IL RUOLO ATTIVO DEL DISTRETTO PER LA PREVENZIONE ED I BUONI STILI DI VITA

MESAGNE (BR)
Sala convegno del Castello
Venerdì, 23 settembre 2016

Luigi Maselli, MD, PhD
Istruttore di Medicina dello Stile di Vita
Direttore Scientifico
CENTRO NAZIONALE RICERCHE
Scienze dello Stile di Vita
TECNOPOLIS PST
- BARI -

Lifestyle Medicine
GLOBAL ALLIANCE

TrueHealth
INITIATIVE

American College of
Lifestyle Medicine

Australasian
Society of
Lifestyle
Medicine

ASSISTENZA IL GIOVANE NEUROLOGO BARESE LUIGI MASELLI AL CONVEGNO DELLA HARVARD MEDICAL SCHOOL: L'ISPIRAZIONE DEI DOTTORI

«Con la medicina dello stile di vita rieduco il paziente al suo benessere»

Il giovane professionista barese **Luigi Maselli**, specialista e ricercatore in Neuroscienze, membro attivo della Global Lifestyle Medicine Alliance, è stato scelto per relazionare al convegno internazionale di «Medicina dello stile di vita», lo scorso 21 giugno, presso il Massachusetts General Hospital di Boston della prestigiosa Harvard Medical School.

«Da ricercatore in Neuroscienze, esperto del comportamento umano - dice Maselli -, sono da decenni impegnato assieme ai colleghi di tutto il mondo nella ricerca, promozione e pratica clinica della medicina dello Stile di vita. Attraverso la pratica di questa "nuova Medicina", chiamata oggi ad affiancare e spesso a sostituire del tutto quella convenzionalmente in uso nei nostri ospedali, ci occupiamo di ri-educare ogni persona alla buona vita, passo per passo e qualunque sia il suo attuale stato di salute. Il nostro obiettivo comune è di condurre il soggetto al raggiungimento del proprio ottimale "stato di benessere fisico, psichico e sociale e non di semplice assenza di malattia", esattamente come definito nella Costituzione dell'Organizzazione mondiale della sanità quale diritto fondamentale che spetta alla Persona».

Patients need doctors who inspire them (I pazienti hanno bisogno di dottori che li ispirino) è il messaggio che il professor Luigi Maselli ha voluto portare all'attenzione dei suoi colleghi, poiché, in base alla sua esperienza clinica, i pazienti che scelgono di migliorare le proprie condizioni di salute, necessitano di motivazione, determinazione, sostegno e coerenza, oltreché professionalità, da parte di chi si prende cura di loro. Il paziente deve poter rispecchiarsi nel suo medico, deve vedere in lui un esempio di buona condotta, e questi deve sempre tendere a migliorare le performances dei suoi pazienti aumentando la loro consapevolezza e passione per la vita.

«Non esistono scorciatoie - spiega Maselli - per raggiungere il completo benessere psicofisico, ma esistono "Simple changes for big rewards" – piccoli cambiamenti per grandi ricompense - cambiamenti che devono essere attuati giorno dopo giorno, traguardo dopo traguardo, attraverso la pratica sportiva, la meditazione, le opportune modifiche all'alimentazione, l'idratazione, la coltivazione di pensieri postivi e relazioni soddisfacenti, poiché lo scopo finale è quello di raggiungere e mantenere nel tempo gli standard qualitativi più che soddisfacenti».

NEUROLOGO Il giovane professionista barese Luigi Maselli

THE
HARVARD
MEDICAL SCHOOL

Stanford
HEALTH CARE

ITALIAN LIFESTYLE MEDICINE
«Benessere e Longevità attraverso la Scienza»

CLINICAL HEALTH PROMOTION CENTRE

REGION H

Clinical Health Promotion Centre

WHO Collaborating Centre for Evidence-Based Health Promotion in Hospitals & Health Services

RESEARCH

EDUCATION

SCIENTIFIC JOURNAL

HPH

CLINICAL EFFECT DATABASES

National Research Center – Lifestyle Sciences

COSA CI ASPETTA?

