


米国ディジーズマネジメントの最新動向

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ディスカッション　ポイント

米国のDMは大きな転換期を迎えた

1. メディケアへの参入と撤退：Phase IからPhase IIへの移行
   外注型DMモデル（external disease management approach)
   →medical home, community-based models
2. Medicare Medical Home Demonstration
   Patient-centered model、真のチームアプローチへの移行
3. ケアマネジメントの強化
   Disease Management→Care Managementへの拡大
4. 新しい慢性疾患ケアモデル
   単疾患アプローチ→包括的アプローチ
   ケアマネジメントの強化
5. 展開の具体
6. オーストラリア等のモデル
7. わが国に必要とされるモデル

転換のきっかけは、2008年の初頭、CMSがMedicare Health Support Demonstrationsを更新しなかったこと

FACT SHEET

COMPLETION OF PHASE I OF MEDICARE HEALTH SUPPORT PROGRAM

Overview

The Centers for Medicare and Medicaid Services (CMS) announced today that Phase I of the Medicare Health Support (MHS) program will end after three years of operations by five Medicare Health Support Organizations (MHSOs).

The MHS program was established in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) as a two-phased initiative. MHS Phase I is a three year pilot program designed to test a variety of care management interventions to invited fee-for-service Medicare beneficiaries with heart failure or diabetes. Phase II would expand the program based on findings from Phase I.
The Secretary of Health and Human Services (HHS) is authorized to expand the MHS program under Phase II if the results of an independent evaluation specify that a participating program (or component of a program) meets all the statutory criteria for expansion. Those criteria include improvement in clinical quality and beneficiary satisfaction, and the achievement of savings targets (at minimum, budget neutrality). http://www.cms.hhs.gov/CCIP/ (Center for Medicare & Medicaid Service)

2003年の法制定（Medicare Health Support (MHS) program

2005年8月/9月開始、2008年7月/8月終了（3年間のプロジェクト）

RCT、68,000人が参加

Aetna Health Management, Healthways, Inc., Health Dialog Service Corporation, Green Ribbon Health, XLHealth Corporationが参加

Phase Iの結果

試行の目的は、
① Clinical quality outcomesを向上させる
② beneficiary satisfactionを向上させる
③ financial saving targetsを達成する

しかし、結果は、
・*期待されたROIを出せなかった。*

However, to achieve budget neutrality, the five MHSOs in current operation need to reduce Medicare claims costs by between $300 and $800 per participant per month for the remaining months of the pilot program. This represents a 20 to 40 percent reduction in claims costs from the current levels that are being billed. Program-wide fees paid to the MHSOs to date total approximately $360 million—an increase of 5 to 11 percent in Medicare costs for participating beneficiaries. Total operational costs to date to CMS are estimated at approximately $27 million.

http://www.cms.hhs.gov/CCIP/ (Center for Medicare & Medicaid Service), cited from FACT SHEET, p.3)

この解釈は？

The 8th annual DM Colloquium (May 19-21, 2008)

DM company CEOs Round tableでは、

ー慢性疾患患者の複雑さを主張→ケースマネジメントにはお金がかかる

ーこの主張をCMSに訴えるとともに、モデル転換を宣言

（ケアマネジメント、包括疾患アプローチへ）

DMAAの幹部は、

ー外注型DM会社は、複数の慢性疾患をもつ要介護高齢者の複雑さを扱うことができると信じていたが、実際は無理だった

→高齢者ケアには地域との強い結びつきや介護家族やケアワーカーを視野に入れたケアが必要であることを理解していなかった。

CMSは、

Phase Iから多くを学んだ。慢性疾患管理は重要だが、プライマリケア領域でのケアマネジメントが中心となる。方法論を変える。

電話やwebでの若者向きの手法は高齢者には不向き。DM企業による外注型アプローチの限界。高齢者にはプライマリケアを担う医療者が中心となるアプローチが必要

CMS契約更新とならなかったことの影響

- 現在、保険者に対して、規模の大きなDM会社と契約しないようにとの方向が出てきている。
- Healthwaysの株価は急落（$25→＄９）、大口の契約を失う、多くの従業員を解雇。
- HealthDialogは、英国の会社に買収される。
- Matriaは、他の会社に吸収合併される。
- LifeMastersは、現在はなんとか持ちこたえている。

DM業界は、Population Health Improvement frameworkにシフト中。
Wellness+DM+CM（この動きは完了）

今後、DM会社が地域/医師たちとどのように連携するかの方法を見つけたらサバイバルするであろう。

今後は、地域やプライマリケアの中でDMとケアコーディネーションが合体する方向。

プライマリケアプロバイダー（医師等）が変化を拒む、変化の方向（従来の実践モデルから新しい実践モデルへの方向転換）を知らないのが障害になる。

Phase IIは？ Medical Home Model by the Center for Medicare and Medicaid

http://www.cms.hhs.gov/CCIP/

DMAAの私の友人は、方向性は間違っていないが、主治医中心にしないで、“health care neighborhoods” “health care community”とすべきだ、と意見を述べていた。

すべてのhealth planにおいて

MedicareとMedicaidは、次の方向にシフト

ケースマネジメントとディジーズ゛マネジメントをもっと使用する方向に

1）Pay for performance

2）EBMと効率的なサービス提供の提供度合いを測定し、報告する方向に

3）Medical home modelは、プライマリーケア提供者に重心を置き、スペシャリスト（循環器専門医や整形外科専門医など）の使用を控える方向に

以下の医師団体が打ち出したMedical Home

FINAL 2-21-07

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

Medical Homeとは？

メディカルホームの考え方の背景

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

米国小児科学会が1967年に提唱。「子どもの診療記録を自宅に置いておこう」

アクセス可能で、継続性があって、包括的な家族中心の、調整された（コーディネートされた）、思いやりのある、文化的に効果的なケア

http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf (cited from Joint Principles of the Patient-Centered Medical Home. February 2007, p.3)

ガイドラインが出ました

Standards and Guidelines for Physician Practice Connections®— Patient-Centered Medical Home (PPC-PCMH™) CMS Version

October 6, 2008

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_PPC.pdf (Medical Home Standards')

(Medical Home Standards')

PPC 3: Care Management

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients' care.

Intent

The practice identifies appropriate evidence-based guidelines and applies them, as appropriate, to the identified needs of individual patients over time and with the intensity needed by the patients.

Element A: Guidelines for Important Conditions — Tier I (required)

The practice adopts and implements evidence-based diagnosis and treatment guidelines for:	Yes	No
1. First clinically important condition	☐	☐
2. Second clinically important condition	☐	☐
3. Third clinically important condition.	☐	☐

Scoring

100%	75%	50%	25%	0%
Practice implements guidelines for 3 conditions	No scoring option	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Data source Materials

Scope of review ONCE—This element is scored once for the organization.

Explanation

IT required: Basic

Condition-specific: Yes

Details: The physicians in the practice adopt evidence-based guidelines and use them. The practice's guidelines must cover three clinically important conditions for its population. The practice's workflow organizers ensure that the guidelines are

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf
(Open Door Forum)

概要が出てきました

MEDICARE MEDICAL HOME DEMONSTRATION (MMHD):

OVERVIEW

Centers for Medicare & Medicaid Services
Baltimore, MD
October 28, 2008

MATHEMATICA
Policy Research, Inc.

What is a Medical Home?

- A practice that scores over the PPC-PCMH-CMS thresholds in:
  - Continuity of care
  - Clinical information systems
  - Delivery system design
  - Decision support
  - Patient/family engagement
  - Coordination of care across providers and settings
  - Improved access to care

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf
(Open Door Forum)

Tiered Structure

- Two tiers of medical homes
  - Tier 1: Basic medical home services, basic care management fee
  - Tier 2: Advanced medical home services, full care management fee

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

Tier 1 Requirements

- 17 required capabilities, for example:
  - Discuss with patients the role of the medical home
  - Establish written standards for patient access
  - Use data to identify/track patients
  - Use integrated care plan
  - Provide patient education/support
  - Track tests/referrals

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

Tier 2 Requirements

- Tier 1 requirements
- Use electronic health record (EHR), certified by the Certification Commission on Health Information Technology (CCHIT), to capture clinical information (for example, blood pressure, lab results, status of preventive services)
- Have systematic approach to coordinate facility-based and outpatient care
- Review post-hospitalization medication lists
- 3 of 9 additional capabilities (for example, use e-prescribing, collect performance measures)

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

Practices That Start as Tier 1 Can Later Apply for Tier 2

- Practices that choose to qualify as Tier 1 initially may still apply to qualify as Tier 2 practices in subsequent years
  - Complete the PPC-PCMH-CMS
  - Provide documentation of Tier 2 capabilities
- Applications accepted Oct. – Nov. 2010 and Oct. – Nov. 2011
- Implementation contractor will review the additional documentation in December of the year of submission
- Once Tier 2 qualification is established, the practice can receive the Tier 2 care management fee

Location and Sample Size

- 8 sites (A site is a state or a part of a state.)
  - CMS has not yet selected the sites
  - Will include urban, rural, medically underserved sites
- Sample across all 8 sites (not each site):
  - 400 practices
  - 2,000 physicians
  - 400,000 Medicare beneficiaries

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

MMHD Time Line

OMB approval (expected)	Dec. 2008
Announce demonstration sites	Dec. 2008
Outreach to and recruitment of eligible practices begins	Jan. 2009
Applications accepted	Jan. – Mar. 2009
Practices notified to apply for qualification; applicants' qualifications evaluated	Apr. – Nov. 2009 (earlier is preferred)
Technical assistance available	Apr. 2009
Applicants notified of qualification	May – Dec. 2009
Qualified practices enroll eligible patients	Upon qualification – Dec. 2011
Demonstration begins; medical home service delivery and payments begin	Jan. 2010
Medical home payments and demonstration end	Dec. 2012
Evaluation ends	Dec. 2013

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

What Is the Care Management Fee?

Per Member Per Month Payments			
Medical Home Tier	Patients with HCC Score <1.6	Patients with HCC Score ≥1.6	Blended Rate
1	**$27.12**	**$80.25**	**$40.40**
2	**$35.48**	**$100.35**	**$51.70**

- **HCC score indicates disease burden and predicted future costs to Medicare**
- **Nationwide, 25% of beneficiaries have HCC ≥ 1.6, and are expected to have Medicare costs that are at least 60% higher than average**

MATHEMATICA Policy Research, Inc.

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_ODF_Slide.pdf (Open Door Forum)

Medical Home Movement

PCPCC (Patient-Centered Primary Care Collaborative)

- is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and many others who have joined together to develop and advance the patient centered medical home. The Collaborative has well over 200 members.

The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the viability of the health care delivery system. In order to accomplish our goal, employers, consumers, patients, physicians and payers have agreed that it is essential to support a better model of compensating physicians.

http://www.pcpcc.net/ (Patient-Centered Primary Care Collaborative Home page)

Primary Care
COLLABORATIVE

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About the PCPCC
The Patient Cente
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Joining the PCPCC

Member Login

Username: *

Password: *

Log in

Create new account
Request new password

-it seems that PCPCC has done a nice job of organizing the employer purchasers and government purchasers around the common goal of supporting primary care medical homes

employers, consumers, patients, physicians and payers have agreed that it is essential to support a better model of compensating physicians.

