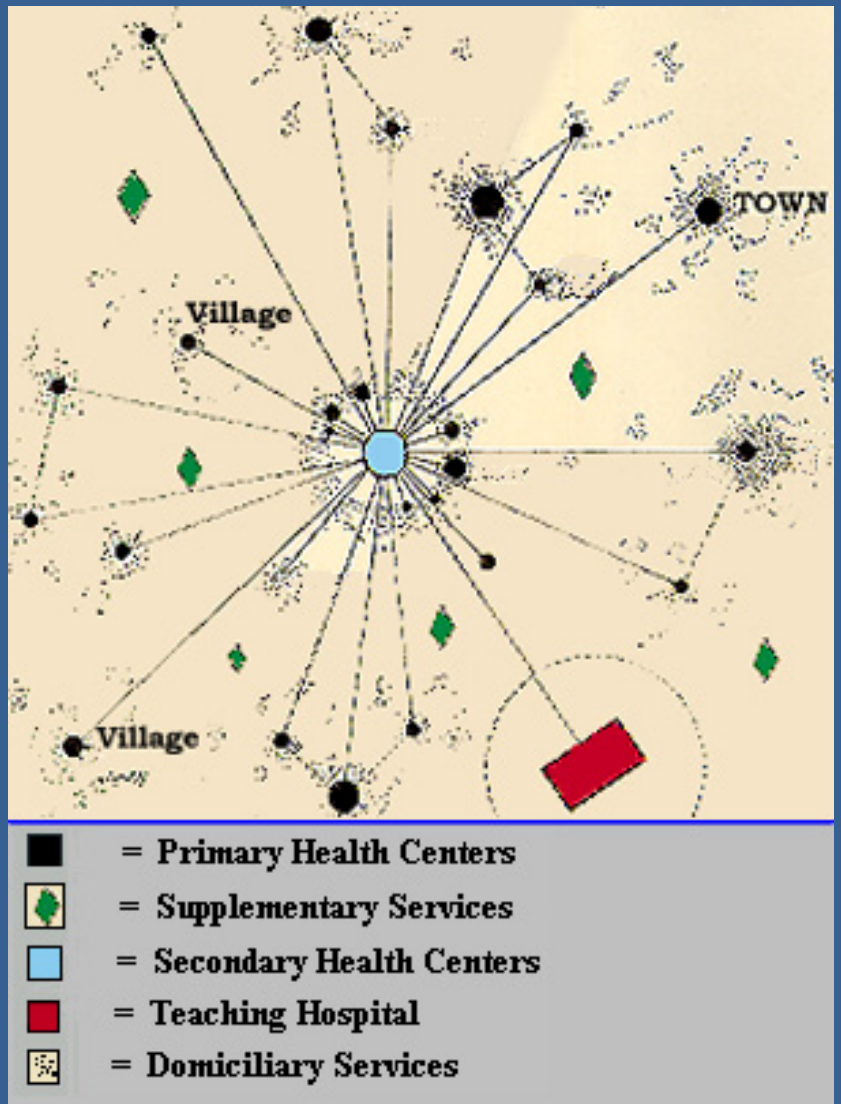
Obiettivi e strategie per un cambiamento di paradigma nell'Assistenza primaria

Gavino Maciocco

gavino.maciocco@unifi.it

The Dawson Report, 1920



Kerr White e coll.

New England Journal of Medicine 1961

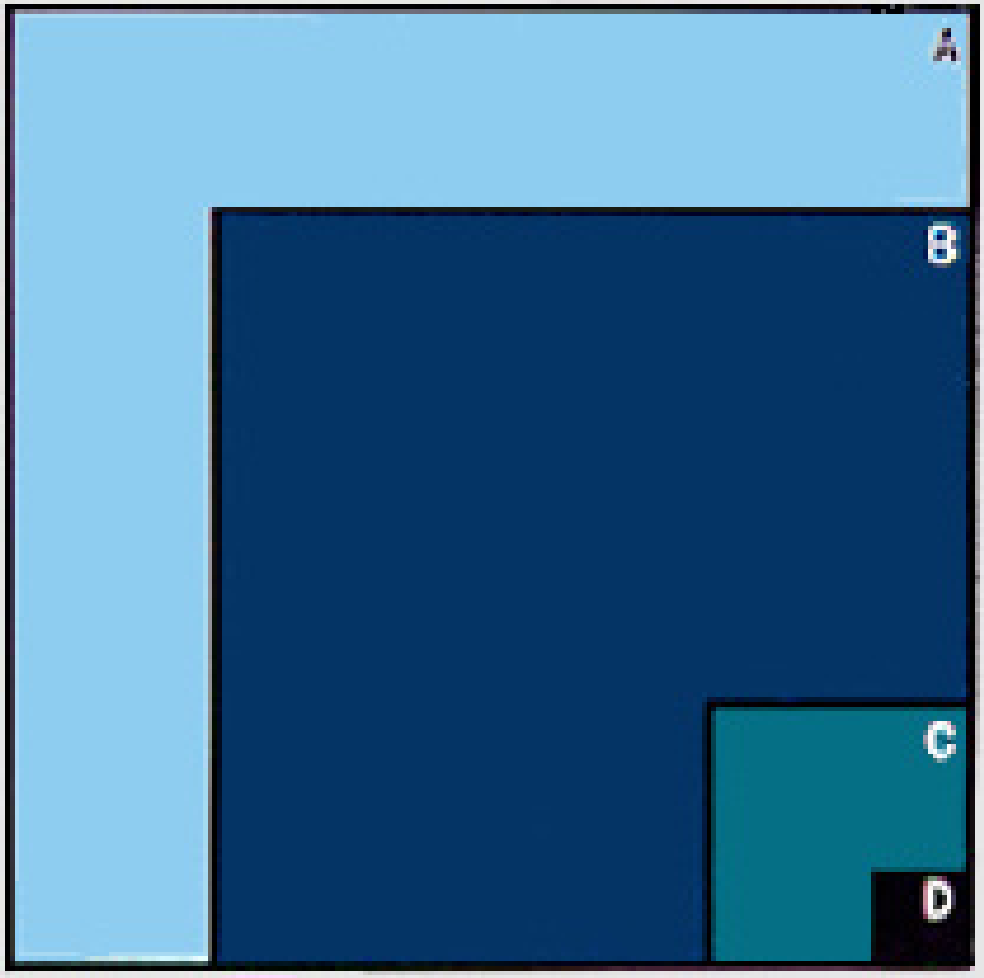
Ecology of Health Problems
Annual Rates, USA