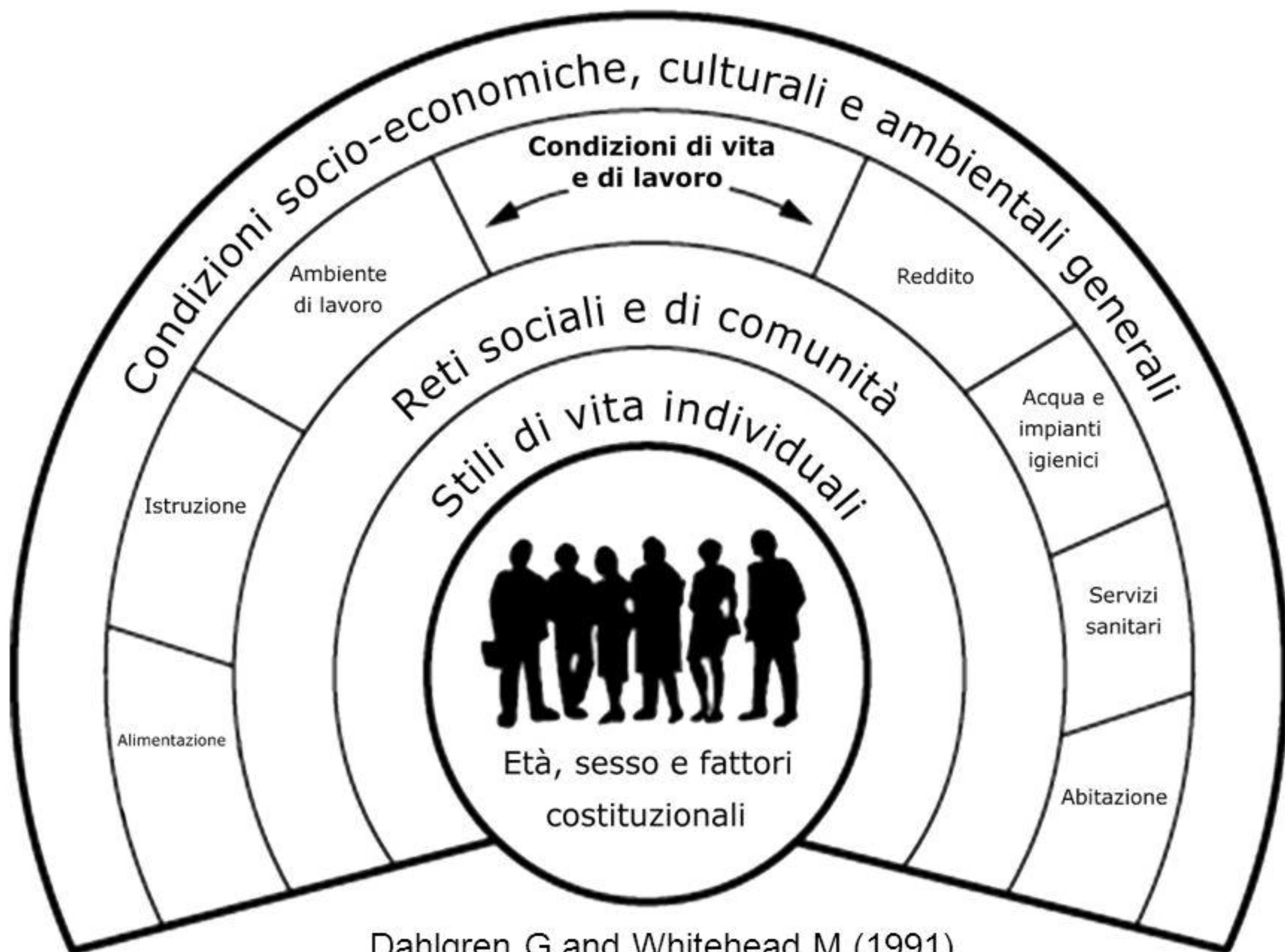
Life expectancy

88
86
84
82
80
78
76
74
72

Women
86.83
80.50
Men

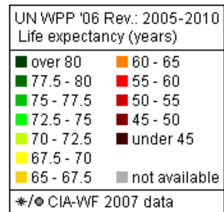
1980 ’85 ’90 ’95 2000 ’05 ’10 ’14

I determinanti della salute



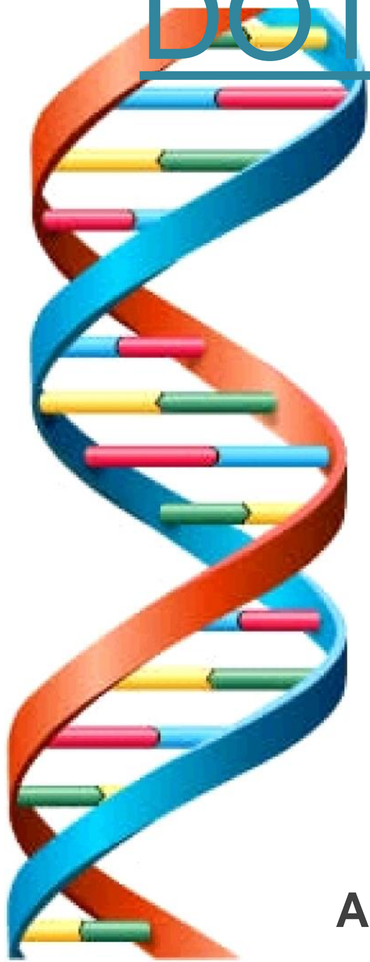
Dahlgren G and Whitehead M (1991)

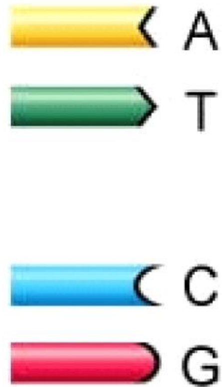
ASPETTATIVA DI VITA NEL MONDO



UN World Population Prospects - The 2006 Revision: 2005-2010 Life Expectancy at birth (years).

