PDT & CdC
esperienze e prospettive

Database amministrativi e misura della continuità assistenziale

Piergiorgio.Duca@unimi.it
Roma AIE Maggio 2007

PubMed

National Library of Medicine NLM

☐ **1: Continuity of Patient Care** Links

Health care provided on a continuing basis from the initial contact, following the patient through all phases of medical care.
Year introduced: 1991(1975)

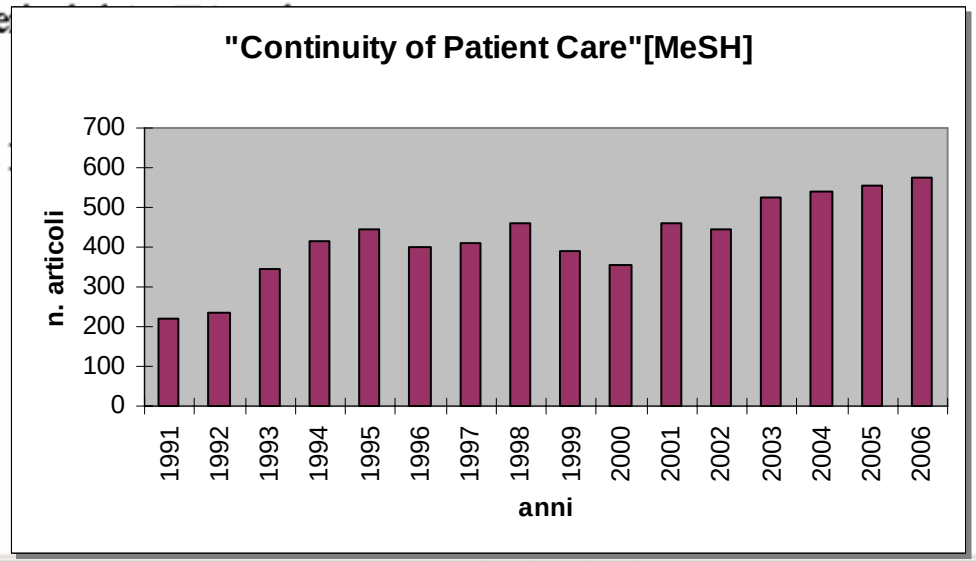
Subheadings: This list includes those paired at least once with this heading in MEDLINE and may not reflect current rules for allowable combinations.

☐ classification ☐ economics ☐ ethics ☐ history ☐ legislation and jurisprudence ☐ organization and administration ☐ standards ☐ statistics and nume

☐ Restrict Search to Major Topic headings only
☐ Do Not Explode this term (i.e., do not include

Entry Terms:

- Care Continuity, Patient
- Patient Care Continuity
- Continuity of Care
- Care Continuity
- Continuum of Care
- Care Continuum

