WP7

Good Practices

The AOK CheckUpPlus for Early Diagnosis in Saxony

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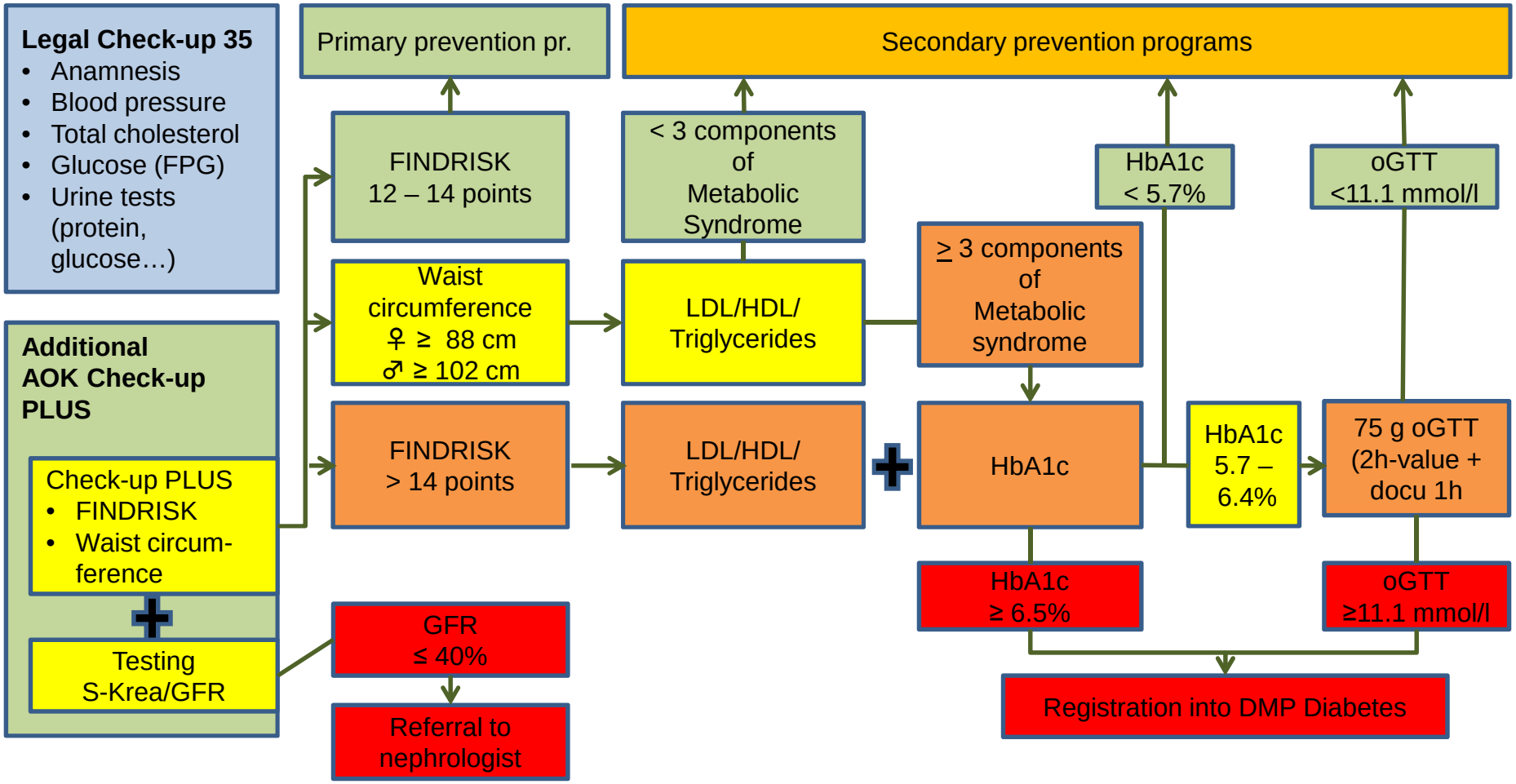
Why a good practice?