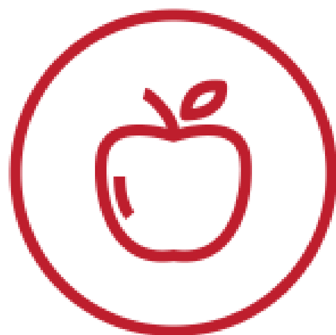
ALCUNI NASCONO BEN DOTATI





ANGELA 103 anni

PER TUTTI GLI ALTRI SERVE TUTTA UNA VITA DI PRATICA



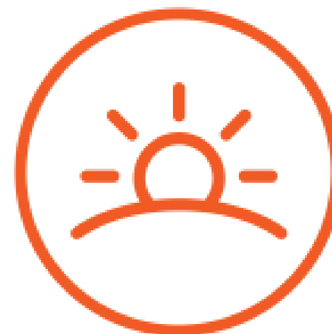
NUTRITION

EXERCISE

TOBACCO
& ALCOHOL

STRESS
MANAGEMENT

SLEEP



HEALTHY
RELATIONSHIPS

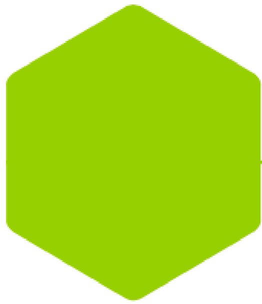
The Future of the Public's Health in the 21st Century

Committee on Assuring the Health of the Public in the 21st Century

ISBN: 0-309-50655-7, 536 pages, 6x9, (2002)

This PDF is available from the National Academies Press at:
http://www.nap.edu/catalog/10548.html

“Knowing is not enough; we must apply.
Willing is not enough, we must do.”



EXECUTIVE SUMMARY

Noncommunicable diseases (NCDs), including cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, and their key risk factors – tobacco, harmful use of alcohol, unhealthy diet and physical inactivity – remain the leading causes of death globally. NCDs are currently responsible for almost 70% of global deaths, the majority occurring in low- and middle-income countries. In recent years NCDs have been increasingly in the spotlight of the global public health community and national leaders. Most recently, the 2030 Agenda for Sustainable Development Goals, adopted at the United Nations of health, national institute, or agency responsible for NCDs in all WHO Member States (194 countries). The survey tool included questions on (i) public health infrastructure, partnerships and multisectoral collaboration; (ii) policies, strategies and action plans; (iii) health information systems and surveillance; and (iv) health-system capacity for detection treatment and care. Data collection was conducted between May and August 2015. For validation and verification of responses, countries submitted supporting documentation for a select number of questions. These were then reviewed by the WHO Secretariat

2015

ASSESSING NATIONAL CAPACITY FOR THE PREVENTION AND CONTROL OF

NONCOMMUNICABLE DISEASES

GLOBAL SURVEY

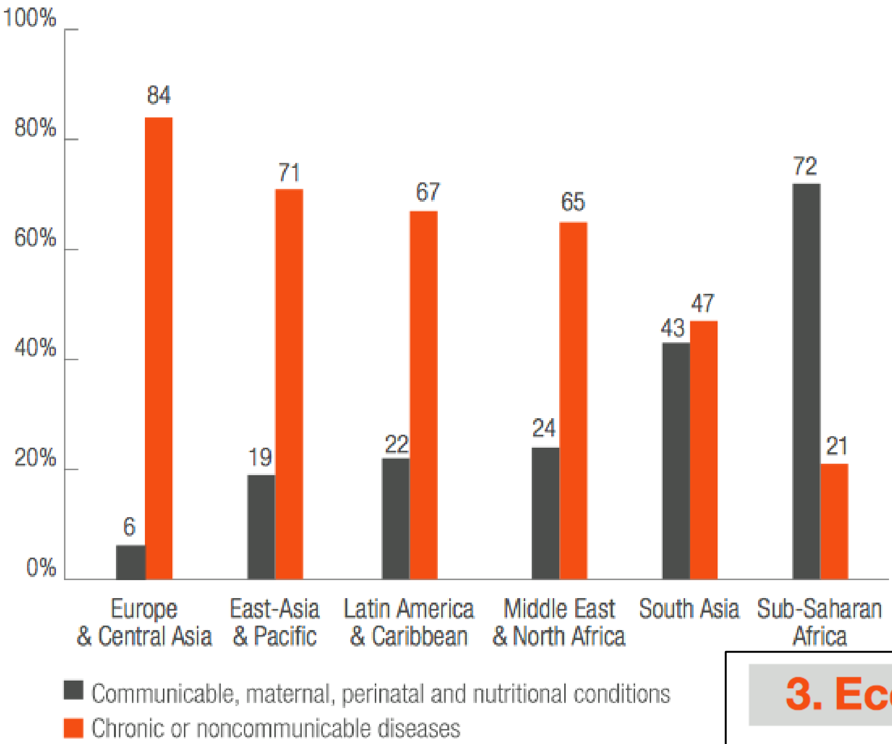
WHO Library Cataloguing-in-Publication Data

Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2015 global survey.

1.Chronic Disease - prevention and control. 2.National Health Programs. 3.Health Surveys. I.World Health Organization.