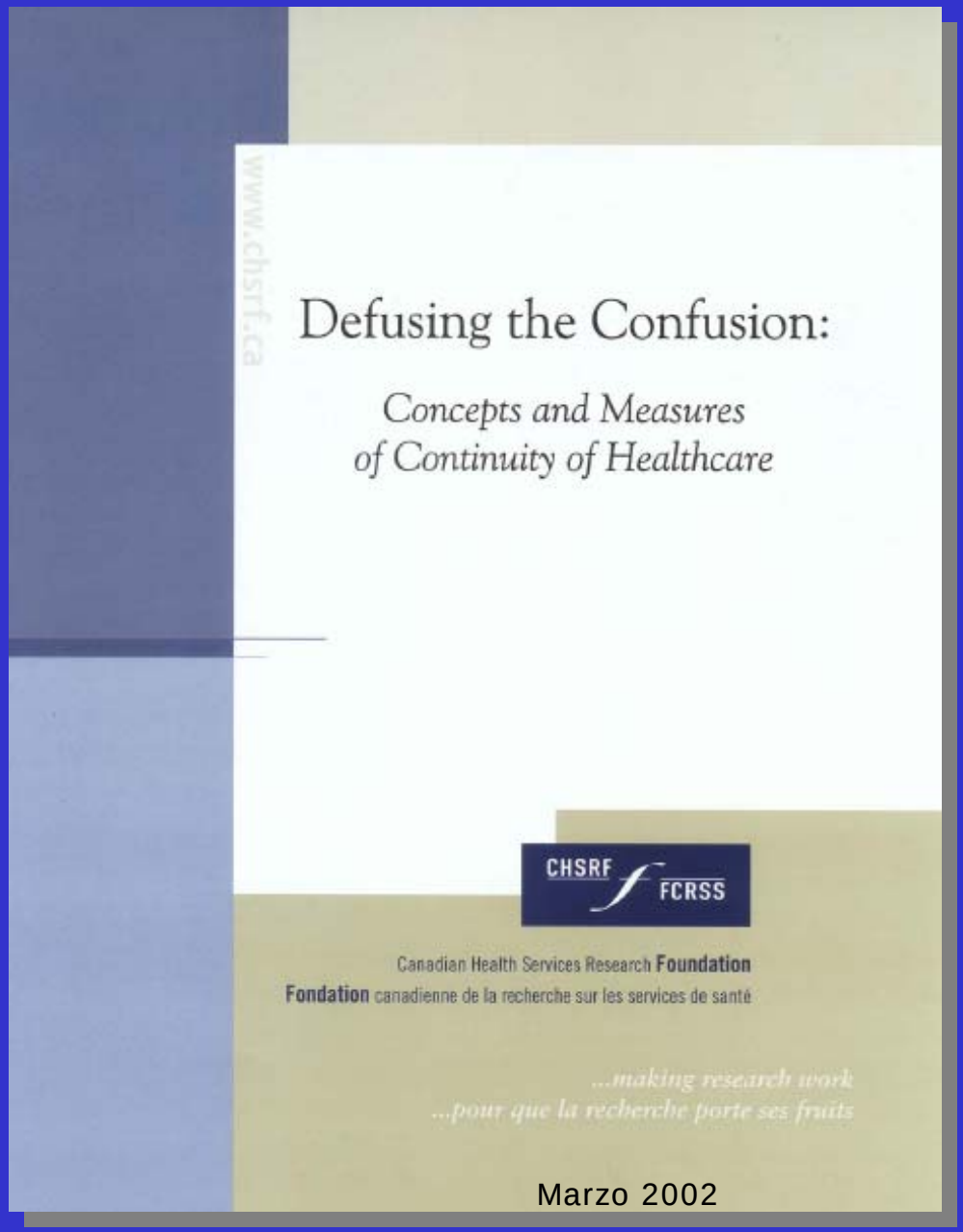


Internet

In the 1970s and 1980s, researchers acknowledged that continuity of care was more complex than regular physician visits

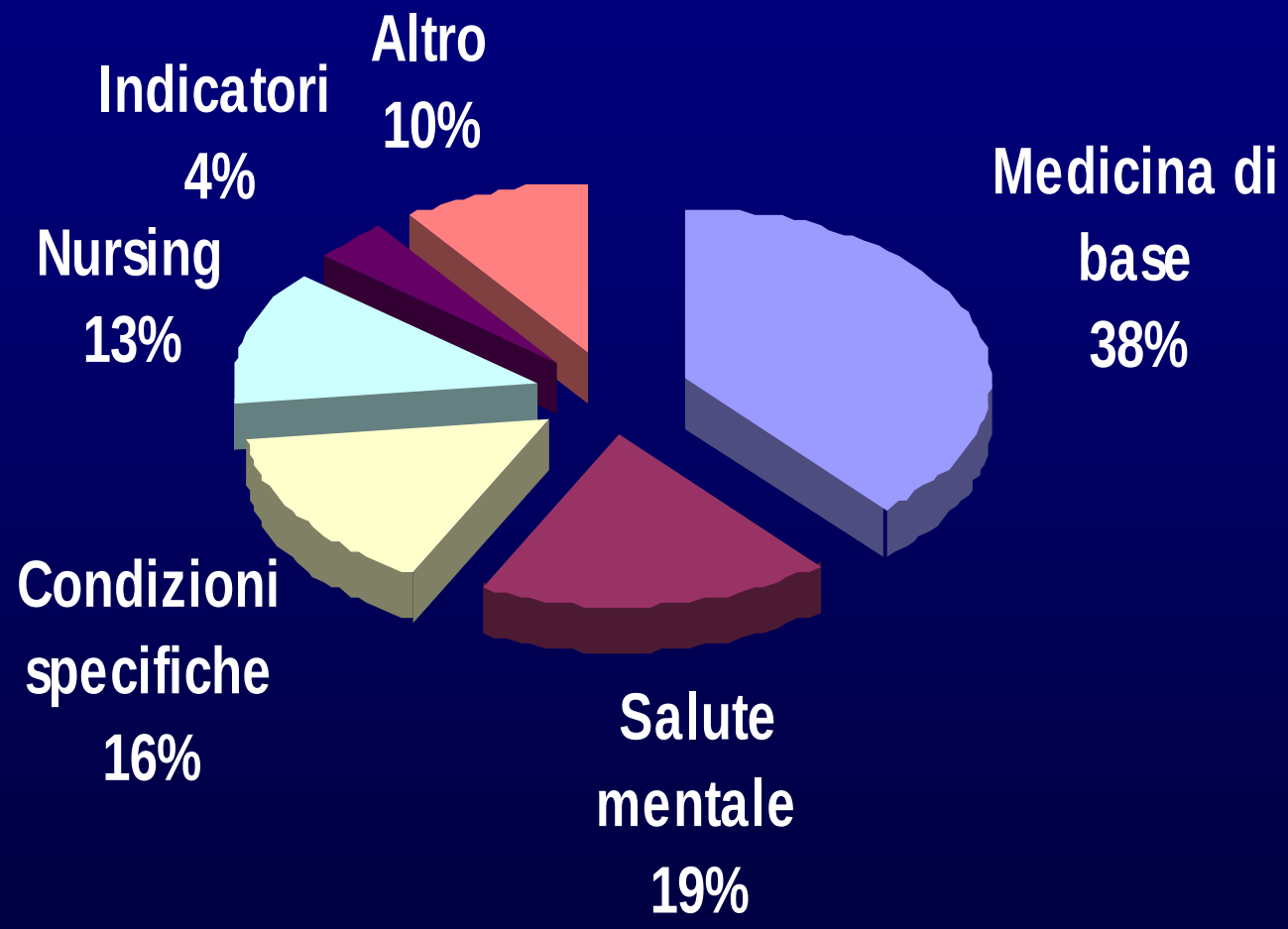
Continuity of care consists of

- continued and consistent care,
- effective information exchange,
- satisfactory patient–provider relationship



