MODELLO ORGANIZZATIVO E RISVOLTI ECONOMICI DELLE DIVERSE TECNICHE

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DECRETO LEGISLATIVO 19 giugno 1999, n. 229

Norme per la razionalizzazione del Servizio sanitario nazionale, a norma dell'articolo 1 della legge 30 novembre 1998, n. 419. *(GU n.165 del 16-7-1999 - Suppl. Ordinario n. 132)*

Modello **Integrato**
ASL: H + Teritorio

Modello **Separato**
SST Teritorio + AO (H)

Modello **Misto**
Combinazione dei 2 precedenti modelli

1. Centralizzazione/Decentralizzazione
2. Ruolo del Privato accreditato
3. Integrazione Socio-Sanitaria
4. Finanziamento e Budget

RETI ASSISTENZIALI

Garantire di livelli uniformi di assistenza nel territorio di competenza

Ottimizzazione uso delle risorse

Programmazione stategica
Coordinamento

Le linee guida organizzative già approvate dal Tavolo sono:

•Le quattro Reti tempo-dipendenti: cardiologica per l'emergenza, neonatologica e dei punti nascita, ictus e trauma severo (**Accordo Stato-Regioni 24/01/2018 - PDF**); il manuale operativo per le reti cliniche tempo-dipendenti è in corso di validazione, cosi come previsto dall'Accordo Stato-Regioni del 24/01/2018;

•Reti oncologiche (in corso di approvazione da parte della Conferenza Stato-Regioni);

•Rete servizi territoriali e integrazione assistenza ospedale-territorio - RESET (documento inviato all'Ufficio di Gabinetto del Ministero della Salute per il successivo iter istituzionale).

RETI ASSISTENZIALI - coordinamento

REGIONE DEL VENETO
giunta regionale
IX Legislatura

PUNTO 94 DELL'ODG DELLA SEDUTA DEL 29/12/2014

DELIBERAZIONE DELLA GIUNTA REGIONALE n. 2707 / DGR del 29/12/2014

OGGETTO:
Riconoscimento dei Centri regionali specializzati delle strutture ospedaliere pubbliche qualificate hub dalla Dgr n. 2122 del 19.11.2013. Dgr n. 14 dell'11.1.2011.

PDTA

Percorso clinico
Percorso organizzativo

CONDIVISO TRA TUTTI I PROFESSIONISTI

LINEE GUIDA E RACCOMANDAZIONI
CONTESTUALIZZATE DIVERSE SITUAZIONI
ORGANIZZATIVO-GESTIONALI LOCALI

PDTA ADULTO

Nota 1: Triage
MMG, Specialista ambulatoriale/ospedaliero

Nota 2: Presa in carico
- anamnesi/EO generali
- ricerca sintomi OSAS e questionario ESS (allegato A)
- anamnesi alimentare (allegato B)
- questionari motori (allegato C)
- test psicometrici per assessment psicologico (allegato D)

Medico Chirurgo,
Medico Internista
Medico Nutrizionista/Dietista

Nota 3: Criteri di esclusione
- età ≥ 70 aa
- ASA IV
- rifiuto del pz all'approccio chirurgico

Nota 4: Fenotipizzazione
- esami di laboratorio
- valutazione nutrizionale con diario alimentare
- polisonnografia se sintomi OSAS/ESS
- assessment psicologico quando richiesto
- auspicabile valutazione Medicina Sport (corollario1)