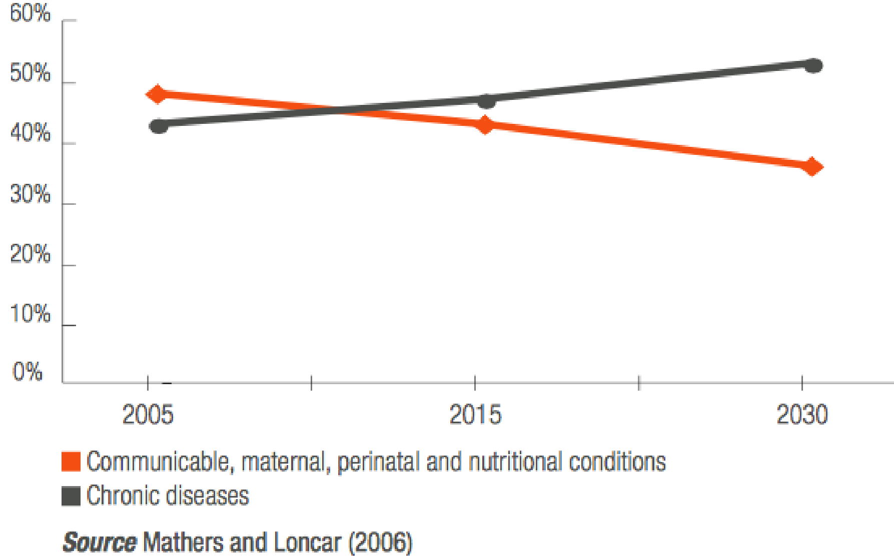
ISBN 978 92 4 156536 3 (NLM classification: WT 500)

Figure 2 Worldwide share of deaths by cause and World Bank region (excluding high-income countries, 2002)



Source Mathers et al. (2003)

Figure 3 Projections of cause-specific deaths (as a percentage of total deaths) in low-income countries, baseline scenario



Source Mathers and Loncar (2006)

3. Economic consequences of chronic disease

Compared with evidence of the public health burden of chronic disease, evidence of the economic consequences is comparatively scarce – especially for developing countries. Though the economic language can sometimes appear to trivialise the human lives involved, there is, in fact, a strong immediate relationship between improved health (in the form of reduced mortality or morbidity) and economic gain. Good health increases the lifetime consumption possibilities of individuals, thereby directly augmenting utility – the maximisation of which is seen by economists to be the ultimate objective of human endeavour.[16]

There are, of course, different ways of measuring the economic consequences of chronic disease, and the boundaries between them are not always clear. For the purpose of the present chapter, three approaches are distinguished: the 'cost-of-illness' (COI) approach (section 3.1), the microeconomic approach (section 3.2) and the macroeconomic approach (section

3.1 Cost-of-illness studies

It seems obvious that there are costs associated with being ill. First, there is the cost of obtaining treatment, whether it is a trip to a shop to purchase a simple painkiller or a major operation in a hospital. Second, there is the income foregone by those who are sufficiently unwell to be prevented from working. Third, and less easy to measure, there is the intangible cost associated with pain, disability and suffering.

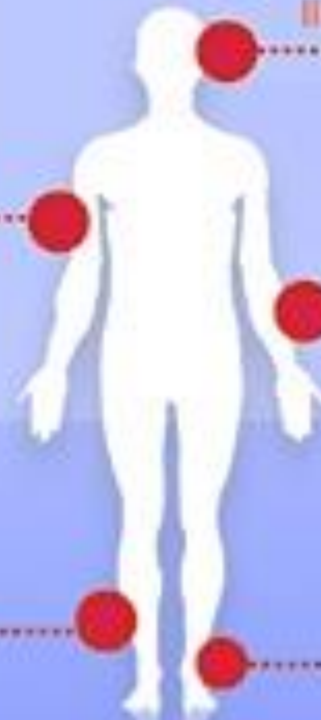
The challenge is how to measure these costs. This question has given rise to an extensive body of research, most of which has focused on high-income countries. Cost-of-illness studies estimate the quantity of resources (in monetary terms) used to treat a disease as well as the size of the negative economic consequences of illness in terms of lost productivity to society or to a specific sector. They represent a useful first step in developing some idea about the economic burden of ill health in general and of chronic disease

YOUR HEALTH IS YOUR WEALTH

Characteristics of

NON-COMMUNICABLE DISEASES

limit productivity



Require long term treatment

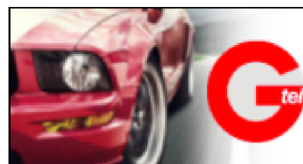
Cost Financial burden to household

Need family involvement for holistic care

Require more than one drug

Why health promotion in hospitals and health services?

Health promotion is often considered by people to be the core business of medicine in general and hospitals in particular. On examination, however this is often far from the reality. Historically hospitals and health services have developed around their ability to treat disease and support patients' health i.e. cure disease and where there is no cure, to alleviate their pain and comfort them. This focus has been challenged in recent decades as an effective response is required to counter the rising levels of chronic ill health and disease that is being seen in association with ageing populations.


