



Nationaal Actieprogramma Diabetes



Per jaar  
ruim 72.000  
mensen met  
diabetes erbij

2009 – 2013



Nationaal Actieprogramma Diabetes | Summary



# **National Diabetes Action Program**

**NAD**

**2009 – 2013**

Dutch Diabetes Federation

Amersfoort, February 2009

## Summary

### Part A The design of the NAD

#### A.1 Background: the problem of diabetes

In our country, more than 600,000 people have diabetes, and yearly, more than 72,000 are added to that number. Additionally, there are an estimated 250,000 people that have the disease but don't even know it (data from the National Institute for Public Health and the Environment (RIVM) about the year 2003). The number of people with diabetes is thus alarmingly on the rise. This is not only true for the Netherlands, but also worldwide. Approximately ten percent of all people with diabetes have type-1 diabetes; the overwhelming majority have type-2 diabetes. Many people with diabetes will inevitably experience complications. Therefore more disease and invalidism follows, and the life expectancy is five to ten years shorter. Thus, the diagnosis of diabetes has extreme consequences for the individual and his quality of life, for his social environment, and for society. Obesity and lack of exercise are important risk factors for type-2 diabetes. This offers starting points for specific prevention. Early detection of risk groups must be high on the program agenda, together with a structural offering of programs for lifestyle change that have been proven to be effective. Good care for people with diabetes is crucial to counteract complications. The promotion of self-management is an essential component of good care, because that helps people with diabetes to be responsible for themselves and exercise control over their own life.

#### A.2 Recent and current policy in the Netherlands

With the *Prevention Memo* (2006) and the Memo entitled *Be Healthy, Stay Healthy: A Vision of Health and Prevention* (2007) the way was paved for a policy in regards to chronic disease, as reflected in the policy brief *Programmatic Treatment of Chronic Diseases* (2008). The contemplated programmatic treatment predominantly applies to diabetes. Thanks to the Dutch Diabetes Federation (NDF), the diabetes field – caregivers, people with diabetes, and researchers – has been united and made accessible, and the relevant stakeholders can achieve results together. The NDF Care Standard is an example of this. This forms the basis for the operationalization of the diabetes chain of care: integrated care-giving from multi-disciplinary cooperatives of caregivers (care groups) with particular attention to the central position of the patient, to the integration of prevention and cure, and for a programmatic treatment with attention to quality monitoring. In these areas, an enormous drive has occurred in the past few years, but there is still a large variety in quality, and fragmentation. Those are points of interest for the NAD, therefore.

#### A.3 Goals and objectives of the NAD

There is urgent need for effective prevention and good care in order to reduce the increasing cost of diabetes. The cabinet has high ambitions for the year 2025 (*Prevention Memo 2006*). The NAD – which will operate until 2013 – has as its goal to promote the available circumstances, conditions and tools that are required to achieve the ambitions of the cabinet. In order to achieve this, a number of goals have been stated. The core goal is the structural implementation of the NDF Care Standard as a guiding principle for the content, the organization and the quality control of the programmatically arranged prevention of diabetes and care for people with diabetes, as well as for the relevant cost structures. To achieve this, five instrumental goals have been stated, directed to:

- prevention, advice, early diagnosis, lifestyle interventions for high-risk groups;
- reinforcement of the position of the patient, self-management, education, trust in therapy;
- anchoring of treatment chains (multidisciplinary, programmatic, directed care giving)
- identification, and where possible, reduction of obstructions in legislation;
- operationalization of the electronic diabetes dossier as a component of the national electronic patient dossier (EPD).

These goals have been translated into the themes that are discussed in chapter A.4, and in Part B. The NAD also has a more general aim with its goals: to gain experience and develop implementation routes that aren't only relevant for diabetes, but also for other chronic disorders. Thus, aspects of the NAD can be expanded to other chronic disorders, and to chronic disease policy in general.

#### **A.4 Set-up and planning of the NAD**

The NAD bundles the initiatives that are targeted directly or indirectly at the optimization of the prevention of diabetes and the care of people with diabetes. This includes both currently running initiatives, as well as activities that will be started on the initiative of the program. Thus, consistency can be assessed and promoted, and additional activities can be started in a targeted fashion. The action program is expected to have a stimulating and strengthening effect on currently running programs and on inactive initiatives. Cooperation with other organization is high on the agenda. That can be expressed in cost-sharing on certain initiatives. The nature and scope of the initiatives in NAD's purview are of course determined by the budget, reserved by the Ministry of Health, Welfare and Sport, of a total of ten million euro.

The goals of the NAD (see chapter A.3) are translated into the following themes:

- core theme: Implementation of the NDF Care Standard
- theme 1: Advice and lifestyle intervention
- theme 2: Position of the client and patient
- theme 3: Organization, quality and knowledge
- theme 4: Legislation and cost
- theme 5: EPD (e-diabetes dossier) and ICT tools

Within the themes, actions will be implemented (activities, projects). Each of the themes more or less covers one or more of the four areas of prevention as defined by the CVZ: universal, selective, indicated and care-related prevention. Thus, there is a matrix structure that makes it transparent to which prevention areas the actions are related.