- *A **very innovative screening** and early detection program, resp. **of persons at high risk** for diabetes and following active prevention*
- *AOKplus insured persons (35-65y) **are screened** by the **CheckUpPlus** program in Saxony instead of the statutorily regulated **CheckUp 35***
- *Depending on the **diabetes risk** (according to **FINDRISK)** other additional diagnostics and primary/secondary prevention offerings, resp. are provided*

Flow Chart of Steps of CheckUpPlus



www.aokplus-online.de/leistungen-services/vorsorge/check-up-plus.html

Positive lessons learned

- *Each participant will be individual managed and guided according to his individual risk or an existing condition.*
- *This procedure of the program is unique so far.*

Negative lessons learned

- *The program has not been evaluated yet.*
- *GPs have to use the program better and more.*
- *The transition to prevention offerings must be improved.*
- *Furthermore, GPs recommend often several interventions, but the insured person doesn´t use them.*

WP7

Good Practices

The Saxonian Health Care Model (SDMP)

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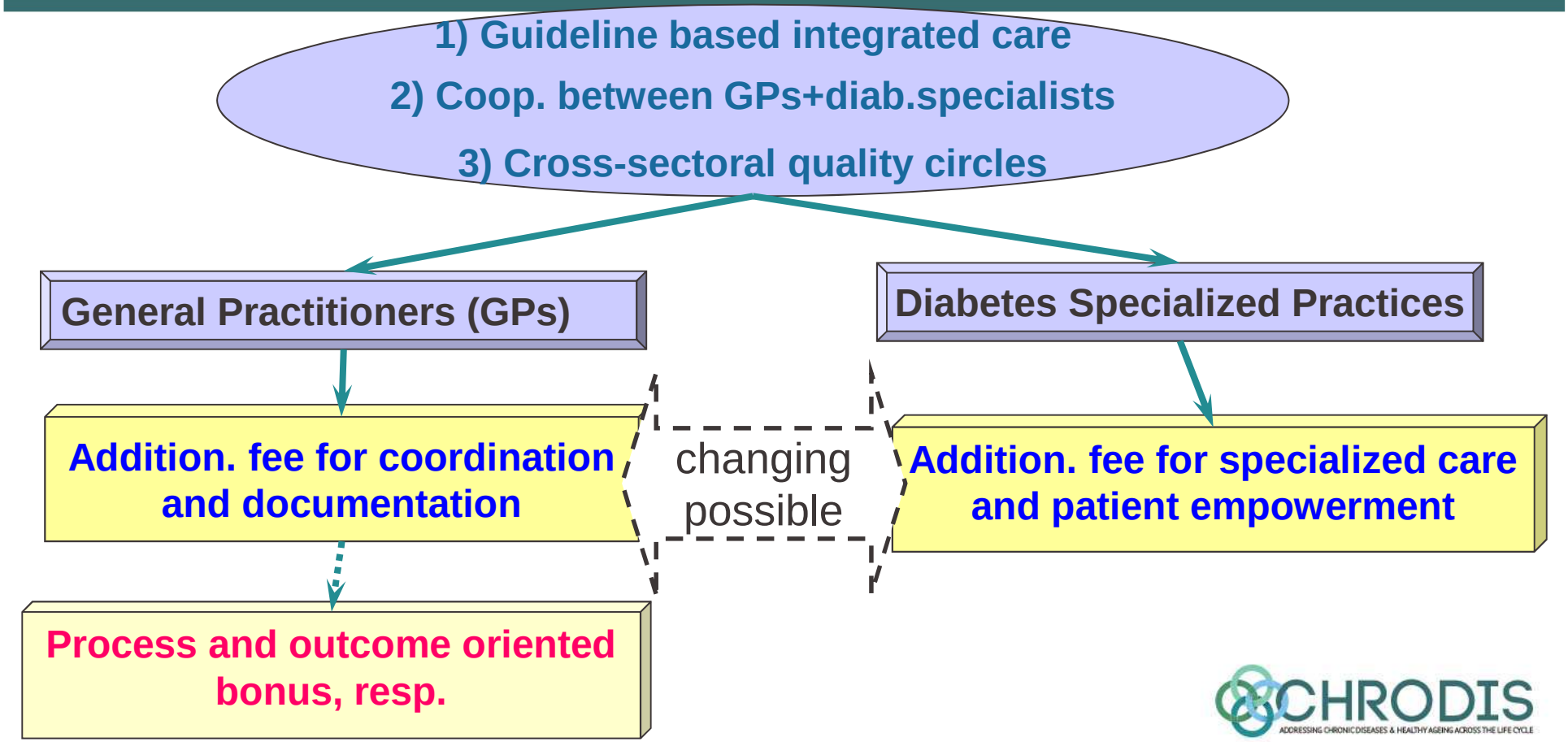
TECHNISCHE UNIVERSITÄT DRESDEN