Inserisci la targa della tua auto e la data di nascita del proprietario
Basta un click!
AA123BB
GG/MM/AAAA
Fai un preventivo
La presente comunicazione è finalizzata al collocamento di contratti assicurativi. Prima della sottoscrizione leggere il fascicolo informativo disponibile su www.genertel.it.
Privacy Genertel

Spesa farmaceutica. Nuovo report Aifa gennaio/maggio 2016. I conti sono già in rosso per 1,2 miliardi: non reggono i tetti di ospedaliera (+821 milioni) e territoriale (+415 milioni). Crolla spesa in farmacia (-4,1%)

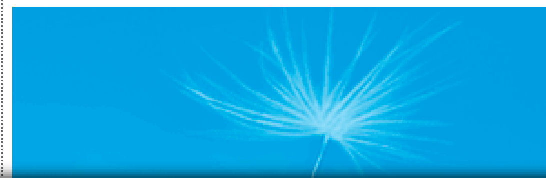
Prosegue invece il boom della distribuzione diretta delle Asl con un incremento della spesa di oltre il 35%. Torna a crescere la compartecipazione alla spesa dei cittadini. Ad aumentare è la quota da pagare se si sceglie un branded invece che un generico, mentre calano i ricavi dal ticket fisso sulla ricetta. IL REPORT AIFA

17 SET - Pubblicato da Aifa il monitoraggio della spesa farmaceutica 2016 con i dati dei primi 5 mesi dell'anno. La spesa territoriale, tra farmacie e distribuzione diretta (senza pay back e senza innovativi) raggiunge i 5.778 milioni di euro e sfonda il tetto programmato di 415 milioni.

La spesa ospedaliera si assesta invece sul 2.573 milioni e sfonda il tetto di ben 821milioni di euro (si è speso in sostanza il 46% in più rispetto a quanto programmato).

Ticket. Torna a salire (+0,9% % rispetto a stesso periodo 2015) il conto per i

QSnewsletter
ISCRIVITI ALLA NOSTRA NEWS LETTER
Ogni giorno sulla tua mail tutte le notizie di Quotidiano Sanità.



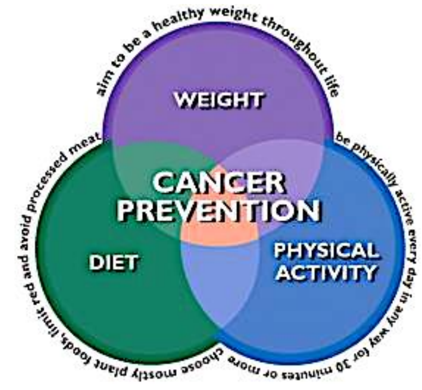
EUROPE

The International Network of Health Promoting Hospitals and Health Services: Integrating health promotion into hospitals and health services

Concept, framework and organization

HPH

Sia i clinici che i pazienti hanno un ruolo ATTIVO nel programma di Lifestyle Medicine



GLASBERGEN

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

“PRATICA CIÒ CHE PREDICHI.
Prima di cercare di correggere gli ALTRI
fai una cosa più difficile:
CORREGGI TE STESSO.”

- Buddha -

ITALIAN LIFESTYLE MEDICINE ASSOCIATION°

Medical Students as a Key Partner in the Co-creation of Evidence-Based Lifestyle Medicine Medical School Education

June 21, 2016

THE HARVARD MEDICAL SCHOOL

SAPIENZA UNIVERSITÀ DI ROMA

Corso Universitario di Alta Formazione post-Laurea

"Health Sciences. The LIFESTYLE MEDICINE"

www.uniroma1.it

How does it work?

In order to realise the full potential of the HPH approach that is to improve the health gain of patients, staff and community, HPH needs to be implemented not only in the framework of limited projects, but as a comprehensive overall approach, integrated within hospital / health service (quality) management systems.

This includes steps like:

1. Commitment
Development of a HPH corporate identity – mission statement and corresponding organisational policy with explicit goals, criteria, targets, standards and indicators for outcomes, processes and structures focusing on health gain of health services. The support of top management is required for implementation on an organisational level.

2. Resources
Setting up a specific HPH management structure including a steering committee, a coordinator and a team, a network of HPH focal persons in all units of the organisation and earmarking a specific HPH budget.

3. Communication
Inform and involve clinicians and staff in health promotion communication (e.g. health circles, newsletters, annual presentations, forum on websites).

4. Action Planning
Develop annual action plans, including specific projects for implementation and development of issue- or population-specific policies (e.g. smoke-free, migrant-friendly). Health Promotion in hospitals and health services needs to be based upon evidence in the same way as other clinical activities and services.

5. Evaluation
Develop and implement a structure for regular observation, monitoring, documentation, evaluation and reporting (e.g. by using the 5 Standards for Health Promotion in Hospitals, Quality of Life Indicators, the EFQM model and/or the Balanced Score Card) and by linking outcome measures to all clinical processes.