Canadian Health Services Research Foundation

www.chsrf.ca


Altro
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Indicatori
4%
Nursing
13%
Medicina di
base
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Condizioni
specifiche
16%
Salute
mentale
19%

bmj.com

Continuity of care: a multidisciplinary review

Jeannie L Haggerty, Robert J Reid, George K Freeman, Barbara H Starfield, Carol E Adair and Rachael McKendry

BMJ 2003;327;1219-1221
doi:10.1136/bmj.327.7425.1219

Three types of continuity

Informational continuity—The use of information on past events and personal circumstances to make current care appropriate for each individual

Management continuity—A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs

Relational continuity—An ongoing therapeutic relationship between a patient and one or more providers

UO	Continuità	G	I	R	Fonte	Indicatore
Trieste	Ospedale-RSA	X			CC	tempi di attesa
Emilia	Osp-hospice-terr	X	X		SDO+AdH	presi in carico
Emilia	Osp-terr **SCC**	X	X		Registro	presi in carico
Abruzzo	Ric ripetuti BPCO	X			SDO	ricoveri/PS
Abruzzo	Osp-RSA	X			CC	tempi di attesa
Marche	Osp-terr **SCC**	X			SDO+Reg	ricoveri, presc
Marche	Codici bianchi PS	X			SDO+Reg	accessi impropri
Marche	Ric ripetuti BPCO	X			SDO	ricoveri/PS
Veneto	Codici bianchi PS	X			SDO+Reg	accessi impropri
Veneto	Osp-terr **SCC**	X			SDO+Reg	ric ripetuti, accessi amb
Veneto	Trauma cranico	X	X		Registro	intervalli, outcome
Puglia	Osp-terr **SCC**	X	X	X	SDO+Reg	ricoveri, presc, rapp inform
Lomb	Pz Schizofrenico	X	X	X	Registro	COC SECON
Lomb	Pz Cardiopatico	X	X		SDO+Farm	ricoveri, presc
Lomb	Lettera di dimissione		X		AdH	completezza

Indicatori

- Dimensioni della continuità
- Specificità di patologia
- Effetti della (dis)-continuità (compliance, soddisfazione, ricoveri evitabili, accessi impropri, continuità prescrittiva, terapie inappropriate)

BMJ 2003 327: 1219-21
JAMA 2002 288: 1775-9
Health Soc Care Comm 2004 12: 475-87

Comunicazione efficace: la lettera di dimissione

- la diagnosi
- i fattori di rischio
- l'esito degli esami
- la condizione del paziente
- la dieta suggerita …
- l'attività fisica consigliata con indicazione di f.c. allenante e modalità di esecuzione
- il profilo psicologico del paziente
- la terapia suggerita
- il calendario dei prossimi appuntamenti

Sistema informativo psichiatrico

In Regione Lombardia, nato nel 1982 su base cartacea, negli anni ’90 si è informatizzato come database relazionale, alimentato con dati relativi a più di 100.000 contatti-paziente/anno.

Cardiopatia ischemica

- Definizione dei casi: codici ICD9cm afferenti agli indicatori AHRQ di mortalità per infarto miocardico acuto, volumi di attività di angioplastica coronarica e by-pass Ao-Co.
- Fonte informativa: SDO.
- Linkage: SDO (ricoveri successivi), prestazioni ambulatoriali, assistenza farmaceutica, schede di morte, riabilitazione.

Chronic Care Model

- community resources and policies,
- healthcare organisation,
- self-management support,
- delivery system design,
- decision support,
- clinical information systems

WHO European Office for Integrated Health Care Services

Integrated care (vision, model, strategy) ← **Continuity of care** (experienced by staff or/and patients) ← **Quality** (access, satisfaction, efficiency, effectiveness) (outcomes) ← **Population health**