DIABETES IN SACHSEN

Sächsische Landesärztekammer
Körperschaft des öffentlichen Rechts

Diabetes-Management Program in Saxony between 2000 – 2002 (3. Diabetes Contract)



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Why a good practice?

- *The integrated SDMP was **very innovative and implemented every-where (statewide)** in Saxony with a coverage of nearly **90% of all patients** with diabetes, of **all diabetes specialists** in own practices and of about **80% of all GP's** in Saxony and **was positive evaluated**.*
- *The SDMP could be **a model for implementation** into other European countries, because of the outstanding **cross-sectoral cooperation**, the **good feasibility** with a small documentation and using of secondary data, the **high acceptance rate** and the **significant improvement of the outcome**.*

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Reasons for SUCCESS

- *The SDMP was a **bottom-up model** with good adaptions to regional conditions and was **very simple**, especially the valid short documentation, and **without any bureaucracy**.*
- *The **documented data** by physicians for the evaluation as well as for the quarterly feedback reports **were very small**, but covered the **multi-morbidity**.*
- *About more than 50% of all GP's took part in **peer-review-methods**.*
- *Additionally, the pay for performance and especially the already prepared **pay for outcome** contributed to the great success.*

Evaluation Outcome of the SDMP 2000-2002

Saxon Diabetes Management – based on integrated care structures and cross-sectoral practice guidelines – resulted in:

I) an early referral of the patients from GP into specialized care, followed by better HbA1c and blood pressure values

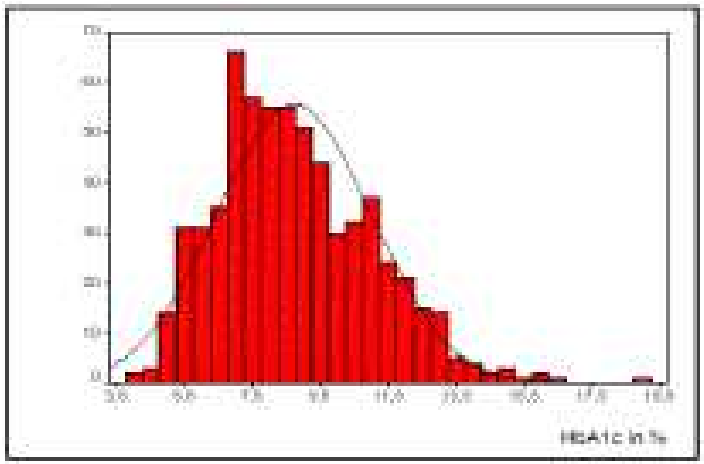
II) a substantial improvement of diabetes care

III) an equalization of regional differences of quality of diabetes care under the influence of homogenously promoted therapeutic strategies by the guidelines

I) HbA1c values of patients with first transfer from GP to diabetes specialized practices

