CURE PRIMARIE

&

Gestione delle Malattie Croniche

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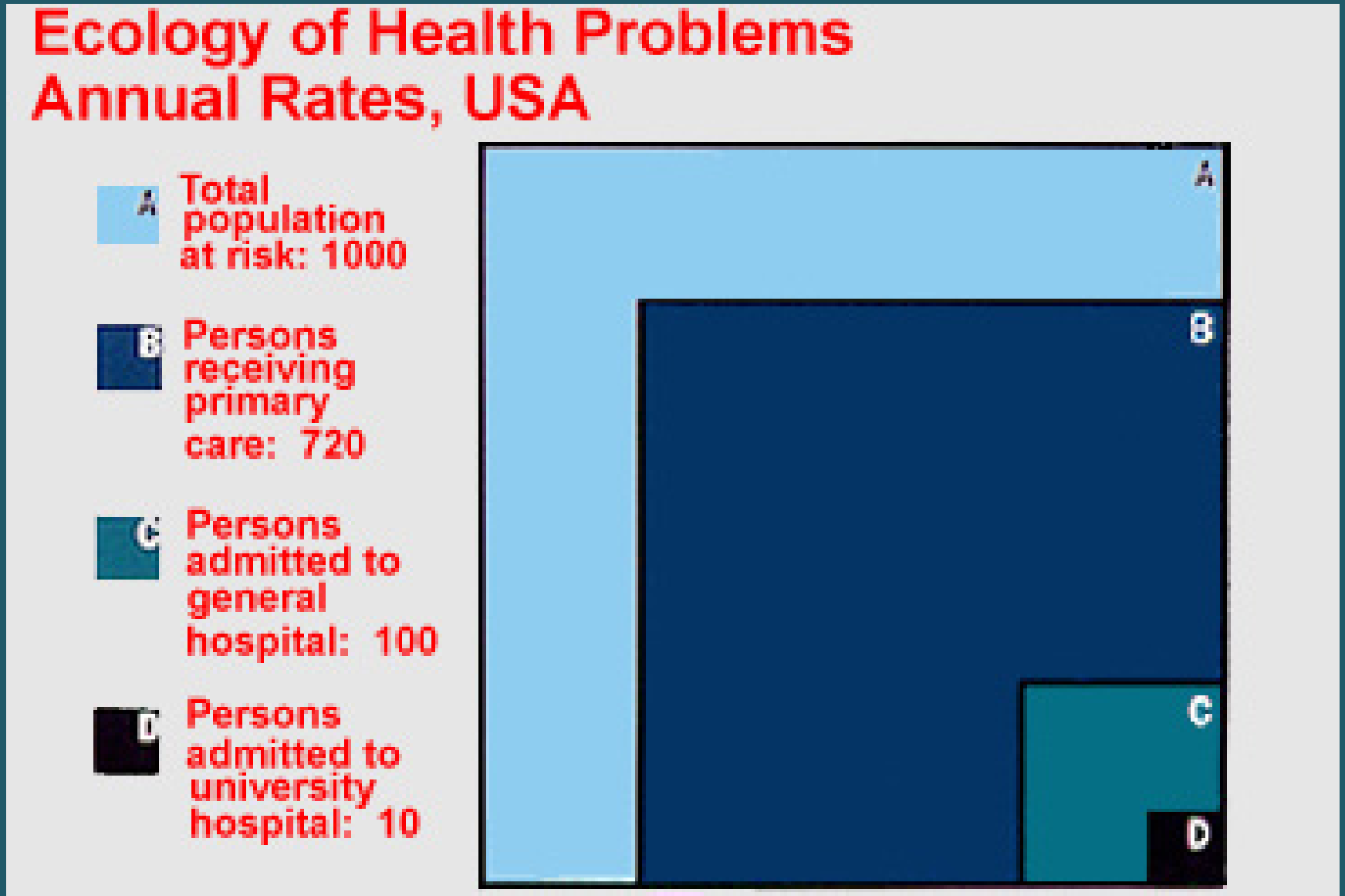
Kerr White e coll.