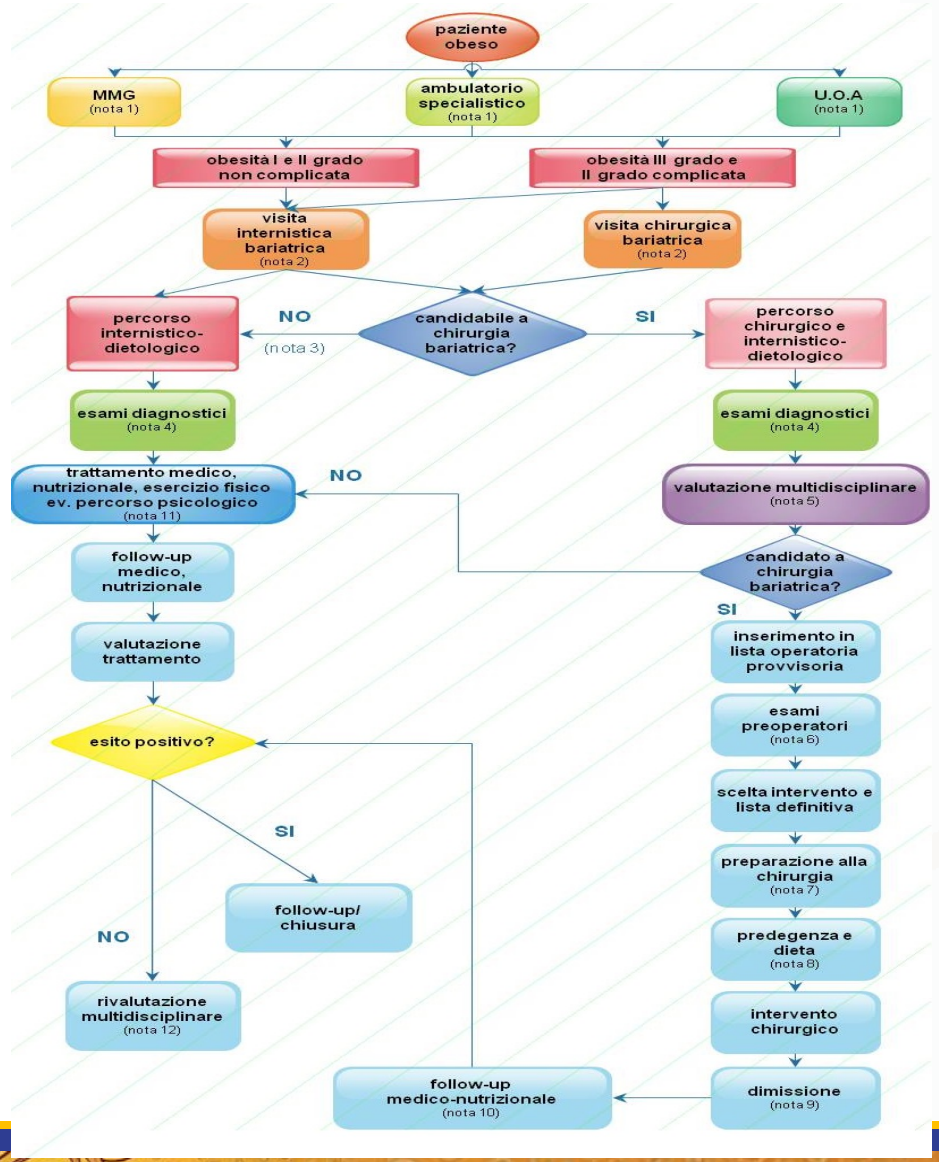
Nota 5: Stadiazione dell'obesità sec. Edmonton Score (allegato E)

Nota 6: Esami preoperatori di I livello
- EGDS con biopsie
- RX tubo digerente prime vie
- Ecografia addome completo

preoperatori di II livello (se necessari)
- pH manometria esofagea
- RMN/TAC

Nota 7: Preparazione
- rivalutazione internistica
- counseling nutrizionale
- ev. nutrizione riabilitativa - ev. supporto psicologico - ev training esercizio fisico in palestra didattica e recall infermieristico

Medico Chirurgo
Medico Internista
Medico Nutrizionista/Dietista
Psicologo Clinico
Medico delloSport
Specialista dell'esercizio
Case manager



Nota 8: Predegenza
- routine preoperatoria
- rivalutazione antropometrica e dieta preoperatoria
- ev. nutrizione riabilitativa
- visita anestesiologica

Medico Nutrizionista/Dietista
Medico Anestesista
Medico Internista/Chirurgo

Nota 9: Dimissione
- indicazioni nutrizionali post-operatorie

Ev. presa in carico delle complicanze chirurgiche, internistiche, nutrizionali
Medico Chirurgo
Medico Internista,
Medico Nutrizionista/Dietista

Nota 10: Follow-up
- 1 mese: chirurgico e dietologico/nutrizionale
- 3/6/12 mesi: internistico e dietologico/nutrizionale
- ev. indagini diagnostiche se complicanze
- ev. valutazione di chirurgia plastica (corollario 2)
- obesità e gravidanza
- 6 e 12 mesi: auspicabile rivalutazione funzionale e prescrizione esercizio fisico (corollario 1)