Service Delivery and Organisation (SDO)

www.sdo.lshtm.ac.uk/cpcontinuity.html

1: Select **CONDITIONS** from the list below

Select All Conditions

aring Loss
art Failure
spital Care
pertension
hemic Heart Disease

cted Conditions

art Failure

2: Select **DOMAINS OF CARE** from the list below

Select All Domains
Diagnosis
Follow-up/Continuity
Prevention/Screening
Treatment

3: Click **DISPLAY** to view indicators by Condition

Display Reset

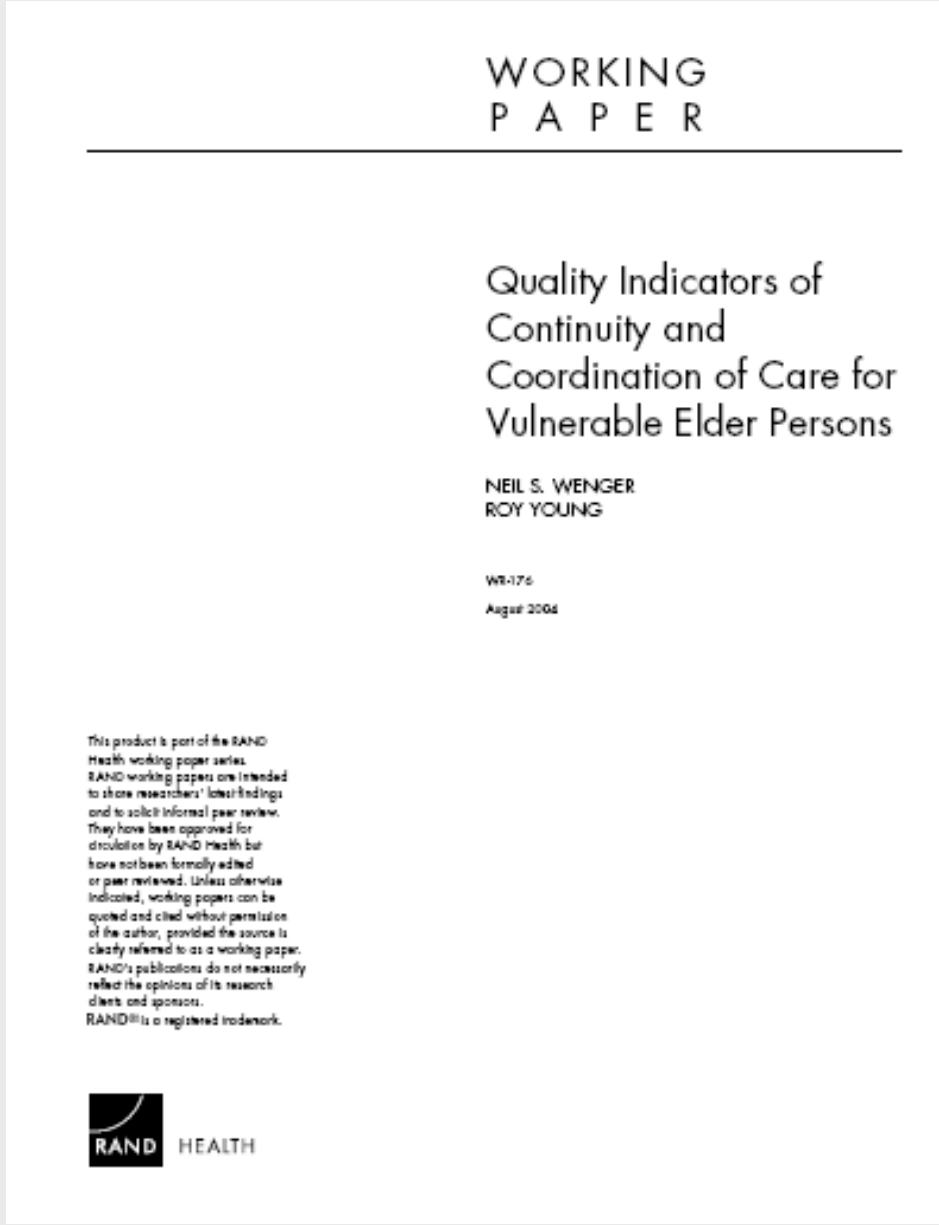
Heart Failure

There are no Indicators for Heart Failure: Follow-up/Continuity

Related Indicators for Heart Failure: Follow-up/Continuity	
Medication continuity after hospitalization	**IF** a vulnerable elder is discharged from a hospital to home, and he or she received a new prescription medication or a change in medication prior to discharge, **THEN** the outpatient medical record should document or acknowledge the medication change within 6 weeks of discharge.
Monitoring for new ACE inhibitor	**IF** a vulnerable elder is newly started on an ACE inhibitor, **THEN** serum potassium and creatinine levels should be checked within 1 month of the initiation of therapy.
Monitoring warfarin	**IF** a vulnerable elder is prescribed warfarin, **THEN** an INR should be determined at least every 6 weeks.
Monitoring warfarin	**IF** a vulnerable elder is prescribed warfarin, **THEN** an international normalized ratio (INR) should be determined within 4 days after initiation of therapy.
Monitoring electrolytes for diuretic	**IF** a vulnerable elder is prescribed a thiazide or loop diuretic, **THEN** he or she should have electrolytes checked at least yearly.
Initial follow-up of diuretic	**IF** a vulnerable elder is newly started on a diuretic, **THEN** serum potassium and creatinine levels should be checked within 1 month of the initiation of therapy.

