient également une liste des contacts utiles. Ce guide lui est remis par le médecin traitant en même temps que le protocole de soins validé par le médecin conseil de la caisse d'Assurance maladie

Les reseaux diabete

ANCRED
Association Nationale de Coordination des Réseaux Diabète

RESDIAB06
Prise en charge du Diabète

© IGN
Angleterre
Mer du Nord
Nord-Pas-de-Calais
Belgique
Manche
Luxembourg
Allemagne
Haute-Normandie
Picardie
Basse-Normandie
Lorraine
Ile-de-France
Champagne-Ardenne
Bretagne
Alsace
Pays-de-la-Loire
Centre
Bourgogne
Franche-Comté
Suisse
Poitou-Charentes
Limousin
Océan Atlantique
Auvergne
Rhône-Alpes
Italie
Aquitaine
Midi-Pyrénées
Provence-Alpes-Côte d'Azur
Languedoc-Roussillon
Corse
Espagne
Andorre
Mer Méditerranée
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Le réseau diabète 72 (1/2)

35 avenue Georges Durand

72 100 LE MANS.

02 43 74 10 68

diabete72@orange.fr

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Infirmière-Directrice technique
06 03 06 32 81
dirtech-reseau@orange.fr

Magali GENDRON
Infirmière d'éducation thérapeutique
06 72 44 34 83
Mag-ide-reseau@orange.fr

Le réseau Diabète 72 (2/2)

Prestations (gratuites)

Des séances d'éducation thérapeutique:

- Un cycle de 2 demi-journées en groupe, animé par un médecin, une infirmière et une diététicienne;
- Des ateliers pieds, traitement, etc.. dans toute la Sarthe.

Des consultations infirmière:

- Conseils individuels à la demande du patient ou du médecin-traitant;
- Éducation à l'auto-surveillance, l'injection à l'insuline, l'adaptation des doses, conseils personnalisés.

Des conseils diététiques:

- Une consultation individuelle/an;
- Ateliers animés par une diététicienne dans toute la Sarthe;
- Atelier cuisine au Mans.

Activité physique:

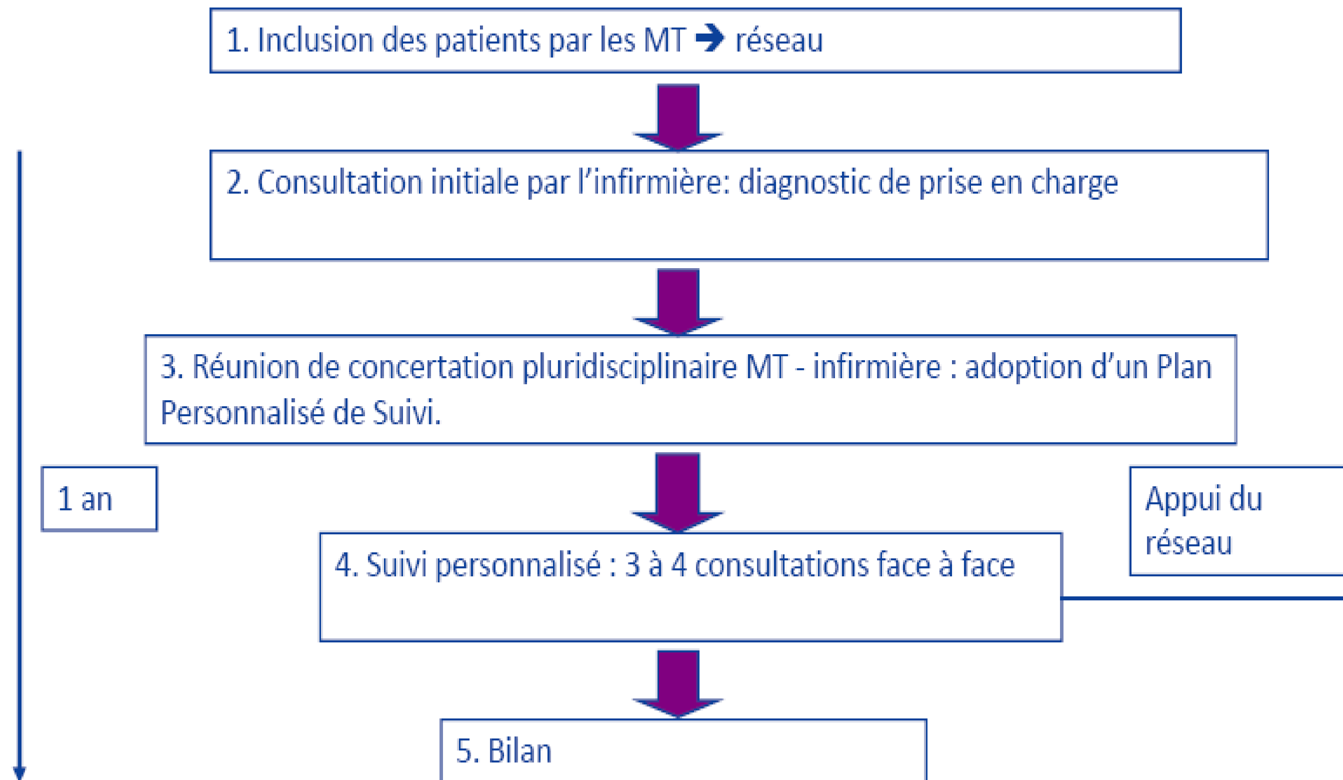
- Une randonnée tous les 15 jours;
- Certificat de non contre-indication obligatoire
- Une ou deux consultations podologiques par an