Medico Chirurgo
Medico Internista
Medico Nutrizionista/Dietista
Medico dello Sport
Chirurgo Plastico

Nota 11: Terapia medica
Percorso medico internistico, nutrizionale, indicazione e promozione dell'attività fisica, farmacologico, ev. percorso psicoterapeutico
Medico Internista
Medico Nutrizionista/Dietista
Medico dello Sport
Psicologo Clinico

Nota 12: Rivalutazione
Multidisciplinare per
- eventuale chirurgia di revisione/conversione
- eventuale ricovero per nutrizione riabilitativa

Chirurgo
Medico Internista
Medico Nutrizionista/Dietoista
Psicologo Clinico

Table 8 Costs attributable to obesity in billions of EUR in Italy in 2020

Direct healthcare costs		
Bariatric surgery	€0.24	1.8%
Diabetes	€0.65	4.9%
Cardiovascular diseases	€6.66	49.9%
Cancer	€0.33	2.5%
Total direct costs	€7.89	59.2%
Indirect costs		
Absenteeism	€2.62	19.6%
Presenteeism	€2.83	21.2%
Total indirect costs	€5.45	40.8%
Total	€13.34	100.0%

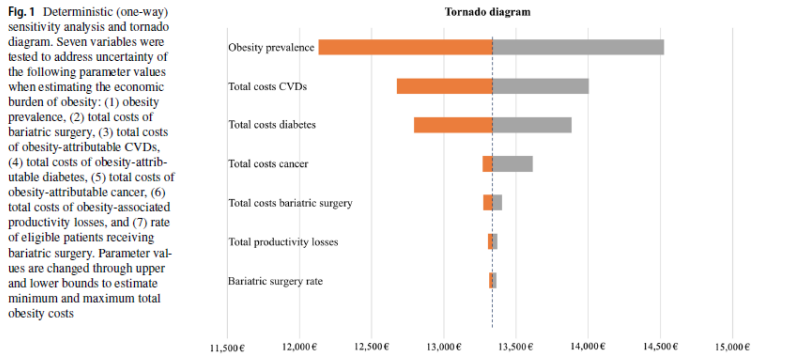


Fig. 1 Deterministic (one-way) sensitivity analysis and tornado diagram. Seven variables were tested to address uncertainty of the following parameter values when estimating the economic burden of obesity: (1) obesity prevalence, (2) total costs of bariatric surgery, (3) total costs of obesity-attributable CVDs, (4) total costs of obesity-attributable diabetes, (5) total costs of obesity-attributable cancer, (6) total costs of obesity-associated productivity losses, and (7) rate of eligible patients receiving bariatric surgery. Parameter values are changed through upper and lower bounds to estimate minimum and maximum total obesity costs

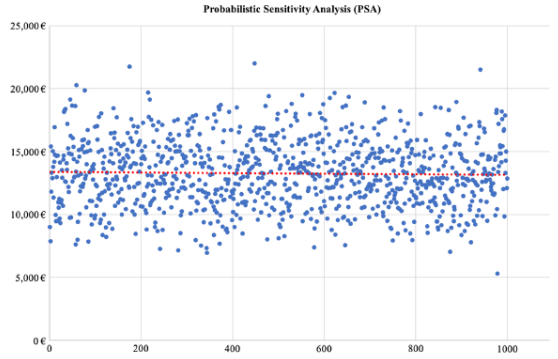


Fig. 2 Probabilistic sensitivity analysis (PSA) performed to address uncertainty of parameter values when estimating the total burden of obesity. The PSA was performed adopting the Monte Carlo method (second order) and calculation of the total obesity costs was replicated with 1,000 simulations

1.4% eligible pts *(D'Angela Assobiomedica C.R.E.A. 2020)*

54% si rivolgono al medico per essere aiutati

36% riceve una diagnosi *(Caterson et al Diabetes Obes Metab 2019)*

Cost effectiveness analysis

CONTRIBUTORS

Authors

- Josiah Kaplan

Cost-effectiveness analysis (CEA) compares the relative costs of the outcomes of two or more courses of action and is considered an alternative to cost-benefit analysis (CBA).