A Total population at risk: 1000

B Persons receiving primary care: 720

C Persons admitted to general hospital: 100

D Persons admitted to university hospital: 10



USA – Family Medicine

- **Fornire ad ogni paziente un medico personale e garantire che esso rappresenti il punto di entrata nel sistema sanitario.**
- **Erogare un set completo di servizi: valutativi, preventivi e clinici generali.**
- **Assicurare una continua responsabilità nei confronti del paziente, incluso il necessario coordinamento dell'assistenza al fine di garantire la continuità delle cure.**
- **Operare nei confronti degli individui avendo presenti i bisogni e le preoccupazioni della comunità.**
- **Fornire un'assistenza appropriata ai bisogni fisici, psicologici e sociali del paziente nel contesto della famiglia e della comunità.**

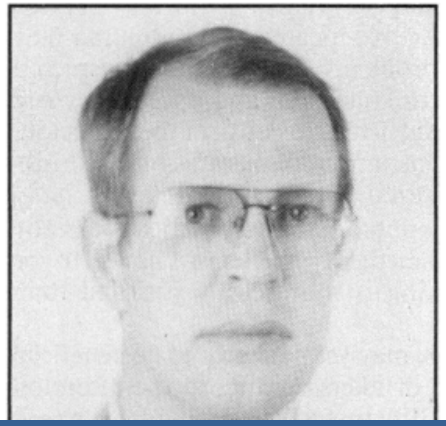
ALMA-ATA 1978

PRIMARY HEALTH CARE

WHO UNICEF

Health for all, primary health care and general practitioners

HANNU VUORI, MD, PhD, MA
Chief, Research Promotion and Development, WHO Regional Office for Europe



Hannu Vuori

Not everybody, however, shares my conviction. There is a lot of scepticism, some ill will and distortion, and much plain ignorance about these concepts. In fact, many health professionals have never heard of them. Let me, therefore, first describe how the WHO sees 'Health for all' and 'Primary health care'. I shall then attempt to outline the possible role of general practitioners in promoting health for all and primary health care and the possible benefits that general practitioners may reap from being allies and proponents of these principles.

Health for all

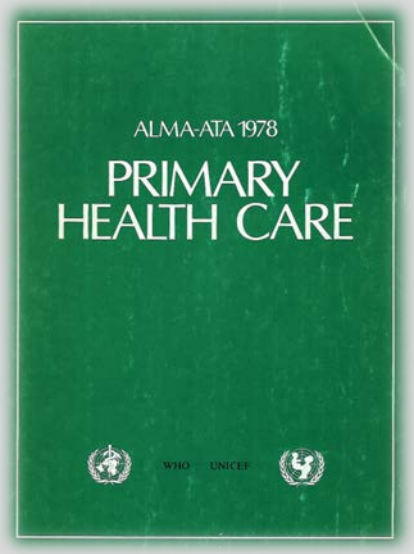
A Utopian goal?

In 1977 the World Health Assembly — the WHO's worldwide 'parliament' consisting of the leading health authorities of the member states — resolved that 'the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of

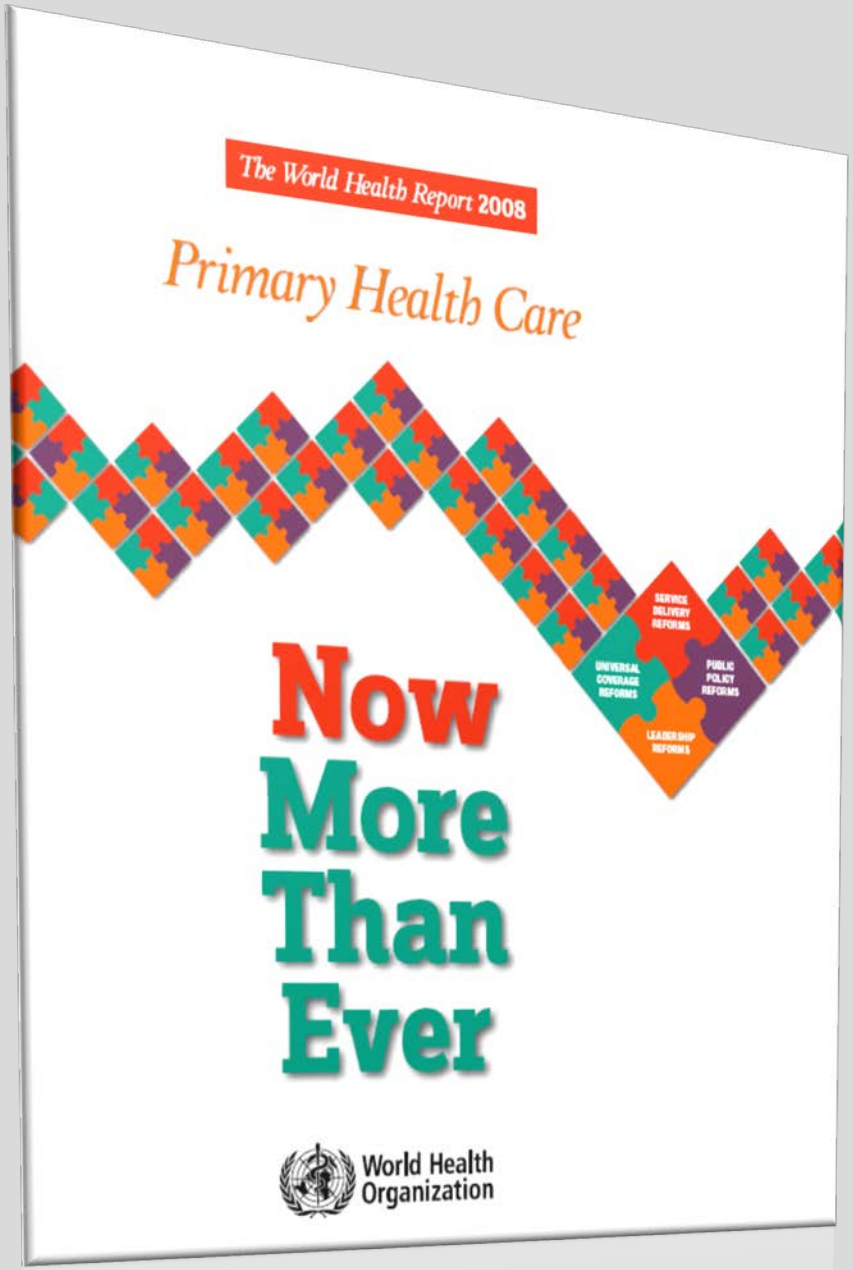
Table 1: From Primary Medical to Primary Health Care