Renseignements et inscription auprès du secrétariat 02 43 74 10 68

Le programme SUDD

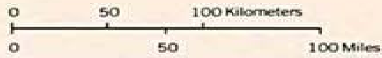
Projet non encore validé

Un projet des réseaux complémentaires à sophia: le programme SUDD



Germany

International boundary
State (Land) boundary
National capital
State (Land) capital
Railroad
Autobahn
Other road



- **State health insurance (Gesetzliche Krankenversicherung (GKV) / Krankenkasse)**
  - The most popular state health insurances are the AOK, BEK, BKK, DAK and KKH. Since 1996, anyone is free to choose between the different state health insurances.
- **Private health insurance (Private Krankenversicherung (PKV) / Privatkasse)**
- **Long-Term Care Insurance**
  - In January of 1995, long-term care insurance (Pflegeversicherung) was added to the social insurance system in Germany.

Le difficoltà della riunificazione

- Venti anni fa, negli anni ottanta, quando la Germania era ancora divisa, anche l'assistenza alle persone con diabete era diversa sulle due sponde del confine interno del Paese
  – Nella Germania Occidentale, la cura specialistica per le persone con diabete era erogata soprattutto dagli ospedali specializzati.
  – Nella Germania Orientale, le persone con diabete mellito erano trattate esclusivamente da diabetologi in Enti Governativi della contea o della città, i cosiddetti "Dispensari".

Le difficoltà della riunificazione

- Questi due sistemi dovevano essere in qualche modo riuniti e integrati dopo la riunificazione delle due Germanie. All'inizio esistevano alcune chiare nozioni:
  - **1.** Nella Germania Ovest era evidente la necessità di un sistema di cura ambulatoriale diffusa per i pazienti diabetici, con una presenza specialistica all'interno
  - **2.** Nella Germania Est si rendeva evidente la necessità di un maggior coinvolgimento della medicina di famiglia.

Dal 1993 prese corpo il concetto di

- “pratica medica focalizzata sulla diabetologia” (Diabetologische Schwerpunktpraxis)
- A questo punto la German Diabetes Association (Deutsche Diabetes – Gesellshaft DDG) ha istituito un’Associazione certificata di “diabetologi DDG”.
- A partire dall’agosto del 2007, è stato adottato dall’Associazione Medica Tedesca un curriculum e un albo ufficiale per diabetologi

I criteri per una pratica clinica focalizzata sulla diabetologia sono i seguenti

- **1.** Il medico dirigente deve essere un medico certificato come medicina generale, internista o pediatra con la qualifica di diabetologo DDG o simile
- **2.** Ci deve essere un educatore impiegato a tempo pieno
- **3.** Deve essere istituita una collaborazione formale e ufficiale con uno psicologo, un podiatra e un ortopedico protesista
- **4.** Un numero minimo di almeno 400 pazienti diabetici debbono essere seguiti ogni trimestre.