ACOVE Topics

- Appropriate Use of Medication
- Chronic Pain
- Continuity and Coordination of Care
- Dementia
- Depression
- Diabetes Mellitus
- End-of-Life Care
- Falls and Mobility Problems
- Hearing Loss
- Heart Failure
- Hospital Care
- Hypertension
- Ischemic Heart Disease
- Malnutrition
- Osteoarthritis
- Osteoporosis
- Pneumonia
- Pressure Ulcers
- Preventive Care
- Stroke and Atrial Fibrillation
- Urinary Incontinence
- Visual Impairment



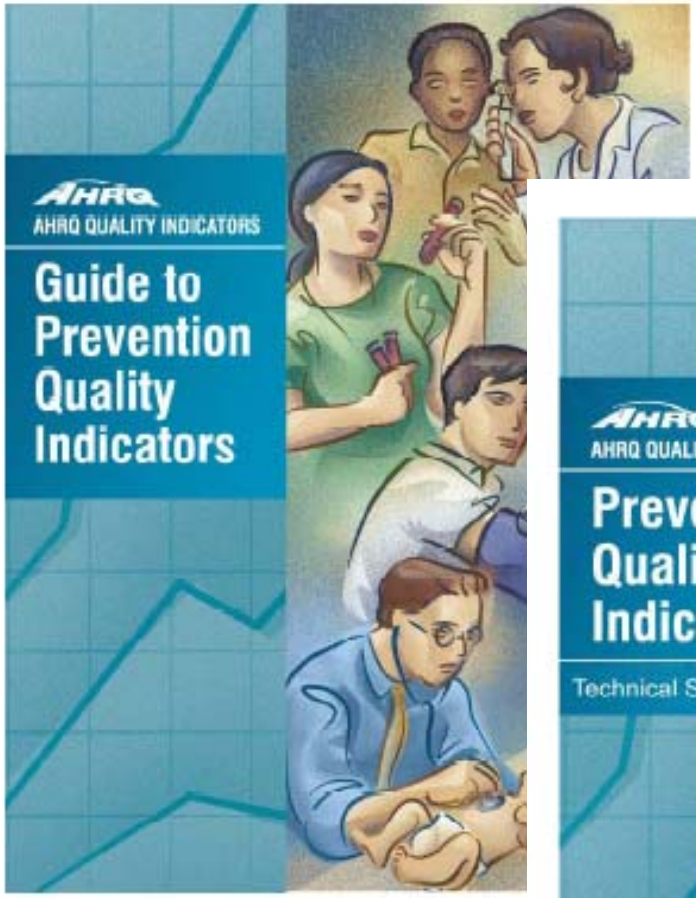
WORKING
PAPER

Quality Indicators of Continuity and Coordination of Care for Vulnerable Elder Persons

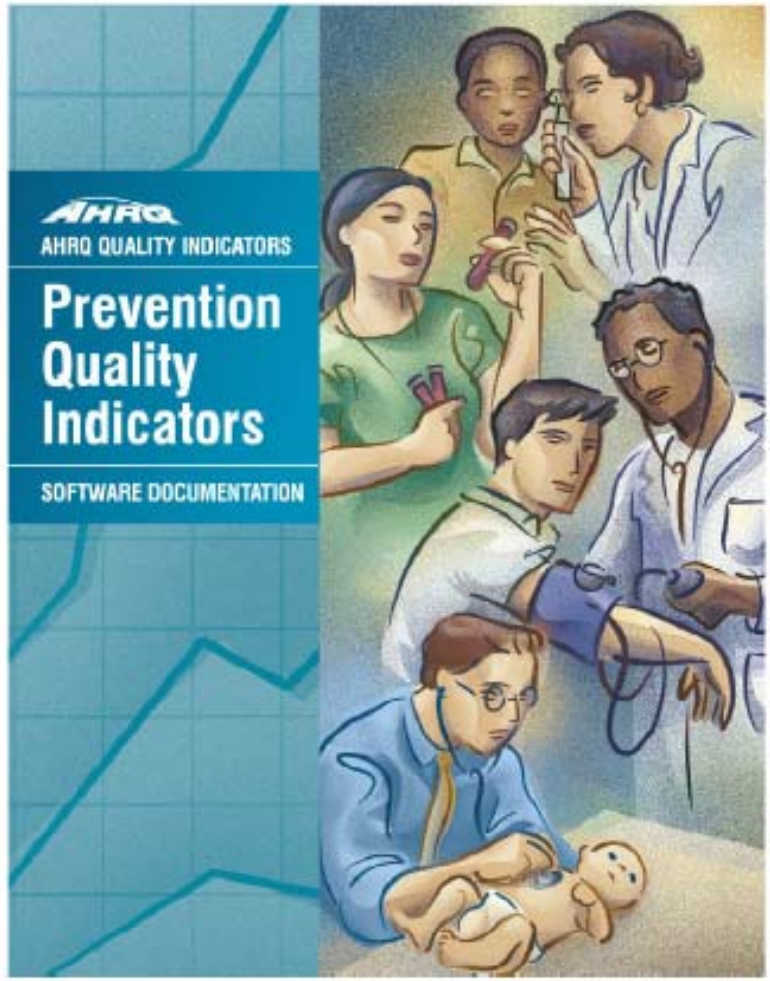
NEIL S. WENGER
ROY YOUNG

WR-176
August 2004

RAND HEALTH


AHRQ
AHRQ QUALITY INDICATORS
Guide to Prevention Quality Indicators


AHRQ
AHRQ QUALITY INDICATORS
Prevention Quality Indicators
Technical Specifications