Before implementation of guideline

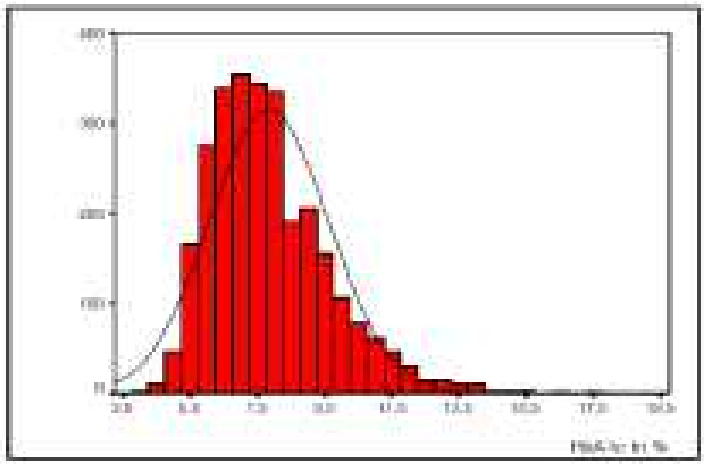
observation phase 07/1996 – 12/1996



Mean	8.8 %
SD =	2.28
Median =	8.5 %
n =	682

After implementation of guideline

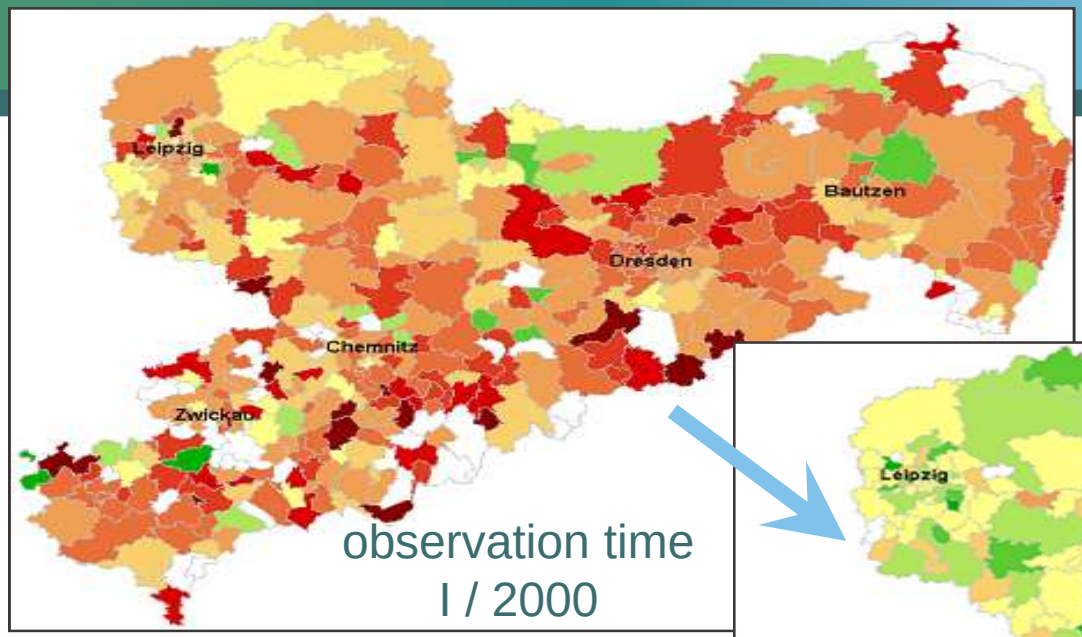
observation phase 07/2002 – 10/2002

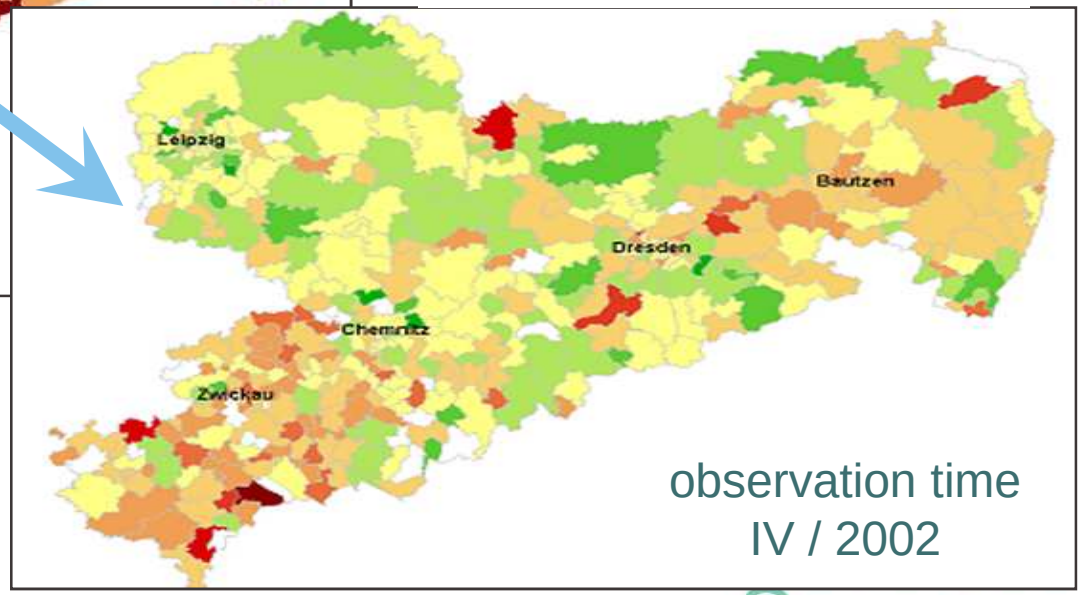