Disease Management (DMP)

- Per superare le difformità a “patchwork” nell’assistenza al diabete in Germania, nel 2002 è partito il primo programma di Disease Management (DMP) per il diabete tipo 2.
- Questi programmi hanno ormai corso legale, e regolano i diversi livelli di cura al diabete in Germania. Tra le altre cose, vengono fornite le indicazioni per il trasferimento della presa in carico dalle cure primarie agli specialisti diabetologi negli ambulatori specializzati e agli ospedali dedicati

Livello 1	Cura continuativa presso il medico delle cure primarie (vicino a casa)
Livello 2	Cura temporanea presso un ambula-torio specializzato da parte di uno specialista diabetologo all'interno di una pratica clinica focalizzata sul diabete
Livello 3	Ricovero presso un ospedale specia-lizzato per il diabete o presso un dipartimento ospedaliero

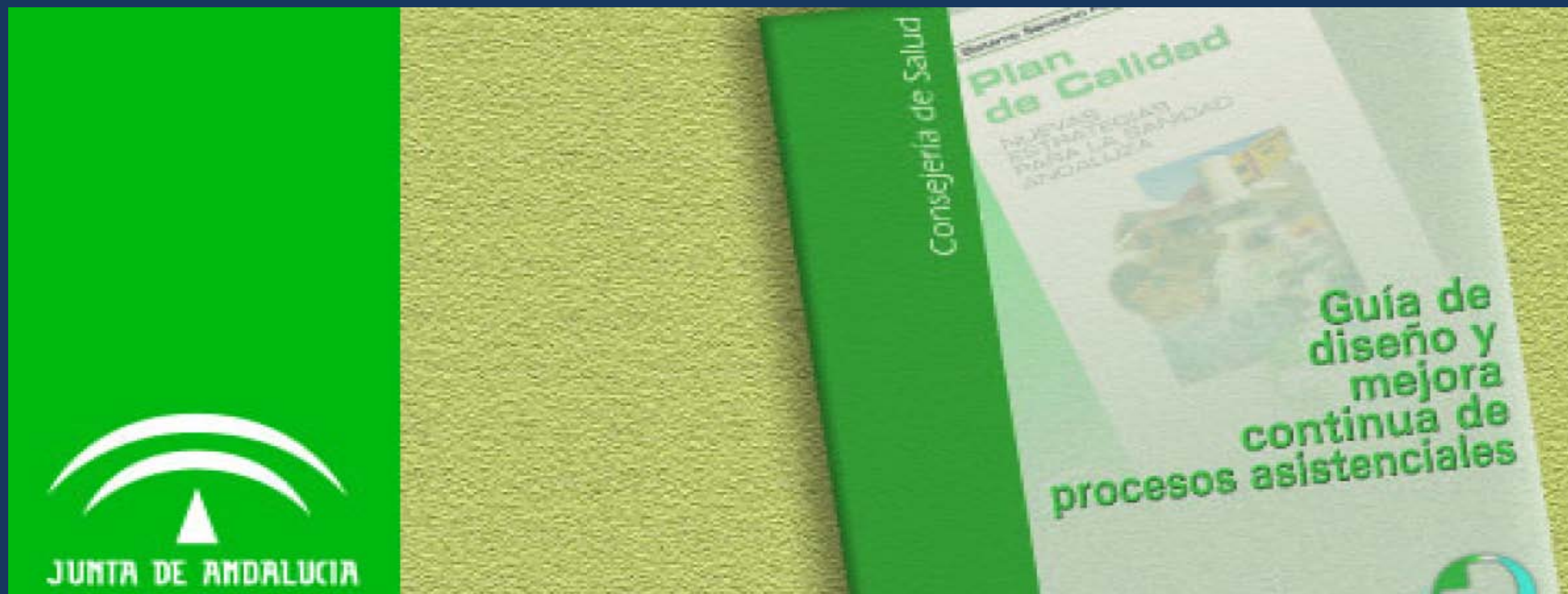
Pagamento a prestazione

- I medici sono rimborsati per le loro prestazioni all'interno del DMP, il che rende conveniente arruolare pazienti. Un aspetto rilevante è costituito dall'enorme sforzo di documentazione per ogni paziente; un set completo di tutti i dati di ogni paziente arruolato nel programma, come i risultati di laboratorio e le prestazioni assistenziali, deve essere documentato e inviato alle Assicurazioni di Malattia, prima che il rimborso venga riconosciuto e dato.