AHRQ
AHRQ QUALITY INDICATORS
Prevention Quality Indicators
SOFTWARE DOCUMENTATION

Joint Commission

The Joint Commission National Library of Healthcare Indicators (NLHI)

International Journal of Integrated Care
ISSN 1568-4156
Volume 7 | 2007

editorial

Imagine that your waist size is measured annually and your data from annual health checkups are stored in the database. A big brother keeps track of you and dictates what you should eat and how much when it exceeds a certain limit. Not a novel by George Orwell, it is an essential part of Japan's health care reform 2008. **[More]**

portal

INIC: the International Network of Integrated Care
Read all about the Kaiser Permanente study tour!

features

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research and theory

Handling the transition of adolescents with diabetes: participant observations and interviews with care providers in paediatric and adult diabetes outpatient clinics
Carina Sparud Lundin, Ella Danielson, Ingbritt Öhrn

projects and developments

The Domiciliary Support Service in Portugal and the change of paradigm in care provision
Silvina Santana, Ana Dias, Elisabete Souza, Nelson Rocha

theses

Health problems after spinal cord injury rehabilitation: who cares? (Summary)
Jos Bloemen-Vrencken

Taking care of integrated care: integration and fragmentation in the development of integrated care arrangements (Summary)
Isabelle Fabbricotti

books

Primary care in the driver's seat? Organisational reform in European primary care
Review by Han van Oosterbos

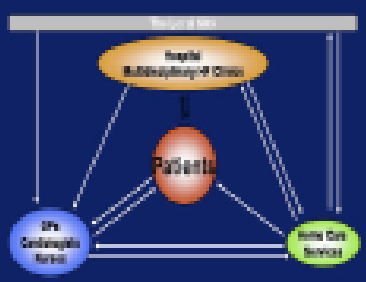
Integrating health and social services for older persons: evidence from nine European countries
Review by Jane Tilly

Home telehealth: connecting care within the community
Review by Dennis L. Kodner

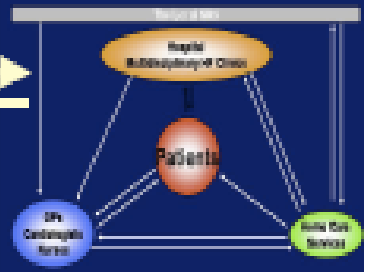
Introduction to telemedicine. Second edition
Review by Mathijs Soede

Towards managed primary care: the role and experience of primary care organisations
Review by H.J.M. Vrijhoef

International Journal of Integrated Care is a joint project of Utrecht University, Maastricht University and Groningen University, the Netherlands



Struttura di III livello
Centro TC



Struttura di Ricovero di Riferimento
Con Ambulatorio SC integrato

Paziente

Medico di Famiglia
Cardiologo ExO

ADI

Clinical networks

Advantages include flexibility, strength, speed, and focus on clinical issues

The NHS seems fond of structural solutions to its problems, even though experience suggests that reorganisation is a distraction, fails to solve the problems it was supposed to address, and creates new ones. Seasoned NHS observers might therefore be sceptical of the growing interest in clinical networks. There are certainly reasons for caution but clinical networks do seem to offer several important advantages to patients and clinicians.

The Scottish Office defines managed clinical networks as "linked groups of health professionals and organisations from primary, secondary, and tertiary care working in a co-ordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure equitable provision of high quality effective services." Their report contrasted these with loose networks and suggests that they differ from hub and spoke models in that the interests of the network would dominate those of individual hospitals.[1,2] These networks may be grouped by function (for example, pathology, emergency medicine, critical care) or client group (children), disease (cancer, renal) or specialty (vascular surgery).

Network organisations have several theoretical advantages in terms of their flexibility, robustness, and ability to respond quickly to a rapidly changing environment.[3] Formal NHS networks have started to ronment that allows self organisation, development and learning—features which seem to be related to improved outcomes and staff retention. Large networks are more likely to cover the large populations needed to support the different disciplines and expertise required for research and training in an increasingly competitive global market.[4,5]

A real attraction of networks is that they focus on clinical issues and create organic and flexible organisations that can respond well to a changing environment. This and their collaborative nature seem to appeal to many clinicians. These positive features, however, that can put them directly at odds with the organisations in which their members sit. Who decides about a consultant appointment, drug formulary, or operational policy—the trust or the network? Who should be accountable for the clinical governance of network members? In fact pragmatic answers can be found, but many networks will have some difficult encounters over these and other issues and will need strong clinical and managerial leadership to deal with them.