6. Education
HPH capacity building (professional education and training, research, development of structures).

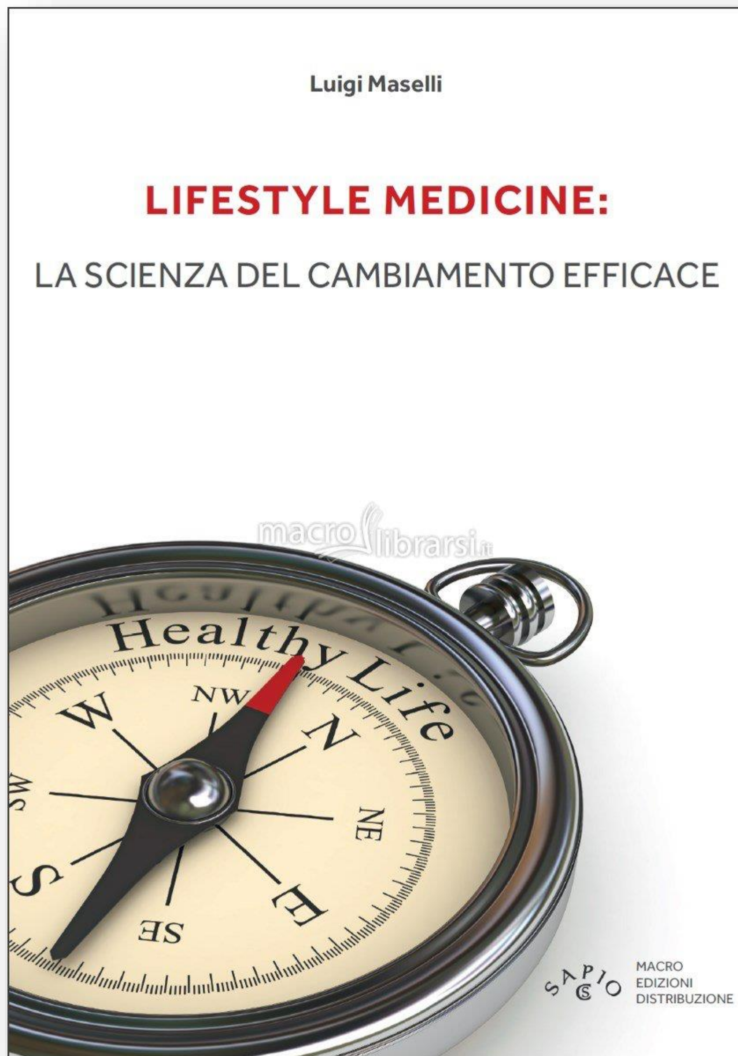
7. Research
Encourage the performance of high quality HPH scientific projects and support the distribution of the results. HPH is a new research field in which Evidence-Based Practice for health promotion is defined as integration of individual clinical expertise, best / actual available evidence, and patient preferences.

8. Sustainability
Introduce procedures to measure and monitor health outcomes, health impacts and health gains for patients, staff and community population over time. These changes are measurable as clinical outcome in terms of mortality, morbidity and health related quality of life, staff health status, user or staff satisfaction and health literacy and population health status.

9. Networking
Network at all levels (local, regional, national and international) to share best practices and strategies for quality improvement and the health orientation of healthcare settings.

By joining the International HPH Network, hospitals and health services become part of an international network where information exchange and sharing is fostered using different tools such as newsletters, conferences, interactive website, online library and activity database as well as specific working groups and taskforces.