CEA is most useful when analysts face constraints that prevent them from conducting cost-benefit analysis. The most common constraint is the inability of analysts to monetise benefits. CEA is commonly used in healthcare, for example, where it is difficult to put a value on outcomes, but where outcomes themselves can be counted and compared, e.g. 'the number of lives saved'.

CEA measures costs in a common monetary value (££) and the effectiveness of an option in terms of physical units. Because the two are incommensurable, they cannot be added or subtracted to obtain a single criterion measure. One can only compute the ratio of costs to effectiveness in the following ways:

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https://doi.org/10.1038/s41366-021-00849-8

ARTICLE

Health Economics

Cost-effectiveness of bariatric surgery and non-surgical weight management programmes for adults with severe obesity: a decision analysis model

D. Boyers[1] · L. Retat[2] · E. Jacobsen[1] · A. Avenell[3] · P. Aveyard[4,5,6] · E. Corbould[2] · A. Jaccard[2] · D. Cooper[3] · C. Robertson[3] · M. Aceves-Martins[3] · B. Xu[2] · Z. Skea[3] · M. de Bruin[7,8] · and the REBALANCE team

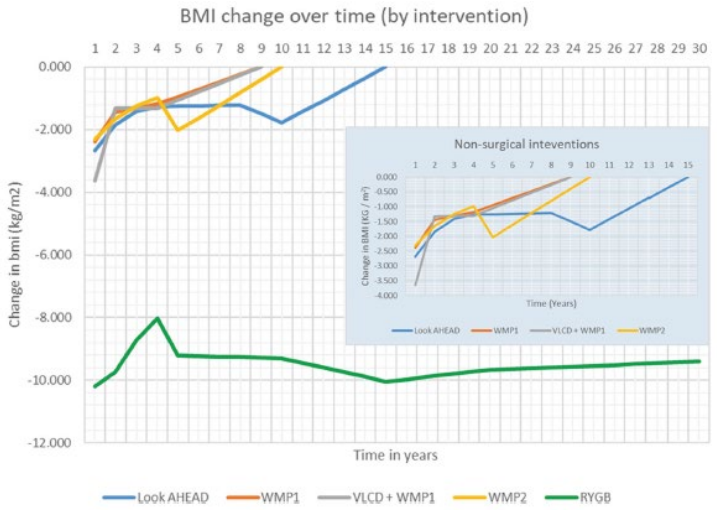
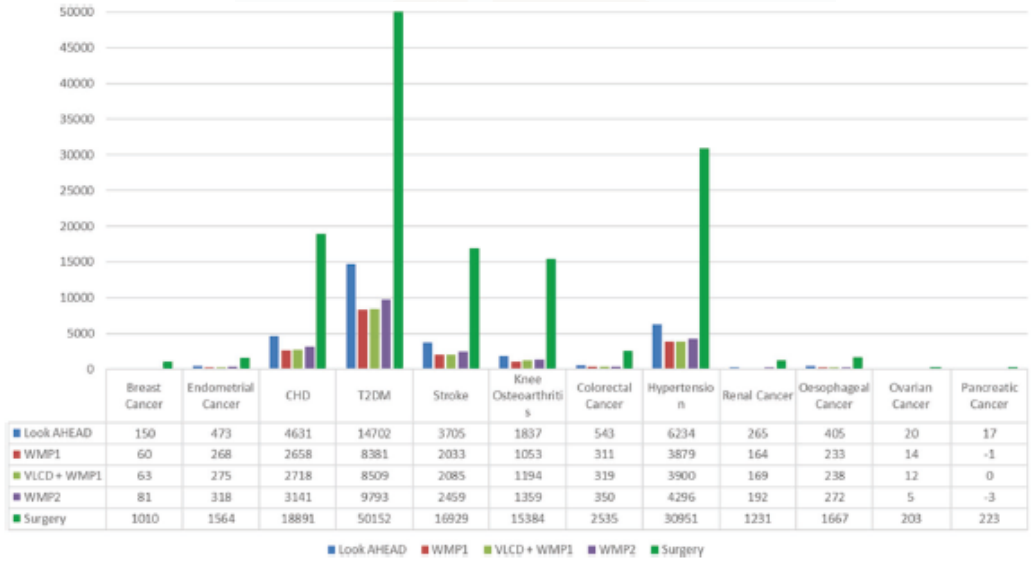


Fig. 1 BMI change over time (base-case analysis). details the modelled BMI change over time. The main figure panel includes all modelled interventions, including surgery. The embedded panel details the BMI change modelled for non-surgical WMPs only. Abbreviations: BMI = Body Mass Index; WMP = Weight Management Programme; VLCD = Very low calorie diet; RYGB = Roux-en-Y gastric bypass surgery.

