Gestione delle comorbilità: i bisogni della popolazione anziana

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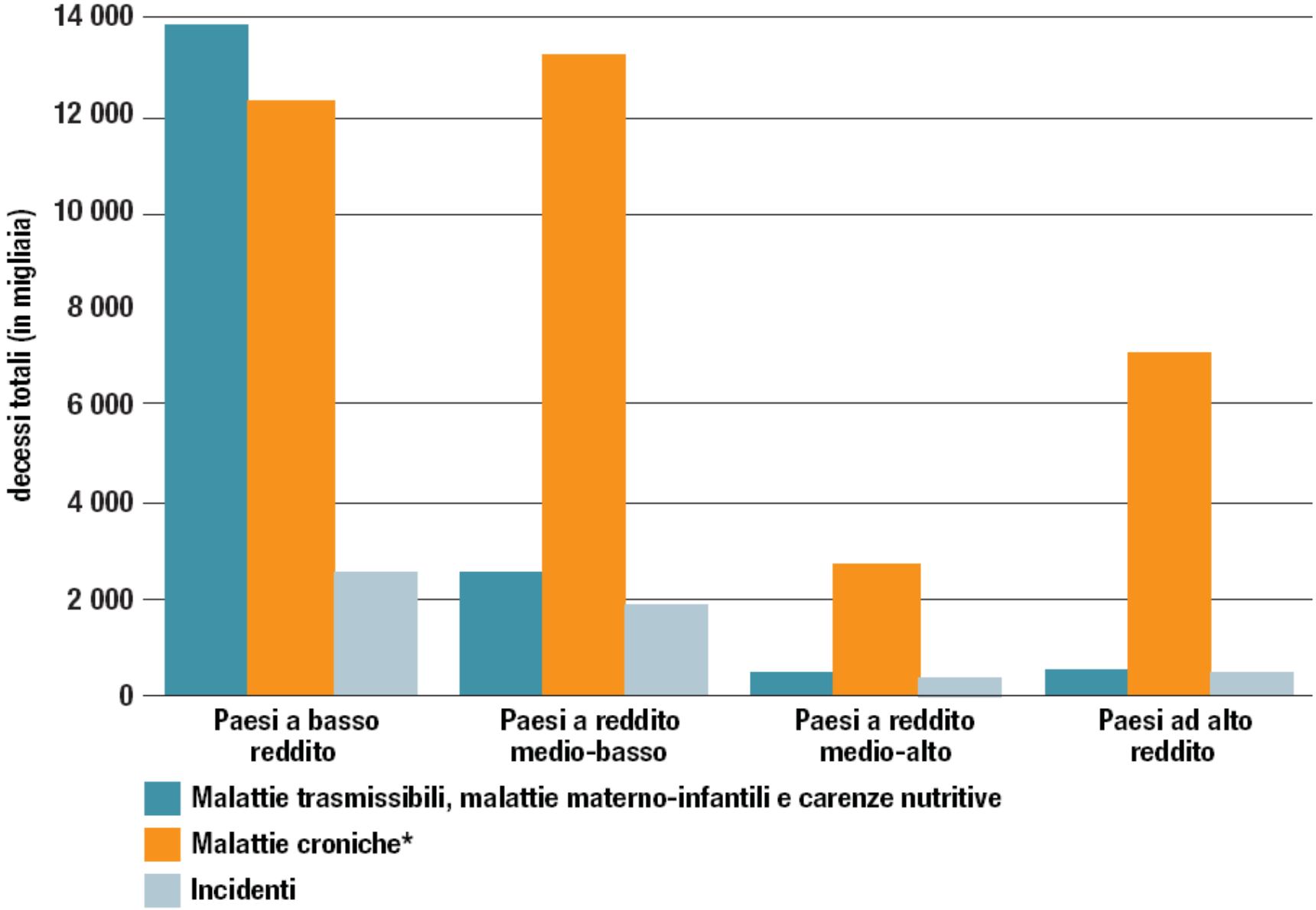
EPIDEMIA MALATTIE CRONICHE
SVILUPPO BIOTECNOLOGIE
L'espressione tempesta perfetta si riferisce al verificarsi simultaneo di una serie di eventi che, presi singolarmente, sarebbero stati molto meno potenti che nella loro fortuita combinazione.
RIDUZIONE DELLE RISORSE DISPONIBILI
DILATAZIONE DISEGUAGLIANZE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

Decessi previsti per cause principali

e per gruppi di reddito per il 2005, tutte le età



Health at a Glance 2015

OECD INDICATORS

OECD

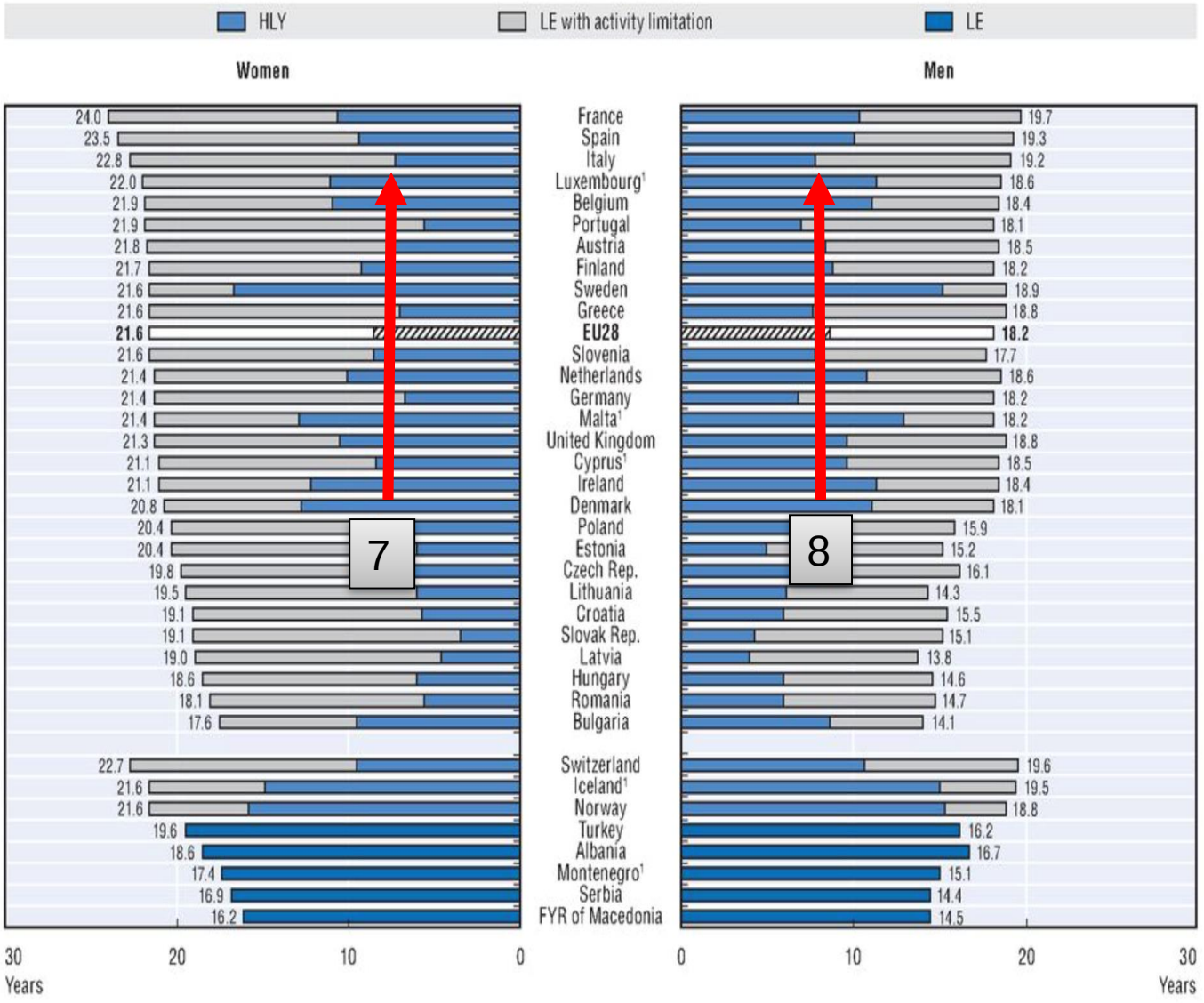
Table 1.1. **Health status**

Top third performers
Middle third performers
Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For the mortality indicator, the top performers are countries with the lowest rates.