COME INTERVENIRE EFFICACEMENTE



COACHING

Nutrition and Exercise

Educational Strategies

Self Esteem

Parenting Strategies

CBT

Neurofeedback

Sleep

Medication

Other Resources

Addressing disease prevention, health education and health promotion

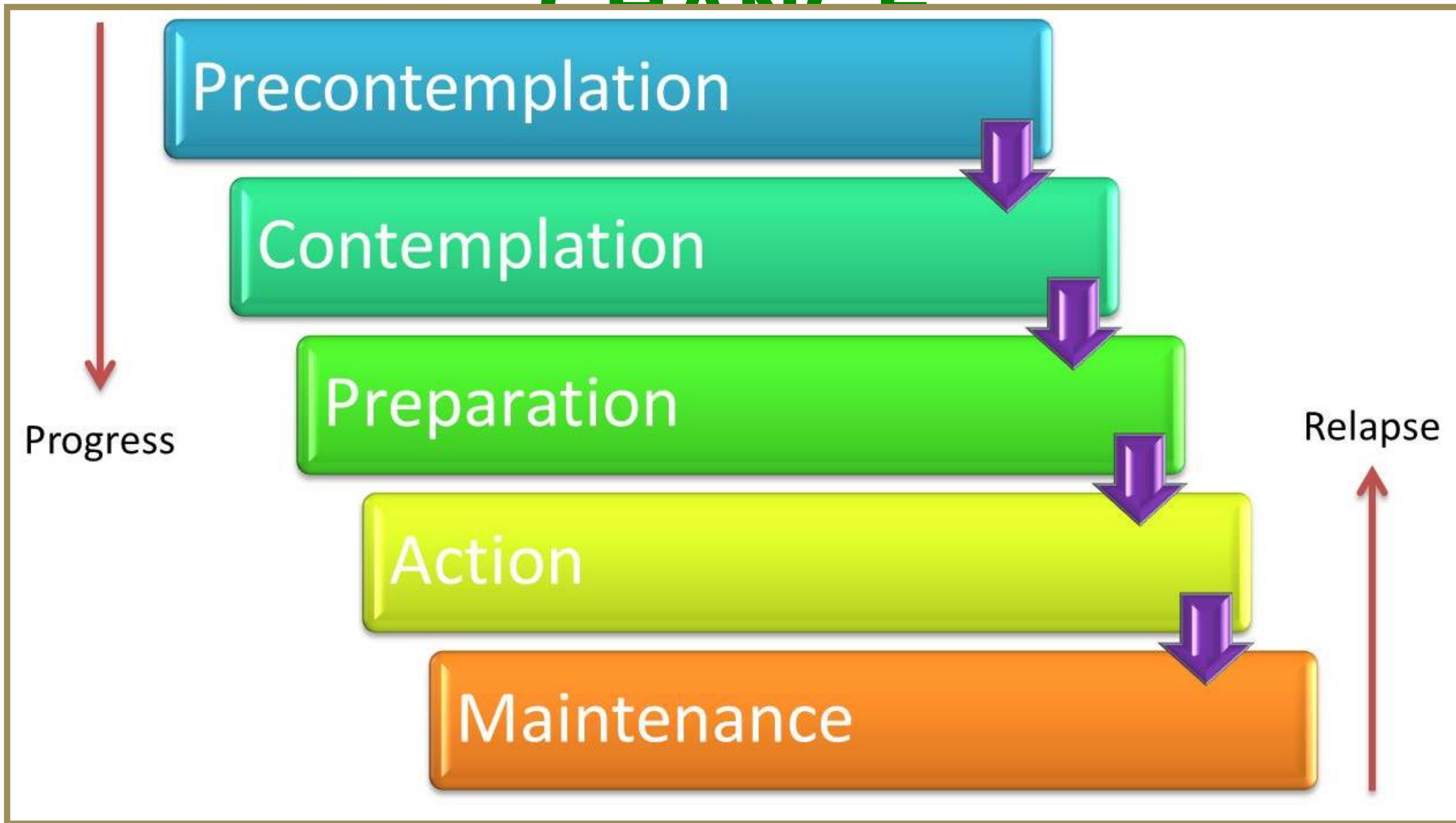
Health promotion focuses on both individual and contextual factors that shape individuals' actions with the aim of preventing and reducing ill health and improving wellbeing. Health promotion can thus be distinguished from disease prevention and health education actions (Table 2).

Health promotion builds-on and incorporates health education and disease prevention measures; there are however, important and principal differences between preventing disease and promoting health. The term "disease prevention" refers to the prevention of specific diseases (heart disease, lung disease, allergy), while the term "health promotion" implies the improvement of individual's self-rated health (health-related quality of life).

Table 2

Topic	Definition
Disease prevention	"measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established"
Health education	"consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and community health"
Health promotion	"the process of enabling people to increase control over, and improve, their health"

TTM of BEHAVIORAL CHANGE



Prochaska, JO; Butterworth, S; Redding, CA; Burden, V; Perrin, N; Leo, M; Flaherty-Robb, M; Prochaska, JM. ***Initial efficacy of MI, TTM tailoring and HRI's with multiple behaviors for employee health promotion***. Prev Med 2008 Mar;46(3):226–31. Accessed 2009 Mar 21.

CLINICAL ASSESSMENT

- Laboratory tests and imaging results (e.g., metabolic syndrome)
- Findings on physical exams
- Any depression screening findings using validated instruments (e.g., PHQ-2 or PHQ-9)
- History of alcohol and substance use
- History of prescribed medications (e.g., steroids can cause psychiatric symptoms)
- History of supplement/over-the-counter use
- Recent life stressors or changes (e.g., postpartum)
- Specific question that the referring provider would like answered or have input on.

LA PERCEZIONE DEL PAZIENTE

Paziente: ____ Data rilevazione: _________________

Scheda di autovalutazione Sintomi Vaghi e Aspecifici (MUS)

- Barrare le risposte con una crocetta -

Soffre da tempo di stanchezza o affaticamento persistente?	Sì	No
Ha da tempo disturbi del tono dell'umore?	Sì	No
Soffre di insonnia persistente da tempo o di risvegli notturni?	Sì	No
Soffre da tempo di sonnolenza persistente durante la giornata?	Sì	No
Si sente da tempo un soggetto ansioso?	Sì	No
Si sente da tempo un soggetto apatico?	Sì	No
Soffre di attacchi di panico?	Sì	No

Benefits of being a HPH

Based on the evidence, there are good arguments for health care to invest in health promotion, and for health promotion and health policy to increase their focus on health care.

Patients and patient organizations

Patient and patient organizations will profit from HPH as:

- → it focuses on the perceived needs of patients (and relatives) in terms of focused actions, communication and information,
- → creates better chances for self determination and self care, thus leading to better quality of life in the hospital,
- → aims to achieve better quality of care, while also improving the sustainability of health outcomes.

IS YOUR GOAL A SMART GOAL?

S
- **SPECIFIC**
- Define the goal as much as possible with no unclear language
- **Who** is involved, **WHAT** do I want to accomplish, **WHERE** will it be done, **WHY** am I doing this – reasons, purpose, **WHICH** constraints and/or requirements do I have?