Fig. 2 Cumulative incidence cases of obesity related disease avoided per 100,000 population with BMI ≥ 35 KG/M2 compared to population trends. details the cumulative incidence of 12 obesity related disease avoided per 100,000 population with a BMI of 35 and above for each modelled intervention compared to standard care. Abbreviations: BMI = Body Mass Index; WMP = Weight Management Programme; VLCD = Very low calorie diet; RYGB = Roux-en-Y gastric bypass surgery.



	Breast Cancer	Endometrial Cancer	CHD	T2DM	Stroke	Knee Osteoarthritis	Colorectal Cancer	Hypertension	Renal Cancer	Oesophageal Cancer	Ovarian Cancer	Pancreatic Cancer
Look AHEAD	150	473	4631	14702	3705	1837	543	6234	265	405	20	17
WMP1	60	268	2658	8381	2033	1053	311	3879	164	233	14	-1
VLCD + WMP1	63	275	2718	8509	2085	1194	319	3900	169	238	12	0
WMP2	81	318	3141	9793	2459	1359	350	4296	192	272	5	-3
Surgery	1010	1564	18891	50152	16929	15384	2535	30951	1231	1667	203	223


Bariatric Spotlight Session III
Moderators:
Micaela Esquivel, MD &
Natalie Liu, MD
GLP1-RA vs Surgery %TBWL
% Total Body Weight Loss

SAGES
2025
SCIENTIFIC SESSION CALL FOR ABSTRACTS
MARCH 12-15, 2025
LONG BEACH, CA - LA'S "WATERFRONT PLAYGROUND"


33° CONGRESSO NAZIONALE SICOB SORRENTO


Bariatric Spotlight Session III
Moderators:
Micaela Esquivel, MD &
Natalie Liu, MD
GLP1-RA vs Surgery %TBWL by Intervention Type
% Total Body Weight Loss
0.0
-5.0
-10.0
-15.0
-20.0
-25.0
-30.0
3 Months
6 Months
1 Year
2 Years
3 Years
Semaglutide
-1.8
-3.4
-3.8
-4.1
-4.5
Tirzepatide
-2.0
-3.5
-3.7
-3.4
-3.1
Sleeve Gastrectomy
-15.5
-23.3
-25.0
-23.6
-22.1
RYGB
-15.2
-21.2
-27.3
-24.5
-21.0
NYU Langone Health
Department of General Surgery

SAGES
2025
SCIENTIFIC SESSION CALL FOR ABSTRACTS
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33° CONGRESSO NAZIONALE SICOB SORRENTO