ATTENTION: REGISTRATION FOR OCTOBER 17th SUMMIT IS NOW CLOSED

Read more

Event

PCPCC releases health plan purchasing guide for employers - goal to advance medical home

Guide provides supporting research, action steps, contracting language and sample RFI language for employers/purchasers

Washington, DC July 16, 2008 Today the Patient Centered Primary Care Collaborative (PCPCC), a coalition representing the country's national business leaders, consumer

IBM Global Business Services

IBM Institute for Business Value

Healthcare 2015 and care delivery

Delivery models refined, competencies defined

IBM

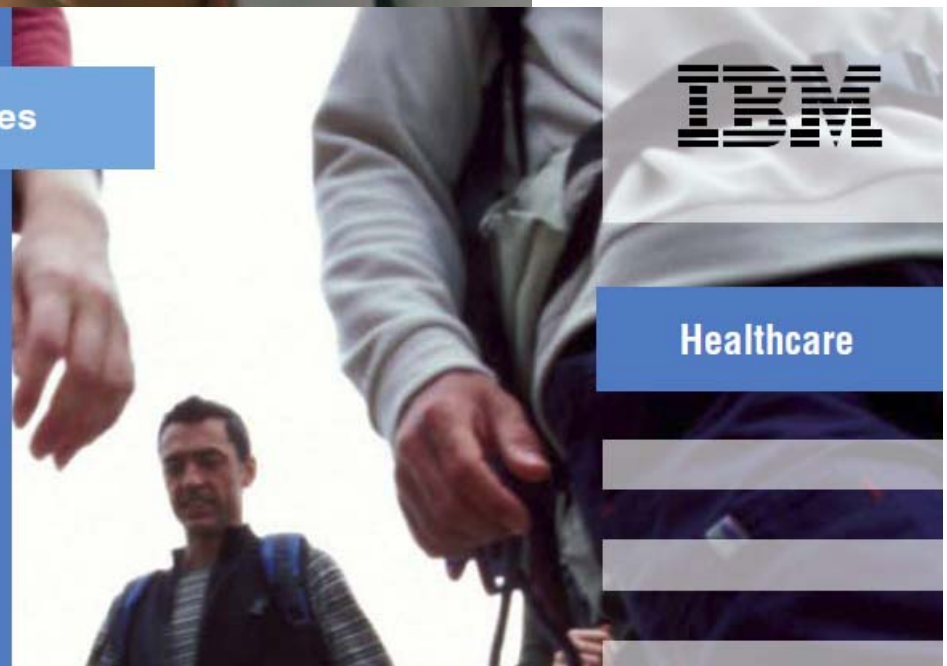
Healthcare

IBM Global Business Services

IBM Institute for Business Value

Healthcare 2015 and U.S. health plans

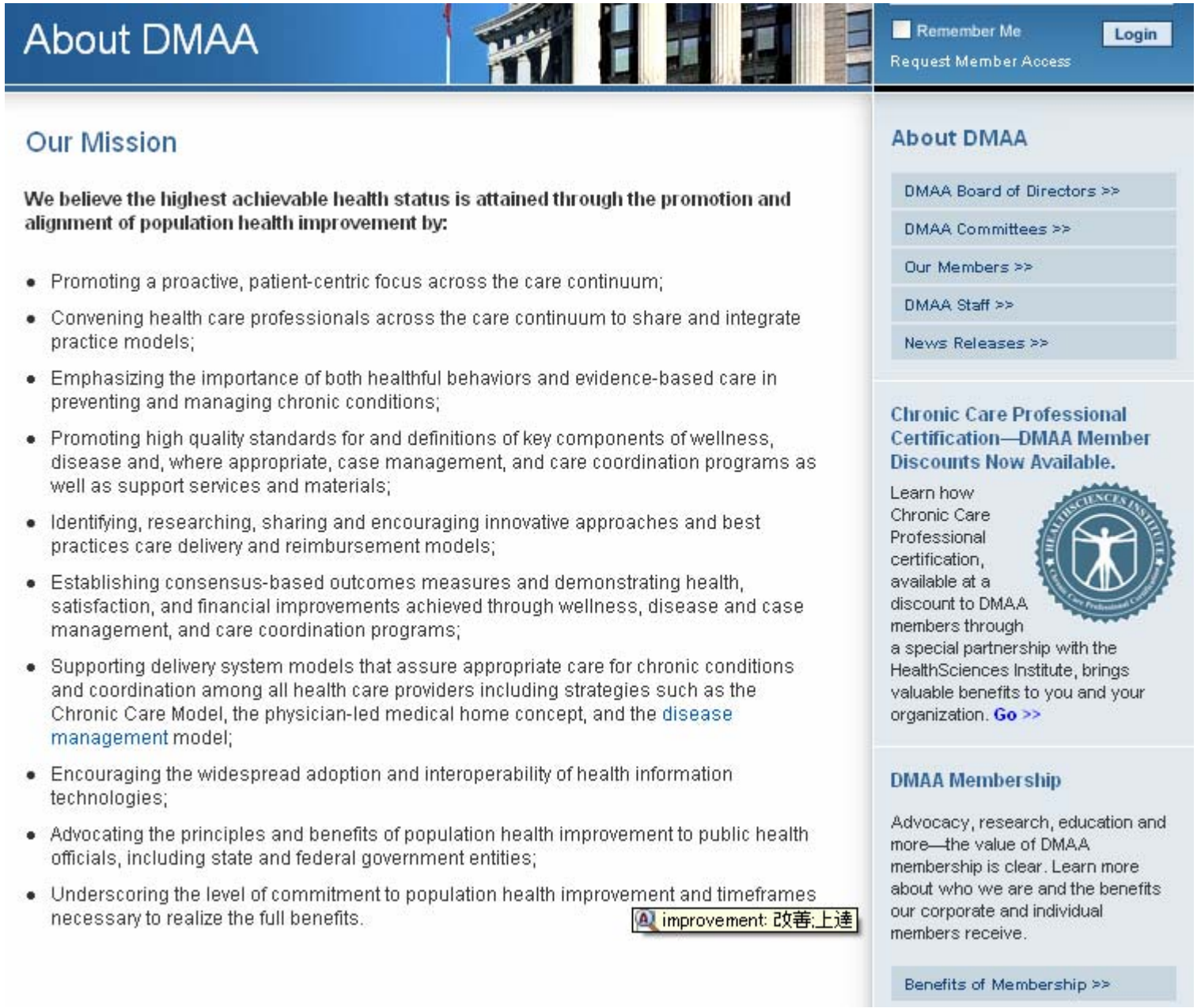
New roles, new competencies



IBM

Healthcare

DMAA :The population health improvement modelへの転換



About DMAA

Remember Me Login

Request Member Access

Our Mission

We believe the highest achievable health status is attained through the promotion and alignment of population health improvement by:

- Promoting a proactive, patient-centric focus across the care continuum;
- Convening health care professionals across the care continuum to share and integrate practice models;
- Emphasizing the importance of both healthful behaviors and evidence-based care in preventing and managing chronic conditions;
- Promoting high quality standards for and definitions of key components of wellness, disease and, where appropriate, case management, and care coordination programs as well as support services and materials;
- Identifying, researching, sharing and encouraging innovative approaches and best practices care delivery and reimbursement models;
- Establishing consensus-based outcomes measures and demonstrating health, satisfaction, and financial improvements achieved through wellness, disease and case management, and care coordination programs;
- Supporting delivery system models that assure appropriate care for chronic conditions and coordination among all health care providers including strategies such as the Chronic Care Model, the physician-led medical home concept, and the disease management model;
- Encouraging the widespread adoption and interoperability of health information technologies;
- Advocating the principles and benefits of population health improvement to public health officials, including state and federal government entities;
- Underscoring the level of commitment to population health improvement and timeframes necessary to realize the full benefits.

improvement: 改善;上達

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Chronic Care Professional Certification—DMAA Member Discounts Now Available.

Learn how Chronic Care Professional certification, available at a discount to DMAA members through a special partnership with the HealthSciences Institute, brings valuable benefits to you and your organization. **Go >>**

DMAA Membership

Advocacy, research, education and more—the value of DMAA membership is clear. Learn more about who we are and the benefits our corporate and individual members receive.

Benefits of Membership >>

http://www.dmaa.org/about_our_mission.asp

DMAAの変化

CMSらの変化を受けて、シフト

Advancing the Population Health Improvement Model

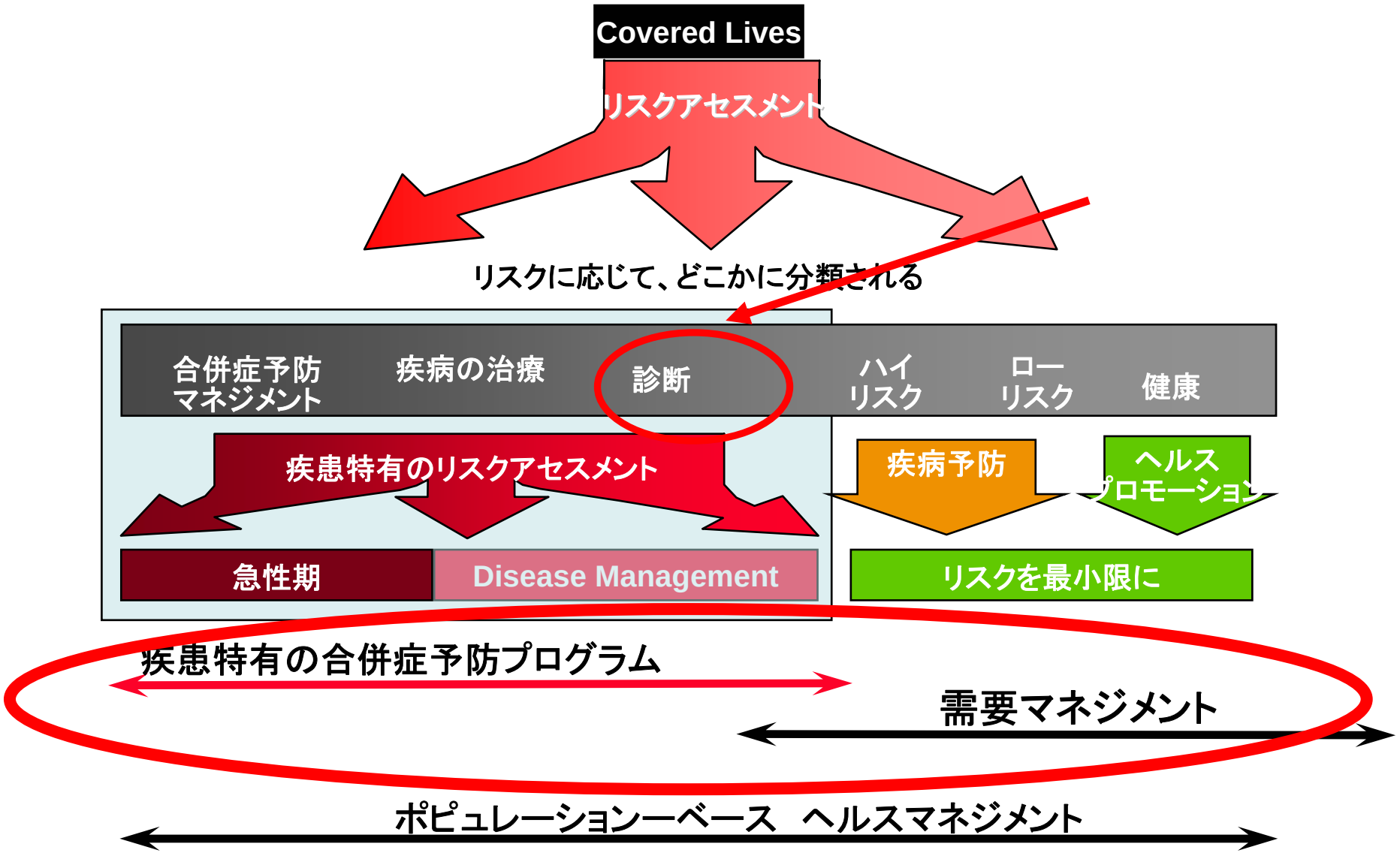
DMAA: The Care Continuum Alliance promotes a proactive, accountable, patient-centric population health improvement model featuring a physician-guided health care delivery system designed to develop and engage informed and activated patients over time to address both illness and long term health.