Conventional		*New*
	Focus	
Illness		Health
Cure		Prevention, care and cure
	Content	
Treatment		Health Promotion
Episodic Problems		Continuous care
Specific problems		Comprehensive care
	Organization	
Specialist		General Practitioners
Physicians		Other personnel groups
Single-handed practice		Team
	Responsibility	
Health sector alone		Intersectoral collaboration
Professional dominance		Community participation
Passive reception		Self-responsibility

Adapted from Vuori (1985)[25]

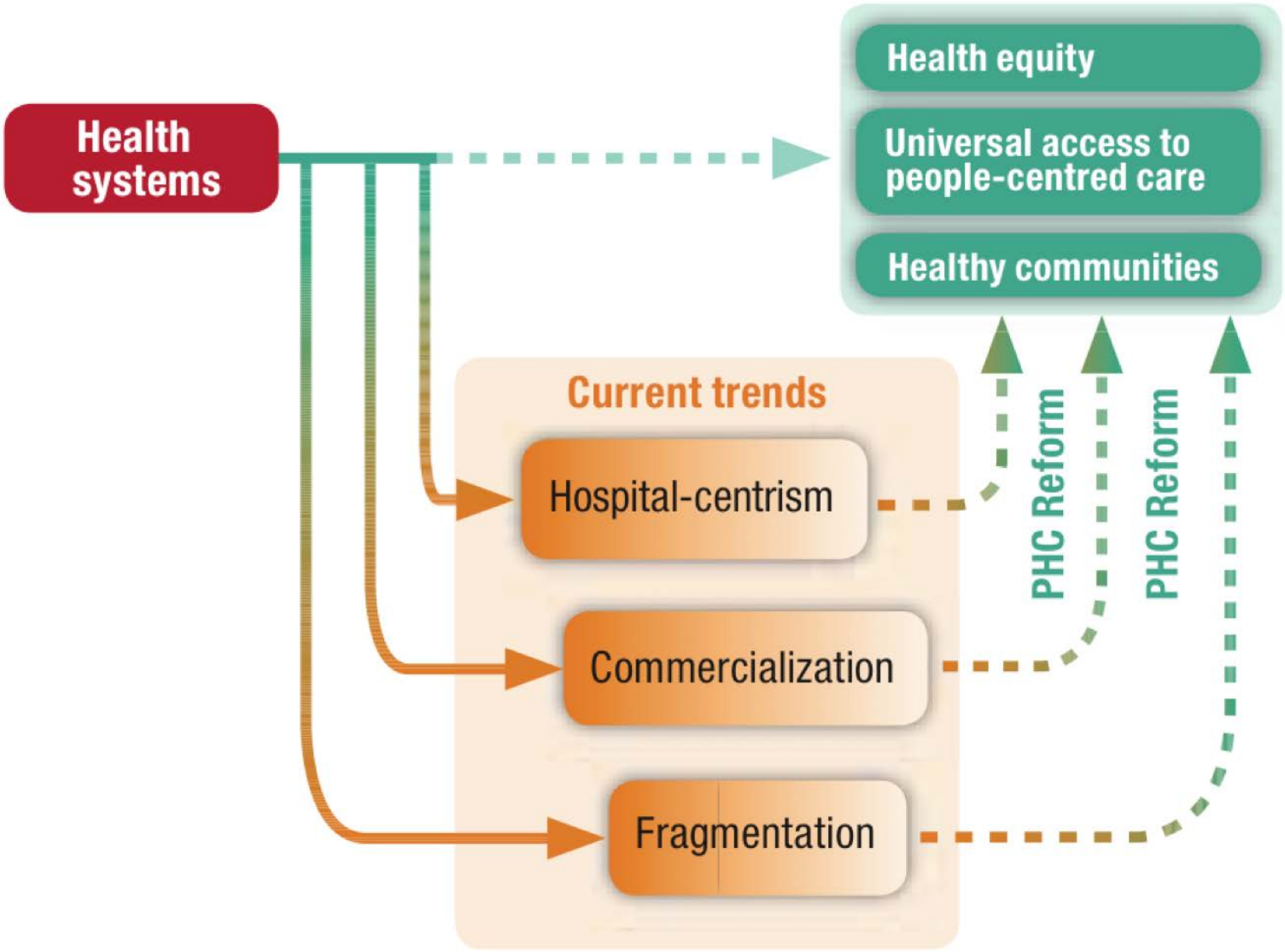

ALMA-ATA 1978
PRIMARY HEALTH CARE
WHO UNICEF

1978


The World Health Report 2008
Primary Health Care
SERVICE DELIVERY REFORMS
UNIVERSAL COVERAGE REFORMS
PUBLIC POLICY REFORMS
LEADERSHIP REFORMS
Now More Than Ever
World Health Organization