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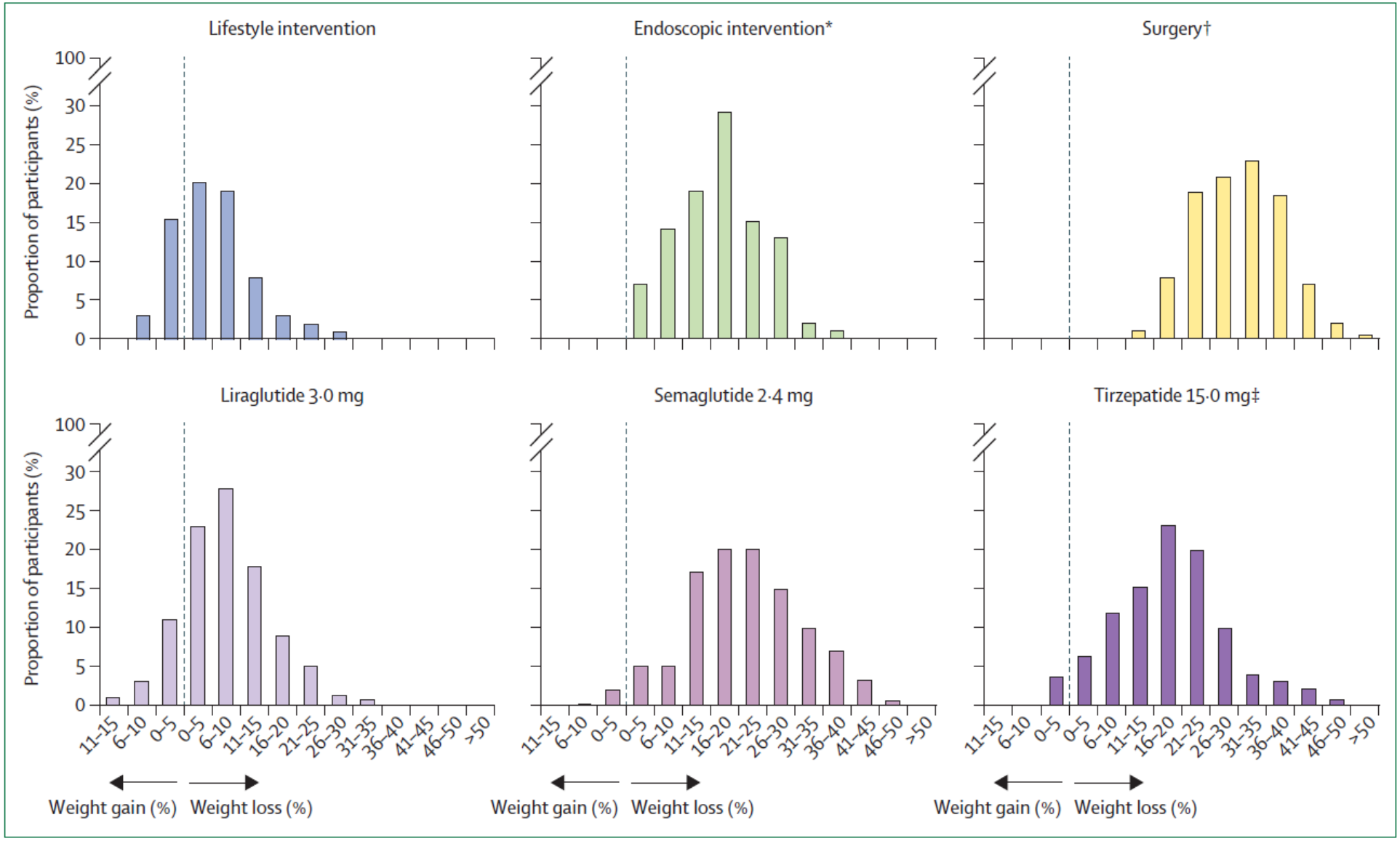


Surgical Endoscopy (2024) 38:6560–6565
https://doi.org/10.1007/s00464-024-11191-1

A cost comparison of GLP-1 receptor agonists and bariatric surgery: what is the break even point?

Salvatore Docimo Jr.[2] · Jay Shah[1] · Gus Warren[1] · Samer Ganam[1,2] · Joseph Sujka[2] · Christopher DuCoin[2]

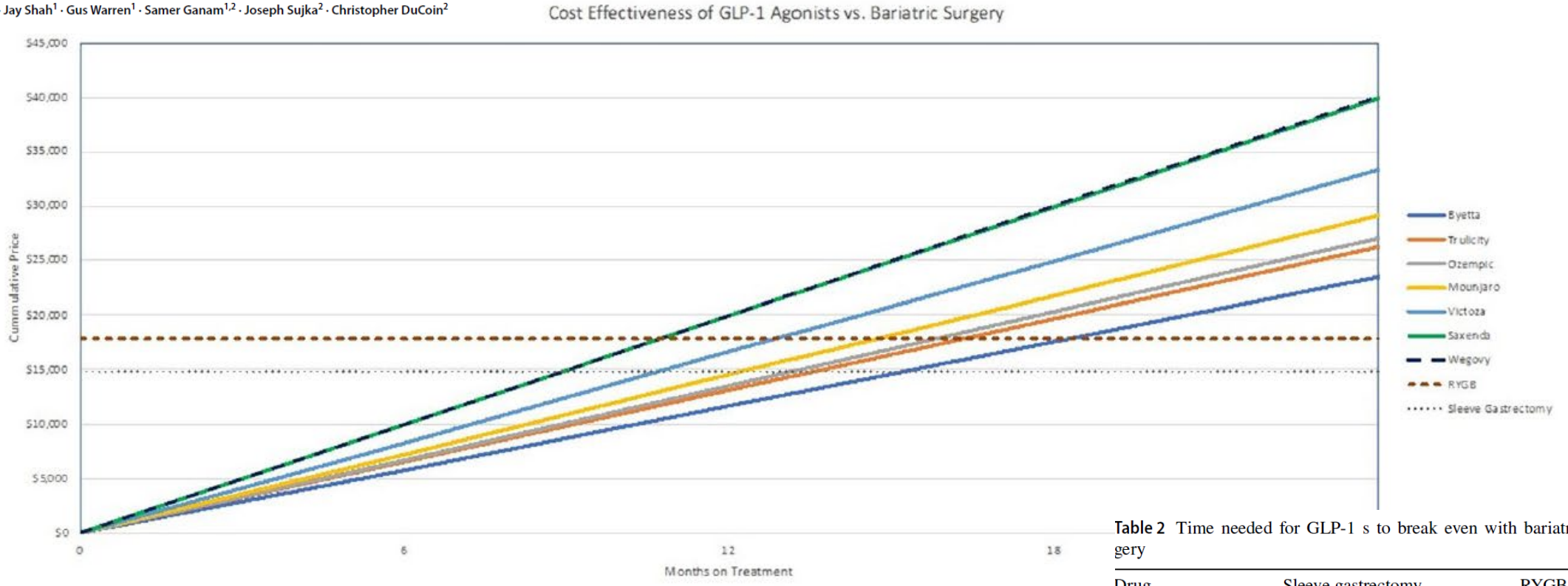


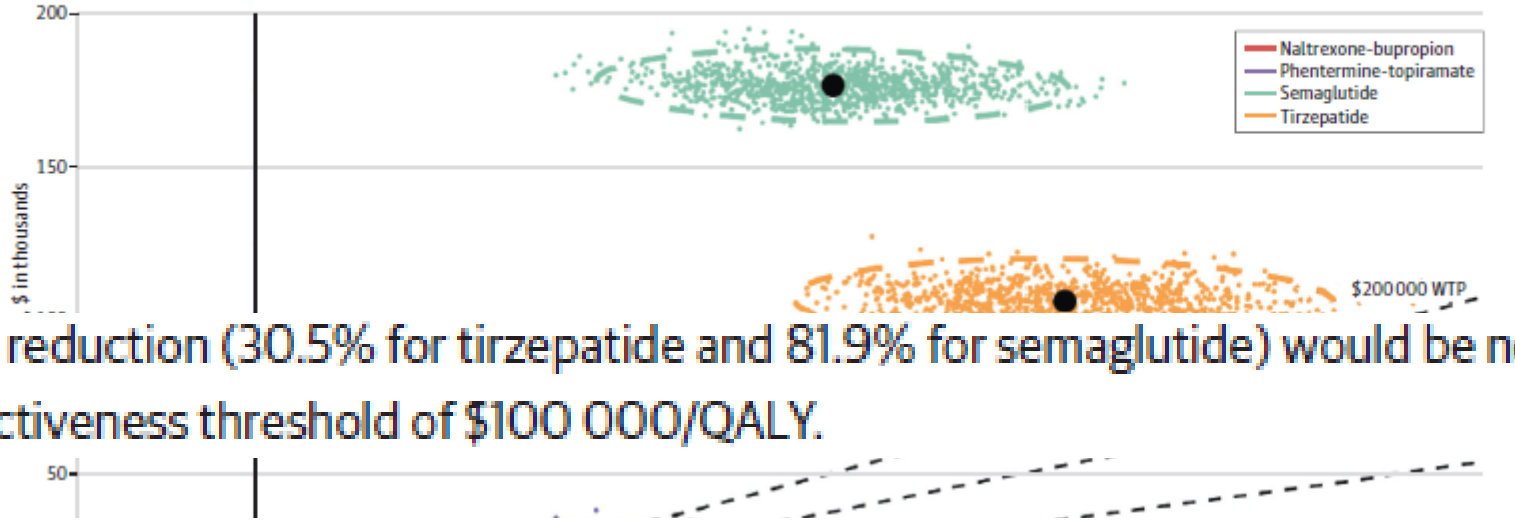
Fig. 1 Cost effectiveness of GLP-1 s vs. bariatric surgery