DMAA members believe that managing health requires the active, integrated involvement of all health care professionals coordinated with the patient and their caregivers and families. We offer these principles to describe the elements of this fully-connected health system, leveraging teams of care providers, focused on proactive, coordinated, quality health care.

http://www.dmaa.org/phi_definition.asp (DMAA)

Source:Warren Todd氏（IDMA)のスライド

ポピュレーションーベース　ヘルスマネジメント



The population health improvement model

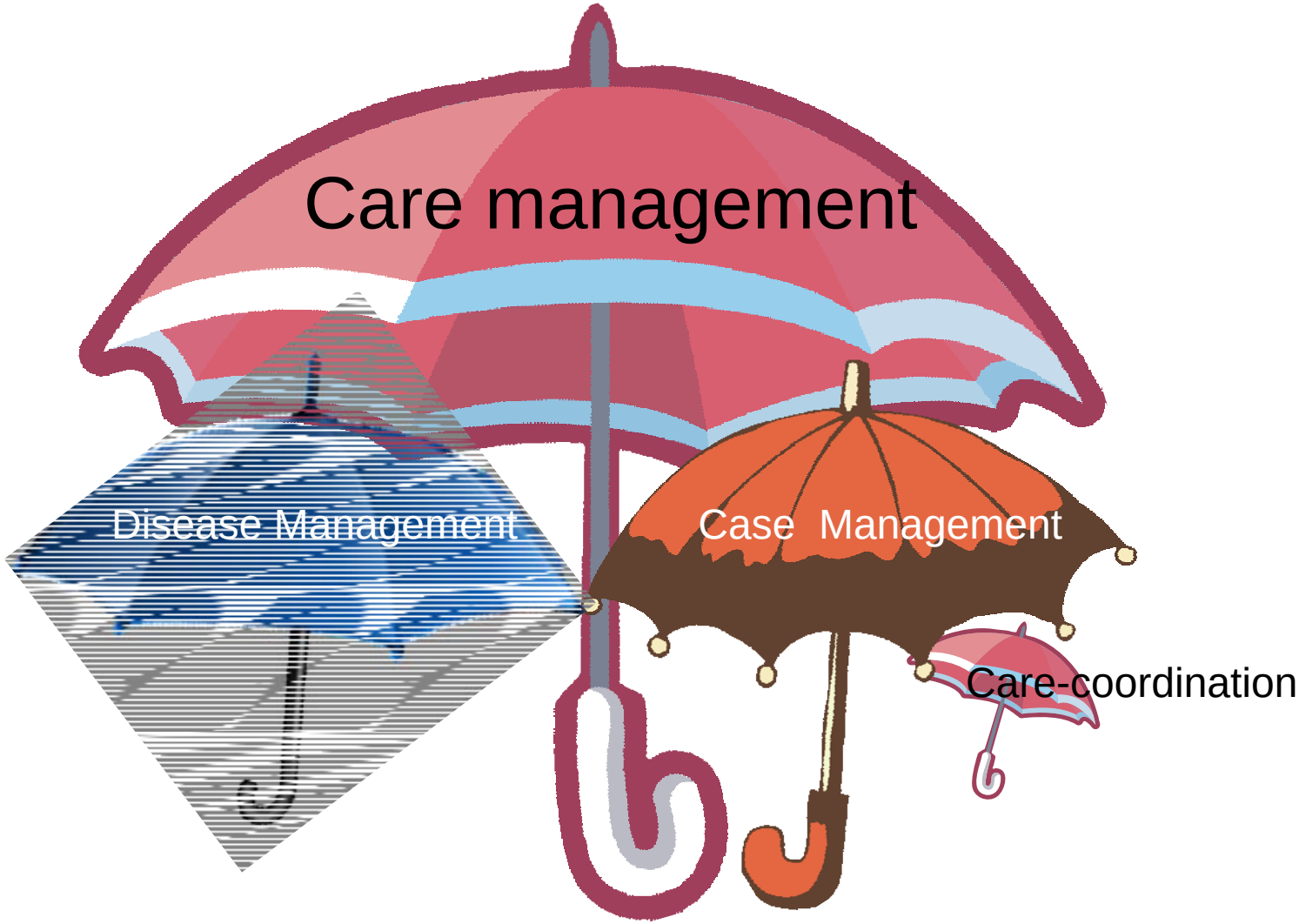
3つのハイライト

1. the central care delivery and leadership roles of the primary care physician （かかりつけ医を中心にすえる）
2. the critical importance of patient activation, involvement and personal responsibility （患者中心に）
3. the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management programs.（ウェルネス、DM、慢性疾患ケアマネジメントプログラムを通してのケアコーディネーション）

The convergence of these roles, resources and capabilities in the population health improvement model ensures higher levels of quality and satisfaction with care delivery. Further, coordination and integration are important tools to address health care workforce shortages, individual access to coverage and care, and affordability of care.

http://www.dmaa.org/phi_definition.asp (DMAA)

ケアマネジメントについての米国の関係者の一般的理解



Key components of the population health improvement model

Population identification strategies and processes;

- Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs;
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles;
- Patient-centric health management goals and education which may include primary prevention, behavior modification programs, and support for concordance between the patient and the primary care provider;
- Self-management interventions aimed at influencing the targeted population to make behavioral changes;
- Routine reporting and feedback loops which may include communications with patient, physicians, health plan and ancillary providers;
- Evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall population health.

http://www.dmaa.org/phi_definition.asp (DMAA)

The population health improvement model

Encourages patients to have a provider relationship where they receive ongoing primary care in addition to specialty care;

- Complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end-of-life care;
- Assists unpaid caregivers, such as family and friends, by providing relevant information and care coordination;
- Offers physicians additional resources to address gaps in patient health care literacy, knowledge of the health care system, and timeliness of treatment;
- Assists physicians in collecting, coordinating and analyzing patient specific information and data from multiple members of the health care team including the patients themselves;
- Assists physicians in analyzing data across entire patient populations;
- Addresses cultural sensitivities and preferences of individuals from disparate backgrounds;
- Promotes complementary care settings and techniques such as group visits, remote patient monitoring, telemedicine, telehealth, and behavior modification and motivation techniques for appropriate patient populations.
- Accountable measurement of progress toward optimized population health should include:Various clinical indicators, including process and outcomes measures;Assessment of patient satisfaction with health care; Functional status and quality of life;Economic and healthcare utilization indicators; and Impact on known population health disparities.

http://www.dmaa.org/phi_definition.asp (DMAA)

e-CareManagement blog

Chronic Disease Management • Technology • Strategy • Issues and Trends

Empowering Health IT for the Medical Home

Posted by Vince Kuraitis on October 12, 2008 · Filed in DM Megatrend # 4: Providers, Guest Posts · Add a comment

by David C. Kibbe, MD MBA

The basic premise of the medical home concept is continuous, uninterrupted care that is managed and coordinated by a personal provider with the right tools that will lead to better health outcomes.

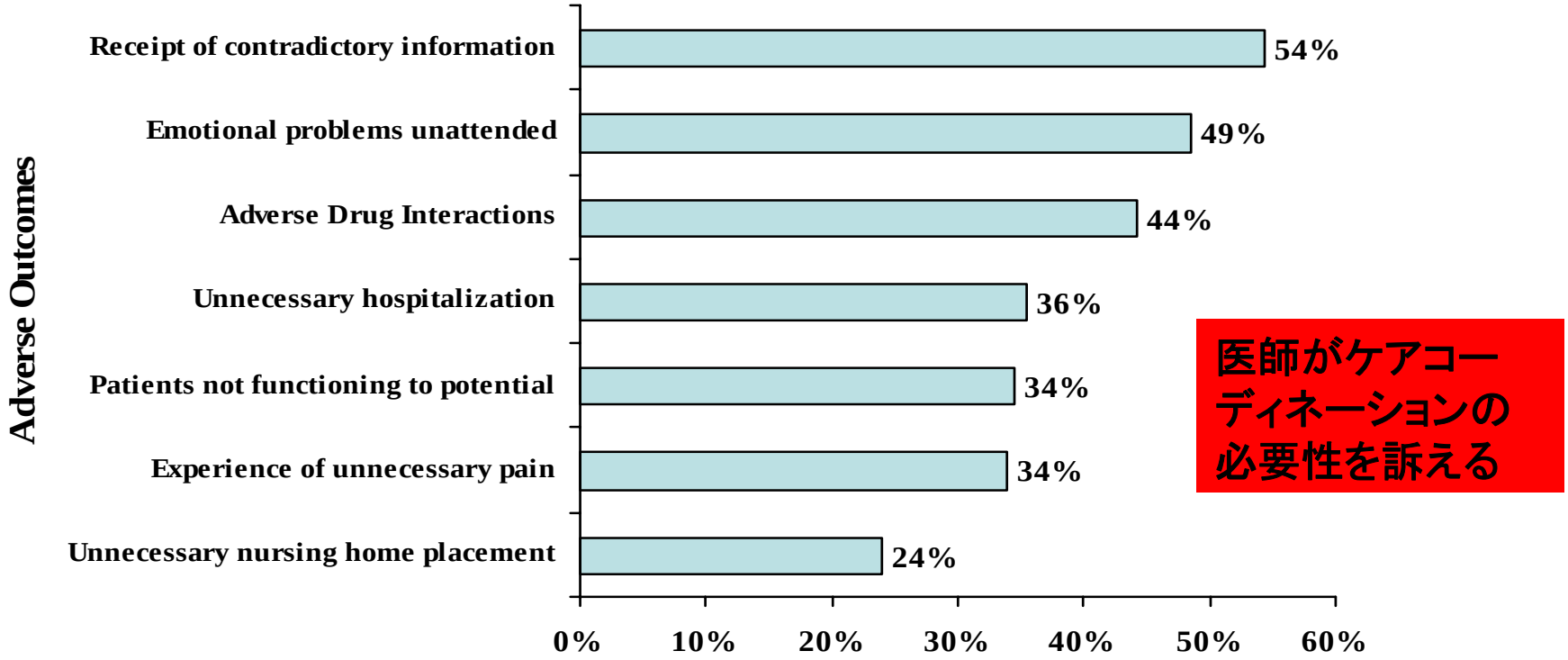
In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, released the Joint Principles of the Patient-Centered Medical Home. In this document they state the characteristics of the Patient Centered Medical Home:

- Personal Relationship
- Team Approach
- Comprehensive
- Coordination
- Quality and Safety
- Expanded Access