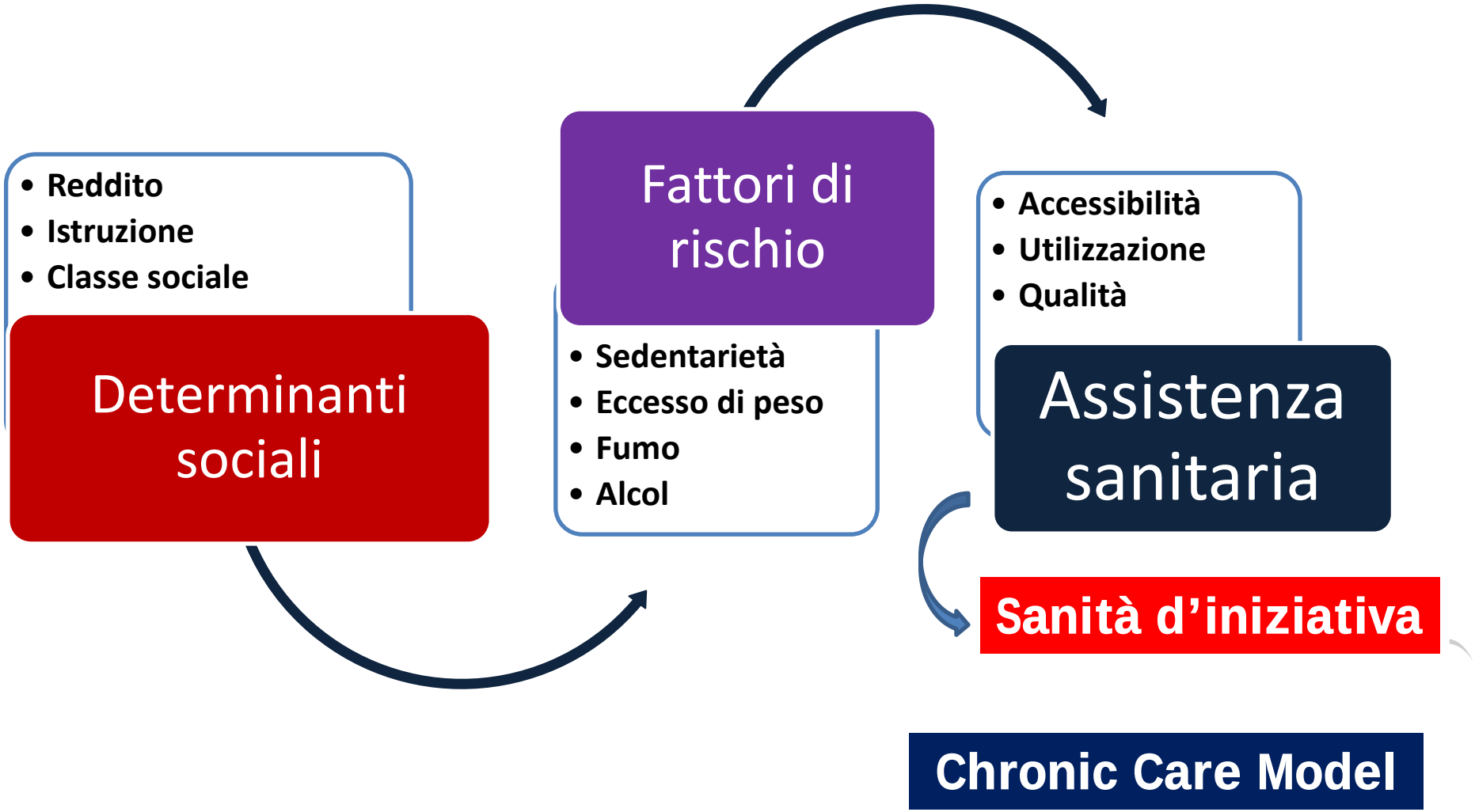
2008

Figure 1.10 How health systems are diverted from PHC core values




EPIDEMIA MALATTIE CRONICHE
SVILUPPO BIOTECNOLOGIE
L'espressione tempesta perfetta si riferisce al verificarsi simultaneo di una serie di eventi che, presi singolarmente, sarebbero stati molto meno potenti che nella loro fortuita combinazione.
RIDUZIONE DELLE RISORSE DISPONIBILI
DILATAZIONE DISEGUAGLIANZE NELLA SALUTE

Malattie croniche. La catena delle cause



JAMA®

Improving Primary Care for Patients With Chronic Illness

Thomas Bodenheimer, MD
Edward H. Wagner, MD, MPH
Kevin Grumbach, MD

The chronic care model is a guide to higher-quality chronic illness management within primary care. The model predicts that improvement in its 6 interrelated components—self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources—can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. Case studies are provided describing how components of the chronic care model have been implemented in the primary care practices of 4 health care organizations.

JAMA. 2002;288:1775-1779 www.jama.com

MR SUGARMAN, A 64-YEAR-old patient with diabetes, comes for his 15-minute visit with Dr Madden. After evaluating Mr Sugarman's acutely painful knee and treating his gastroesophageal reflux disease, Dr Madden has 3 minutes left to assess diabetic control. Having fruitlessly searched through Mr Sugarman's medical records to find the last

One hundred million persons in the United States have at least 1 chronic

gnette describing Dr Madden—routinely experience this tyranny of the

JAMA®

Improving Primary Care for Patients With Chronic Illness

The Chronic Care Model, Part 2

Thomas Bodenheimer, MD
Edward H. Wagner, MD, MPH
Kevin Grumbach, MD

This article reviews research evidence showing to what extent the chronic care model can improve the management of chronic conditions (using diabetes as an example) and reduce health care costs. Thirty-two of 39 studies found that interventions based on chronic care model components improved at least 1 process or outcome measure for diabetic patients. Regarding whether chronic care model interventions can reduce costs, 18 of 27 studies concerned with 3 examples of chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced health care costs or lower use of health care services. Even though the chronic care model has the potential to improve care and reduce costs, several obstacles hinder its widespread adoption.

JAMA. 2002;288:1909-1914 www.jama.com

A PREVIOUS ARTICLE[1] DESCRIBED the chronic care model, a guide to improving the management of chronic illness, particularly within primary care. That article featured several case studies of organizations that have implemented components of the model. This article examines research evidence demonstrating that components of the model can improve quality and reduce costs and examines some

BMJ

The NHS versus Kaiser

Same inputs: different outcomes. Why does the NHS do worse? p 135

Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente

BMJ 2002;324:135–43

Richard G A Feachem, Neelam K Sekhri, Karen L White

Table 3 Comparison of inputs and use in NHS and Kaiser, 2000

Inputs	NHS	Kaiser, California
Specialists per 100 000 people		
Pediatricians	4.9*	12.3
Obstetricians-gynaecologists	4.1*	8.3
Oncologists	0.9*	1.7
Radiologists	4.3*	6.0
Cardiologists	0.8†	2.4
Primary care facilities		
Percentage of primary care physicians in single handed practices	9%‡	0%
Average No of primary care physicians per office	3-5‡	20-40
Percentage of primary care physicians with laboratory, imaging, or pharmacy on site	25%-pharmacy (few with other services)	>95%
Percentage of primary care physicians connected to clinical IT system	100% by 2002	>95% today
Use		
Average acute length of stay (days)	5.0§	3.9
Acute bed days per 1000 per year	1000	270

Sources: NHS plan,[1] OECD,[6] HEDIS,[8] unpublished Kaiser data, Department of Health,[23 24] Office of Health Economics.[25]

*1999 Includes registrars as well as consultants for England.

†1998 Consultants for England.

‡1998 data.

§1996 latest OECD data.

¶1997 latest OECD data.