Mean	7.8 %
SD =	1.77
Median =	7.5 %
n =	2.79

II) Mean HbA1c value in Saxony

7,1±1,3% ⇒ 6,8 ± 1,2%





≤ 6,2%
≤ 6,4%
≤ 6,6%
≤ 6,8%
≤ 7,0%
≤ 7,2 %
≤ 7,4 %
≤ 7,6 %
≤ 7,8 %
> 7,8 %

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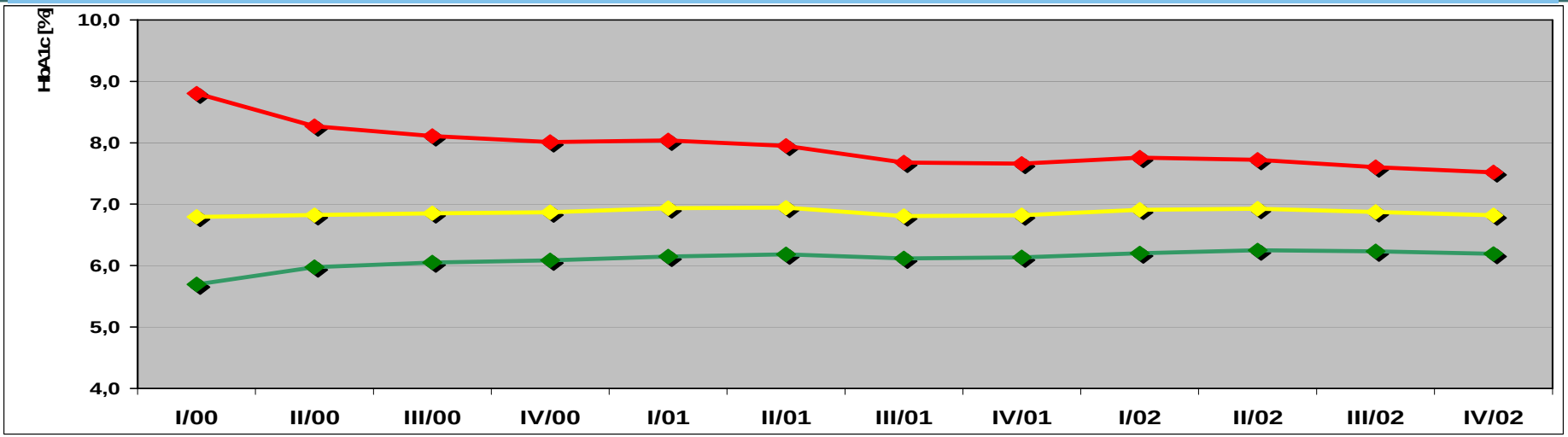
Improvement of metabolic control (HbA1c)