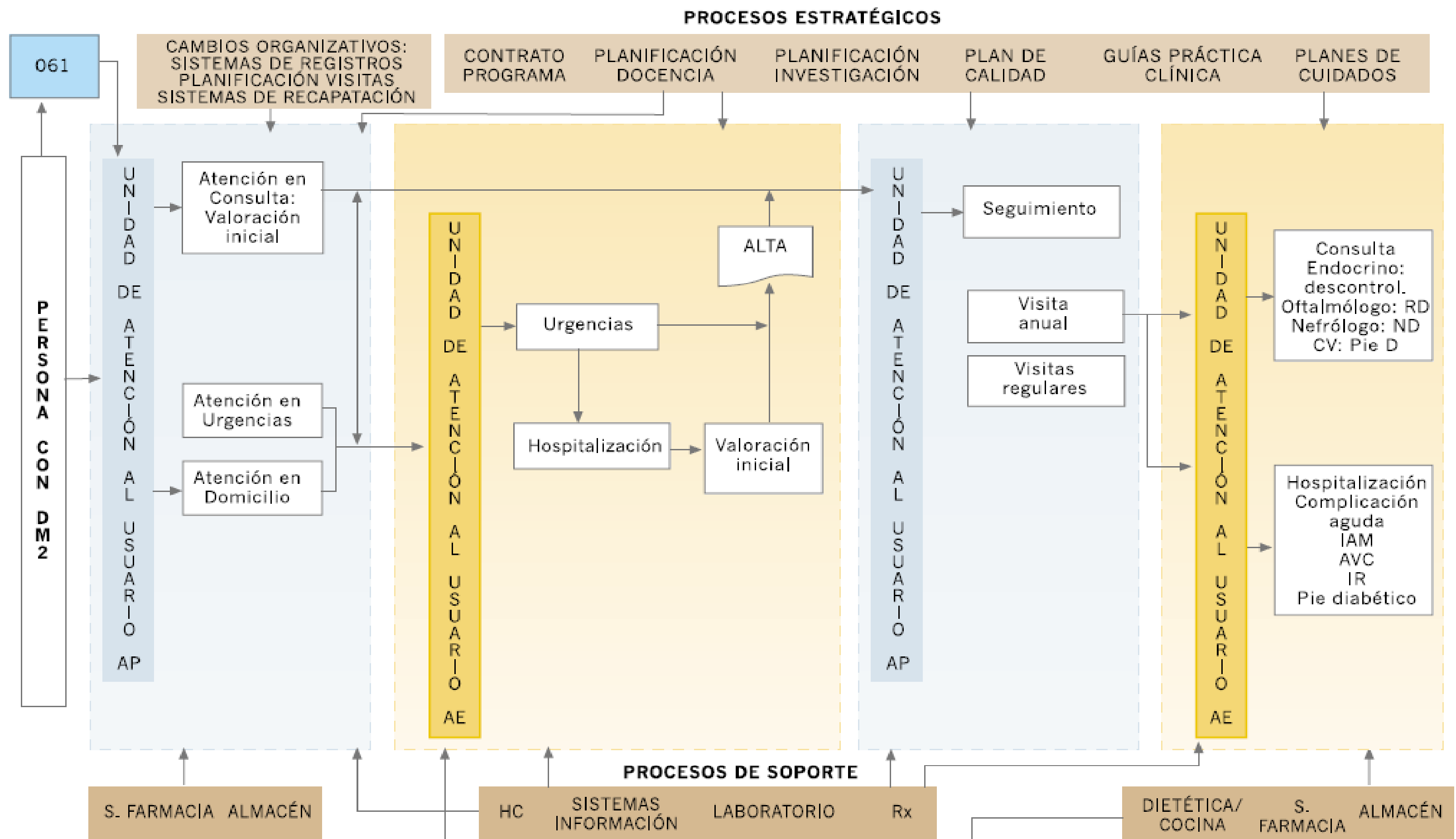
SPAGNA
MADRID
PORTOGALLO
OCEANO
ATLANTICO
MAR
MEDITERRANEO
Isole Canarie
OCEANO
ATLANTICO