Table 2 Time needed for GLP-1 s to break even with bariatric surgery

Drug	Sleeve gastrectomy	RYGB
Wegovy	8.93 months	10.72 months
Saxenda	8.96 months	10.75 months
Victoza	10.72 months	12.86 months
Mounjaro	12.27 months	14.72 months
Ozempic	13.20 months	15.84 months
Trulicity	13.59 months	16.31 months
Byetta	15.23 months	18.28 months

Obesity Surgery (2021) 31:3279–3290
https://doi.org/10.1007/s11695-021-05415-9

Figure 2. Probabilistic Sensitivity Analysis for the Cost-Effectiveness of the Antiobesity Medications vs Lifestyle Modification Over a Lifetime



substantial price reduction (30.5% for tirzepatide and 81.9% for semaglutide) would be needed to meet a cost-effectiveness threshold of $100 000/QALY.

JAMA He

Original Investigation

Lifetime Healt
in US Adults

Jennifer H. Hwang, DO; Ned

Conclusions

This economic evaluation found that although tirzepatide and semaglutide offered substantial long-term health benefits, they were not cost-effective at current net prices. Efforts to reduce the net prices of new antiobesity medications are essential to ensure equitable access to highly effective antiobesity medications.

Each dat
ellipses illustrate the 95% uncertainty intervals for these results. The solid black circles indicate the mean values for the 1000 simulations. The willingness-to-pay (WTP) are depicted by dashed lines.

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Conclusions

For adults with severe obesity, RYGB surgery was the most expensive, but also the most beneficial intervention in terms of QALY gains and can thus be considered most efficient. Lifestyle WMPs are likely to be cost-effective compared with no intervention, and adding a VLCD to a WMP was not found to be cost-effective.

COST-EFFECTIVENESS OF BARIATRIC SURGERY AND ANTI-OBESITY MEDICATIONS

Ira Leeds *New Haven CT*[1], Lee Ying *New Haven CT*[1], Grace Chao *New Haven CT*[1], Genevieve Gill-Wiehl *New Haven CT*[1], John Morton *MADISON CT*[2]
Yale[1] Yale School of Medicine[2]

Introduction: Prior to anti-obesity medications (AOMs), weight loss surgery (WLS) had demonstrated cost-effectiveness. The purpose of this study was to conduct a cost-effectiveness analysis comparing weight loss surgery versus AOMs with a long-term societal perspective.
Methods: Utilizing TreeAge Pro®, a decision tree was designed for a base case of a patient with body mass index > 40 utilizing long-term use of AOMs versus weight loss surgery (Figure 1). Strategies in the decision tree included escalating therapy from AOMs to WLS, surgical revision conversion if treatment response not met, use of adjuvant AOMs after weight loss surgery, and complications of weight loss surgery. Sensitivity testing was performed to identify a potential breakeven point. The model was informed by systematic review and expert opinion as needed. Future costs and quality of life years (QALYS) were by convention discounted at 3% per year and standardized to 2019 U.S. dollars.
Results: Weight loss surgery as initial therapy was the dominant strategy yielding 21.96 versus 20.58 QALYs for long-term AOMs alone at a cost of $301,374 versus $687,885, respectively. Drivers of inferiority for AOMs included the high continuing costs relative to the lower cost of weight loss surgery. On sensitivity analysis, no combination of more willingness to convert from medications to surgery, drug pricing, or medication adherence changed the dominance of an upfront surgery recommendation.
Discussion: Relative to AOMs, the low cost and durability of surgery argues it is the societally favorable option with better expected quality of life as well as lower total costs.

IH Top Oral Abstracts
Tuesday, June 11th, 2024
8:00 AM – 9:30 AM

The best and cost-effective approach is multimodality treatment

Le linee guida sono le fondamenta del PDTA

Il PDTA è la madrelingua del team multidisciplinare

Empowerment del soggetto preso in carico

Empowerment del Team

Accountability della nostra pratica clinica

Risorse!


33° CONGRESSO
NAZIONALE SICOB
SORRENTO
29 · 31 OTTOBRE
2025
S.I.C.OB.
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PALACE

Grazie