mittlere initiale HbA1c-Werte												
> 7,5%	8,8% (N=32.314)	8,3% (N=29.044)	8,1% (N=28.939)	8,0% (N=29.818)	8,0% (N=29.053)	8,0% (N=29.771)	7,7% (N=29.671)	7,7% (N=29.929)	7,8% (N=30.059)	7,7% (N=30.156)	7,6% (N=29.939)	7,5% (N=32.314)
6,2 - 7,5%	6,8% (N=46.781)	6,8% (N=67.526)	6,9% (N=67.526)	6,9% (N=67.526)	6,9% (N=67.526)	6,9% (N=67.526)	6,8% (N=67.526)	6,8% (N=67.526)	6,9% (N=67.526)	6,9% (N=67.526)	6,9% (N=67.526)	6,8% (N=67.526)
≤ 6,1%	5,7% (N=26.109)	6,0% (N=54.506)	6,0% (N=54.506)	6,1% (N=54.506)	6,1% (N=54.506)	6,2% (N=54.506)	6,1% (N=54.506)	6,1% (N=54.506)	6,2% (N=54.506)	6,2% (N=54.506)	6,2% (N=54.506)	6,2% (N=54.506)
missings	(N=0)	(N=12.150)	(N=12.391)	(N=9.226)	(N=10.882)	(N=9.346)	(N=9.904)	(N=8.662)	(N=8.426)	(N=7.963)	(N=8.697)	(N=0)

Medizinische Fakultät Carl Gustav Carus der TU-Dresden — Institut für Medizinische Informatik und Biometrie

Stand August 2007

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Rothe et al. Diabetes Care 2008;31:863

Risk distributation according to vascular complications based on both: HbA1c +Blood Pressure

Observation time I / 2000 (n = 105.204)

HbA1c \ BP	low	moderate	high
low	3,3%	10,3%	11,2%
moderate	4,9%	18,0%	21,5%
high	3,1%	11,3%	16,3%

Risk level

HbA1c

- ≤ 6,5 %
- 6,6 - 7,5 %
- > 7,5 %

Blood pressure

- ≤ 130/80 mmHg
- 131/81 - 140/90
- > 140/90 mmHg

Observation time IV / 2002 (n = 105.204)

HbA1c \ BP	low	moderate	high
low	4,8%	12,8%	9,3%
moderate	7,4%	24,1%	19,6%
high	2,8%	9,4%	9,8%

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Clinical Care/Education/Nutrition/Psychosocial Research
ORIGINAL ARTICLE

Evaluation of a Diabetes Management System Based on Practice Guidelines, Integrated Care, and Continuous Quality Management in a Federal State of Germany

A population-based approach to health care research

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Diabetes Care 31:863–868, 2008

OBJECTIVE — The aim of this study
gram (SDMP), which is based on integr
quality management. The SDMP was implemented into diabetes contracts between health insurance providers, general practitioners (GPs), and diabetes specialized practitioners (DSPs) unified in the Saxon association of Statutory Health Insurance Physicians.

RESEARCH DESIGN AND METHODS — The evaluation of the SDMP in Germany represents a real-world study by using clinical data collected from participating physicians.