Indicator	Life expectancy at birth - Men	Life expectancy at birth - Women	Life expectancy at 65 - Men*	Life expectancy at 65 - Women*	Mortality from cardiovascular diseases**
Australia	8	7	3	7	7
Austria	18	13	16	13	26
Belgium	22	19	23	14	15
Canada	13	17	10	10	5
Chile	27	27	27	28	16
Czech Rep.	28	28	29	30	31
Denmark	21	25	25	26	10
Estonia	32	26	31	27	32
Finland	23	8	20	9	24
France	15	3	2	2	2
Germany	18	19	16	22	25
Greece	17	9	13	11	27
Hungary	33	33	34	34	33
Iceland	2	16	10	20	23
Ireland	15	23	19	24	21
Israel	3	11	3	17	3
Italy	3	4	8	4	17
Japan	5	1	6	1	1
Korea	20	5	20	5	4
Luxembourg	9	11	6	8	12
Mexico	34	34	28	32	22
Netherlands	11	19	16	20	8
New Zealand	11	19	8	17	18
Norway	9	13	15	14	11
Poland	30	29	30	28	30
Portugal	24	9	23	11	14
Slovak Rep.	31	31	33	31	34
Slovenia	25	17	26	14	28
Spain	5	2	3	3	6
Sweden	5	13	10	17	19
Switzerland	1	6	1	5	13
Turkey	29	32	32	33	29
United Kingdom	14	24	14	23	9
United States	26	29	22	25	20

3.3. Life expectancy (LE) and healthy life years (HLY) at 65, by gender, 2014



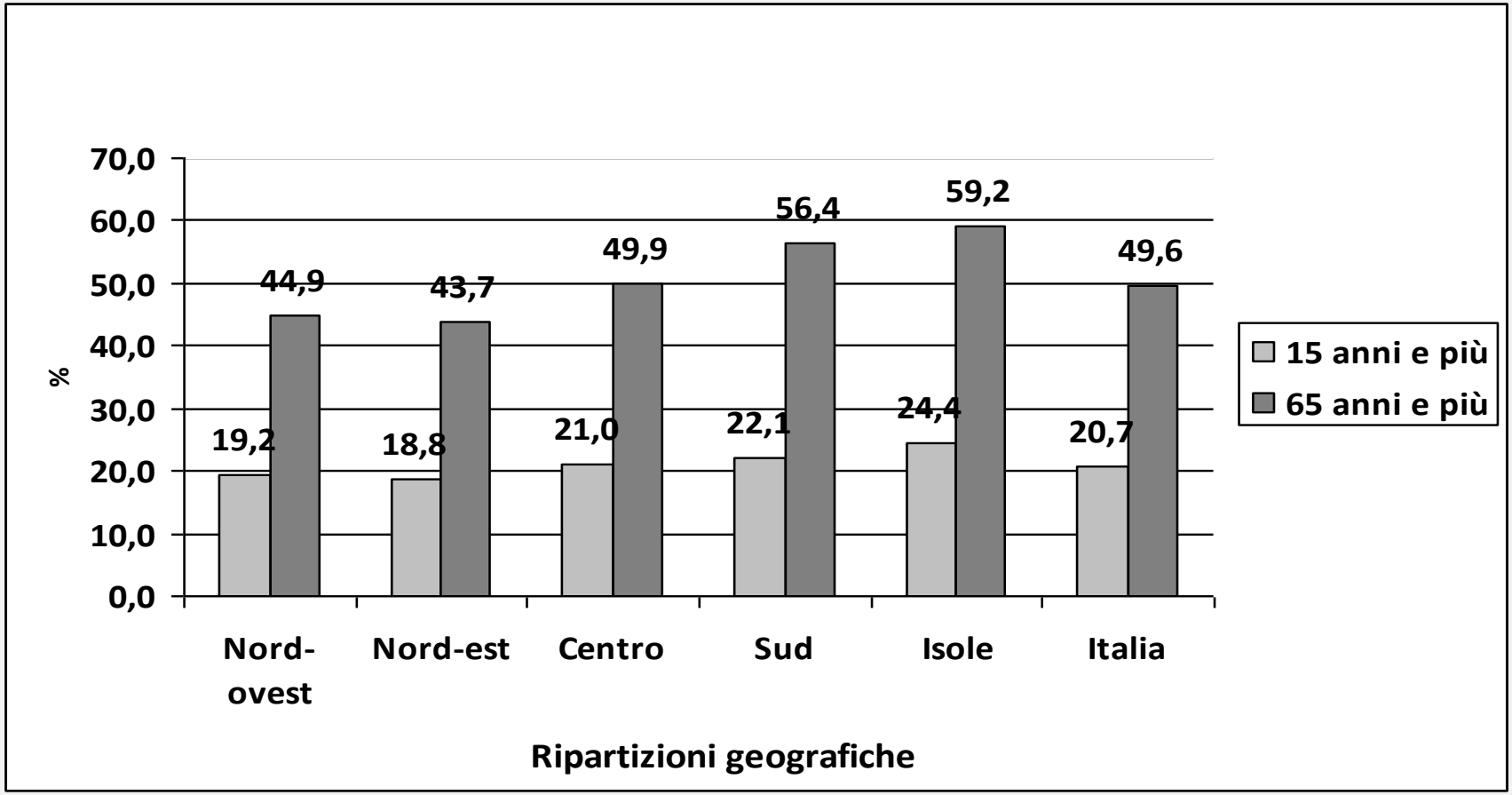
Note: Countries are ranked in descending order of life expectancy at 65 for women.

1. Three-year average (2012-14).

Source: *Eurostat Database.*

StatLink http://dx.doi.org/10.1787/888933428539

Persone di 15 anni e più e 65 anni e più che dichiarano di essere affette da almeno una malattia cronica grave, per ripartizione geografica. Anno 2015 (Elaborazione dati ISTAT).