#### **A.5 Organization of the NAD**

The NDF have developed a proposal for a national action program for diabetes, with a subsidy from the Ministry of Health, Welfare and Sport: the NAD. This will now be presented to the minister with a request for subsidy for the implementation. The board of directors of the NDF has the final responsibility for the content and implementation of the NAD. The NDF direction has established a management group, and this is authorized to supervise the NAD. The members are there as their own representatives. A small project group has been created, with the knowledge and skill to support the implementation of the NAD. In addition, there is a sounding board group, consisting of members of the Diabetes Expert Network, organized by the NDF. Finally, an advisory committee will be established by the Ministry of Health, Welfare and Sport. There is intensive cooperation with the Netherlands Organization for Health Research and Development (ZonMw) and with the RIVM. Also, with relevant health-promoting institutions and health funds, and harmonization and cooperation are pursued with the Institute for Health Care Improvement (CBO), as well as with the Health Care Insurance Organization (ZN), the Health Care Insurance Board (CVZ) and the Dutch Health Care Authority (NZa), because the NAD is not alone in the chronic disease policy. On the basis of project proposals that were prepared earlier, there are a limited number of prioritized actions determined, so that when the NAD formally starts, activities are also really tackled.

#### **A.6 Communication**

Good communication about the NAD is of course very important. Recognizable, image-creating, fast, clear and regular publicity on ongoing activities and achieved results: these are all components of good communication. Meetings will be convened, a digital newsletter will be created, and there will be a modern, accessible and interactive website created.

#### **A.7 Evaluation and monitoring**

There will be an evaluation investigation on the NAD as a whole. This consists of an impact evaluation that targets the degree in which program objectives have been met, and a process evaluation that is more qualitative in nature, and targets issues such as bottlenecks, and success and failure factors. The evaluation investigation will be conducted by an independent institute. It will be put out to tender in 2009, and completed in 2013. Monitoring of the progress of actions will be done by concise annual progress reports to the management group. Of course, a final report on each action will be submitted to the management group.

### **Part B The themes and actions of the NAD**

The NAD is built from a core theme and five other themes, each with a defined goal. To achieve that goal, actions will be conducted in each theme. In part B, each topic is explained and systematically developed with an inventory of desired and current activities appropriate to the goal of each relevant theme. From an inventory of activities that could possibly be undertaken by the NAD, an initial prioritization of activities will be made, which will start in 2009. The capacity of the program is expressly not planned from the beginning, so that additional actions can be added during the program's progress. The following projects are prioritized actions for 2009.

## **Core theme**

### **IMPLEMENTATION OF THE NDF CARE STANDARD**

#### 0.01 Prevention of diabetes in NDF Care Standard

Implementation: work group(s) established by NDF

#### 0.02 Self-management of diabetes in NDF Care Standard

Implementation: work group established by NDF

## **Theme 1**

### **ADVICE AND LIFESTYLE INTERVENTIONS**

#### 1.01 Blueprint for program concerning advice and lifestyle interventions for people with an increased risk of diabetes

Implementation: work group established by NDF in association with representatives from the Public Health Service (GGD) and ROS, amongst others)

#### 1.02 Research on absent lifestyle interventions for three important risk groups

Implementation: Diabetes Fund in association with representatives of target groups and potential proposers of the interventions

## **Theme 2**

### **POSITION OF THE CLIENT AND PATIENT**

#### 2.01 Implementation of the patient version of the NDF Care Standard: the "Care Indicator"

Implementation: Netherlands Diabetes Association (DVN) in association with NDF, CZ (a health insurance company), Council for Public Health and Health Care (RVZ), diabetes care groups, the University of Maastricht, representatives from GGD, education institute and caregivers

#### 2.02 People with diabetes in the labor pool: 'Diabetes Works!'

Implementation: DVN in association with Small and Medium Business Netherlands (MKB Nederland), Confederation of Netherlands Industry and Employers (VNO-NCW), Coronel Institute for Work and Health, University of Maastricht

#### 2.03 Objective and trustworthy information for diabetes patients

Implementation: DVN in association with NIV, DNO, National Institute for the Public Health and Environment (RIVM), Diabetes Fund, NDF

## **Theme 3**

### **ORGANIZATION, QUALITY AND KNOWLEDGE**

#### 3.01 Chain approach: cooperation and harmonization between care professionals

Implementation: GGD Netherlands (project leadership and coordination) and LVG

#### 3.02 Education of care givers: professional development with respect to prevention

Implementation: NHG (project leadership and coordination)

#### 3.03 Education of care givers: professional development with respect to education

Implementation: NDF

#### 3.04 Filling in knowledge gaps to achieve NAD goals

Implementation: Diabetes Fund

## **Theme 4**

### **LEGISLATION AND COSTS**

#### 4.01 The identification and ensuring reduction of obstacles in financing of prevention

Implementation: NDF, RIVM and ZN in association with CVZ, LVG, NDF, NZa, Association of Netherlands Municipalities (VNG) and Ministry of Health, Welfare and Sport (VWS)

## **Theme 5**

### **EPD (E-DIABETES DOSSIER) AND IT TOOLS**

#### 5.01 Test phase in the e-diabetes dossier implementation route

Implementation: The National IT Institute for Health Care in the Netherlands (Nictiz), in harmonization and close cooperation with NDF

#### 5.02 Indicators as instruments for the guarding and promotion of quality

Implementation: initiative NDF, in harmonization with Nictiz and the Netherlands Health Care Inspectorate (IGZ)

Colophon



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