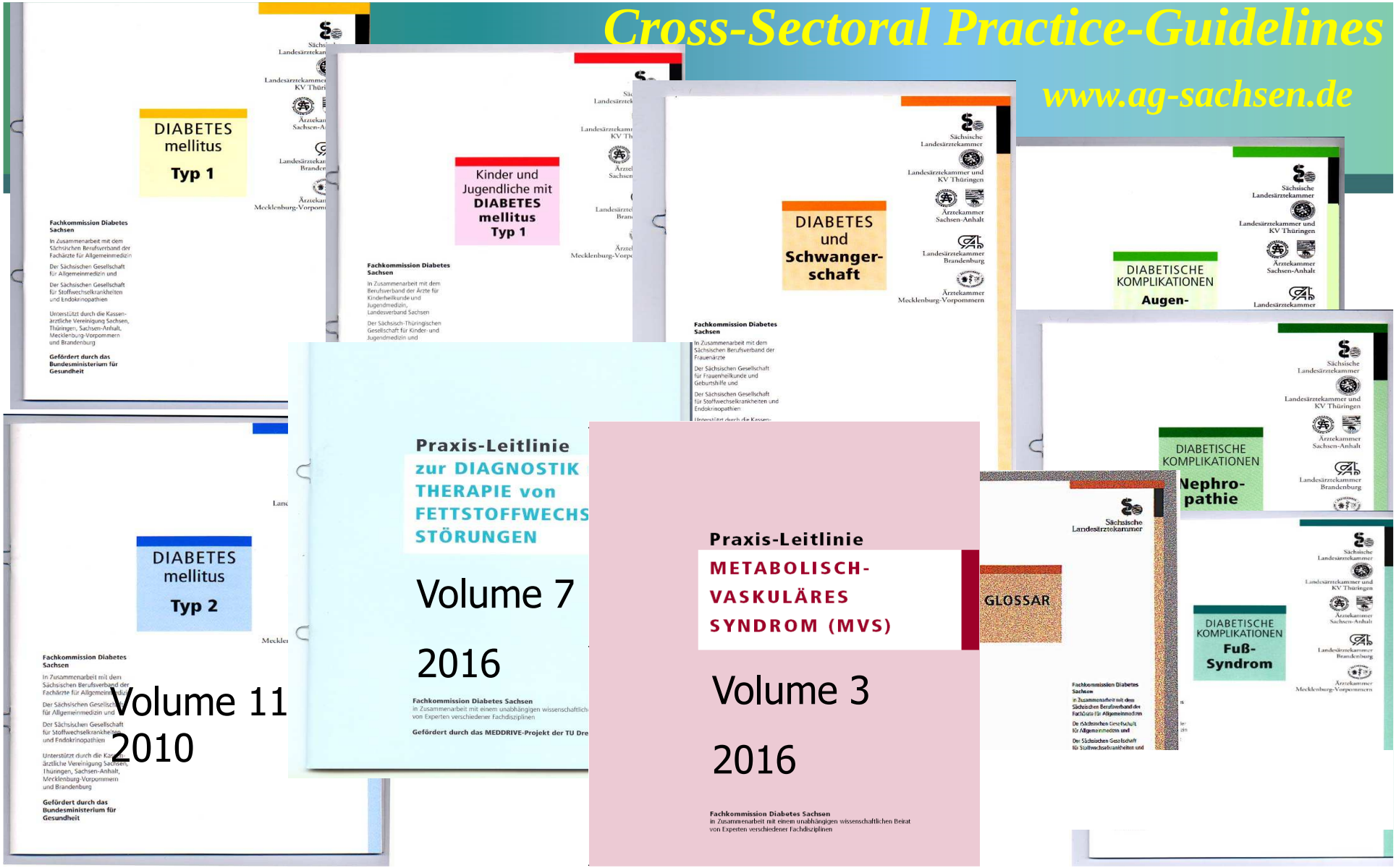
The growing interest in evidence-based medicine and outcome and a commitment to integrated care across primary and secondary care sectors all contribute to making disease manage-