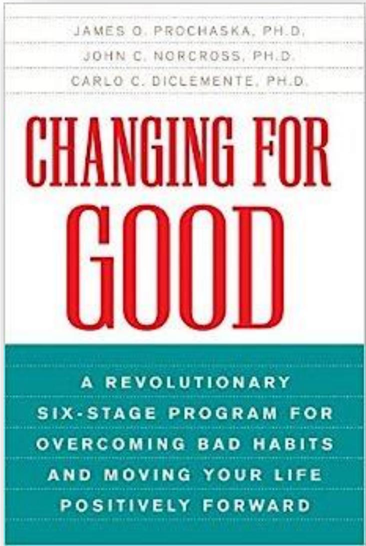
M
- **MEASURABLE**
- Can you track the progress and measure the outcome?
- How much, how many, how will I know when my goal is accomplished?

A
- **ATTAINABLE/ACHIEVABLE**
- Is the goal reasonable enough to be accomplished? How so?
- Make sure the goal is not out or reach or below standard performance.

R
- **RELEVANT**
- Is the goal worthwhile and will it meet your needs?
- Is each goal consistent with the other goals you have established and fits with your immediate and long term plans?

T
- **TIMELY**
- Your objective should include a time limit. Ex: I will complete this step by month/day/year.
- It will establish a sense of urgency and prompt you to have better time management.

G O A L



Yes, I did it!

I WILL DO IT

I CAN DO IT

I'LL TRY TO DO IT

HOW DO I DO IT?

I WANT TO DO IT

I CAN'T DO IT

I WON'T DO IT

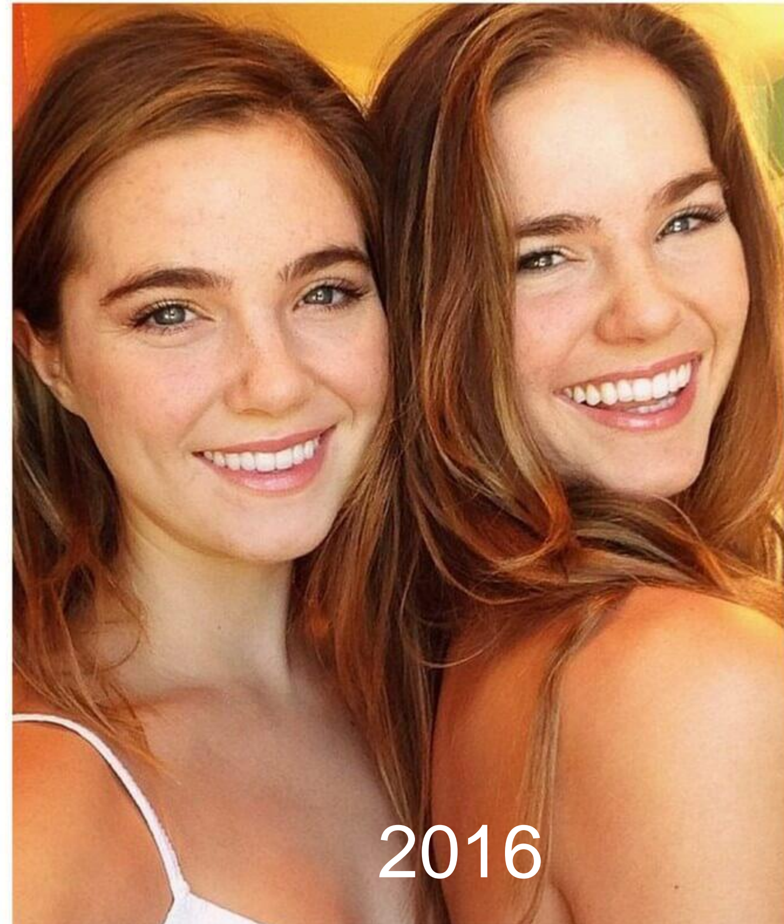
WHICH STEP HAVE YOU REACHED TODAY?

Paziente: Matt BASS 44 anni
Diagnosi di partenza: Obesità di 1° grado Kg.111.6, Ipertensione lieve
Specialista di riferimento: Dr. David KATZ

TrueHealth INITIATIVE

Paziente: KAREN HAUSERMAN 44 anni
Diagnosi di partenza: Obesità di 3° grado Kg.181.4, Infarto lieve, Reflusso Gastroesofageo, Prediabete, Artrosi delle Ginocchia
Specialista di riferimento: Dr. Caldwell Blakeman ESSELSTYN

2014



Paziente: Nina e Randa NELSON anni 22, gemelle omozigote
Diagnosi di partenza: Acne Cistica
Specialista di riferimento: Dr. John McDougall

TrueHealth
INITIATIVE

Paziente: Kyra WILLIAMS 11 anni
Diagnosi di partenza: ADHD, Sovrappeso Kg.52, Prediabete
Specialista di riferimento: Dr. Luigi Maselli

TrueHealth INITIATIVE

THANK YOU DOC

lmaselli@italianlifestylemedicine.org

ENJOY YOUR