Vince Kuraitis

Bio 1.0 Bio 2.0

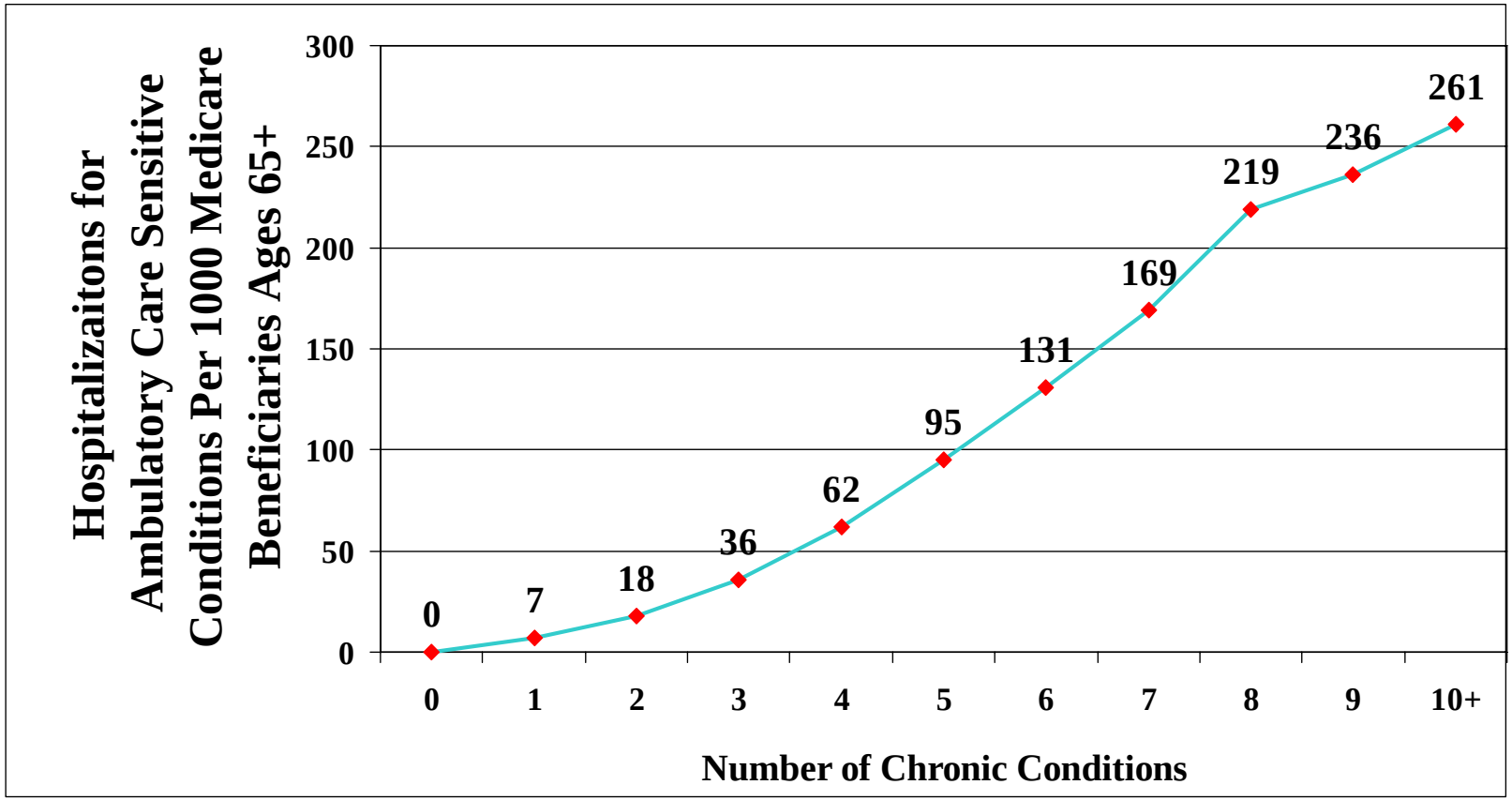
Physicians Believe that Poor Care Coordination Produces Bad Outcomes



Percent of Physicians Who Believe that Adverse Outcomes Result from Poor Care Coordination

Source: *National Public Engagement Campaign on Chronic Illness–Physician Survey*, conducted by Mathematica Policy Research, Inc., 2001. Cited:Horvath, J. Chronic Conditions in the US)

Poor Care Coordination Leads to Unnecessary Hospitalizations



Source: Medicare Standard Analytic File, 1999. Cited:Horvath, J. Chronic Conditions in the US)

IOMの報告書、The National Quality ForumがCare Coordinationの重要性を示した

IOMがPatient-Centered Careの定義を見直し、明確に定義した。

INSTITUTE OF MEDICINE

Educating Health Professionals to Be Patient-Centered

Current Reality, Barriers, and Related Actions

Elisa Knebel, Program Officer, Board on Health Care Services

Patient-Centered Care

as an essential component of quality care.

In contrast to care that is clinician-centered or disease-focused, patient-centered care customizes treatment recommendations and decision making in response to patients' preferences and beliefs.

In such a partnership, clinicians' decisions are informed by an understanding of patients' needs and understanding of their environment, which includes home life, job, family relationships, cultural background, and other factors. This partnership also is characterized by informed, shared decision making, development of patient knowledge, skills needed for self-management of illness, and preventive behaviors (2001).

Cited: Educating health professionals to be patient-centered. IOM, p.3)

改めてチームアプローチの重要性

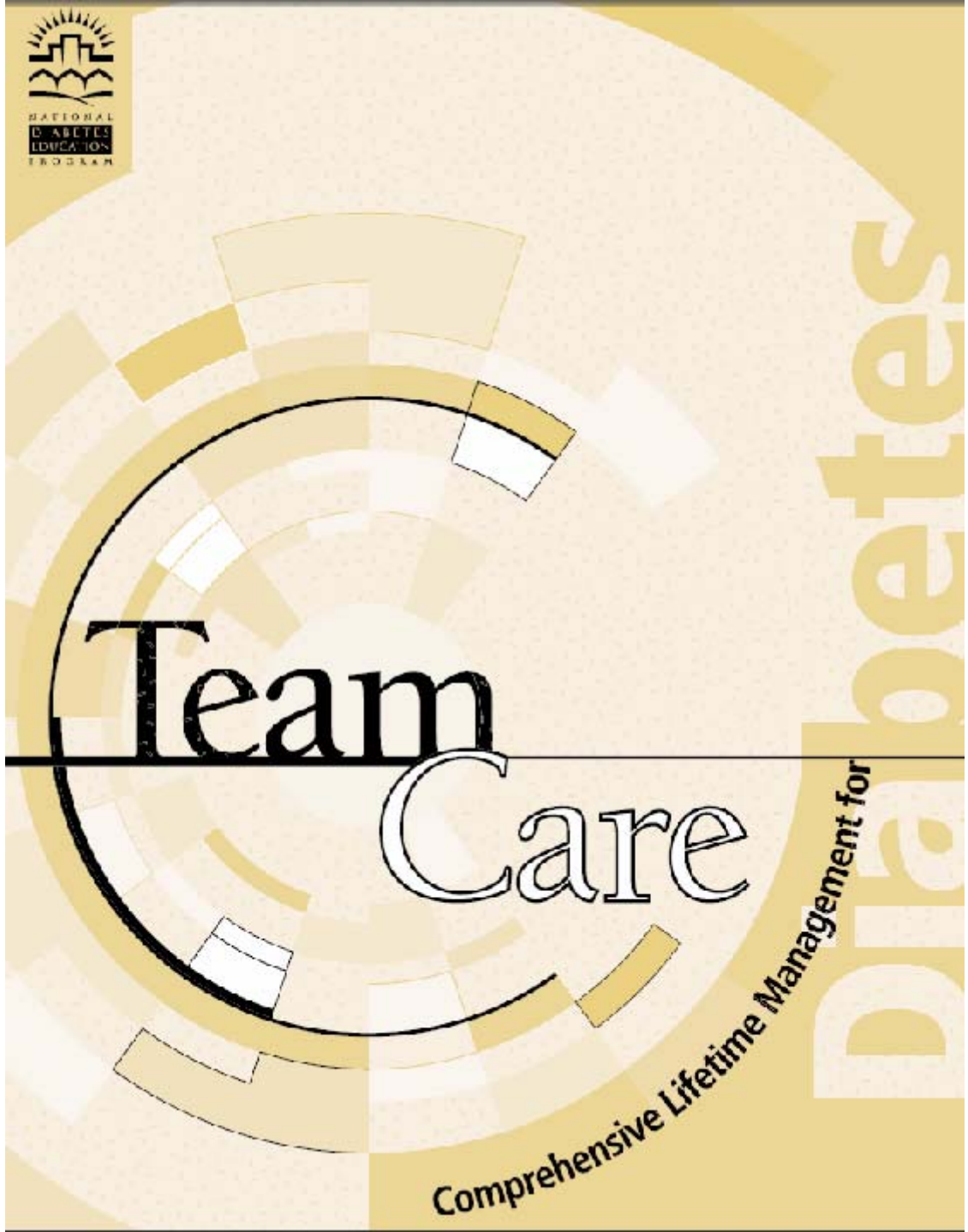
The practice uses a team approach in managing patient care. Shared responsibilities are designed to maximize use of each team member's level of training and expertise. In small practices, this may be designated roles for the physician, the nurse and the administrative person if there is one. ***In most practices, the availability of nurse case managers will only be through the patients' health plans or other large organization****. In some practices physicians may handle significant patient care responsibilities, especially for complex patients.* ***Disease management or care management may be provided internally by the practice or group or available to the patient externally, usually through the health plan****.*

http://diseasemanagementcareblog.blogspot.com/

The Chronic Care Model：チームアプローチの重要性

- 複雑なモデルなので、10人以下のMDでは無理（しかし、米国では70-80%の医師がこの中に入る）
- The Academy of Family Practice Physicians patient-centered medical homeがロードマップを出している。
- 真のチームを作る難しさ、急性期対応型の父性型実践モデルを変えないといけない。
- 薬剤師は薬剤師で独自に動いている。医師はみんなが自分達に従うものと思っている。病院の看護師は「自分達は急性期医療の現場にいる」と思っている。専門性を強調しすぎることが真のチームアプローチを困難にしている。

