Questionnaires on NDP

First sight

Jelka Zaletel
NIJZ

Co-funded by
the Health Programme
of the European Union

This presentation arises from the Joint Action addressing chronic diseases and healthy ageing across the life cycle (JA-CHRODIS) which has received funding from the European Union, under the framework of the Health Programme (2008-2013).

QF = 11x

Q1= 9x

Contacts from JA did not work, used IDF’s contacts:

Cyprus, Czech Republic, Estonia, Latvia, Malta

No partners in JA, used IDF’s contacts:

Hungary, Luxembourg, Poland*, Romania, Slovakia, Switzerland

No contact at all

Liechenstein

DOs:

- Make sure that you have necessary resources/funding to **coordinate** the NDP
- Include all stakeholders, support **networking** and create opportunities for **exhange** of ideas and experiences
- Define **measurable** outcome indicators (and measeure them)

DON'Ts:

- Don't make too wide, **unclear** or unmeasurable targets
- Don't ignore **diabetes patients**' opinions and perspectives in any phase
- **Don't assume** that the organizations' leaders will be committed to your targets and actions just because you presented them

What to do in NDP (not in prioritized order)

- Facilitate systematic collection of quality indicators and electronic **publication of these data to patients, citizens**, municipalities, regional health authorities, health trust, key stakeholders, researches and health personnel.
- Give economic support to **local initiatives** to carry out the goals set in the plan. Emphasize the importance of strengthen health equity and literacy.
- Establish a **legal obligation for the municipalities (or other health entity) to report** on quality and indicators of health service and the achievement of goals set in the NDP during a defined amount of time.

What to do in NDP (not in prioritized order), part 2

- Have an **action plan ready** and performed a needs assessment when launching the NDP. This plan should contain responsibilities and deadlines concerning implementation of the goals set in the NDP.
- The **goals should be divided in national, regional and local settings** to make it easier for the correct level of health care to adapt the targets.
- The goals should be credible and trustworthy. Setting goals too high might kill the motivation. It is better to break it up to **intermediate and reachable goals**. Performance management of the goals requires a present knowledge of the baseline status of the indicators to be reported.

It seems that what is working is:

1. The National Diabetes working group
2. The National Diabetes Framework development and the integrated care model
3. Model of care for the diabetic foot
4. Integrated Diabetes Care Nurses
5. The National Diabetic Retinal Screening Programme
6. Assessing National guidelines for pre gestational and gestational diabetes

It would appear that the challenges include :

1. Reduction in resources
2. **Reform of health structures**
3. Contract negotiations
4. Lack of **key drivers at highest executive** level.

DO work:

- **Constant and repeated stressing** of the problem from specialists site (endocrinologists and GP's) to the Ministry of Health (this is very hard andtime consuming work)
- **Collaboration** between Endocrinologists, GP's, patient organisation - as we all seek for better care.
- Additional **finances**, provided in a timly manner.

DOES NOT work:

- Lack of **persistency** of the programme (for three years only and then start again).
- **Narrow approach** to the problem - a few previous attempts were focused mainly on early diagnosis, but all other aspects were not covered.

Do's:

1) Preparation of a draft of NDP by diabetologists :

Actions are nessesary for
a) (primary) prevention,
b) early diagnosis of DM (secondary prevention),
c) diabetes management and chronic care management (programs), respectively,
d) epidemiology and health care research and

*e) patient education and empowerment***,**

but only a statewide disease management program with patient education is available

2) Thereafter talking with the Ministry of Health and starting an initiative of the government, so-called "Bundesratsinitiative"

3) RKI is making surveys to get epidemiological data, and a law for prevention is in preparation by the Ministry of Health

Good coordination among experts in diabetology to point out needs and to concrete actions to improve diabetes care.

Donts:

1) No implementation of the NDP, since we have 16 federal states, therefore a (national) NDP will be difficult to implement
2) Thus, we have no national prevention program at the moment, no early diagnosis/no screening, no chronic care program (for mulitmorbid patients with diabetes),
no register for T2DM (and not for complications), and health care research and data of care quality are only scarcely available and patient education is only for subscribed patients (in the disease management programs).

THINGS WORKING

1. The implementation of the protocol for treatment in patients with type 2 diabetes mellitus in the primary care program in our country, including process indicators.
2. Better coordination between primary care and specialty care in some local areas.
3. In the implementation plan, mobile retinographs were established at Primary Care to helps GPs to detect diabetic retinopathy (in some regions).

THINGS NOT WORKING

1-Electronic clinical record at national level.

2-Implementation of the Primary Care Clinic Data Base

3-Implementation of a structured therapeutic education program, with a primary care nurse educator equivalent to the endocrinology educator training program nurse.

The NDP should try and take into account the whole pathway from primary prevention to secondary prevention and living with diabetes, and various levels of provision of care: primary / community, more specialised. If something has to be left out, it tends to be prevention.

- **Do**: try to create a plan for whole pathway
- **Don't**: leave things out (but the easiest, and most sensible, is prevention)

Improving access to services and quality of these services(e.g. foot and eye screening) is very important and probably the “easiest” to change; but, maybe as important to focus on outcomes? (e.g. BP, HbA1c, albumin etc)

- **Do**: consider balance between processes and patient outcomes
- **Don’t**: focus too much on the one or the other

Length of time for the NDP:

- Do: consider something long-term enough to ensure that the health service will commit on long term change
- Don’t: do be careful of political influence, change of priorities etc.

With the increase of diabetes prevalence, other means of indirect care need to be increasingly considered, and prioritised even, such as self-management.

- **Do**: consider the value and importance of self-management and self-care
- **Don't**: there is confusion and some reluctance in the health service on how to increase "health literacy" and "patient empowerment", so do provide practical examples of how to help people manage their diabetes more.

DO:

- Involve patients
- Open the windows to new knowledge and sciences we are not familiar with
- Use mainly available resourses, thus having almost zero cost project, at least at the beginning
- Promote joint projects of several stakeholders

DON'Ts:

- Don't use only project-like leadership
- Carefullness with private money
- Don't build new syloses
- Don't shut the doors to newcomers

The Joint Action on Chronic Diseases and promoting healthy ageing across the life cycle (JA-CHRODIS)*

* THIS PRESENTATION ARISES FROM THE JOINT ACTION ON CHRONIC DISEASES AND PROMOTING HEALTHY AGEING ACROSS THE LIFE CYCLE (JA-CHRODIS) WHICH HAS RECEIVED FUNDING FROM THE EUROPEAN UNION, IN THE FRAMEWORK OF THE HEALTH PROGRAMME (2008-2013)

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE