PREMESSE EBM ALLA GESTIONE INTEGRATA

Sandro Gentile

Dipartimento di Medicina Clinica e Sperimentale
Seconda Università di Napoli

Determinants of Quality in Diabetes Care Process

The population-based Torino Study

ROBERTO GNAVI, MD[1]
ROBERTA PICARIELLO, BSC[1]
LUDMI LA KARAGHIOSOFF, BSC[1]
GIUSEPPE COSTA, MD[1,2]
CARLO GIORDA, MD[3]

Diabetes Care 32:1986–1992, 2009

In summary, this study provides the first population-based data on quality in the diabetes care process in a large southern European cohort and indicates that, despite the increasing prevalence of diabetes and the widespread availability of up-to-date guidelines and screening procedures, a nonnegligible portion of the diabetic population still do not receive proper care. On the other hand, the good news is that there are no sex or social inequities in health care. Diabetes centers, although with several limitations, seem to perform screening regardless of the severity of disease or other conditions. Conversely, patients who are only cared for by general practitioners are at greater risk of receiving low-quality care, as the physicians may lack sufficient knowledge, decision support, or time to appropriately schedule their patients' annual control examinations. However, it must be highlighted that the purpose of a surveillance system is not to rank doctors but to provide evidence for improvement. Our findings suggest that care provided to patients with diabetes can be improved by increasing the intensity of disease management programs to foster greater participation by general practitioners, thus increasing knowledge and decision support and raising appropriateness. Moreover, an effort to improve diabetes care in elderly patients is a priority.

Annals of Internal Medicine | ORIGINAL RESEARCH

Defining Patient Complexity From the Primary Care Physician's Perspective

A Cohort Study

Richard W. Grant, MD, MPH; Jeffrey M. Ashburner, MPH; Clemens C. Hong, MD, MPH; Yuchiao Chang, PhD; Michael J. Barry, MD; and Steve J. Atlas, MD, MPH

Ann Intern Med. 2011;155:797-804. www.annals.org

Results: Physicians identified 1126 of their 4302 eligible patients (26.2%) as complex and assigned a mean of 2.2 domains of complexity per patient (median, 2.0 [interquartile range, 1 to 3]). Mental health and substance use were identified as major issues in younger complex patients, whereas medical decision making and care coordination predominated in older patients ($P < 0.001$ for trends by decade). Major independent predictors of PCP-defined complexity ($P < 0.001$) included age (probability of complexity increased from 14.8% to 19.8% with age increasing from 55 to 65 years), poorly controlled diabetes (from 12.7% to 47.6% if hemoglobin A_{1c} level ≥9%), use of antipsychotics (from 12.7% to 31.8%), alcohol-related diagnoses (from 12.9% to 27.4%), and inadequate insurance (from 12.5% to 19.2%). Classification agreement for complex patients ranged from 26.2% to 56.0% when PCP assignment was compared with each of the other methods.

Il 25% dei pazienti in carico ai GPs sono ad alta complessità

I maggiori determinanti di complessità sono:

- ***Età avanzata***
- ***Diabete scompensato***

Martin C. Gulliford, FRCP
Smriti Naithani, MSc
Myfanwy Morgan, PhD
Division of Health and Social Care Research, King's College, London, UK

Measuring Continuity of Care in Diabetes Mellitus: An Experience-Based Measure

Ann Fam Med 2006;4:548-555. DOI: 10.1370/afm.578.

ABSTRACT

PURPOSE Continuity is an important attribute of health care, but appropriate measures are not currently available. We developed an experience-based measure of continuity of care in type 2 diabetes.

METHODS A 19-item measure of experienced continuity of care for diabetes mellitus (ECC-DM) was developed from qualitative patient interview data with 4 continuity subdomains: longitudinal, flexible, relational, and team and cross-boundary continuity. The measure was implemented in a survey of 193 patients with type 2 diabetes from 19 family practices. Associations of ECC-DM scores with clinician organizational characteristics were estimated.

RESULTS Potential ECC-DM scores ranged from 0 to 100 with an observed mean of 62.1 (SD 16.0). The average inter-item correlation was 0.343 and Cronbach's α was 0.908. Factor analysis found 4 factors that were generally consistent with the proposed subdomains. Patients' mean scores varied significantly between practices (P = .001), ranging from 46 to 78 at different family practices. Experienced continuity was lower for patients receiving only hospital clinic care than for those receiving some diabetes care from their family practice (difference 13.7; 95% confidence interval [CI], 8.2-19.2; P <.001). Patients had higher ECC-DM scores if their family practice had a designated lead doctor for diabetes (difference 8.2; 95% CI, 2.7-13.6; P = .003).

CONCLUSIONS The results provide evidence for the reliability, construct validity, and criterion validity of the experienced continuity-of-care measure. The measure may be used in research and monitoring to evaluate patient-centered outcomes of diabetes care. Patients' experiences of continuity of care vary between health care organizations and are influenced by the organizational arrangements for care.