Prevalenza di multimorbosità per fasce d'età e condizione socioeconomica (Fonte: Barnett K)

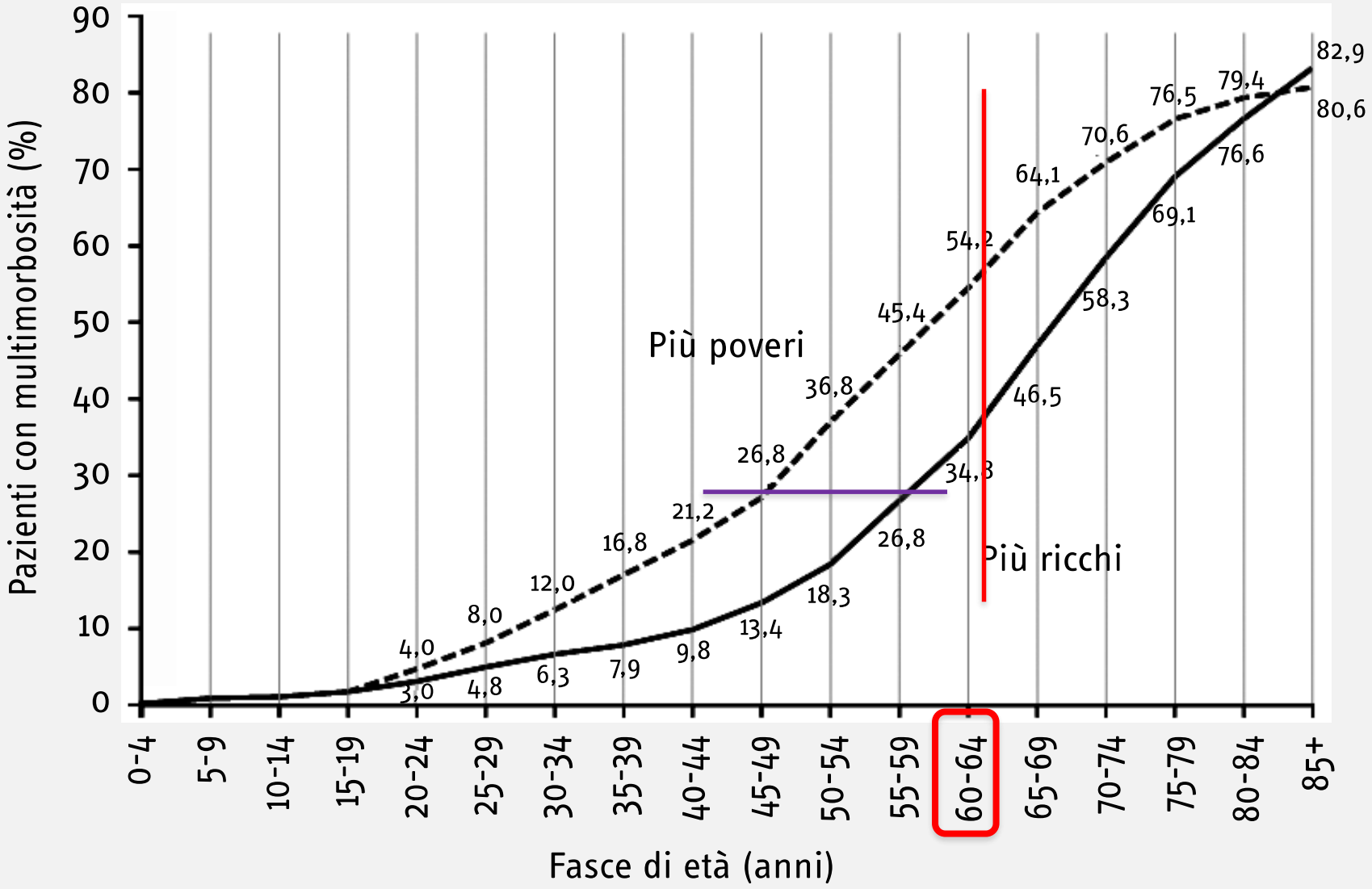


Table 1.2. **Risk factors**

Top third performers
Middle third performers
Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available.

Indicator	Smoking in adults	Alcohol consumption	Obesity in adults*	Overweight and obesity in children**
Australia	4	22	30*	20
Austria	26	34	8	14
Belgium	15	20	9	5
Canada	6	11	29*	21
Chile	33	10	28*	28
Czech Rep.	25	32	20*	5
Denmark	12	17	10	23
Estonia	31	33	18	7
Finland	10	14	26	17
France	30	30	11	13
Germany	23	28	25*	3
Greece	34	7	19	33
Hungary	32	30	31*	24
Iceland	2	6	21	9
Ireland	16	26	24*	11
Israel	11	2	13	13
Italy	24	4	4	31
Japan	17	7	1*	15
Korea	19	12	2*	16
Luxembourg	9	29	23*	19
Mexico	3	3	33*	30
Netherlands	13	14	6	7
New Zealand	8	16	32*	27
Norway	7	5	3	1
Poland	27	27	14	2
Portugal	14	25	12	25
Slovak Rep.	18	22	16*	3
Slovenia	22	17	17	22
Spain	29	20	15	26
Sweden	1	7	7	9
Switzerland	21	22	4	11
Turkey	27	1	22*	n.a.
United Kingdom	20	19	27*	32
United States	5	13	34*	29

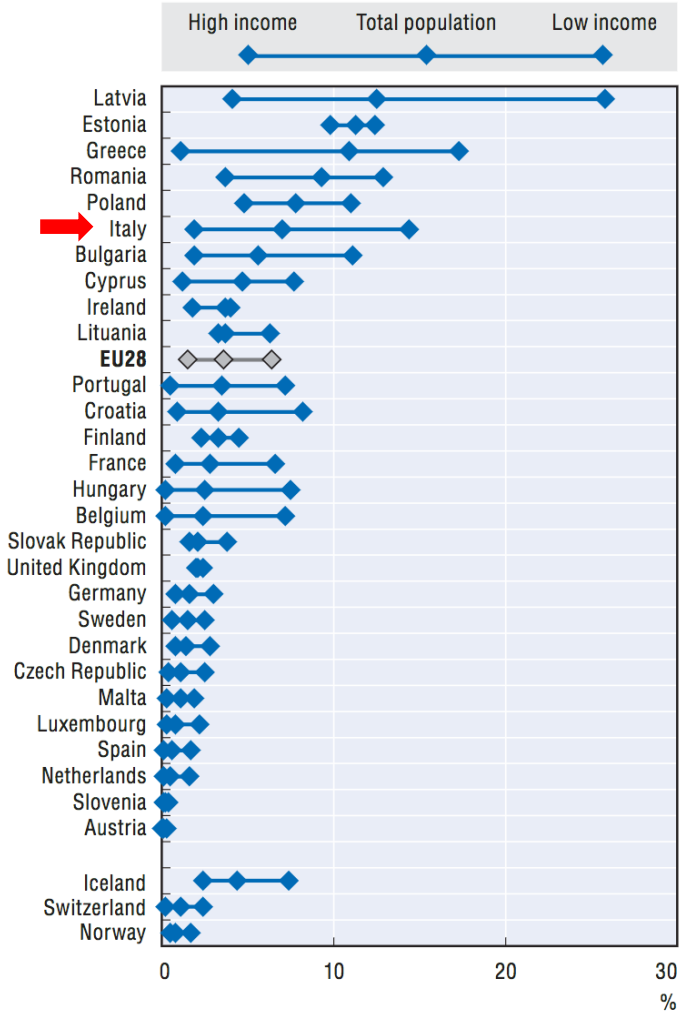
Table 1.3. **Access to care**

Top third performers (or between 95% and 100% for health care coverage)
Middle third performers (or between 90% and 95% for health care coverage)
Bottom third performers (or less than 90% for health care coverage)

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For out-of-pocket medical expenditure, unmet care needs and the waiting times indicators, the top performers in terms of access are countries with the lowest expenditure as a share of household consumption, the lowest unmet care needs or lowest waiting times.