New England Journal of Medicine 1961



USA (1970) – 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.**

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

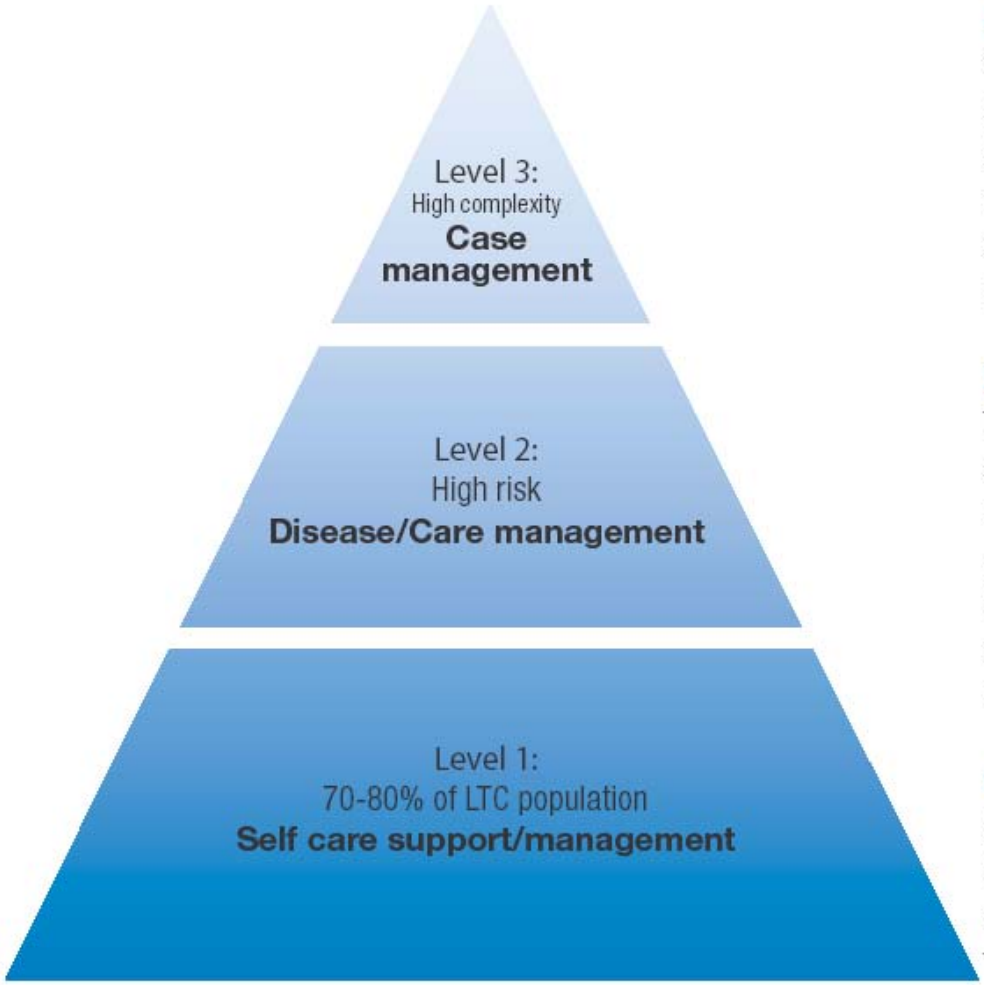
OMS (1980)

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]