National Diabetes Education Program が多職種チームによる生涯のマネジメントモデルを提唱



Chronic Care Professional Model

- a shared vision and true team, patient-centered approaches-

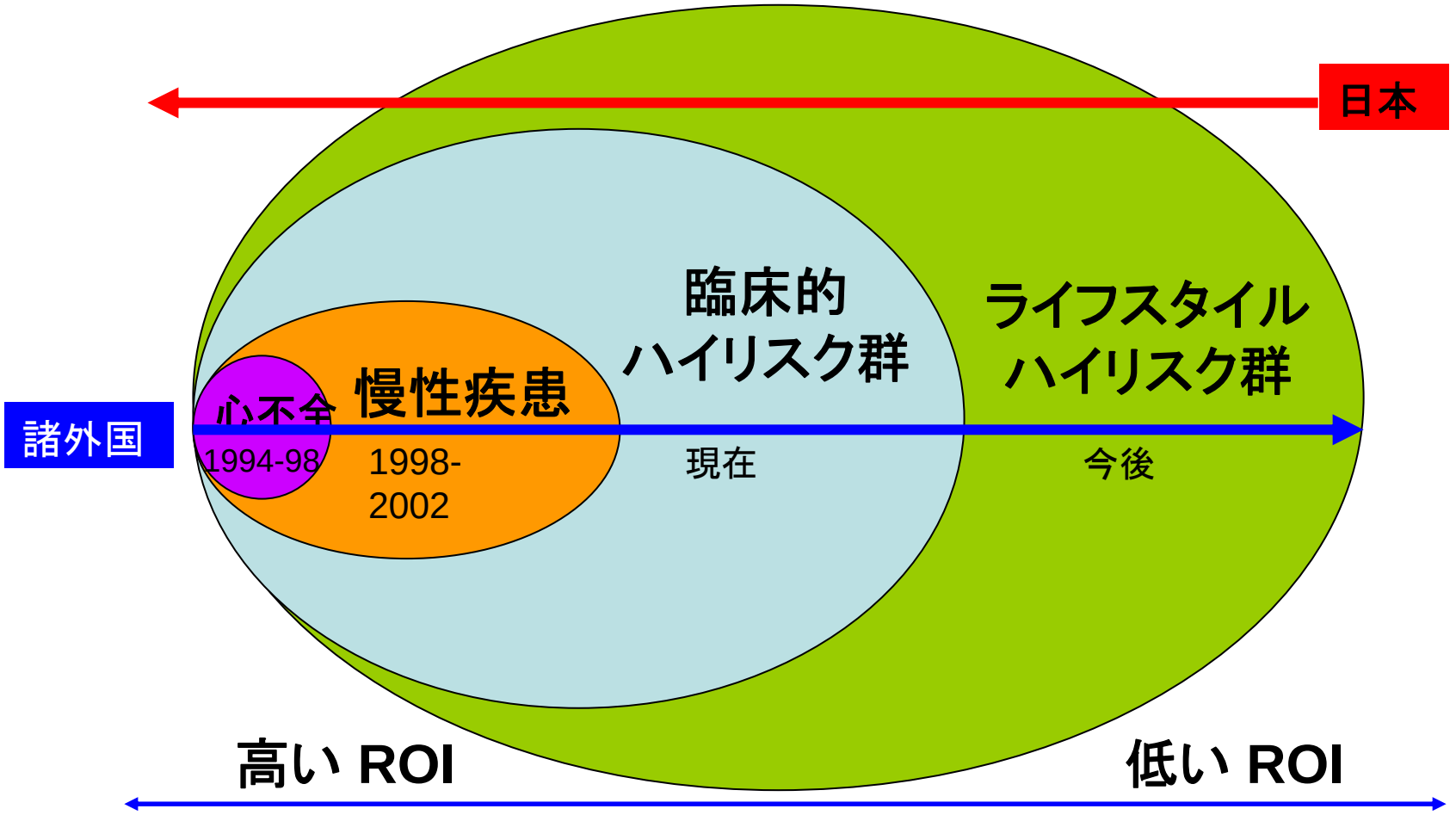
Kaiser Permanenteで実施

USの複数の州で実施

カナダのカルガリーのDMプログラム

医師、薬剤師、ナースプラクティッショナー、看護師、栄養士とでチームを組んで、Chronic Care Professional programを提供する

ポピュレーションアプローチの発展



Source：Warren Todd氏（IDMA)のスライド

Source: LifeMasters, 2004

疾病管理の変遷

第一世代（1990年代）

服薬コンプライアンスのみに注目するような断片的なケアを提供するプログラム

第二世代（1990年代後半～）

重症患者や医療コストが高額となるリスクが極めて高い患者をターゲットとして働きかけを行うプログラム

第三世代（2000年辺りから）

特定の疾患に罹患しているか、罹患するリスクを有する患者の集団全体を対象とするプログラム

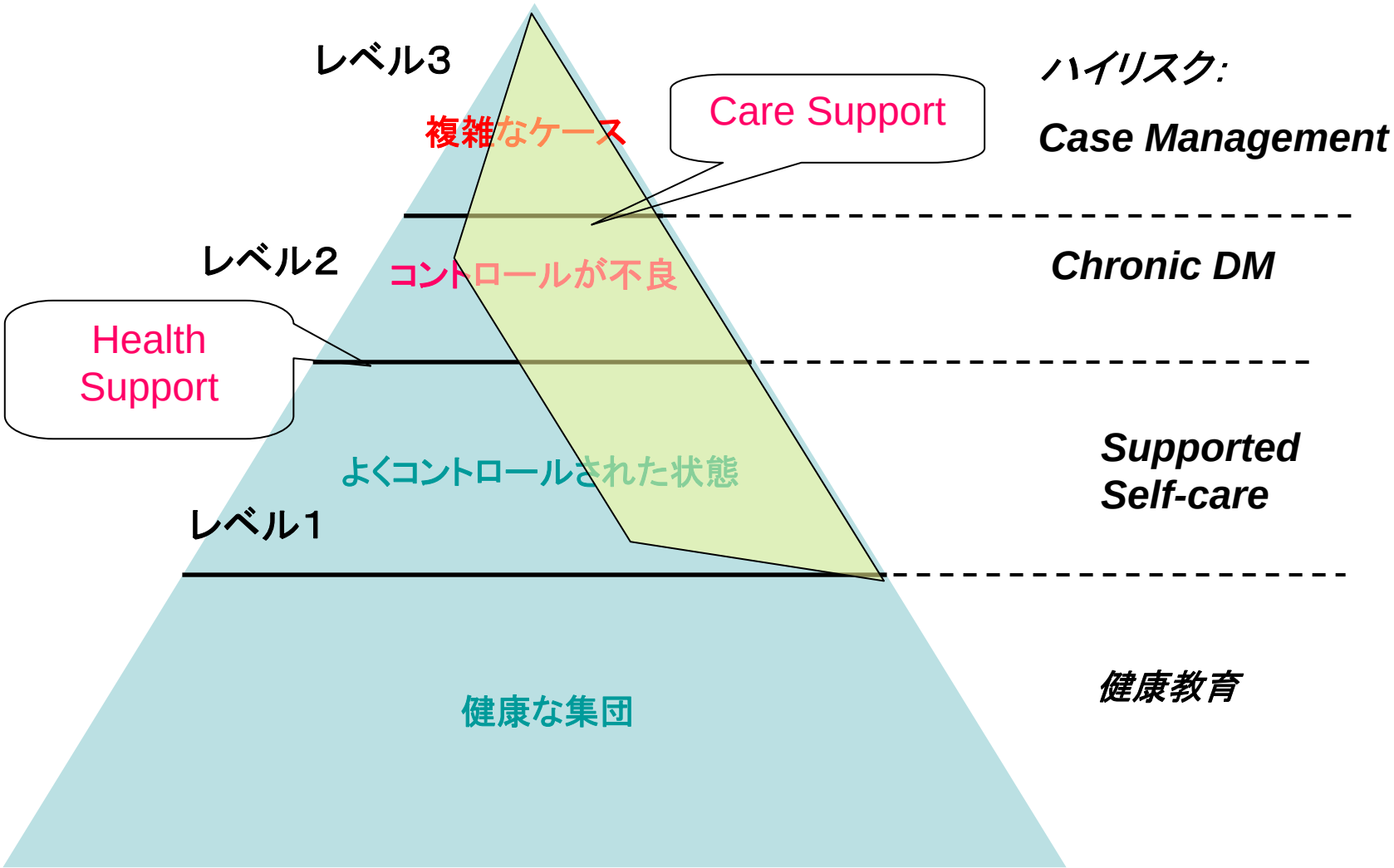
現在（2004年くらい～）

真の健康管理モデルとして、病気の治療よりも最適な健康状態の維持にウエイトが置かれるようになり、生涯にわたる健康教育を通じて、病気の予防のみならず、安全かつ健康なライフスタイルの維持を促進することを使命とする（代替医療やヒーリングも含まれる。）

現在から2015くらい

External DM model to Primary Care, Team approach-based, Medical Home Model

DMとCMのバランス



（Healthwaysが提示したものを森山が改変）

Self Management

Diabetes self-management education (DSME) is defined as “the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards.”

・行動変容の理論やモデル
・エンパワメントインタビュー
（その人の関心事を引き出す。最も焦点を当てること1つに絞る。それを、自分で選択、設定してもらう。）

1. 情報収集/問題のアセスメント
   理解度（内容）、ステージ（意識・脅威認知）、
   心理社会的要因、データの評価
2. 優先順位の決定（critical thinking）
3. 具体的なプランの提示
   情報提供/スキルの教育
   問題解決技法の習得
4. 情緒的支援も含めた、長期的支援
5. モニタリング、データフィードバック