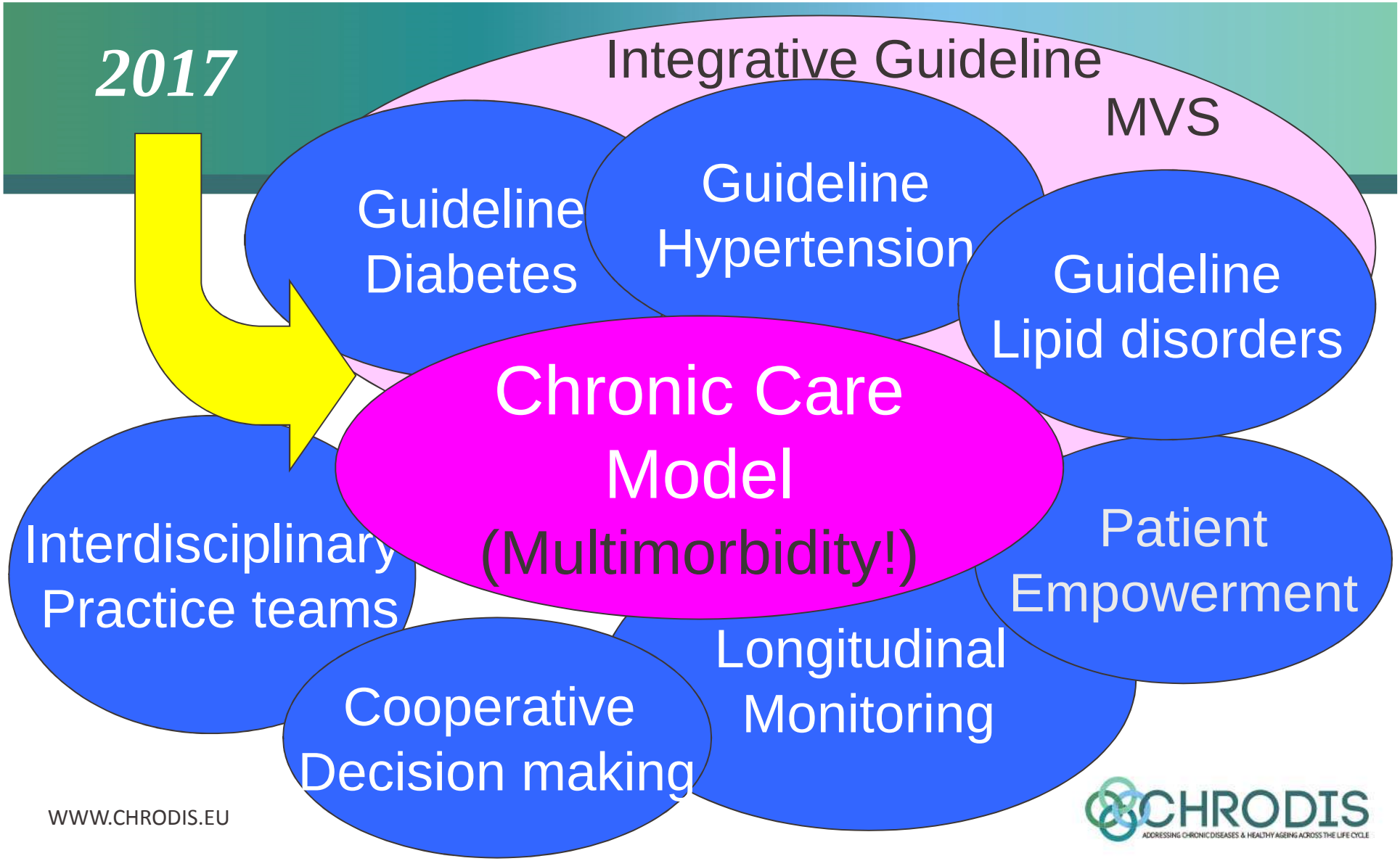
largely untested, making evaluation essential.

There is evidence of regional variations in diabetes management in different primary care settings within the same

Cross-Sectoral Practice-Guidelines

www.ag-sachsen.de




2017
Integrative Guideline
MVS
Guideline
Diabetes
Guideline
Hypertension
Guideline
Lipid disorders
Chronic Care
Model
(Multimorbidity!)
Interdisciplinary
Practice teams
Patient
Empowerment
Longitudinal
Monitoring
Cooperative
Decision making
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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)

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