Indicator	Health care coverage	Share of out of pocket medical expenditure in household consumption	Unmet medical care needs*	Unmet dental care needs*	Waiting times for cataract surgery - median	Waiting times for knee replacement - median
Australia	1	22	n.a.	n.a.	8	12
Austria	1	18	1	2	n.a.	n.a.
Belgium	1	20	11	8	n.a.	n.a.
Canada	1	11	n.a.	n.a.	2	4
Chile	1	28	n.a.	n.a.	13	8
Czech Rep.	1	7	5	4	n.a.	n.a.
Denmark	1	14	7	10	4	1
Estonia	2	12	21	19	9	13
Finland	1	18	19	11	10	7
France	1	3	15	15	n.a.	n.a.
Germany	1	5	9	5	n.a.	n.a.
Greece	3	32	23	20	n.a.	n.a.
Hungary	1	30	14	9	1	6
Iceland	1	21	18	22	n.a.	n.a.
Ireland	1	22	17	17	n.a.	n.a.
Israel	1	16	n.a.	n.a.	3	3
Italy	1	22	20	21	n.a.	n.a.
Japan	1	3	n.a.	n.a.	n.a.	n.a.
Korea	1	34	n.a.	n.a.	n.a.	n.a.
Luxembourg	1	5	4	3	n.a.	n.a.
Mexico	1	30	n.a.	n.a.	n.a.	n.a.
Netherlands	1	2**	1	1	n.a.	n.a.
New Zealand	1	9	n.a.	n.a.	7	5
Norway	1	16	8	15	12	10
Poland	2	13	22	13	14	14
Portugal	1	29	16	23	6	11
Slovak Rep.	2	22	11	6	n.a.	n.a.
Slovenia	1	7	n.a.	n.a.	n.a.	n.a.
Spain	1	26	3	18	11	9
Sweden	1	26	11	14	n.a.	n.a.
Switzerland	1	33	6	12	n.a.	n.a.
Turkey	1	1	n.a.	n.a.	n.a.	n.a.
United Kingdom	1	3	9	7	4	2
United States	3	14	n.a.	n.a.	n.a.	n.a.

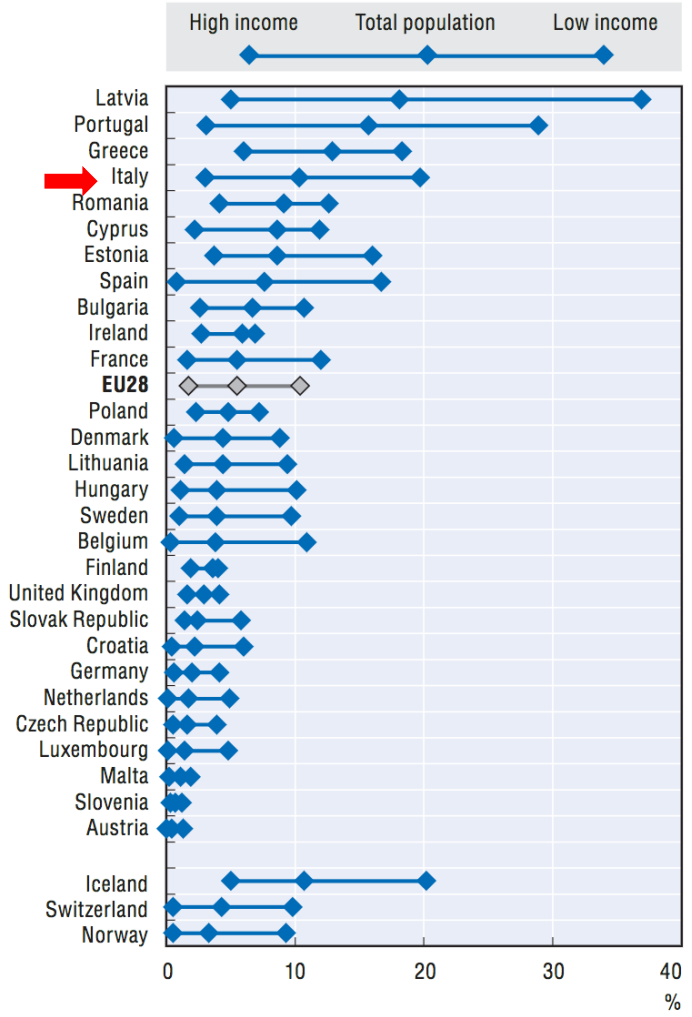
7.4. Unmet need for medical examination for financial, geographic or waiting times reasons, by income quintile, 2014



Source: *Eurostat Database*, based on EU-SILC.

StatLink http://dx.doi.org/10.1787/888933429732

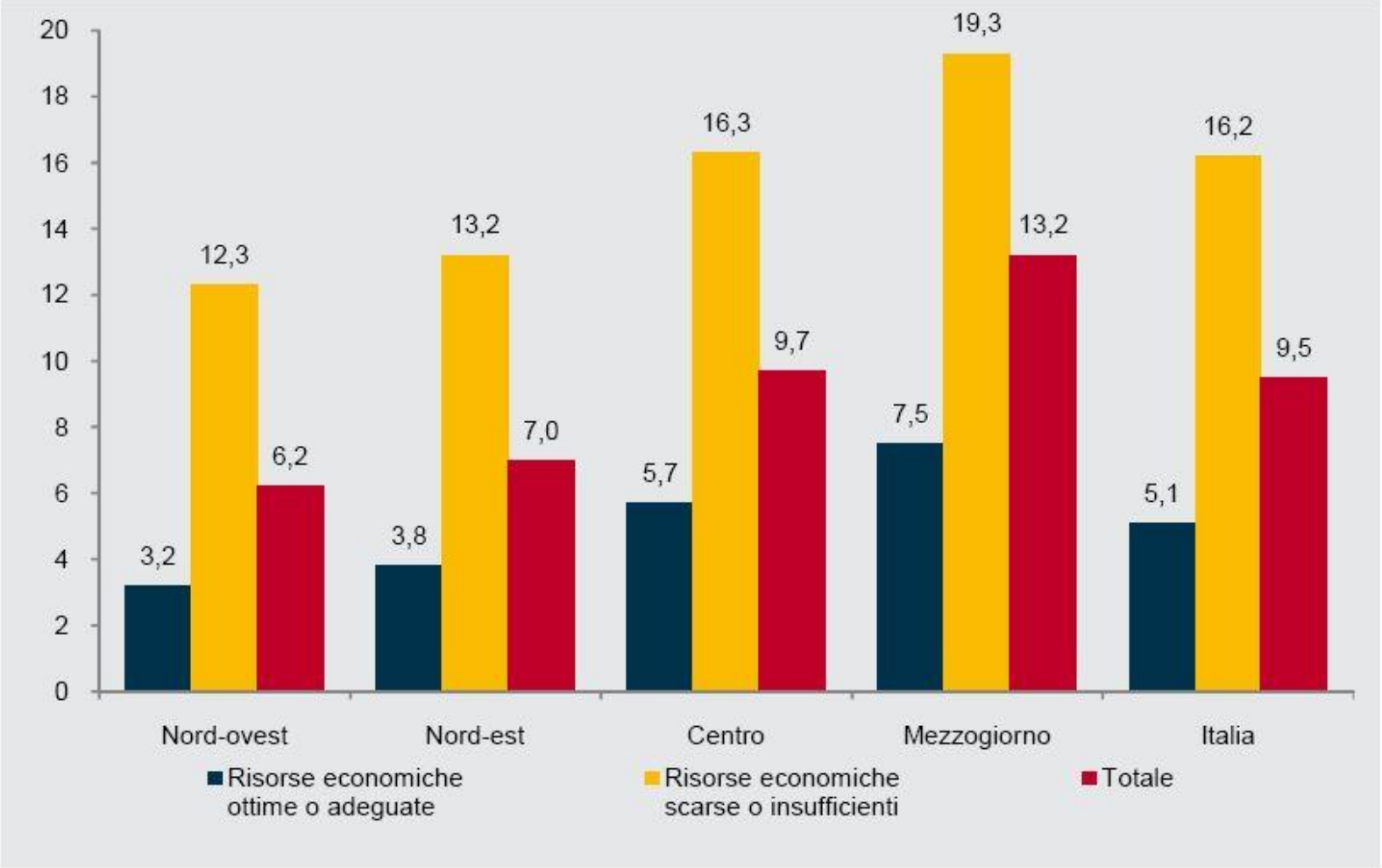
7.5. Unmet need for dental examination for financial, geographic or waiting times reasons, by income quintile, 2014



Source: *Eurostat Database*, based on EU-SILC.