A more hazardous possibility is that networks will be seen as the next structural panacea and turned into new NHS organisations. For some services there may be significant advantages from shifting the managerial focus away from institutions and towards services for

NETWORK SCIENCE

Committee on Network Science for Future Army Applications

Board on Army Science and Technology
Division on Engineering and Physical Sciences

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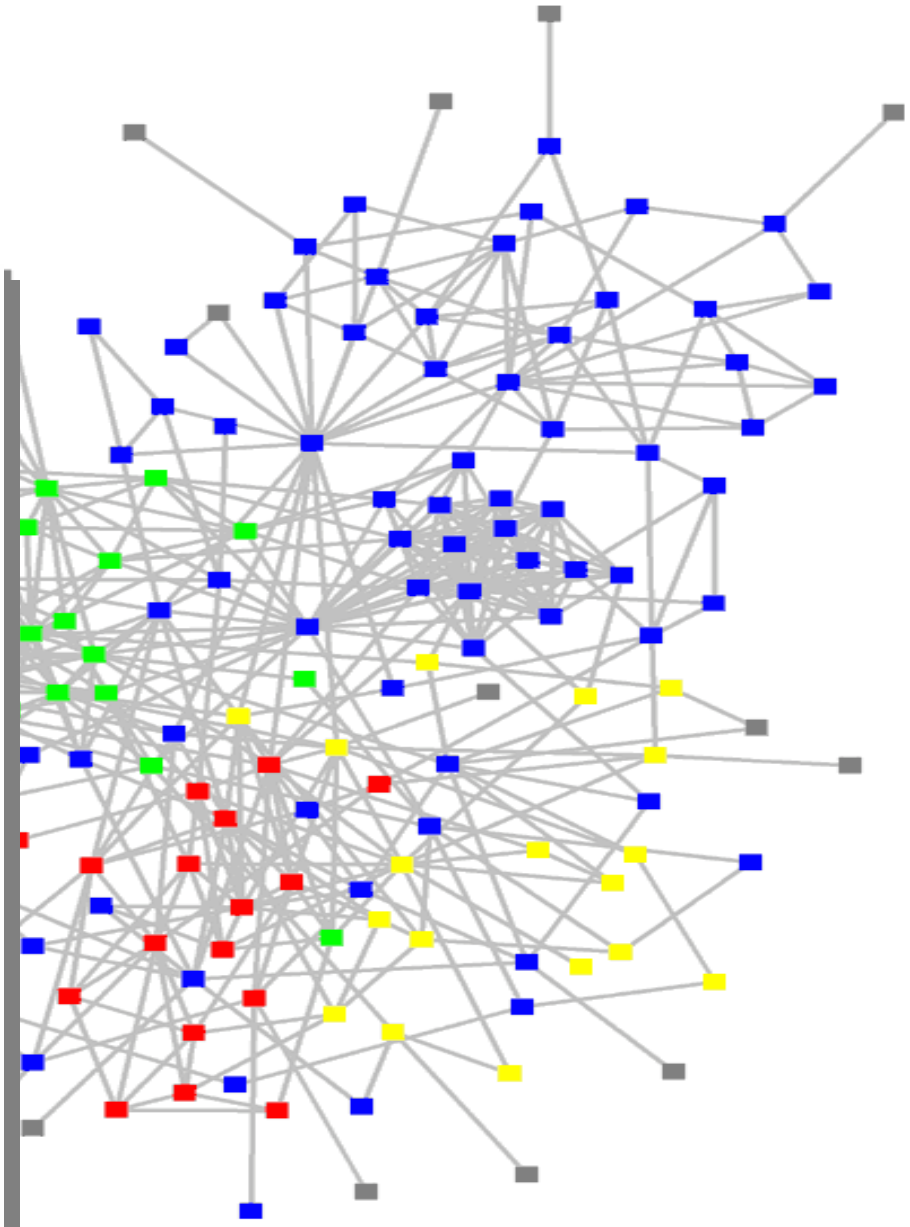
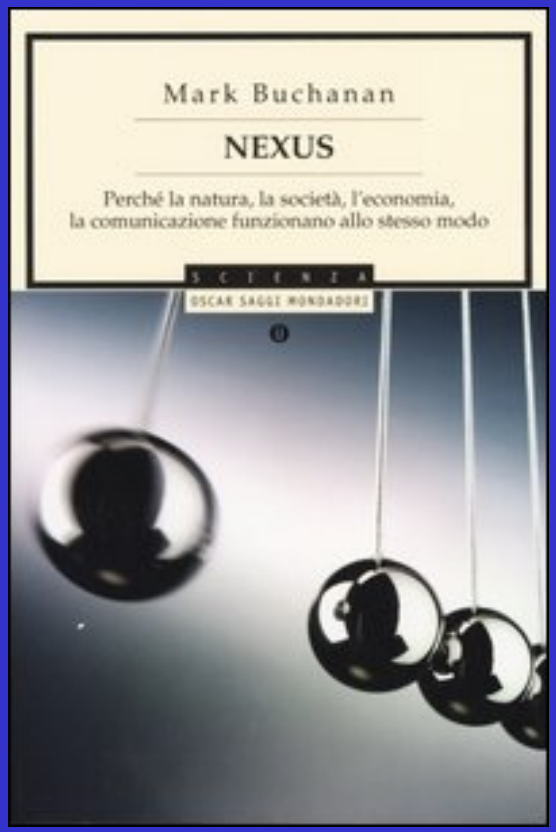
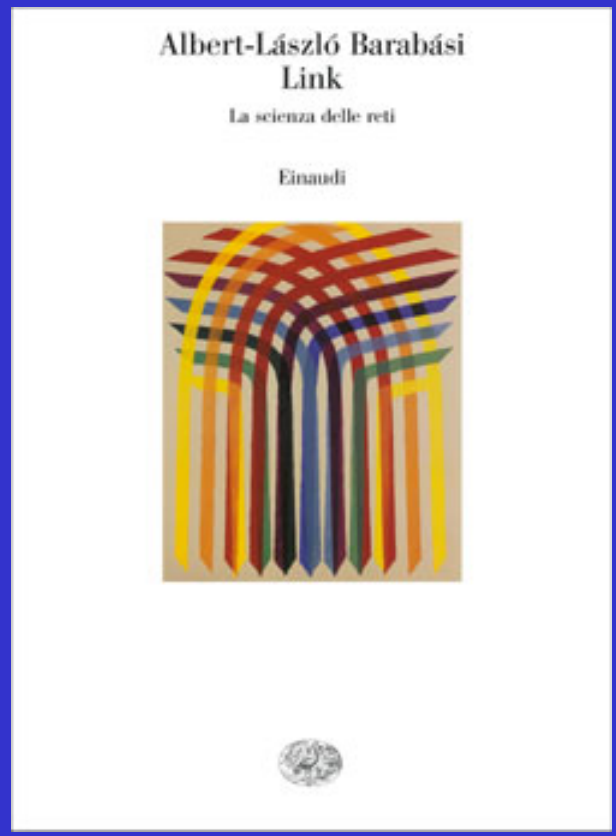