Making the NHS more like Kaiser Permanente

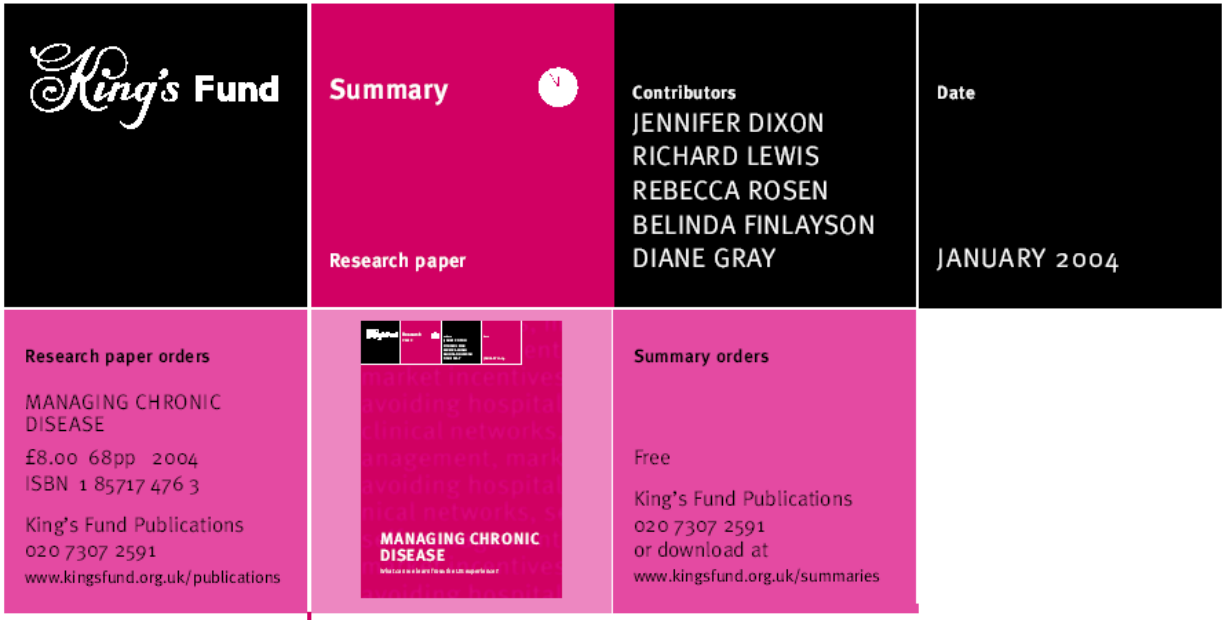
Donald Light, Michael Dixon

BMJ 2004;328:763–5

The NHS needs to break down the barriers between primary, secondary, and tertiary care

MANAGING CHRONIC DISEASE

What can we learn from the US experience?



Population management

More than care and case management

Deciding the right approach

It is important to have the information and knowledge to be able to carry out a risk-stratification on local populations to identify those who are most at-risk.

Level 3

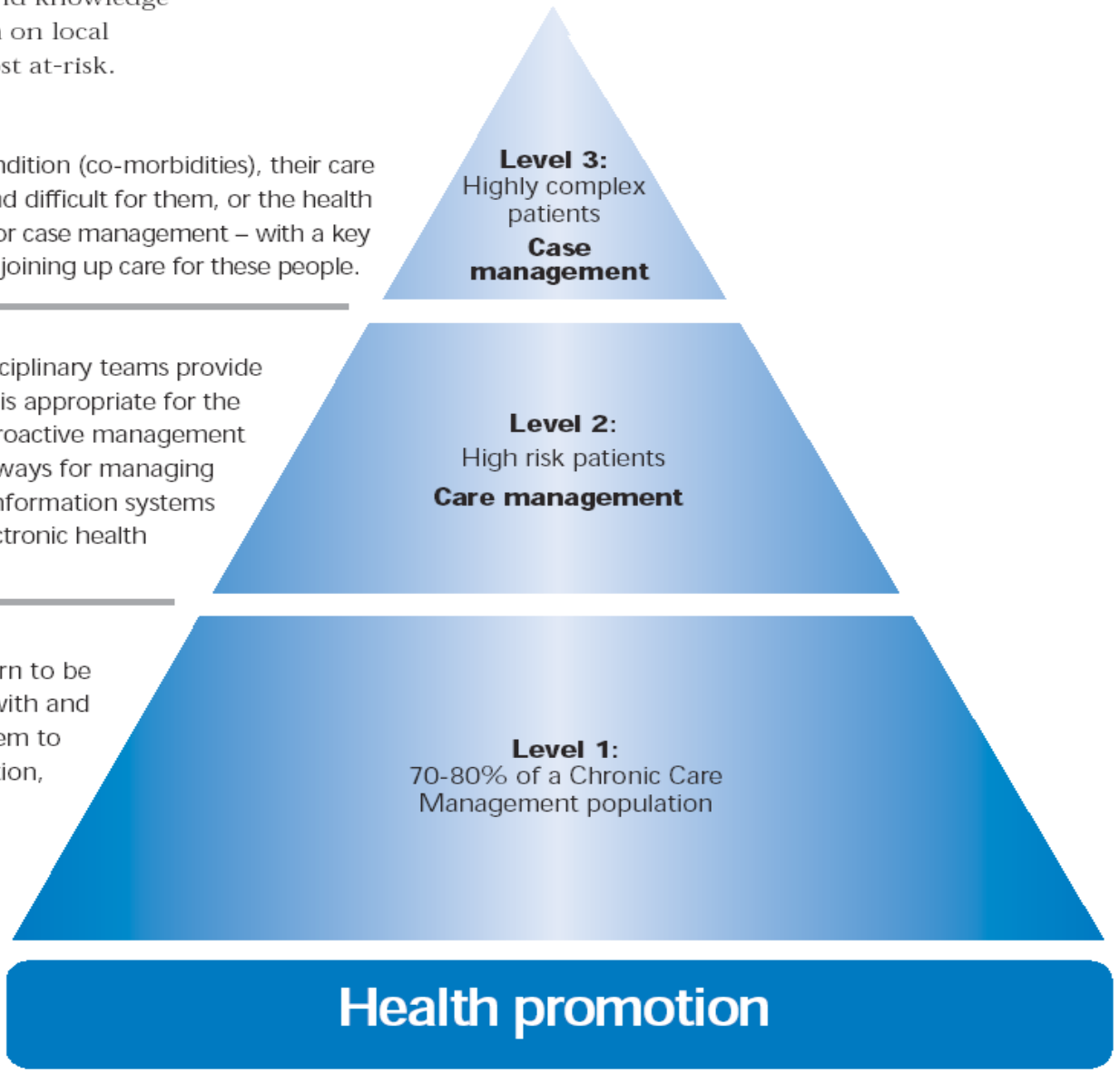
As people develop more than one chronic condition (co-morbidities), their care becomes disproportionately more complex and difficult for them, or the health and social care system, to manage. This calls for case management – with a key worker (often a nurse) actively managing and joining up care for these people.