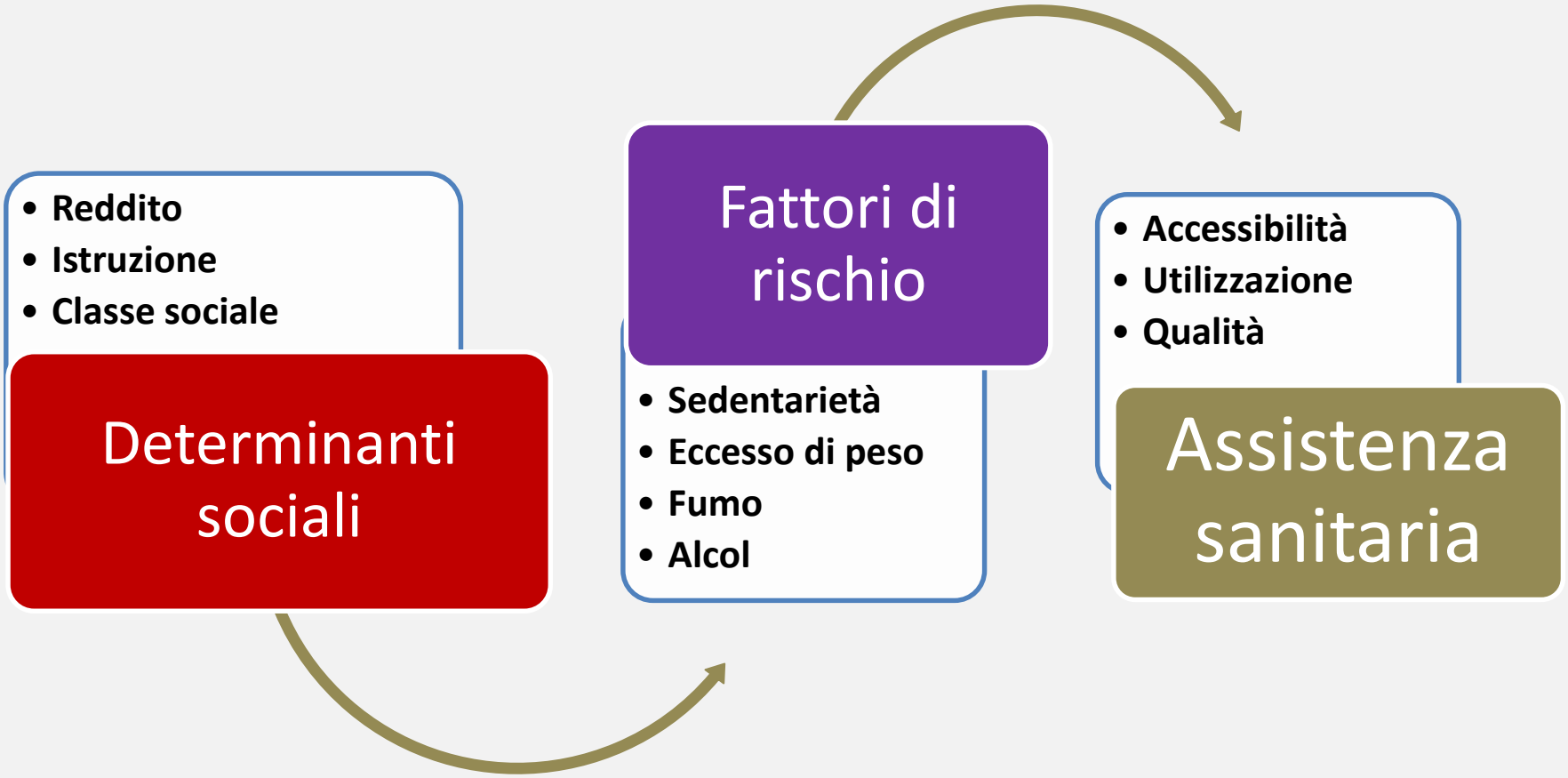
StatLink http://dx.doi.org/10.1787/888933429747

Figura 5.12 **Persone che negli ultimi 12 mesi hanno rinunciato a prestazioni sanitarie** (a) **o all'acquisto di farmaci a causa di motivi economici o carenze delle strutture di offerta per risorse economiche della famiglia e ripartizione geografica - Anno 2013** (tassi standardizzati per 100 persone)



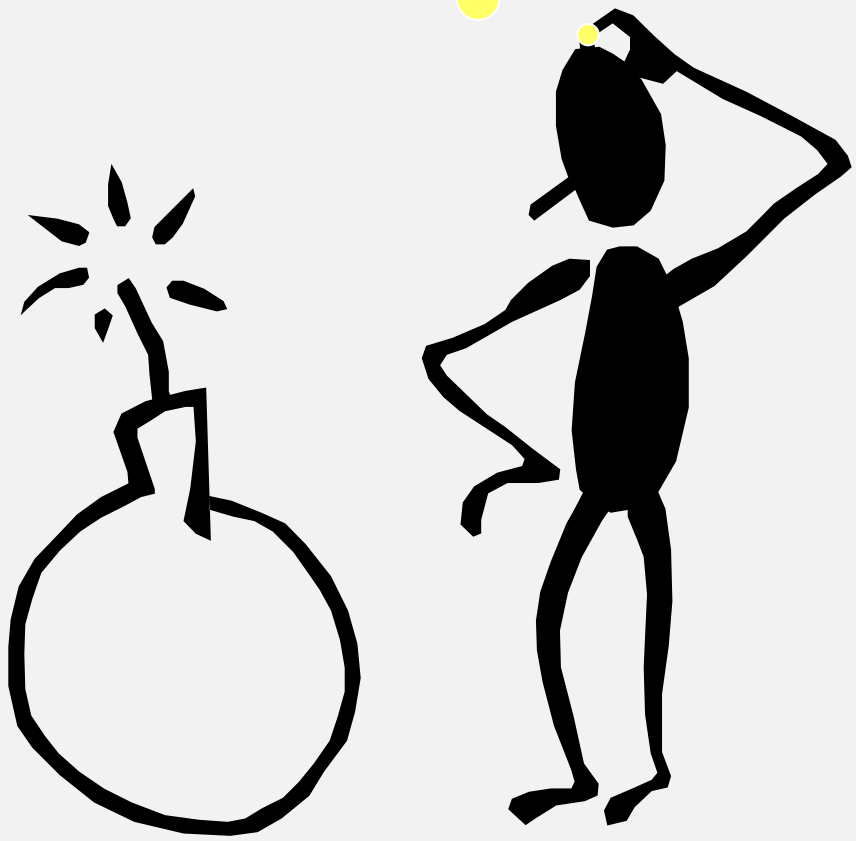
Fonte: Istat, Condizioni di salute e ricorso ai servizi sanitari
(a) Visite, accertamenti, interventi chirurgici.

Malattie croniche. La catena delle cause



- “Nonostante si viva in un mondo dominato dalle patologie croniche, nei luoghi di cura si pratica una medicina quasi esclusivamente per acuti: all’alba del XXI secolo persistono i modelli del XIX secolo”
- *(R. Rozzini e M. Trabucchi, 2013)*

Aspettare……



Sale d’attesa

PRONTO SOCCORSO

Paradigma dell'attesa

- Il **paradigma dell'*attesa*** è quello tipico delle malattie acute: attesa di un evento su cui intervenire, su cui mobilitarsi per risolvere il problema. Applicare alle malattie croniche il paradigma assistenziale delle malattie acute provoca danni incalcolabili. **Ciò significa che il "sistema" si mobilita davvero solo quando il paziente cronico si aggrava, si scompensa, diventa "finalmente" un paziente acuto.** Ciò significa rinunciare non solo alla prevenzione, alla rimozione dei fattori di rischio, ma anche al trattamento adeguato della malattia cronica di base.