Disease Managementの進展：
単疾患アプローチ→包括的・統合アプローチ

患者のニーズにフォーカス

Care Management

人は複数の疾患をもつ

本質的な問題は何か←生活の中に潜む問題

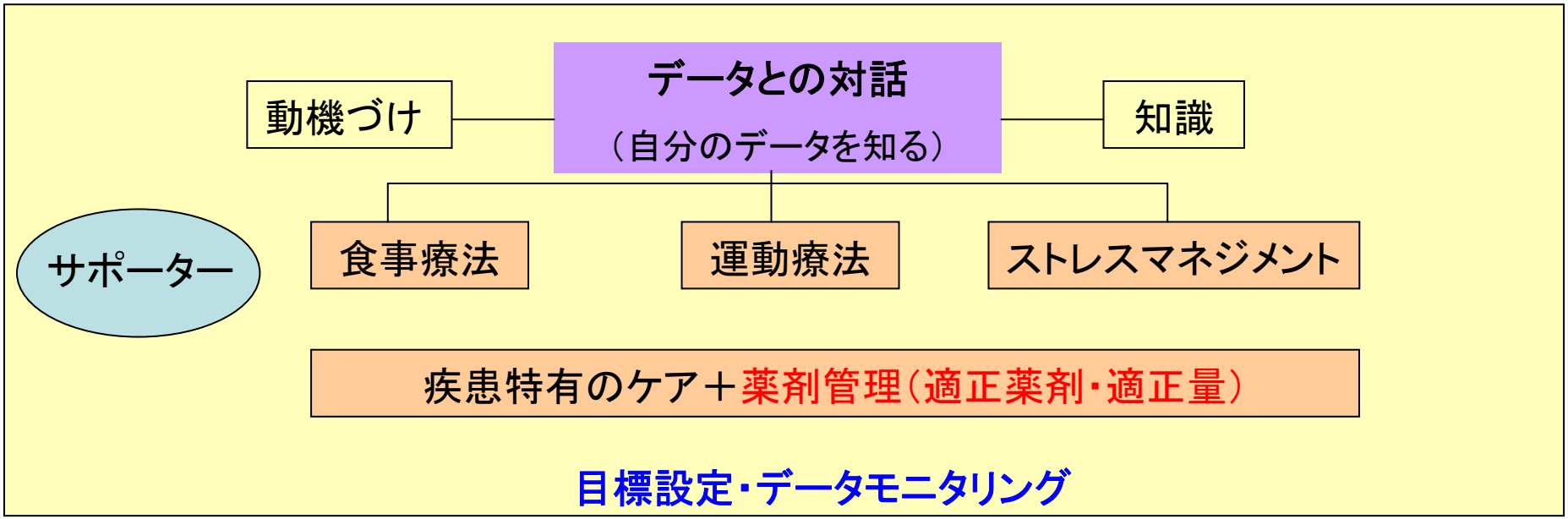
ストレス→高血圧等

20年以上のベテラン看護師
ナース・プラクティッショナー
の活用

優先順位の決定

ストーリーを聞きながら、声のトーンなど五感で判断

ー本質問題、最も死亡に影響するものー

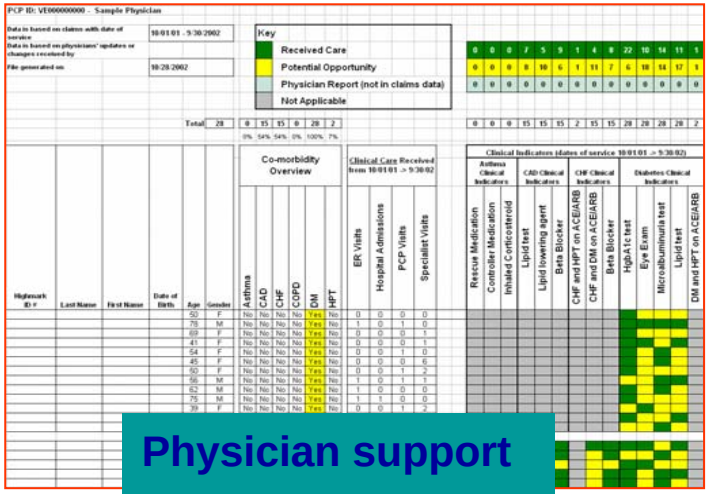


（森山美知子, 2008）

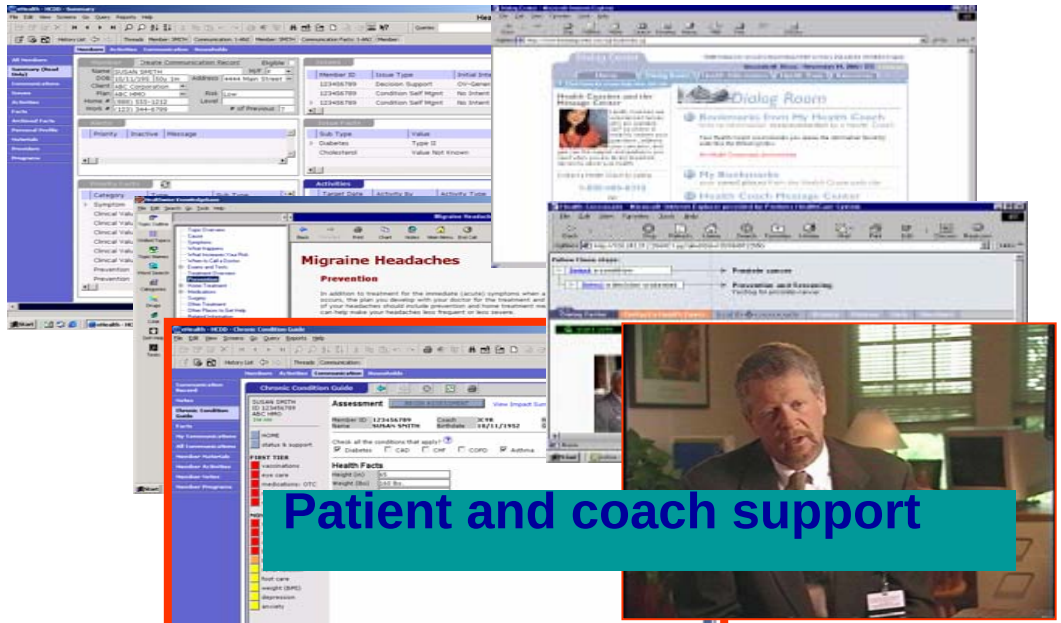
質の高い意思決定ができるようにサポート

“Health Coach”

- アウトカムの設定（データマネジメント）
- データとの対話，医師とのコミュニケーションの促進
- 意思決定への支援（shared decision making）とモチベーションインタビュー
- 優先順位の設定（複数の疾患を有する）
- 資源活用の助言（ケースマネジメント）
- 行動変容とその継続（生活の中で）



Physician support



Patient and coach support

From Health Dialog HP

どの指標が最も死亡や障害に影響するのか：優先順位の決定

130mmHg

80mmHg

薬剤管理の重要性の強調

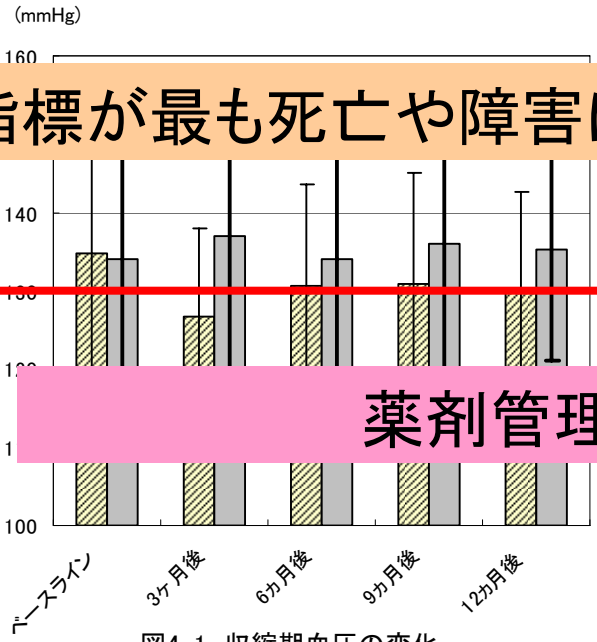


図4-1　収縮期血圧の変化

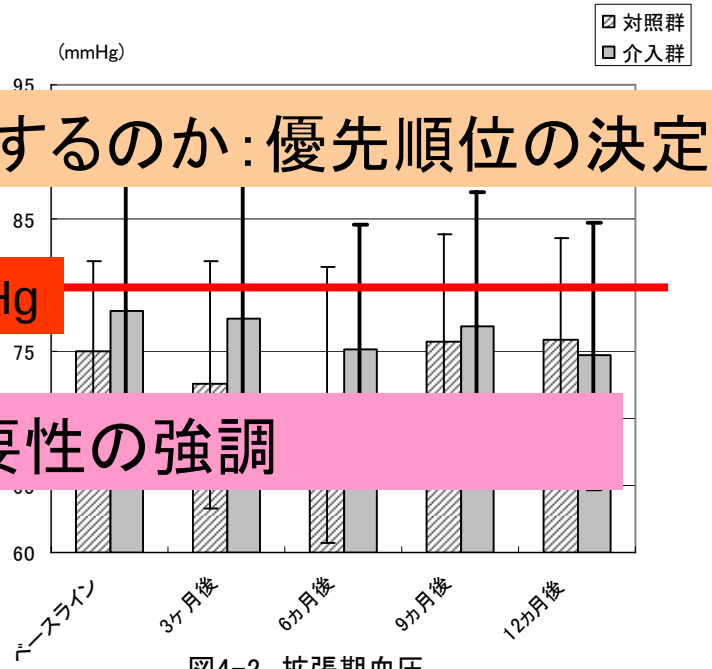


図4-2　拡張期血圧

生理学的データの正常からの逸脱

良

150mg/dl

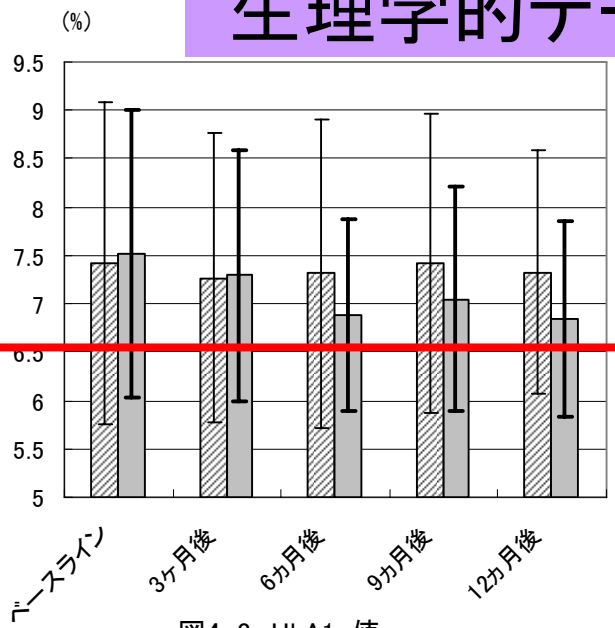


図4-3　HbA1c値

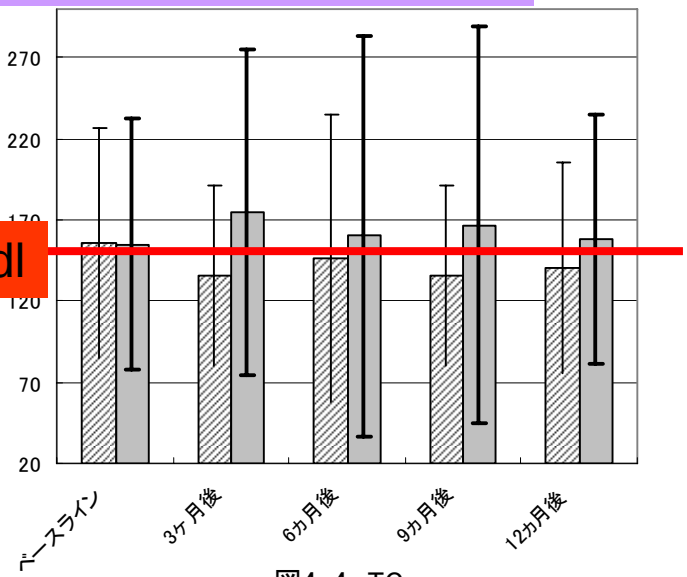


図4-4　TG

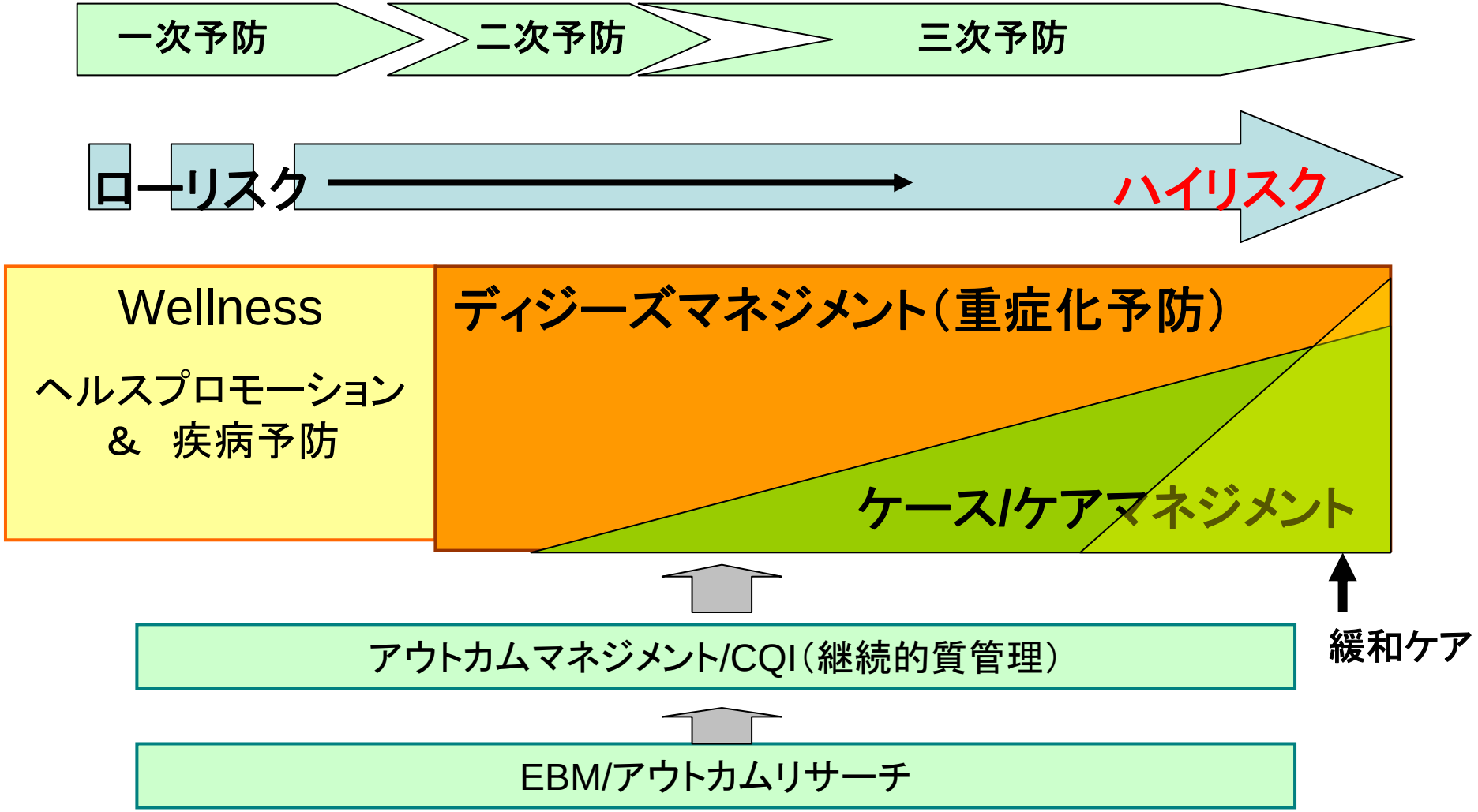
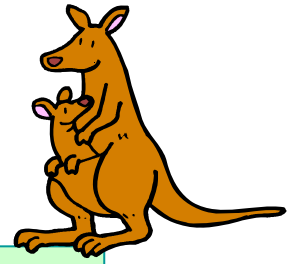