Level 2

Disease/care management, in which multidisciplinary teams provide high quality evidence based care to patients, is appropriate for the majority of people at this level. This means proactive management of care, following agreed protocols and pathways for managing specific diseases. It is underpinned by good information systems – patient registries, care planning, shared electronic health records.

Level 1

With the right support many people can learn to be active participants in their own care, living with and managing their conditions. This can help them to prevent complications, slow down deterioration, and avoid getting further conditions. The majority of people with chronic conditions fall into this category – so even small improvements can have a huge impact.



Sperimemtare il CCM a Firenze

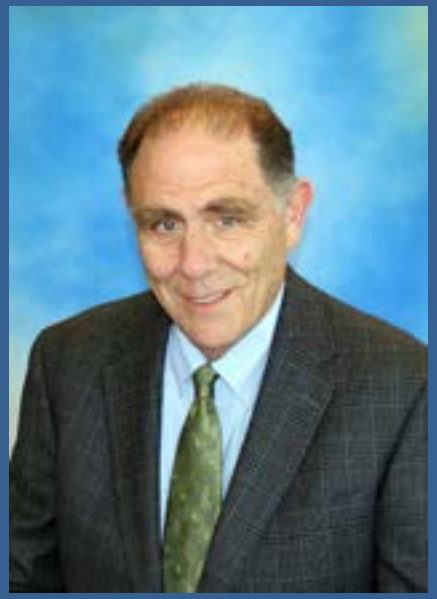
SST Servizio Sanitario della Toscana

Vecchie malattie *Nuove* risposte

Modelli innovativi per l'assistenza alle malattie croniche

5-6 maggio 2005
Palazzo degli Affari
Firenze

Segreteria del Convegno:
Ufficio Congressi
Newtours S.p.A.
Via A. Righi, 8 - 50019 Sesto F.no - FI -
Phone: +39 055 3361.1 - Fax: +39 055 3033.895
E-Mail: belluomini@newtours.it



Lettura magistrale: Il Chronic Care Model
Ed Wagner - MacColl Institute for Healthcare Innovation, Seattle, USA

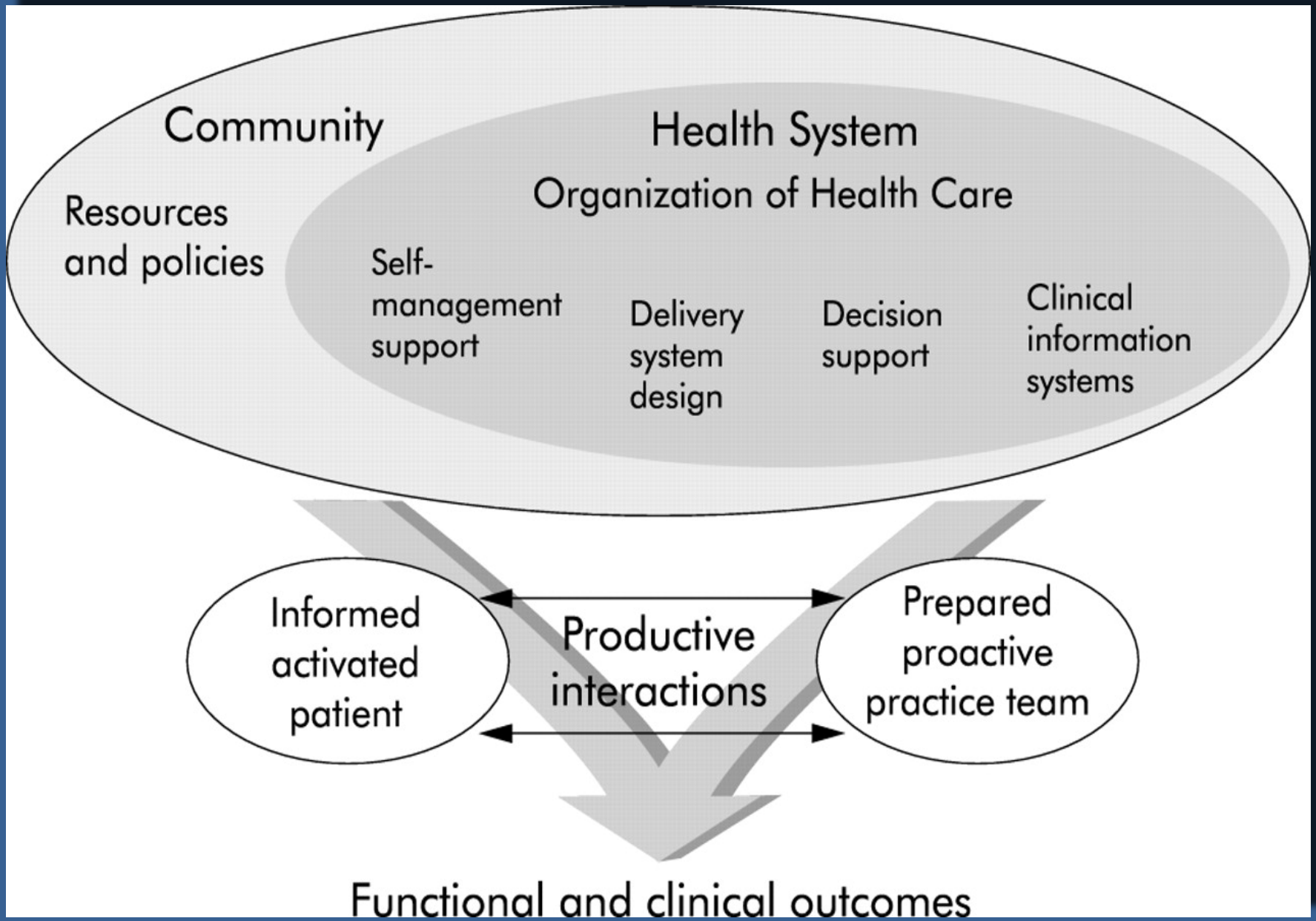
Chronic Care and and the Future of Primary Care