Anticipatory Health Care

Our aim was to improve health in the whole registered population by identifying treatable problems at an early, often presymptomatic stage, and to learn from our mistakes by looking for them systematically.

This proactive policy depended on practice organisation, teamwork, and structured records.

Twenty five years of case finding and audit in a socially deprived community

Julian Tudor Ha
Margaret Jones, Pam Walton

PRAC ne Edwards, Mary Hart, Janet Jones,

Abstract

Objective—To evaluate audit and case finding (whole population care) in a community over 25 years.

Design—Contemporary screening for and audits of care of chronic disease and risk factors; retrospective review of computerised practice records; and comparisons of mortality and social indices with neighbouring communities.

Setting—One general practice in Glyncorrwg, West Glamorgan.

Subjects—1800 people registered with the practice in 1987 and 558 people who died from 1964 to 1987, whose records had been retained.

Main outcome measures—Detection of high blood pressure, smoking, airways obstruction, obesity, diabetes, and alcohol problems in adults aged 20-79; prevalence of smoking in this population and in hypertensive and diabetic groups; age standardised mortality ratios in relation to indices of social deprivation.

Results—In the population aged 20-79 (1207

development of structured process, may diminish health outputs.

Introduction

For health as for commodity production, absolute growth conceals relative decline. By 1980 the United Kingdom ranked highest in the European Community and Scandinavia for all causes mortality in men and women aged 45-64.[1]

The close and causal relation between mortality, morbidity, and social class for all major causes[2,3] is the main explanation for the exceptionally high mortality and morbidity in Scotland, Northern Ireland, and parts of northern England and south Wales, for all causes as well as for coronary disease. As inequalities in wealth have grown so have inequalities in sickness and death.[4] These differences are compounded by increasing inequalities in clinical resources available to deal with them: fed by the market, the inverse care law[5] thrives. As predicted by thoughtful economists,[6,7] the new general practitioner contract accelerates previous

Interpreting the Evidence

THE existence of large social and geographical inequalities in mortality and morbidity in Britain is known, and not all of them are diminishing. Between 1934 and 1968, weighted mean standardised mortality from all causes in the Glamorgan and Monmouthshire valleys rose from 128% of England and Wales rates to 131%. Their weighted mean infant mortality rose from 115% of England and Wales rates to 124% between 1921 and 1968.[1] The Registrar General's last Decennial Supplement on Occupational Mortality for 1949–53 still showed combined social classes I and II (wholly non-manual) with a standardised mortality from all causes 18% below the mean, and combined

stance, outpatient waiting-lists by area
, age and cause specific hospital mor-

Non-statistical Eviden

Paradigma dell'iniziativa

- Il paradigma dell'*iniziativa* è quello che meglio si adatta alla gestione delle malattie croniche, perchè i suoi attributi sono:
- a) **La valutazione dei bisogni della comunità e l'attenzione ai determinanti della salute** (anche quelli cosiddetti "distali", ovvero quelli socio-economici, che sono alla base delle crescenti diseguaglianze nella salute, anche sul versante dell'utilizzazione e qualità dei servizi, nei portatori di malattie croniche);
- b) **La propensione agli interventi di prevenzione**, all'utilizzo di sistemi informativi e alla costruzione di database, alle attività programmate e agli interventi proattivi (es: costruzione di registri di patologia, stratificazione del rischio, richiamo programmato dei pazienti, etc);
- c) **Il coinvolgimento e la motivazione degli utenti**, l'attività di counselling individuale e di gruppo, l'interazione con le risorse della comunità (associazioni di volontariato, gruppi di autoaiuto, etc.).

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

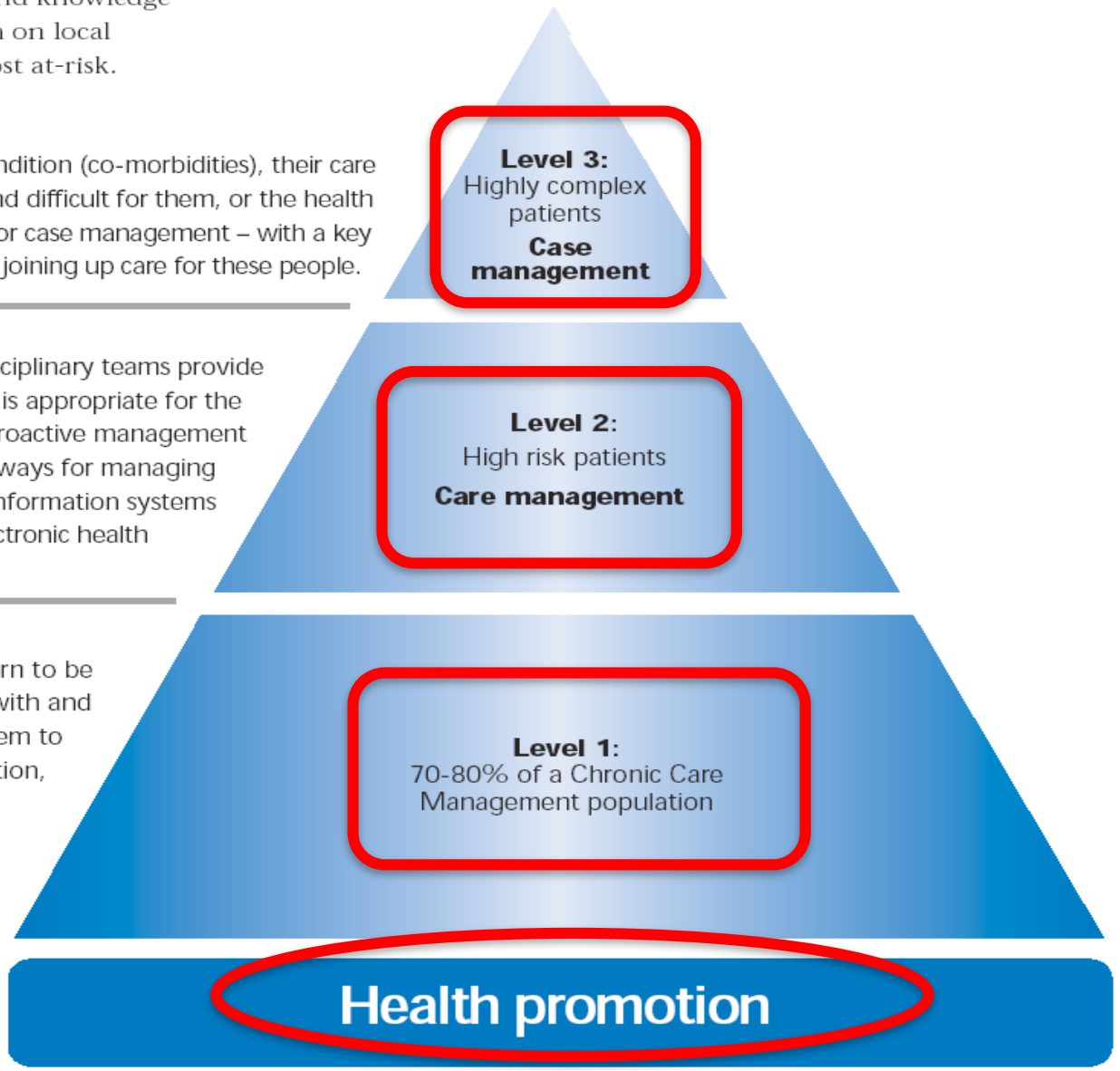
As people develop more than one chronic condition (co-morbidities), their care becomes disproportionately more complex and difficult for them, or the health and social care system, to manage. This calls for case management – with a key worker (often a nurse) actively managing and joining up care for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