Kaiser Population Management

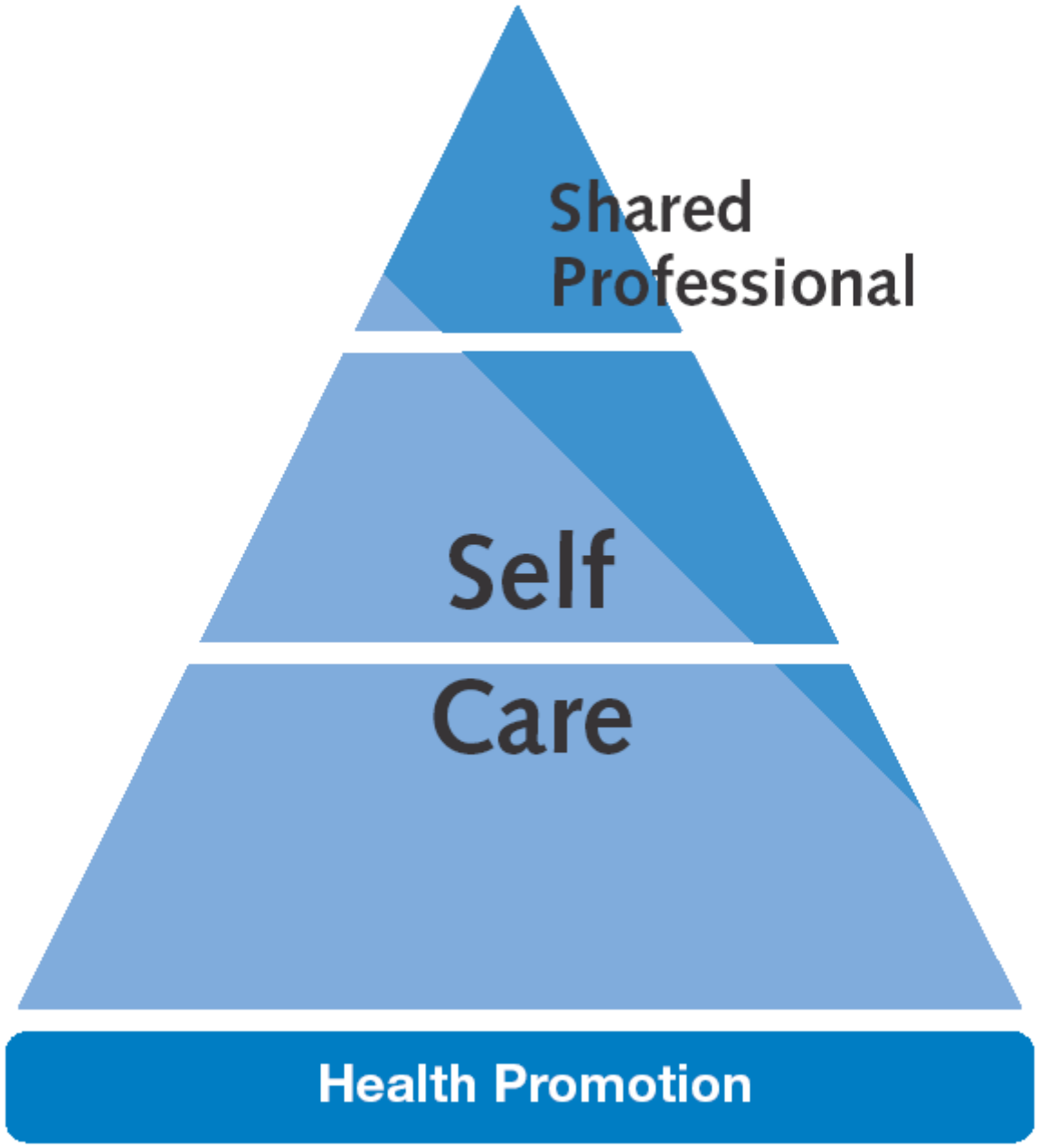


Level 3: Case management – requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a community matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care. This is described in more detail in **chapter 2**.