図　慢性疾患管理 / 慢性疾患マネジメント＝疾病ケアマネジメント

（森山美知子, 2007）

わが国にも馴染みやすい
重症化予防システム

Disease Management in オーストラリア
重症化予防（Frequent Flyer Program）



病　棟

紹介

GP

連携

地域の社会資源等

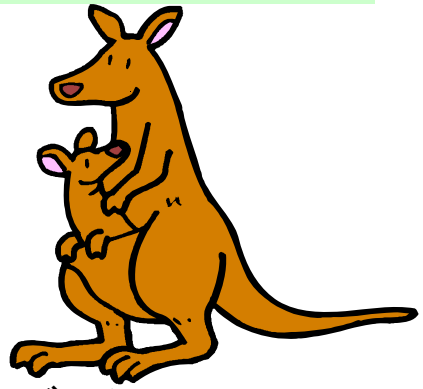
連携

外来：Disease Management部署

- ●専門医と患者のマッチング
- ●専門医の外来の提供
- ●ケアコーディネーションのための看護師による専門外来
- ●GPとの連携
  ＋ケアコーディネーション
- ●疾患別セルフマネジメントのための集団教育
  （電話やe-mailでの指導）
- ●受診や服薬コンプライアンスを促す電話コール

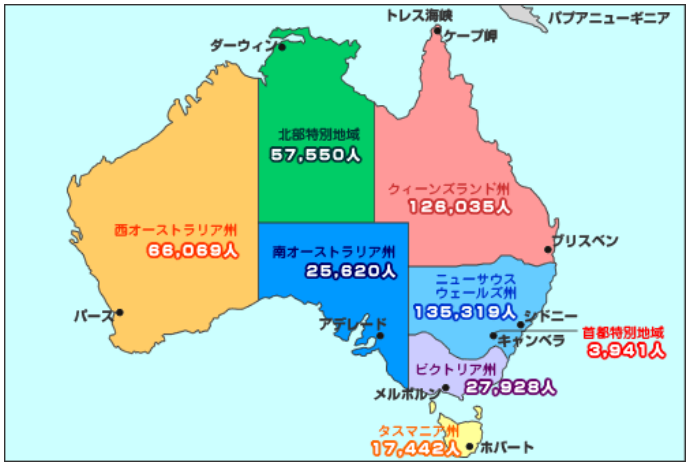
看護師や薬剤師の配置

オーストラリア, ビクトリア州南部厚生局
The Better Living Better Health Program (BLBH)



政府主導の重症化予防（入院防止、救急利用防止）プログラム

- IT 活用
- 地域でのスクリーニング（GPとの連携，ハイリスク者の特定）
- ケアコーディネーション, ケアプランの策定,
- 患者・家族教育（教育、セルフマネジメント、運動リハビリ、心理サービス）
- 慢性疾患患者の退院プログラム
- 専門医、家庭医（GP)、多専門職種（看護師、リハ、薬剤師、栄養士等）の連携



対象　慢性疾患＋複雑なニーズ

医療機関を頻繁に利用する者

慢性呼吸器疾患

慢性心不全

糖尿病

複雑なニーズ, 加えて複雑な心理ニーズ　他

英国スコットランド政府

（WHOヨーロッパによるディジーズマネジメント）

ファミリーヘルスナース・プロジェクト

慢性疾患/生活習慣病は家族性に発生する

- 家族の健康行動を評価
- 家族の健康対処能力を評価
- 家族に健康対処スキルを教える

どのようにしてケアの連続性を確保し、
重症化予防するのか

Lose – Lose - Lose

◆患者：教育を受ける機会が少ないこと、ケアが連続しないことにより、自己管理が不十分　→重症化

◆専門職が専門性を発揮できないこと

（患者・家族教育やリハビリテーションが十分にできないこと）

→コ・メディカルのジレンマ（Powerlessness）、

→医師のオーバーワーク

◆ライフスタイルに合った医療サービスが提供されていない

→医療に適切にかかる機会の制限（日中時間をとって受診できない）

現在の仕組みは、医療者にとっては「本来の仕事ができない」という自律性の喪失を、患者・家族にはQOLの低下を、保険者や国には経済的・社会的損失を招いている。

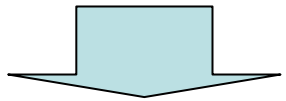
Win – WIn - Win

急性期医療の枠組みの中でのサービス提供

→新しい慢性疾患ケアモデルの導入

◆医療従事者（それぞれの職能）は、自分の専門能力が発揮でき、オーバーワークが減る。（人材不足や地域・領域偏在の解消，配置の適正化）

◆患者は自身の健康管理ができ、無駄に仕事を中断しなくて良い。



◆医療費の適正化につながる。
◆社会的損失の減少

背　景

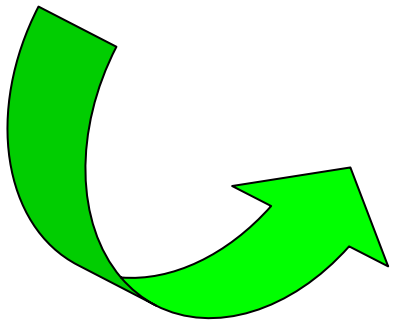
わが国の動き
疾病管理の導入

一次予防

特定健診･特定保健指導

三次予防

診療報酬で対応



この連続性をどのように
確保するのか

生活習慣病管理料

SMBGの加算

糖尿病合併症管理料

地域連携クリティカルパス

退院調整

超急性期脳卒中加算

もう、ベッドサイドケアだけでは限界

背　景

「公的保険医療制度に飼いならされてしまい、自分の力で生きることを忘れてしまった日本人」

「ベッドサイドでバイタルサインを計り、配膳し、点滴を交換する。看護師はそれだけでいいのか？」

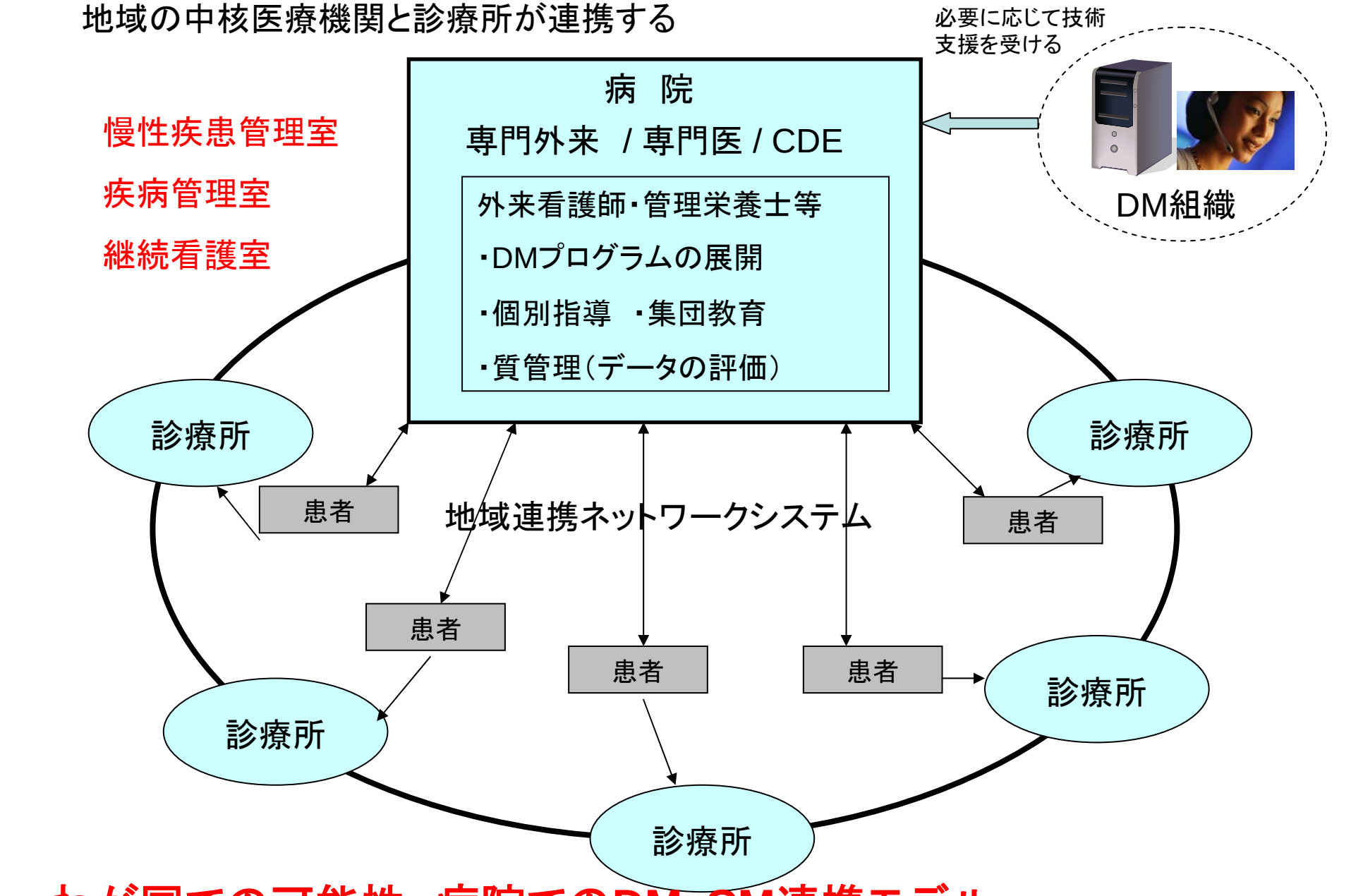
現在の医療提供体制は、戦後、急性期疾患（感染症）を中心とした時代に構築されたもの