Score di Variabilità delle cure
46 - 78

Continuità di Cura
- ***bassa in Ospedale***
- ***più Alta x GPs***

La continuità di cura è fortemente influenzata dal tipo di organizzazione

The impact of second-level specialized care on hospitalization in persons with diabetes: a multilevel population-based study

Diabet. Med. 23, 377–383 (2006)

C. Giorda, A. Petrelli*, R. Gnavi*, and the Regional Board for Diabetes Care of Piemonte†

Relazione tra ore di diabetolgia e frequenza ricoveri/durata degenze ospedaliero

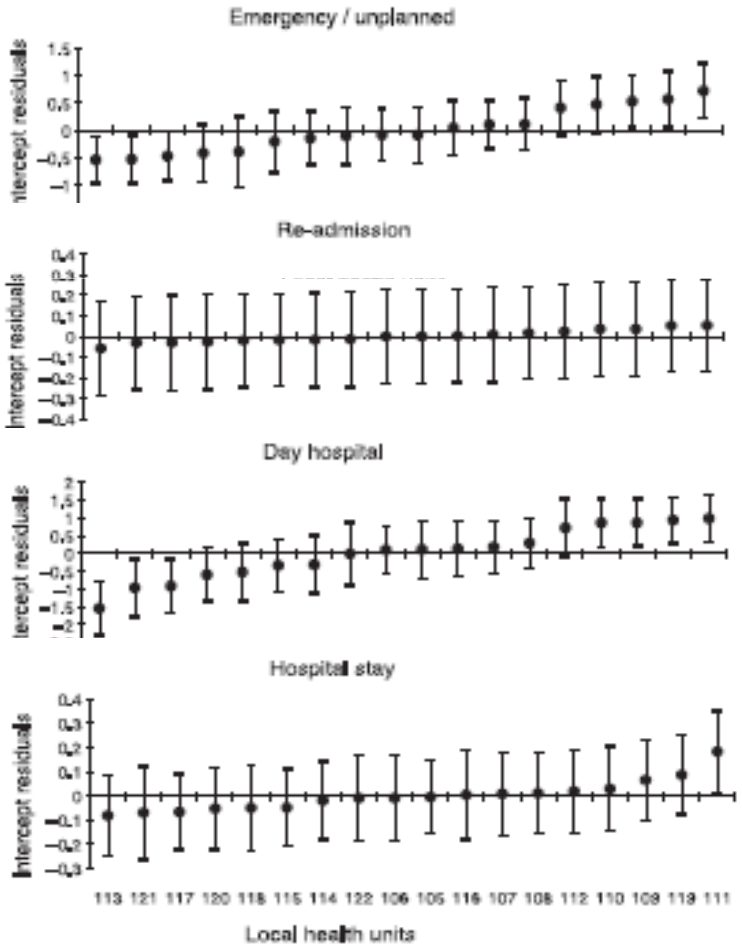
Abstract

Aims We evaluated whether differences in the use of specialized care have an impact on rates of hospitalization for diabetes.

Methods In 2001 we determined the number of hours of second-level diabetes care provided by local health units (LHU) of the Piemonte Region (Italy) and created an indicator of the mean weekly number of hours of care per 1000 residents for each LHU. From the database of the Piemonte Hospital Information System, we extracted all hospitalizations for 20–75-year-old residents with a main discharge diagnosis of diabetes mellitus (n = 3457). For each LHU, we calculated the hospitalization rate, the percentage of unplanned hospital admissions, the mean length of hospital stay, the percentage of day-hospital admissions and the percentage of re-admissions for diabetes-related complications within 6 months. The association between the indicators of specialized care and of hospital care was studied using two-level generalized hierarchical linear regression models (level 1: patient; level 2: LHU), taking into account the clustered nature of the data. Age, educational level and an indicator of disease severity were used as adjustment parameters.

Results In the tertile of LHUs that provided the greatest number of hours of diabetes care, we observed, compared with the lowest tertile fewer unplanned hospital admissions [odds ratio (OR) 0.37; 95% confidence interval (CI) 0.20–0.67], greater day-hospital use (OR 1.99; 0.72–5.49) and a lower mean duration of hospital stay (coefficient –0.26; 95% CI –0.45 to –0.06), independently of the socio-economic level, which was a separate risk factor.

Conclusions The intensity of specialized diabetes care greatly influences the characteristics of hospitalization.



OPEN ACCESS Freely available online

PLoS one

The Impact of Adherence to Screening Guidelines and of Diabetes Clinics Referral on Morbidity and Mortality in Diabetes

Carlo Giorda[1]*, Roberta Picariello[2], Elisa Nada[3], Barbara Tartaglino[3], Lisa Marafetti[1], Giuseppe Costa[2,4], Roberto Gnavi[2]

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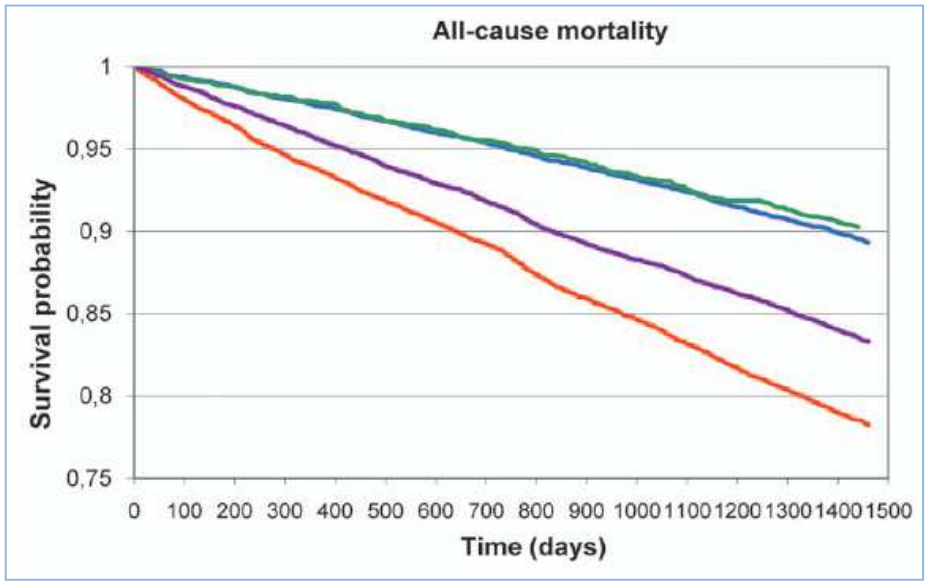
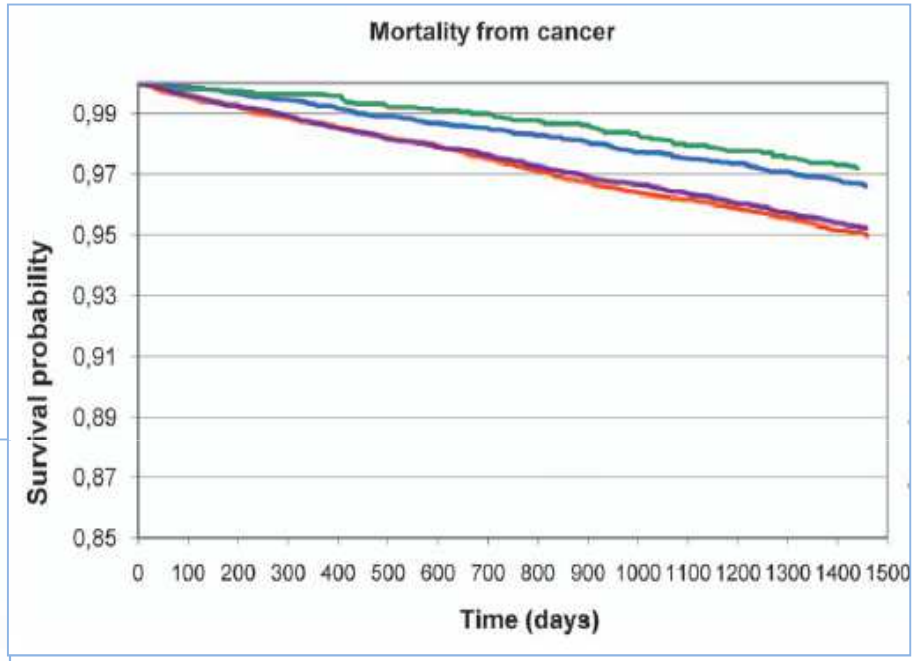
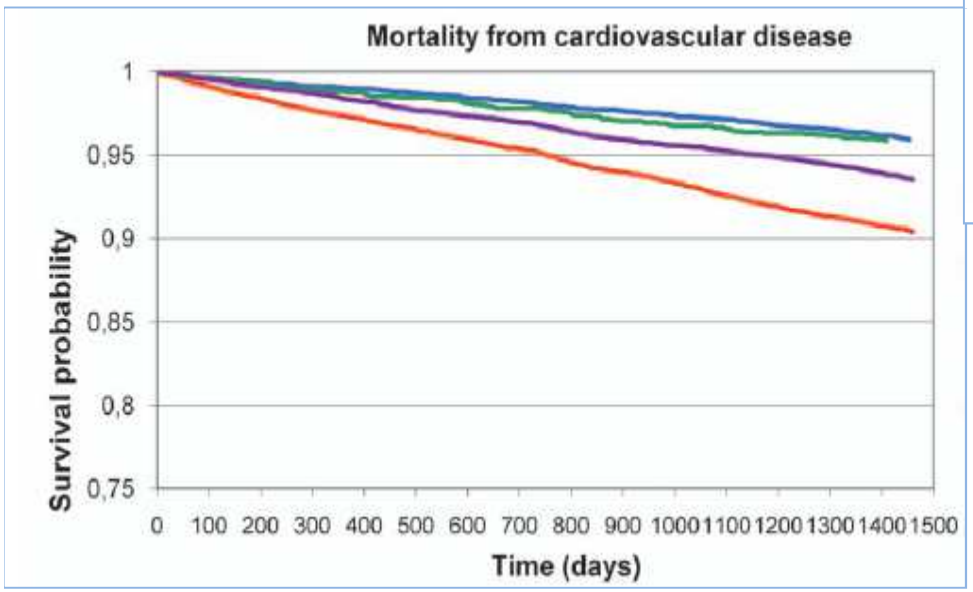
Abstract

Despite the heightened awareness of diabetes as a major health problem, evidence on the impact of assistance and organizational factors, as well as of adherence to recommended care guidelines, on morbidity and mortality in diabetes is scanty. We identified diabetic residents in Torino, Italy, as of 1st January 2002, using multiple independent data sources. We collected data on several laboratory tests and specialist medical examinations to compare primary versus specialty care management of diabetes and the fulfillment of a quality-of-care indicator based on existing screening guidelines (GCI). Then, we performed regression analyses to identify associations of these factors with mortality and cardiovascular morbidity over a 4 year- follow-up. Patients with the lowest degree of quality of care (i.e. only cared for by primary care and with no fulfillment of GCI) had worse RRs for all-cause (1.72 [95% CI 1.57–1.89]), cardiovascular (1.74 [95% CI 1.50–2.01]) and cancer (1.35 [95% CI 1.14–1.61]) mortality, compared with those with the highest quality of care. They also showed increased RRs for incidence of major cardiovascular events up to 2.03 (95% CI 1.26–3.28) for lower extremity amputations. Receiving specialist care itself increased survival, but was far more effective when combined with the fulfillment of GCI. Throughout the whole set of analysis, implementation of guidelines emerged as a strong modifier of prognosis. We conclude that management of diabetic patients with a pathway based on both primary and specialist care is associated with a favorable impact on all-cause mortality and CV incidence, provided that guidelines are implemented.


All-cause mortality
Survival probability
1
0,95
0,9
0,85
0,8
0,75
0 100 200 300 400 500 600 700 800 900 1000 1100 1200 1300 1400 1500
Time (days)


Mortality from cancer
Survival probability
0,99
0,97
0,95
0,93
0,91
0,89
0,87
0,85
0 100 200 300 400 500 600 700 800 900 1000 1100 1200 1300 1400 1500
Time (days)


Mortality from cardiovascular disease
Survival probability
1
0,95
0,9
0,85
0,8
0,75
0 100 200 300 400 500 600 700 800 900 1000 1100 1200 1300 1400 1500
Time (days)


GP and Specialist, with GCI
GP and Specialist, without GCI
GP and GCI, without Specialist
Only GP

Table 3. Rates ratios (RR) and 95% confidence intervals for mortality and for incidence of major cardiovascular events care; 2003–2006.

		Level of care			
		Specialist and GP, with GCI	Specialist and GP, without GCI	GP and GCI, without Specialist	Only GP
		RR	RR (95% CI)	RR (95% CI)	RR (95% CI)
Mortality	All causes	1	1.29 (1.17–1.41)	0.95 (0.81–1.12)	1.72 (1.57–1.89)
	Cardiovascular disease	1	1.19 (1.03–1.38)	1.06 (0.82–1.37)	1.74 (1.50–.2.01)
	CHD	1	1.16 (0.93–1.46)	1.31 (0.91–1.88)	1.48 (1.18–1.86)
	Stroke		1.04 (0.76–1.40)	0.77 (0.43–1.38)	1.93 (1.44–2.57)
	Cancer	1	1.26 (1.07–1.50)	0.86 (0.63–1.17)	1.35 (1.14–1.61)
Incidence	AMI	1	1.24 (1.04–1.47)	1.22 (0.92–1.60)	1.31 (1.10–1.55)
	Stroke	1	1.14 (0.95–1.38)	0.77 (0.54–1.09)	1.32 (1.09–1.59)
	LEA	1	1.57 (0.99–2.50)	1.15 (0.51–2.56)	2.03 (1.26–3.28)

doi:10.1371/journal.pone.0033839.t003

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10.1093/intqhc/mzl071

Performance improvement based on integrated quality management models: what evidence do we have? A systematic literature review

MIRELLA MINKMAN[1], KEES AHAUS[2] AND ROBBERT HUIJSMAN[3]

Abstract

Purpose. Health care organizations have to improve their performance for multiple stakeholders and organize integrated care. To facilitate this, various integrated quality management models can be used. This article reviews the literature on the Malcolm Baldrige Quality Award (MBQA) criteria, the European Foundation Quality Management (EFQM) Excellence model (Excellence award models) and the Chronic Care Model. The focus is on the empirical evidence for improved performance by the implementation of interventions based on these models.

Data sources. A systematic literature review from 1995 to May 2006 in the Pubmed, Cochrane, and ABI- databases was conducted.

Study selection. After selection, 37 studies were included, 16 in the Excellence award model search and 21 in the Chronic Care Model search.

Data extraction and results of analysis. Data were retrieved about the main intervention elements, study design, evidence level, setting and context factors, data collection and analysis, principal results and performance dimensions. No Excellence Award model studies with controlled designs were found. For the Chronic Care Model, one systematic review, one meta analysis and six controlled studies were included. Seventeen studies (2 in Excellence award model, 15 in Chronic Care Model) reported one or more significant results.

Conclusion. There is some evidence that implementing interventions based on the 'evidence-based developed' Chronic Care Model may improve process or outcome performances. The evidence for performance improvement by interventions based on the 'expert-based developed' MBQA criteria and the EFQM Excellence model is more limited. Only a few studies include balanced measures on multiple performance dimensions. Considering the need for integrated care and chronic care improvement, the further development of these models for guiding improvements in integrated care settings and their specific context factors is suggested.

Keywords: performance improvement, total quality management, chronic disease, organizational models, evidence-based

International Journal for Quality in Health Care 2005; Volume 17, Number 2: pp. 141–146
Advance Access Publication: 21 January 2005

Review Article

Integrated care programmes for chronically ill patients: a review of systematic reviews

MARIELLE OUWENS, HUB WOLLERSHEIM, ROSELLA HERMENS, MARLIES HULSCHER AND RICHARD GROL

Abstract

Objective. To investigate effectiveness, definitions, and components of integrated care programmes for chronically ill patients on the basis of systematic reviews.

Design. Literature review from Ja

Main measures. Definitions and

Results. Searches in the Medline
chronically ill patients. Despite co
care, integrated care programmes
present for the management of p
very similar, namely reducing frag
the programmes differed widely.
port and patient education, often
care team; multidisciplinary clinic

- Frammentazione delle cure
- Inappropriata applicazione delle conoscenze
- Efficacia delle cure
- Multidisciplinarità
- Integrazione
- Professional's education
- Quality of care
- Integrated care

e quality of care.

ure programmes for
es and outcomes of
ent definitions were
e programmes were
ocus and content of
f-management sup-
idisciplinary patient

Conclusion. Integrated care programmes seemed to have positive effects on the quality of care. However, integrated care programmes have widely varying definitions and components and failure to recognize these variations leads to inappropriate conclusions about the effectiveness of these programmes and to inappropriate application of research results. To compare programmes and better understand the (cost) effectiveness of the programmes, consistent definitions must be used and component interventions must be well described.

Keywords: disease management, health services research, integrated care, quality improvement

Lavoro originale Gianpiero Marino

Il Giornale di AMD 2012;15:89-91

Primi accessi al servizio di diabetologia: implicazioni cliniche e gestionali

G. Marino, G. Guarino, S. Gentile
gisuseppina.guarino@uniba2.it

Dipartimento di Medicina Clinica e Sperimentale, AUO Seconda Università di Napoli

Parole chiave: diabete mellito tipo 2, precocità di accesso, cure specialistiche, disease management, costi del diabete
Key words: type 2 diabetes mellitus, early referral, secondary care, disease management, diabetes costs

Il Giornale di AMD, 2012;15:89-91

L'efficacia della precocità di un intervento ottimizzato per la cura del diabete mellito è ampiamente dimostrata in letteratura: ***premessa di SUBITO!***

Esistono protocolli condivisi tra MMG e Diabetologi sulla precocità di approccio fin dal momento della diagnosi

Tuttavia, solo in poche realtà sono applicati reali protocolli di gestione integrata e l'accesso al Servizio di Diabetologia è regolato da flussi gestiti dal Medico di Medicina Generale, principalmente per :

- scompenso metabolico
- necessità di trattamento insulinico
- presenza di complicanze

SCOPO

Valutare le caratteristiche cliniche e l'impatto assistenziale di diabetici tipo 2, in rapporto alla maggiore o minore precocità di accesso al Servizio di Diabetologia

I pazienti sono stati divisi in 2 gruppi:

- **Accessi precoci ≤ 1 anno dalla diagnosi**
- **Accessi tardivi: > 1 anno dalla diagnosi**

Criteri di arruolamento:

- DM Tipo 2

- mai visti da nessun diabetologo prima

CRATTERISTICHE DEMOGRAFICHE DEI SOGGETTI AFFERITI AL SERVIZIO di DIABETOLOGIA: ANNO 2005

Nuovi accessi nell'anno: n. 313 diabetici tipo 2

		Accesso Precoce *n. 111**	Accesso Tardivo *n. 202***	*p*
Età *(anni)*	*M±DS*	62±16	64±14	*ns*
	range	41-76	38-77	
M/F		60/51	106/96	*ns*
	n. (ratio)	1.18	1.10	
Fumatori	*n.*	38	68	
	(%)	(34.2)	(33.7)	*ns*
BMI *(kg/m²)*	*M±DS*	27.2±12	28.2±14	
	range	24-41	25-42	*ns*
HbA1c *(%)*	*M±DS*	7.7±2.1	10.8±2.2	
	range	5.8-11.3	7.2-12.2	***<0.01***

** range: 3-12 mesi; ** range: 1.5-9 anni*

CRATTERISTICHE CLINICHE DEI SOGGETTI AFFERITI AL SERVIZIO di DIABETOLOGIA: ANNO 2005

Nuovi accessi nell'anno: n. 313 diabetici tipo 2

2005	Accesso Precoce	Accesso Tardivo	Δ (%)	p
TN Diabete *(M±DS)*	1.5±0.6	2.6±0.8	+ 74.0	**<0.01**
Necessità Insulina *n. (%)*	9 (8.1)	38 (18.8)	+ 10.7	**<0.01**
TN Ipertensione *(M±DS)*	1.7±0.8	2.8±0.6	+ 64.7	**<0.01**
TN Lipidi *(M±DS)*	0.4±0.4	1.3±0.5	+ 294.0	**<0.0001**
Accessi N./Anno *(M±DS)*	2.3±0.4	3.6±1.6	+ 56.5	**< 0.01**
TN = Numero di Trattamenti				

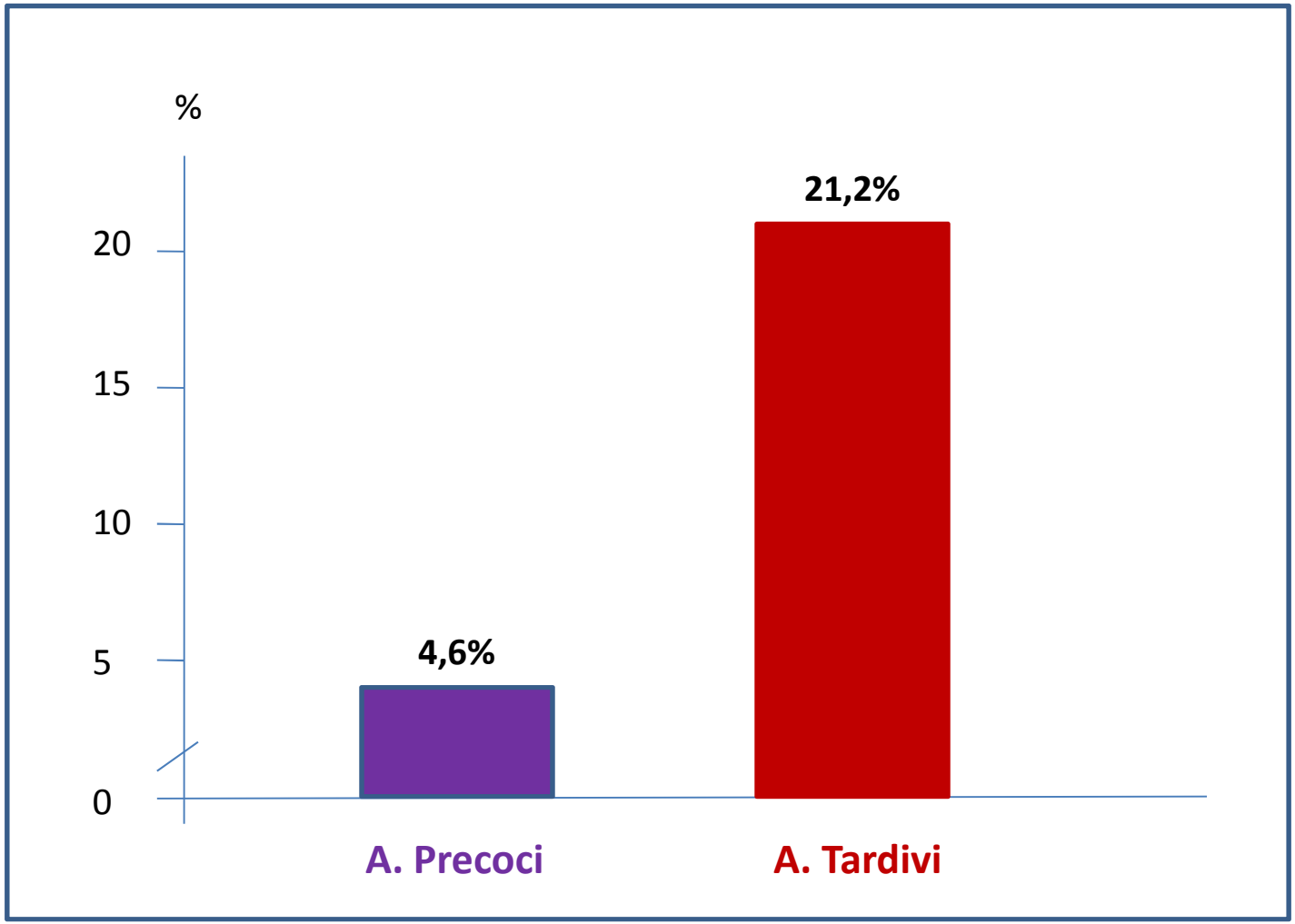
COMPLICANZE e PARAMETRI CONNESSI

2005 *N. (%)*	Early Referral	Late Referral	Δ	*P*
Soggetti numero *(%)*	(n. 111)	(n. 202)		
Retinopatia: (%)				
- **NP**	1 (0.9)	59 (29.2)	20.2	**<0.001**
- **PP**	- -	26 (12.9)	12.9	**-**
- **Pr**	- -	3 (1.5)	1.5	**-**
- **M**	- -	16 (7.9)	7.9	**-**
- **B**	- -	1 (0.5)	0.5	**-**
- ***overall***	*1 (0,9)*	*69 (34.2)*	*33.3*	***<0.0001***
Neuropatia:				
- **A**	26 (23.4)	148 (73.3)	49.9	**<0.01**
- **Pe**	14 (12.6)	32 (15.8)	3.2	**n s**
Nefropatia:				
- **MI**	20 (18.0)	82 (40.6)	22.6	**<0.01**
- **MA**	1 (0.9)	36 (17.8)	16.9	**<0.01**
- **CKD**	- -	7 (3.5)	-	**-**
- ***overall***	*21 (18.9)*	*118 (58.4)*	*36.5*	***<0.0001***
Pressione Arteriosa >130/80 mm Hg	49 (44.1)	107 (52.9)	8.8	**<0.05**
Colesterolo Totale > 200 mg/dl	21 (18.9)	68 (33.7)	14.8	**<0.05**
Trigiceridi >150 mg/dl	42 (37.8)	147 (72.8)	35.0	**<0.001**
Ulcere/ amputazione	- -	24 (11.9)	-	**-**
TSA	9 (8.1)	57 (28.2)	20.1	**<0.01**
POA	2 (1.8)	24 (11.8)	10.0	**<0.001**
Difunzione erettile	7 (6.3)	59 (29.9)	23.6	**<0.01**

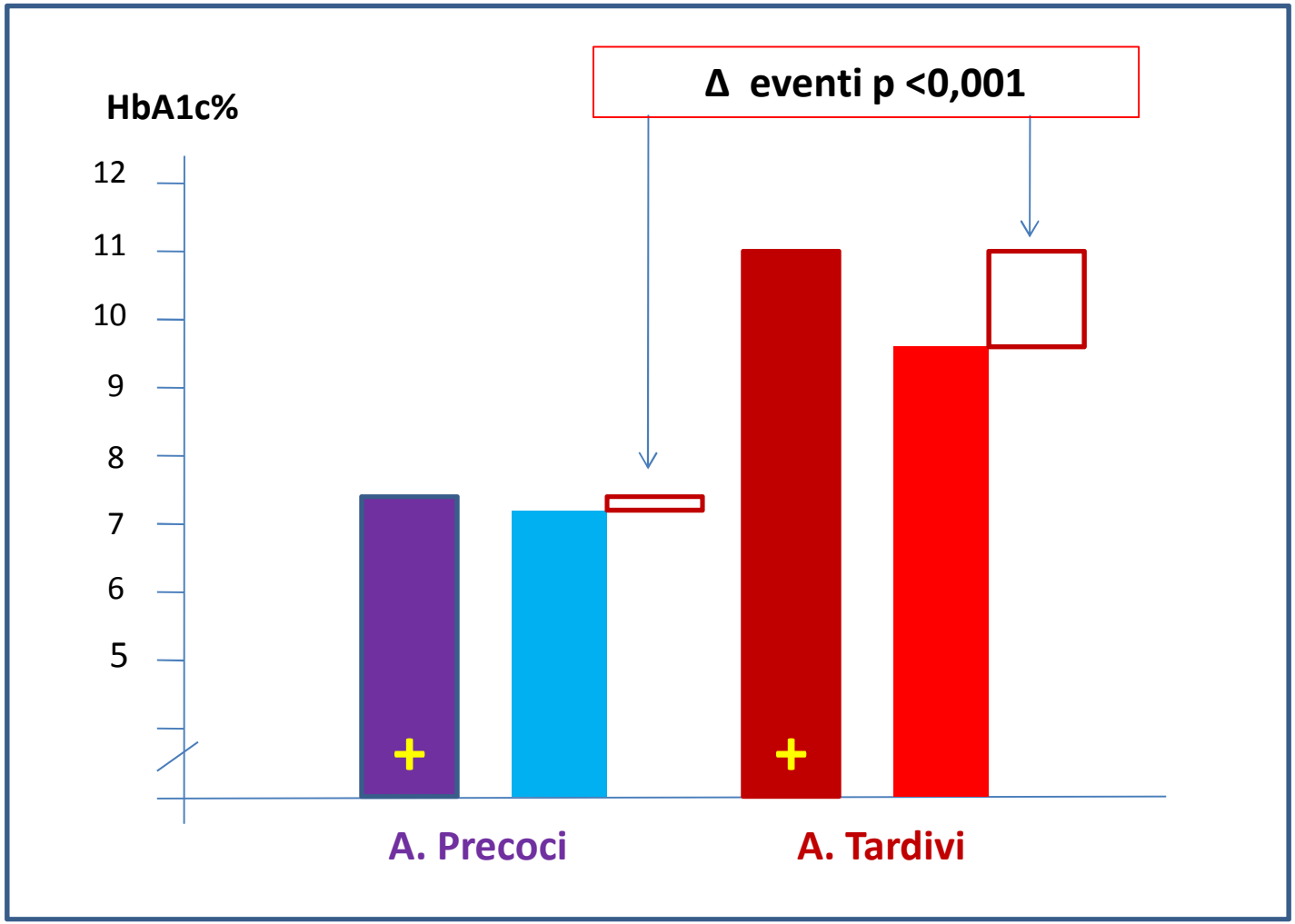
Consumo di farmaci distinto per Precocità di Accesso

2005	Accessi Precoci	Accessi Tardivi	Δ	*P*
Soggetti numero *(%)*	111	202		
CVD medications				
- Statins	21 (18.9)	68 (33.8)	14.8	***<0.05***
- Fibrates	42 (37.8)	147 (72.8)	35.0	***<0.001***
- ACE Inhibitors	29(26.1)	84 (41.5)	15.4	***<0.01***
- ARBs	34(30.6)	68 (33.6)	7.9	***<0.05***
- Thiazides	35(31.5)	89 (44.1)	12.6	***<0.01***
- Other BP drugs	22(19.6)	44 (21.8)	33.3	***<0.001***
- ASA	13*(11.7)	73^ (36.1)	24.4	***<0.01***
- Other anitiplatelets	2** (1.8)	24^^ (11.9)	10.1	***<0.01***

FREQUENZA di EVENTI CV in FUNZIONE della PRECOCITA' di ACCESSO



FREQUENZA di EVENTI CV in FUNZIONE della PRECOCITA' di ACCESSO in rapporto al valore di HbA1c



FOLLOW-UP A 5 ANNI
COMPLICANZE, TRATTAMENTI, ACCESSI

2005	Early Referral	Late Referral	Δ (%)	p
TN Diabetes *(M±DS)*	1.5±0.6	2.6±0.8	+ 74.0	<0.01
Patients requiring Insulin[*] *n. (%)*	9 (8.1)	38 (18.8)	+ 10.7	<0.01
TN Hypertension *(M±DS)*	1.7±0.8	2.8±0.6	+ 64.7	<0.01
TN Lipids *(M±DS)*	0.4±0.4	1.3±0.5	+ 294.0	<0.0001
Access Number/Year *(M±DS)*	2.3±0.4	3.6±1.6	+ 56.5	0.01

Follow-up 2010	Early Referral*	Late Referral*	Δ (%)	p
TN Diabetes *(M±DS)*	1.7±0.7	2.9±0.6	+ 58.6.0	<0.01
Patients requiring Insulin[1] *n. (%)*	12 (10.8)	52 (25.7)	+ 14.9	<0.01
TN Hypertension *(M±DS)*	1.8±0.7	3.4±0.8	+ 52.9	<0.01
TN Lipids *(M±DS)*	0.8±0.5	4.8±0.6	+ 166.6	<0.0001
Access Number/Year *(M±DS)*	2.5±0.4	5.5±1.0	+ 45.5	0.01
	ns	P<0.01		

CONCLUSIONI

Un accesso precoce al Servizio di Diabetologia consente di ridurre nel tempo:

- complicanze CV
- consumo di farmaci
- numero di accessi/anno/paziente
- costi

L'andamento epidemiologico comporterà sempre più pazienti al primo accesso al SdD

Il SdD deve organizzare i propri percorsi per mantenere efficacia e qualità del servizio offerto e deve coordinarsi al meglio e in rete con i MMG del territorio

PROGETTO ALLEANZA PER IL DIABETE IN CAMPANIA 2011-2013

Razionale

Un cura efficace ed appropriata della malattia diabetica richiede una riorganizzazione dell'attuale sistema assistenziale fatto ancora di compartimenti stagni incapaci di interagire tra loro.

Come elemento di criticità della scarsa applicazione della gestione integrata, spicca la scarsissima connessione interdisciplinare tra MMG e Centri di secondo livello per la cura del Diabete.

E' necessaria la ricerca e la programmazione di nuovi modelli assistenziali efficaci per ridurre l'impatto della malattia su più ampia scala, rispettosi delle disponibilità economiche.

La realizzazione di una connessione strutturata permetterebbe una maggiore aderenza al percorso diagnostico-terapeutico come da LG, il che permetterebbe di ottenere migliori performances e gli outcomes.

Risulterebbe estremamente più efficace il monitoraggio degli interventi in tema di prevenzione primaria e secondaria, l'educazione alla salute e la erogazione delle prestazioni diagnostiche e dei presidi terapeutici secondo algoritmi controllati nelle diverse postazioni di cui si compone il percorso diagnostico terapeutico.

Obiettivi:

Realizzare una rete assistenziale integrata tra MMG e SdD

- Individuare le competenze di primo e secondo livello di cura nel modello integrato nel rispetto del documento di indirizzo AMD, SID e SIMG
- Introdurre il criterio della valutazione dell'"appropriatezza delle prestazioni sanitarie"
- Identificare indicatori di struttura, processo ed esito in tutti i punti di snodo del PDT del DMT2
- Sperimentare un modello di valutazione continua della spesa per farmaci, presidi e prestazioni diagnostiche
- Migliorare la prevenzione e la cura del diabete mellito di tipo 2 nella Regione Campania

RISULTATI

"ALLEANZA PER IL DIABETE" NELLA REGIONE CAMPANIA

Armentano V, *Arpino G, *De Camillis U, De Rosa N, Gentile S, Perrelli A, *Piccinocchi G,
AMD Campania e *SIMG Campania

- 600 MMG
- 108 SdD
- 90 Indicatoti
- 12.672 DM2
- 3 anni di sperimentazione:
  - dati 2009 vs 2007 e 2008 già analizzati;
  - 2010 e 2011 da analizzare,
  - 2012 in corso
- Formazione: 2 cicli formativi già attuati su tutti i partecipanti
- miglioramento della qualità assistenziale

INDICATORE	um	DIC_2007	DIC_2008	DIC_2009
Totale pazienti	nr	164113	165522	168785
Pazienti non diabetici ma con almeno un fattore di rischio per diabete	%	28,04	29,31	30,19
Pazienti diabetici	nr	10651	11652	12672
Pazienti diabetici : Prevalenza	%	6,49	7,04	7,51
Pazienti diabetici con ipertensione	%	69,38	71,21	72,63
Pazienti diabetici con dislipidemia	%	31,18	32,5	33,51
Pazienti diabetici con ipertensione e dislipidemia	%	24,52	25,95	27,15
Pazienti diabetici con registrazione dato fumo nell'anno	%	31,51	27,77	31,22
Pazienti diabetici con registrazione BMI	%	67,56	69,1	69,85
Richiesta microalbuminuria nei pazienti diabetici	%	15,37	18,55	21,47
Richiesta creatininemia nei pazienti diabetici	%	66,24	69,65	69,52
Pazienti diabetici con richiesta di fondo oculare nei 2 anni precedenti	%	31,59	30,6	32,1
Pazienti diabetici con richiesta di profilo lipidico	%	70,15	69,77	68,61
Pazienti diabetici con richiesta di Ecg	%	7,17	32,81	36,77
Pazienti diabetici con misurazione di PA	%	44,98	49,81	46,3
Pazienti diabetici con richiesta Hb glicata	%	73,19	82,44	81,71
Pazienti diabetici con Hb glicata <7	%	54,44	60,31	61,51
Pazienti diabetici con LDL <100	%	36,41	38,2	42,01
Pazienti diabetici con PA<=130/80	%	44,35	47,52	50,84
Pazienti diabetici con stadio 5° IRC	%	1,54	1,02	1,3
Pazienti diabetici con stadio 4° IRC	%	3,2	3,24	3,87
Pazienti diabetici con stadio 3° IRC	%	41,48	41,31	41,31
Pazienti diabetici con stadio 2° IRC	%	39,88	41,06	38,34
Pazienti diabetici con stadio 1° IRC	%	14,02	13,81	15,83
Pazienti diabetici con VFG <=45 e trattati con metformina o metformina in associazione	%	45,27	41,87	42,12
Totale ricoveri nei pazienti diabetici	nr	137	133	139

Um = unità di misura; T0 = tempo zero (tempo di inizio della ricerca: ultimi 12 mesi, 24 mesi o intero periodo di assistenza dei pazienti in esame, quest'ultimo indicato dalla lettera T)