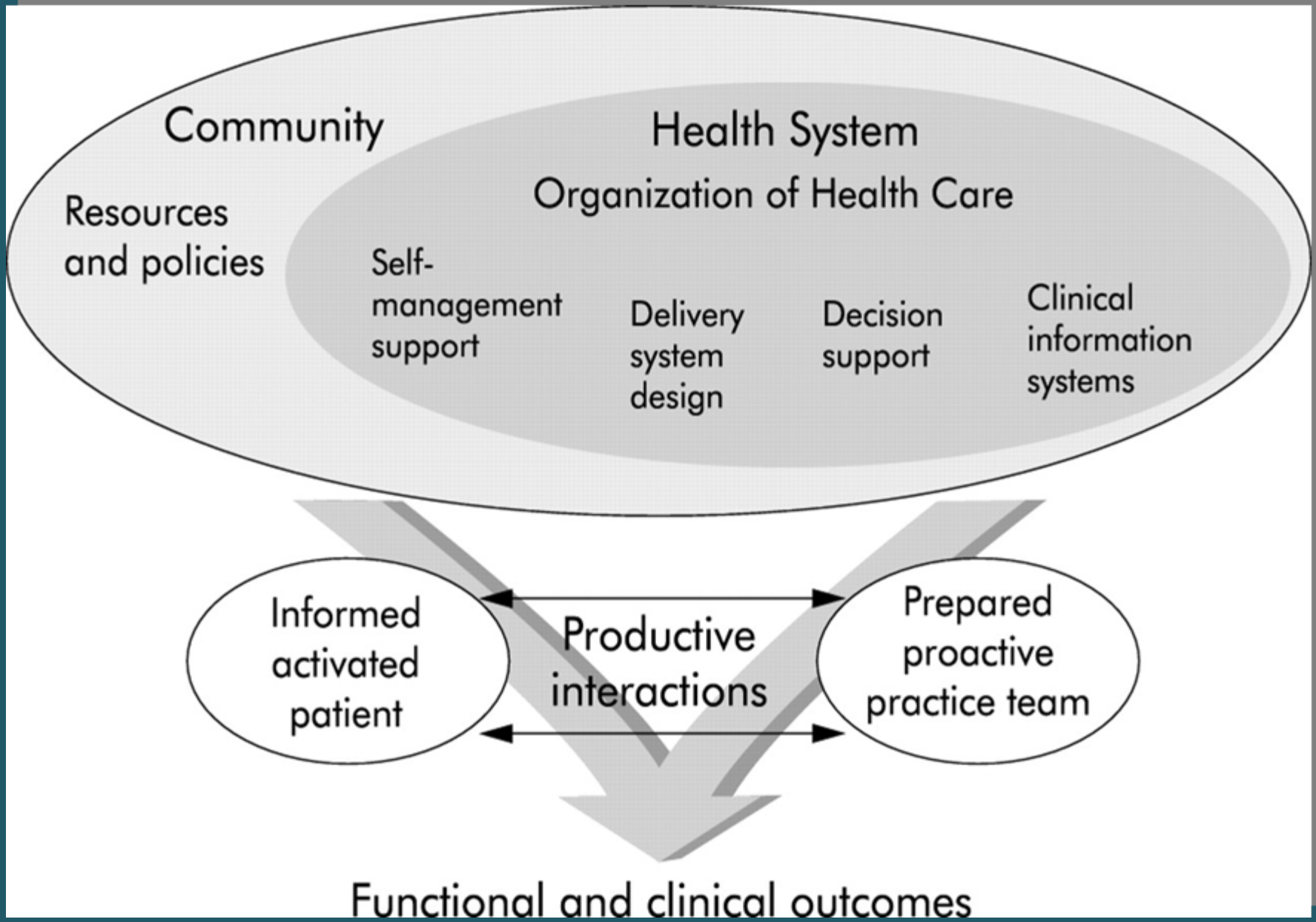
Level 2: Disease-specific care management – This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework. This is described in more detail in **chapter 3**.

Level 1: Supported self care – collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. This is described in more detail in **chapter 4**.

Ratio of Shared Professional Care to Self Care
across the Long Term Conditions population base.



THE CHRONIC CARE MODEL



MANAGING CHRONIC CONDITIONS

Experience in eight countries

European Observatory on Health Systems and Policies

DENMARK
FRANCE
GERMANY
THE NETHERLANDS
SWEDEN
UNITED KINGDOM
AUSTRALIA
CANADA

- The overall aim that we set ourselves in this book was to compile an **in-depth assessment of the health system response to the rising burden of chronic disease** in each of the eight countries, by focusing on three key areas:
- (1) **a detailed examination of the current situation**;
- (2) **a description of the policy framework and future scenarios**; and
- (3) **evaluation and lessons learnt, building on a common template developed by the editors**.

- The **template** was informed, to great extent, by the **Chronic Care Model** (CCM) developed by Wagner and colleagues in Seattle.
- This model presents a structure for organizing health care; it comprises four interacting components that are considered key to providing high-quality care for those with chronic health problems:
- **self-management support,**
- **delivery system design,**
- **decision support, and**
- **clinical information systems**.

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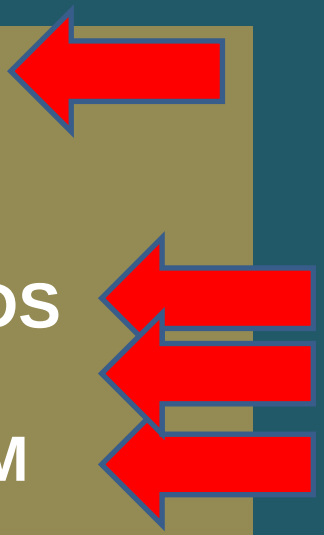

EXPANDED CHRONIC CARE MODEL