Level 2

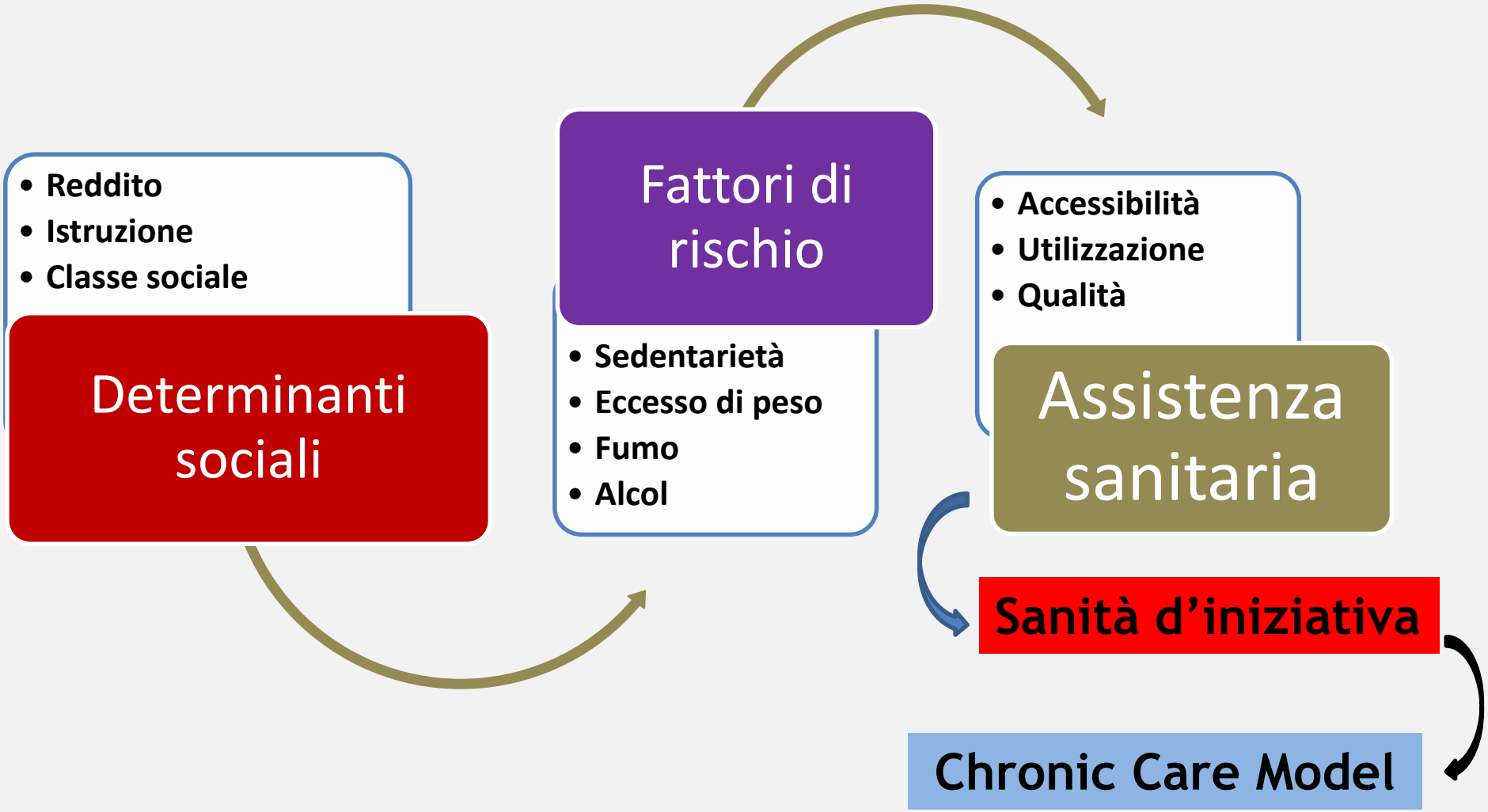
Disease/care management, in which multidisciplinary teams provide high quality evidence based care to patients, is appropriate for the majority of people at this level. This means proactive management of care, following agreed protocols and pathways for managing specific diseases. It is underpinned by 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.



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®

The Chronic Care Model

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

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

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

SST Servizio Sanitario della Toscana

Vecchie malattie *Nuove* risposte

Modelli innovativi per l'assistenza alle malattie croniche

5-6 maggio 2005
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E-Mail: belluomini@newtours.it

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

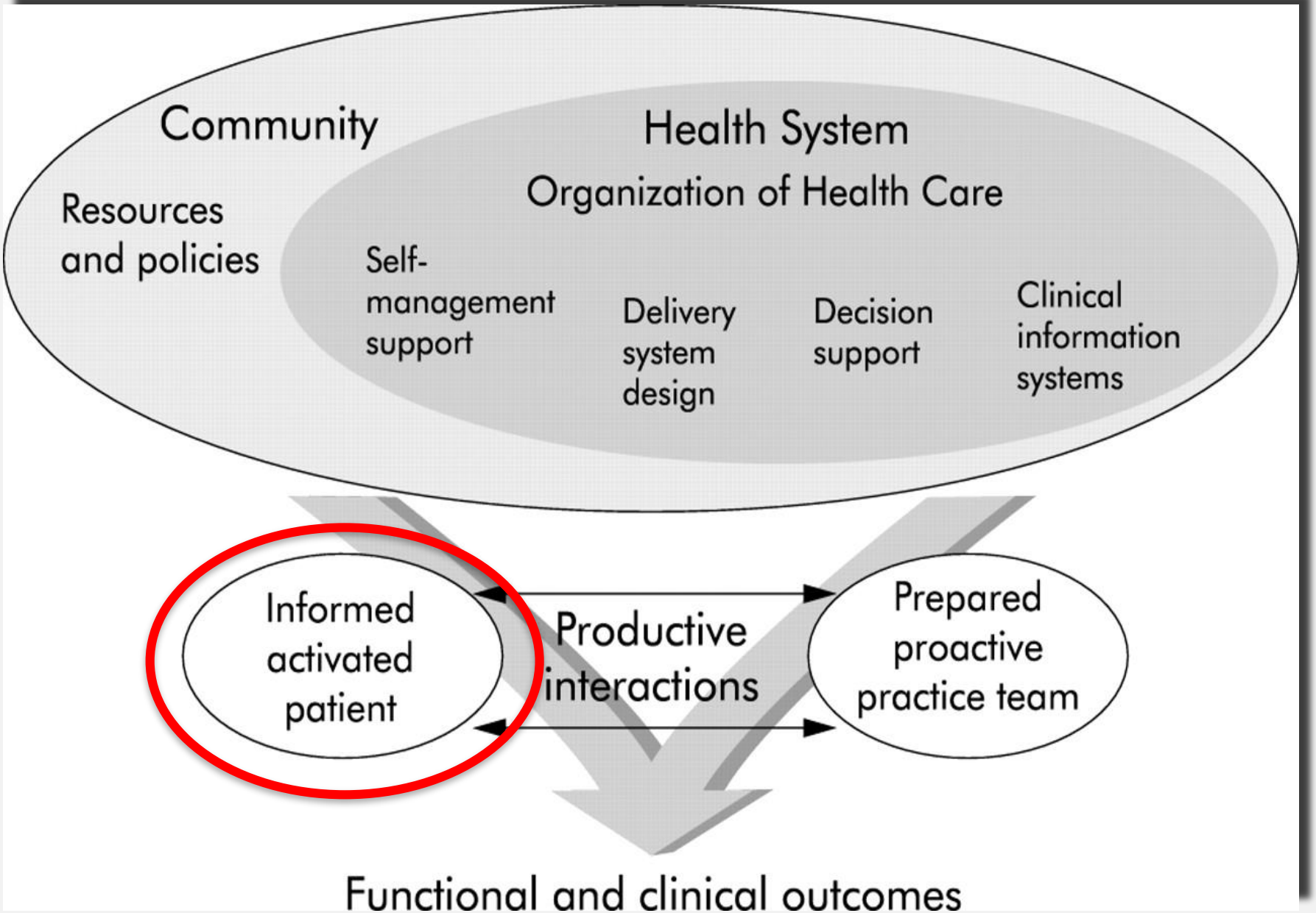
Chronic Care and and the Future of Primary Care

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



What characterizes an "informed, activated patient"?