Ed Wagner, MD, MPH

“Current care systems cannot do the job”

- Oriented to acute illness
- Interactions not productive of good care or satisfying to patients or clinical staff

THE CHRONIC CARE MODEL



Regione Toscana

Diritti Valori Innovazione Sostenibilità

Piano Sanitario Regionale

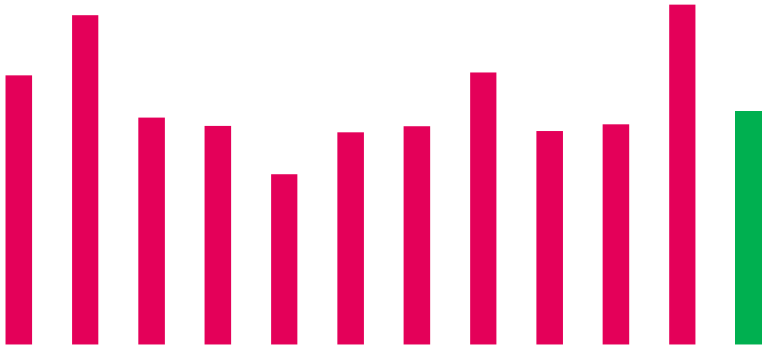
Aggiornamento ai sensi dell'art.18, comma 3,
e dell'art.142, comma 3 della L.R. 40/2005

2008 -2010

Parte Prima
UN PIANO PER LA SALUTE, UNA SANITÀ D'INIZIATIVA

Estensione a livello regionale : stato attuale

Copertura popolazione > 16	*43% (ca. 1.350.000)*
N. MMG coinvolti	*1.098*
N. moduli sanità di iniziativa attivati	*137*



Pazienti in carico PDTA Sanità di iniziativa in Regione Toscana	
	N. assistiti in carico
Diabete	60.750
Scompenso Cardiaco	13.500
BPCO	33.750
Ictus/ TIA	27.000

Si stima che circa il 9,1% degli assistiti di un MMG sia in carico ai PDTA Sanità di Iniziativa

Il Sole 24 ORE Sanità

Toscana

SST Servizio Sanitario della Toscana

Roma

Versione Pdf del supplemento al n. 41
anno XV del 6-12 novembre 2012
per la pubblicazione sul sito
della Regione Toscana
www.regione.Toscana.it

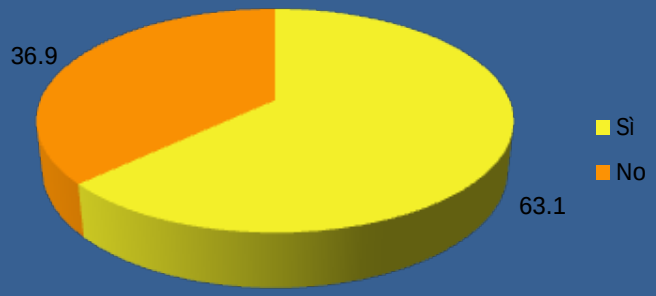
MODELLI *Sondaggio tra 6.500 pazienti sui vantaggi del Chronic care model*

Sanità d'iniziativa a pieni voti

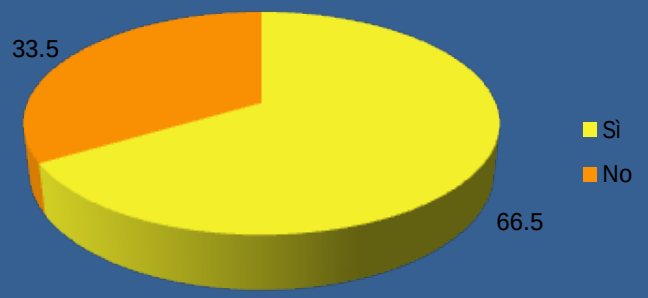
Più informazione ed empowerment con la presa in carico da parte del team

Gli outcome

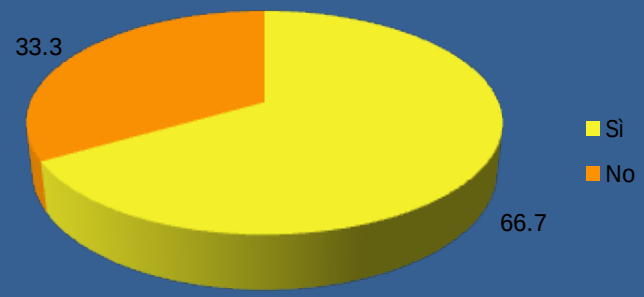
Gestire meglio la malattia



Maggiori informazioni



Benefici per la salute



Una migliore assistenza

Saluteinternazionale.info - Newsletter mensile - Numero 34 - Windows Internet Explorer
http://www.saluteinternazionale.info/newsletter/numero34.html
Bing
bing
Preferiti
Saluteinternazionale.info - Newsletter mensile - ...
Pagina
Sicurezza
Strumenti

Se non visualizzi correttamente questa email, leggi la versione online

SALUTEINTERNAZIONALE.info

Salute Internazionale è su Mi piace facebook

La newsletter di SaluteInternazionale #34

EDITORIALE / Gavino Maciocco

Chronic Care Model in salsa tedesca

L'introduzione del Chronic Care Model (CCM) non ha prodotto solo effetti positivi sulla salute della popolazione tedesca e sul budget delle assicurazioni sociali, ha anche rafforzato il sistema delle cure primarie, molto debole in Germania. I vari componenti del CCM sono stati applicati in maniera rigorosa: dalla creazione di registri di patologia alla proattività degli interventi, dal supporto all'autocura all'adesione a linee guida definite a livello centrale. Tutto ciò ha richiesto lo sviluppo di équipe di cure primarie coordinate da un medico di famiglia che ha la responsabilità della presa in carico del paziente e

Internet | Modalità protetta: attivata
100%
3 Esplor...
6 Intern...
Five-Year...
Doc_Parer...
MES_Siste...
Bologna_...
MES_Syst...
ARS_Lithu...
IT
23.40

Arruolati CCM

	2006	2012
Diabete tipo 1	29.000	156.000
Diabete tipo 2	1.948.000	3.749.000
Cancro della mammella	67.000	126.000
Cardiopatia ischemica	635.000	1.700.000
Asma	6.000	799.000
BPCO	8.000	633.000
Totale	2.693.000	7.163.000

Figura 1. Mortalità e complicanze maggiori da diabete tra pazienti arruolati (*intervention*) e gruppo di controllo. 2007.