新たな医療サービス提供体制の必要性

新しい慢性疾患ケアモデル

入院は高度化、慢性疾患管理は外来・地域にシフト

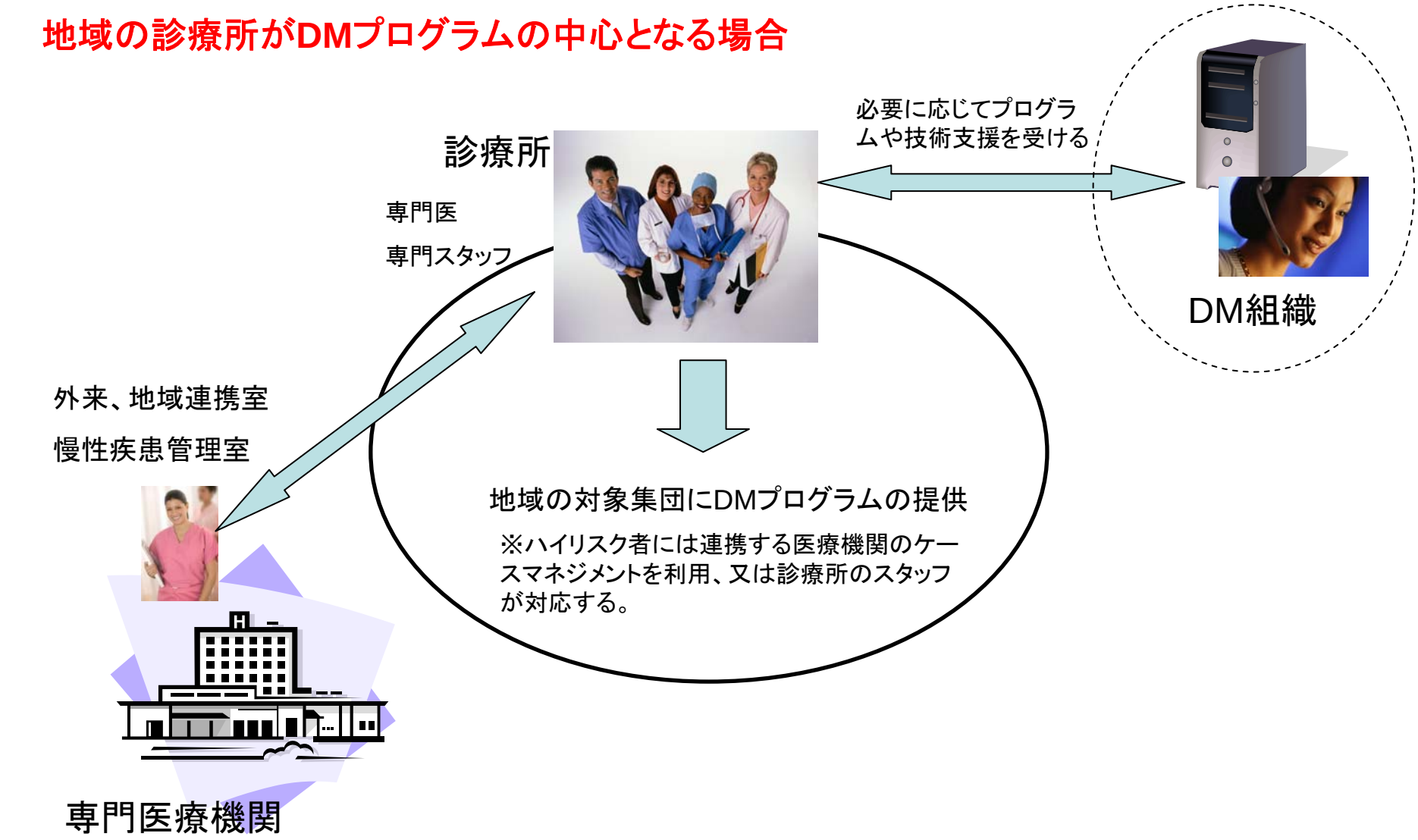
地域の中核医療機関と診療所が連携する



わが国での可能性　病院でのDM・CM連携モデル

CDE：糖尿病療養指導士

地域の診療所がDMプログラムの中心となる場合



わが国での可能性　病院でのDM･CM連携モデル

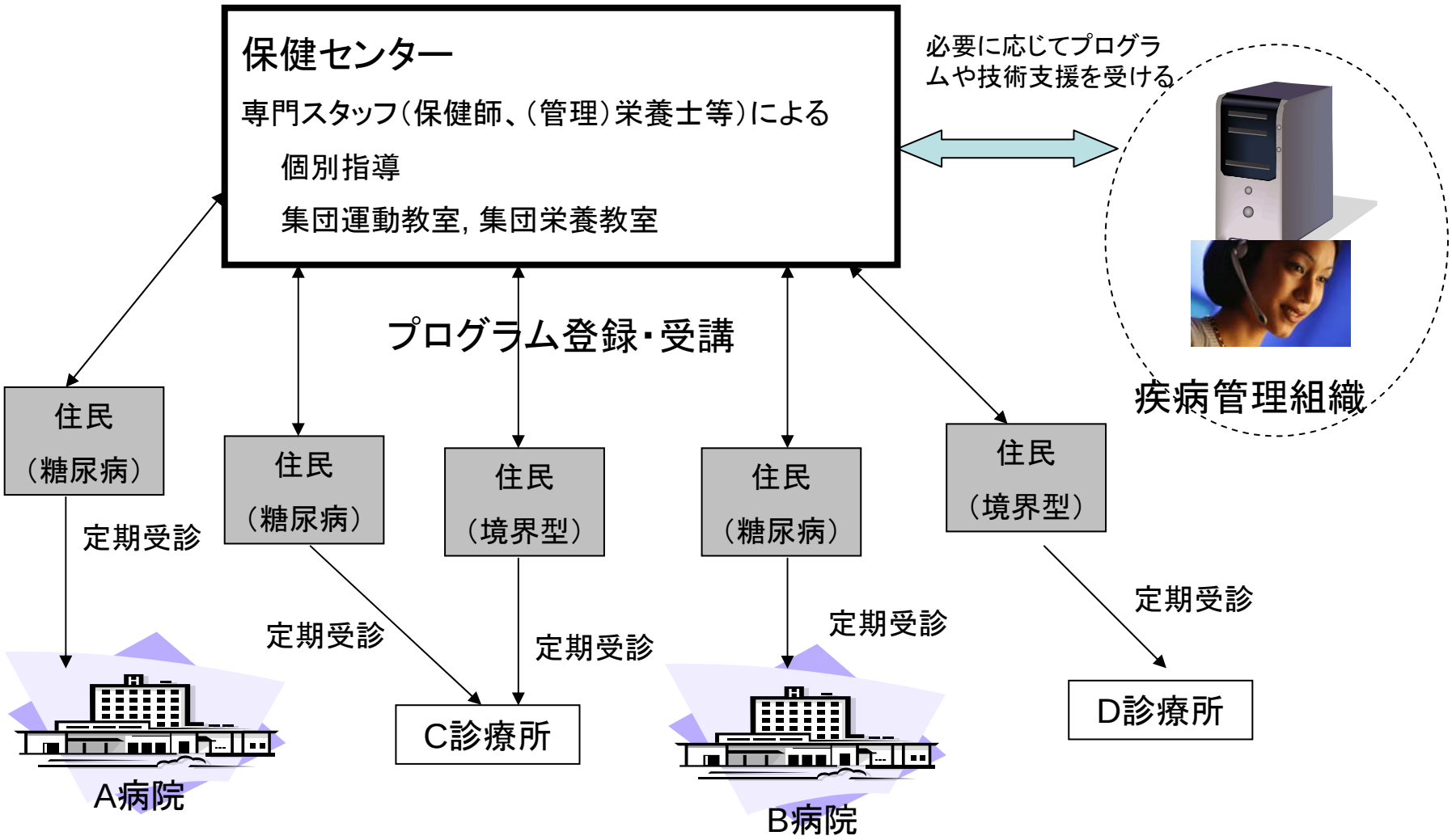
保険者機能の強化

地域の行政機関（保健センター）が中心になる場合

地域の住民で健診結果で要指導・要医療になった人を登録・指導

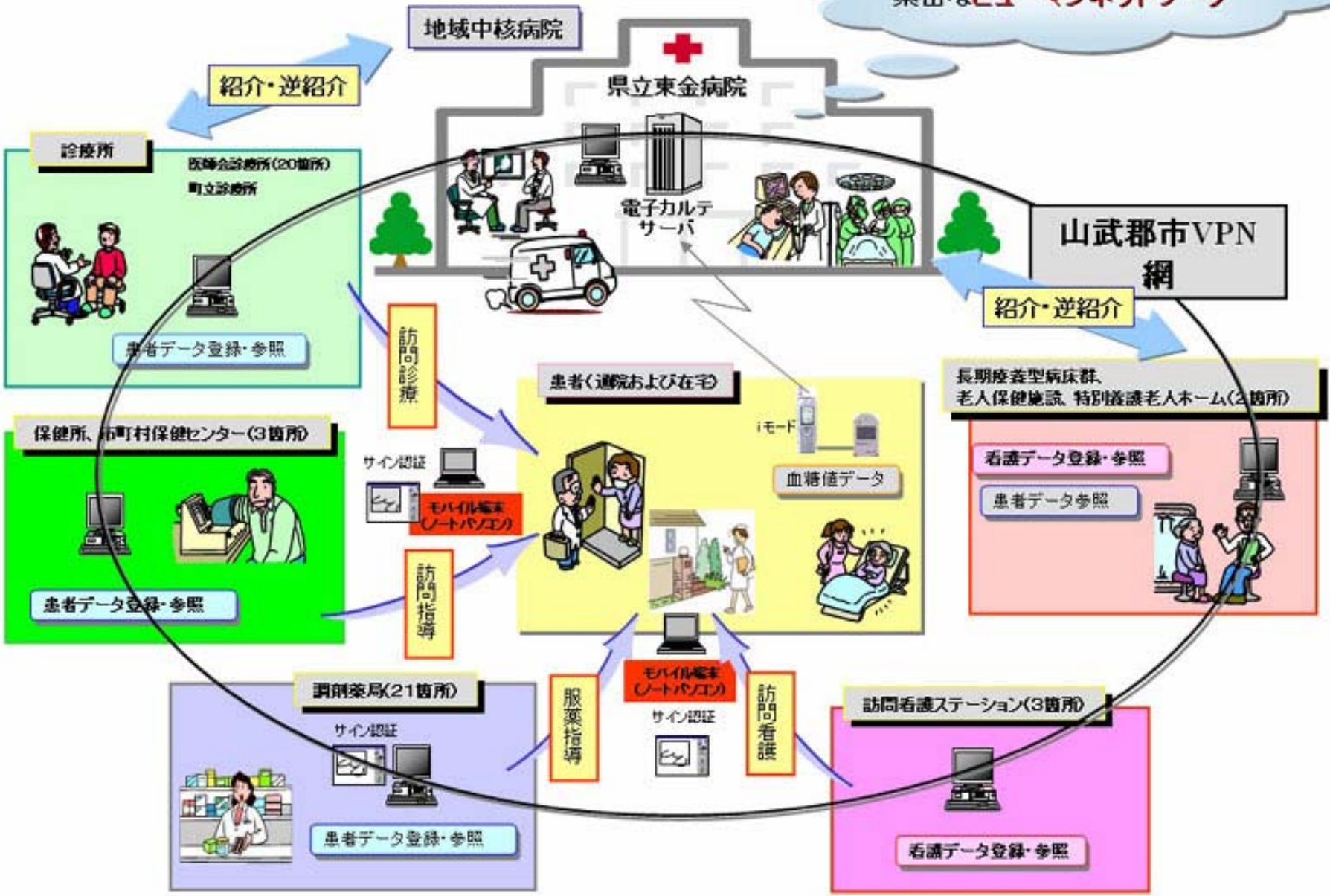
（特定健診・特定保健指導の対象者以外にも、病名がつき、医療機関に通院する人も対象とする。）

※階層化による、重症度等に応じたサービス提供



わかしお医療ネットワーク

定期的研修会に裏打ちされた
緊密なヒューマンネットワーク

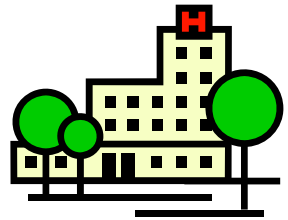


広島大学大学院保健学研究科
看護開発科学講座

基 町 団 地

専門看護師
管理栄養士
理学療法士

派遣
技術支援

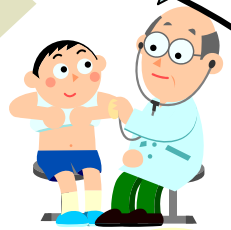


地域中核病院

24時間後方支援体制
（急性増悪・緊急時の対応）
技術支援

基町健康管理室
（ナースクリニック）

連携



地元開業医

地域包括支援センター

健康管理プログラムの提供＋ケースマネジメント