They have goals and a plan to improve their health, and the motivation, information, skills, and confidence necessary to manage their illness well.

Kate Lorig

STANFORD
PATIENT EDUCATION
RESEARCH CENTER

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

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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

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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.

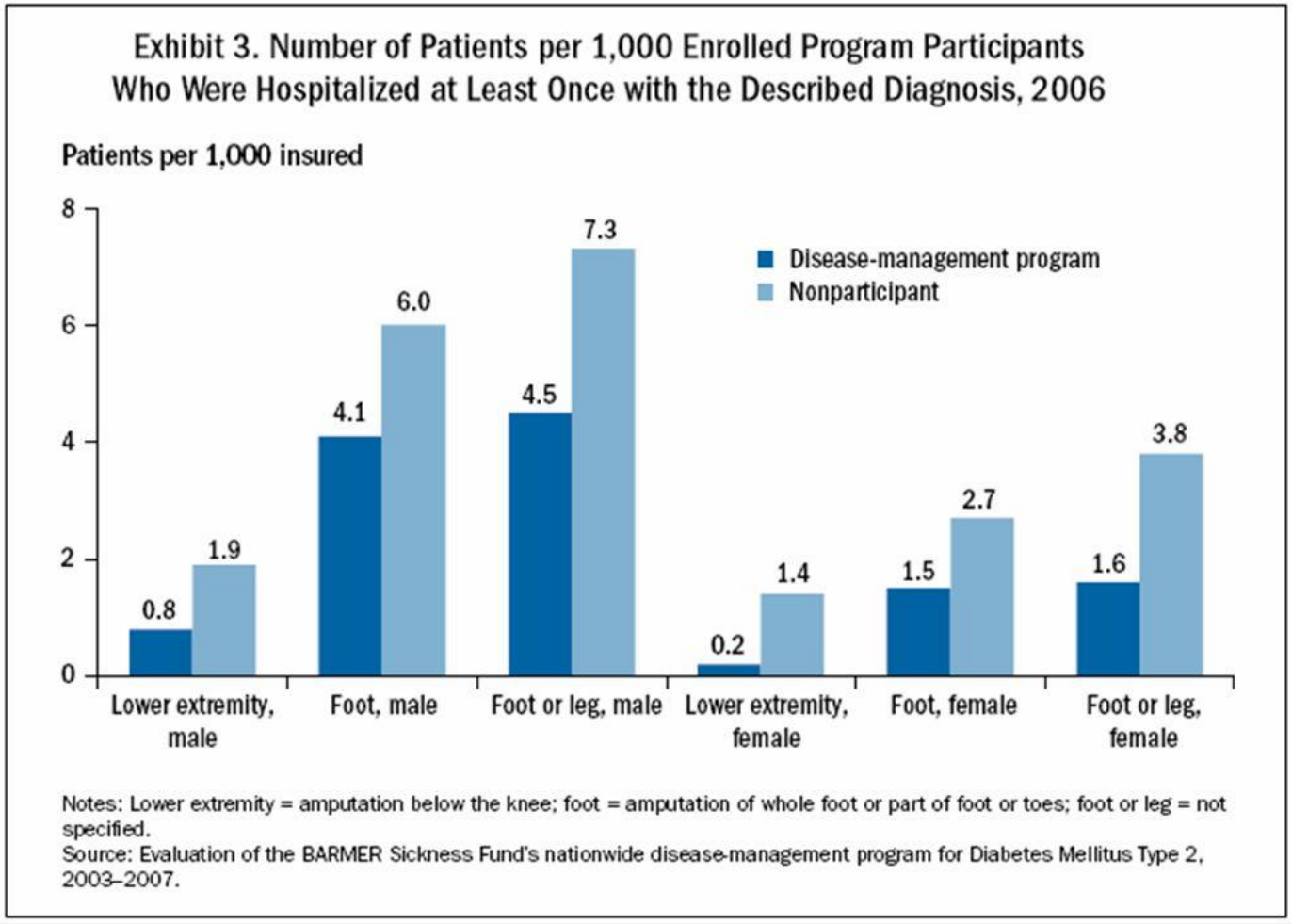

Figura 3. Costi e utilizzazione dei servizi tra pazienti arruolati (*intervention*) e gruppo di controllo. 2003-7.

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

The ten characteristics of the high-performing chronic care system

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The Chronic Care Model

The Chronic Care Model developed by Wagner provides a framework for describing the elements needed in a system that aspires to provide high-quality care for people with chronic diseases (Wagner, 1998). The Model was based on a review of available literature about promising strategies for chronic illness management, much of which derived from experience in European health care systems.

The Chronic Care Model has been used in a range of settings to support the reorientation from acute care to chronic care (Singh and Ham, 2006).

The ten characteristics of the high-performing chronic care system

1

The first and arguably most important characteristic of the high-performing chronic care system is 'ensuring universal coverage', for without universal coverage it is difficult to act consistently on the other characteristics. Recent

2

The second characteristic is the provision of 'care that is free at the point of use', or at least care that is provided at a cost that does not act as a major deterrent to sick patients seeking medical help. The RAND study of the Health

3

The third characteristic is that 'the delivery system should focus on the prevention of ill health' and not just the treatment of sickness. Despite progress in a

4

The fourth characteristic is that 'priority is given to patients to self manage their conditions with support from carers and families'. The importance of self-

5

The fifth characteristic is that 'priority is given to primary health care'. This

6

The sixth characteristic is that 'population management is emphasised' through the use of tools to stratify people with chronic diseases according to their risk and offering support commensurate with this risk.

7

The seventh characteristic is that 'care should be integrated to enable primary health care teams to access specialist advice and support when needed'. The

8

The eighth characteristic, closely linked to the last point, is 'the need to exploit the potential benefits of information technology in improving chronic care'. Not least, information technology underpins effective population man-

9

The ninth characteristic is to ensure that 'care is effectively coordinated'. Coordination is particularly important in the care of people with multiple conditions who are at much greater risk of hospital admission than people with single diseases (Wolff *et al.*, 2002). The role of primary care physicians in providing coordination has been emphasised in a number of studies (Starfield

10

The tenth characteristic, alluded to in the review of the evidence above, is to 'link these nine characteristics into a coherent whole as part of a strategic approach to change'. This is important in view of evidence that it is the *cumulative* effect of different elements that explains the degree of impact of the Chronic Care Model rather than individual components. By extension, the argument of this paper is that

Conclusion

The evidence summarised in this paper indicates that a start has been made in reorienting health care systems to meet the challenge of chronic diseases. Guided by the Chronic Care Model, policy makers and health care leaders are beginning to take the actions required to rise to this challenge.

Barbara Starfield (1932-2011)

"The well known but underappreciated secret of the value of primary care is its person and population, rather than disease, focus"

“It is time that primary care physicians take leadership in moving medical care where it needs to be: to the care of patients and populations and not the care of diseases. It is not only biologically correct to do so – it is also more effective, more efficient, safer, and more equitable”.