PROCESO ASISTENCIAL INTEGRADO

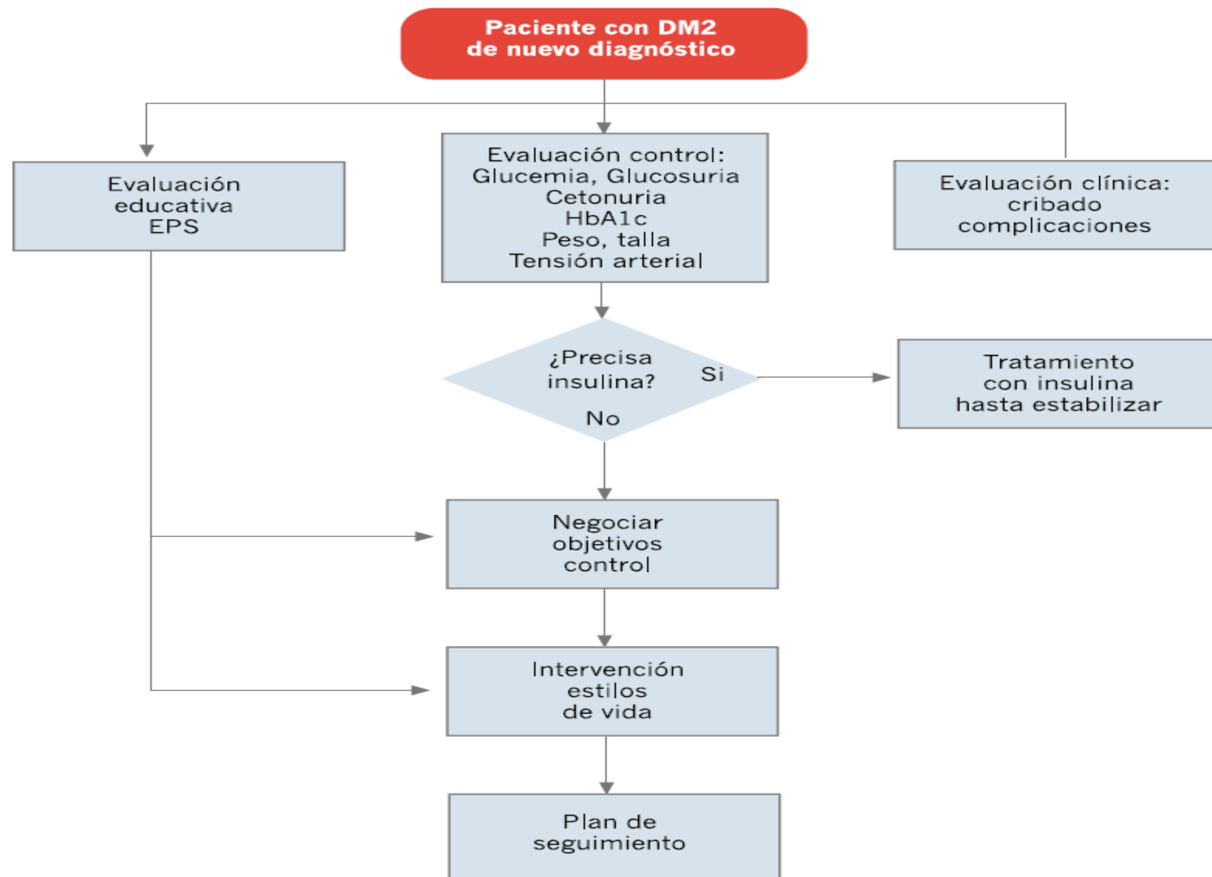
PROCESO ASISTENCIAL INTEGRADO



Percorsi in Spagna



Percorsi in Spagna



Conclusioni - 1

- Nei maggiori Paesi Europei la direzione verso cui si va è quella del “Chronic Care Model”, con corresponsabilizzazione della persona con diabete alla gestione della malattia, unito al Disease Management, inteso come modello di erogazione di prestazioni Evicdence Based
- L’applicazione di questi modelli è fortemente condizionata dal sistema di copertura dei cittadini e dai sistemi di pagamento degli operatori

Conclusioni - 2

- Ciò che sembra ormai essersi affermato con i migliori risultati è:
  - Il “contratto annuale sul piano di cura condiviso”
  - Il pagamento di incentivi sulla base di performances calcolate da appositi indicatori
  - Un sistema di disincentivi per le persone diabetiche che non rispettano il contratto
  - Un sistema di “reti” intercorrelate
  - Un registro contenente il “Patient Record”

Grazie per la cortese attenzione