Mortality And Major Diabetic Complications In Intervention (Enrolled) And Control Groups, German Disease Management Program, 2007

	Intervention		Control	
	Number	Percent	Number	Percent
Mortality	458	2.30	935	4.70
DIABETIC COMPLICATIONS				
Myocardial infarction (ICD: I21, I22)	165	0.83	219	1.10
Stroke (ICD: I63)	180	0.91	226	1.14
Chronic renal insufficiency (ICD: N18, N19)	71	0.36	94	0.74
Amputation of lower leg or foot (OPS: 5-865, 5-864)	95	0.48	152	0.76
Occurrence of at least one of the four complications	496	2.49	667	3.35

1. Stock S. et Al. German Diabetes Management Programs Improve Quality Of Care And Curb Costs. Health Affairs 2010; 29(12): 2197–2205

Figura 2. Numero di pazienti per 1000 pazienti partecipanti al programma che sono stati ricoverati almeno una volta con la diagnosi descritta (in confronto con i pazienti non partecipanti). 2006.

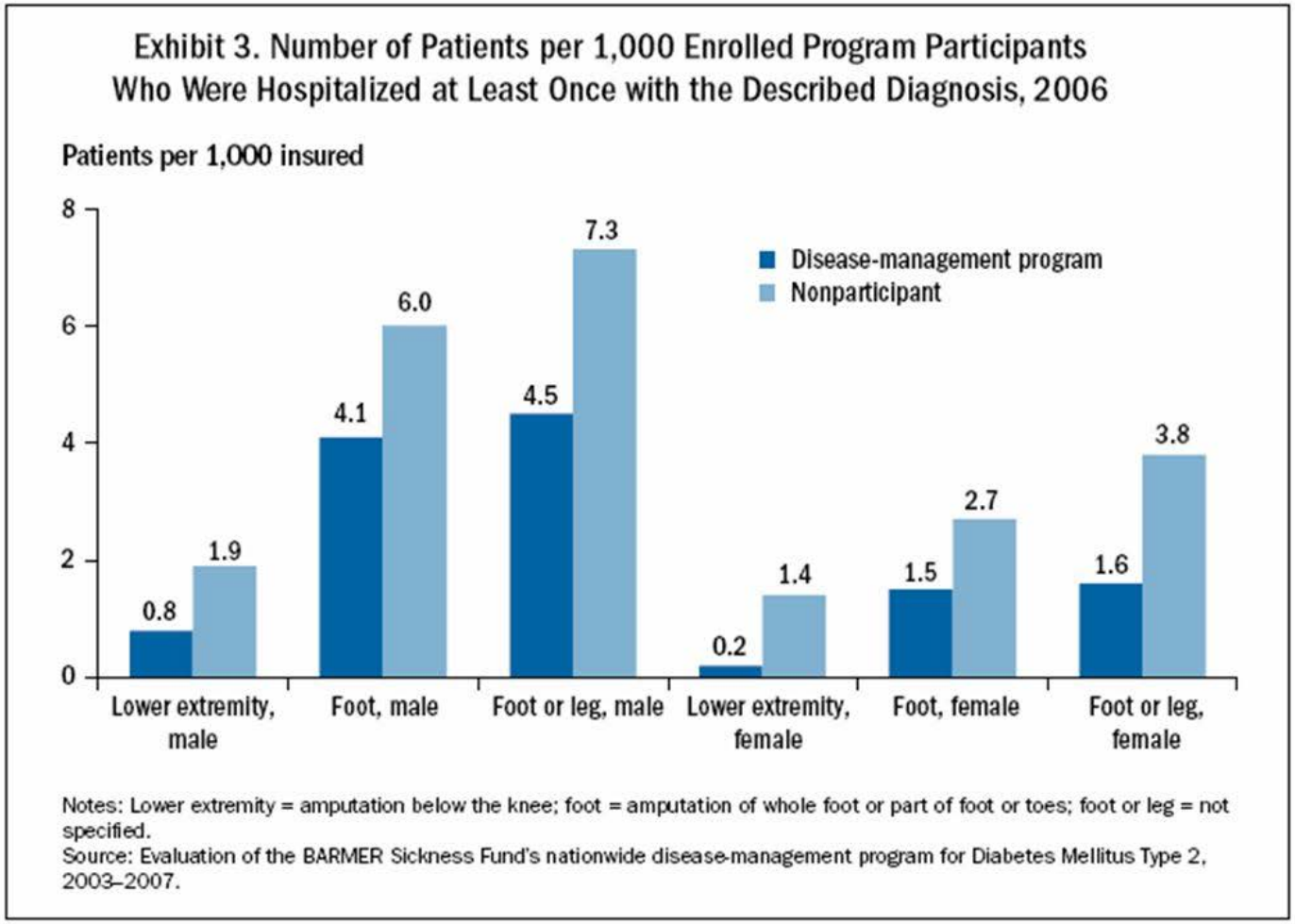


Figura 3. Costi e utilizzazione dei servizi tra pazienti arruolati (*intervention*) e gruppo di controllo. 2003-7.

Various Cost And Health Services Use Indicators In Intervention (Enrolled) And Control Groups, German Disease Management Program, 2003–7

	Intervention	Control
Overall cost difference, 2007–2003	US$1,443.65	US$1,890.40
Overall costs, 2007	US$5,273.99	US$5,896.54
Hospital costs, 2007	US$2,664.71	US$3,292.65
Drug costs, 2007	US$2,609.28	US$2,603.89
Length of hospitalization per insured, days, 2007 (mean/median)	4.97/0.00	6.41/0.00
Number of hospital stays per insured, 2007 (mean/median)	0.55/0.00	0.62/0.00

1. Stock S. et Al. German Diabetes Management Programs Improve Quality Of Care And Curb Costs. Health Affairs 2010; 29(12): 2197–2205

IL TEAM

LA COMUNITA’

LE STRUTTURE

LE MALATTIE

Acute Care

Intensività assistenziale
"Technology-intensive"

Orientato alla produzione di prestazioni

Presidia soprattutto l'efficienza

Tende all'accentramento (Economie di scala)

Punta all'eccellenza

Primary Care

Estensività assistenziale
"Labor-intensive"

Orientato alla gestione di processi assistenziali

Presidia soprattutto l'efficacia

Tende al decentramento (Partecipazione)

Punta all'equità

I due pilastri del SSN
e i due diversi paradigmi