Mark Buchanan
NEXUS
Perché la natura, la società, l'economia,
la comunicazione funzionano allo stesso modo
SCIENZA
OSCAR SAGGI MONDADORI


Albert-László Barabási
Link
La scienza delle reti
Einaudi

Progetto

E' stato attivato un progetto del Ministero della Salute 2006-2008) sugli indicatori per le reti oncologiche (Toscana e Piemonte) aperto alla partecipazione di altre regioni.

Il lavoro è svolto in stretta collaborazione tra registro tumori , epidemiologi e clinici oncologici

Gli studi di IMPATTO degli screening oncologici forniscono informazioni importanti per valutare il governo clinico

L'Airtum dovrebbe sviluppare la sorveglianza e monitoraggio in collaborazione con Alleanza contro il cancro , AIOM e altre Soxieta scientifiche , attivando gruppi per patologia

In Piemonte nel 2001 la proporzione di donne che hanno ricevuto un trattamento radioterapico entro 6 mesi dalla chirurgia conservativa è stata del 67,8% sul totale delle operate per carcinoma mammario.

STUDIO QUADRI

QUALITÀ DELL'ASSISTENZA ALLE PERSONE DIABETICHE NELLE REGIONI ITALIANE

PARTNERS

I RISULTATI IN PIEMONTE

2004 - 2006

Società della Salute

23 dicembre 2004 - 14 dicembre 2006

A DUE ANNI DALL'INIZIO DELLA SPERIMENTAZIONE

La Sds Area pratese si presenta.....

Incontro Sds Area pratese IV Commissione regionale

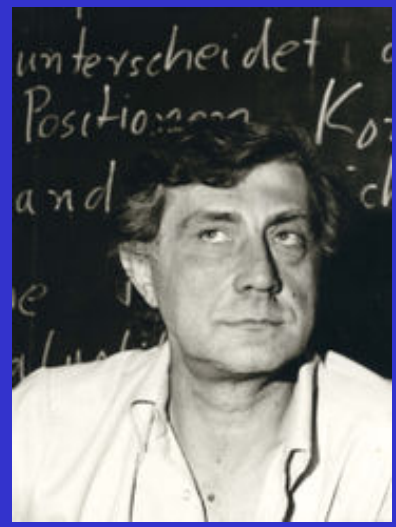
Prato 14 dicembre 2006

www.sds.prato.it

“La salvezza del malato mentale è quella di restare nelle nostre case, coinvolgendo nella sua problematica la nostra vita reale,

così che la sua presenza richiederà strutture terapeutiche vicine a lui, psichiatri a domicilio, organizzazioni comunitarie in cui possa sentirsi protetto, luoghi di lavoro dove possa trovare un ruolo, una funzione che giustifichi - davanti a se stesso - la sua presenza nel mondo”

(F.Basaglia,1967)



EMPOWERMENT

Non basta a cittadini sempre più esigenti, ricevere una diagnosi corretta ed una terapia "solo" efficace da un curante incurante dei valori e dei voleri dell'altro; non basta loro un incontro ed un ascolto impersonale, un'interazione che li inchiodi ad essere meri beneficiari di una prestazione e non li "invita" ad essere ***codecisori e co-terapeuti****.*

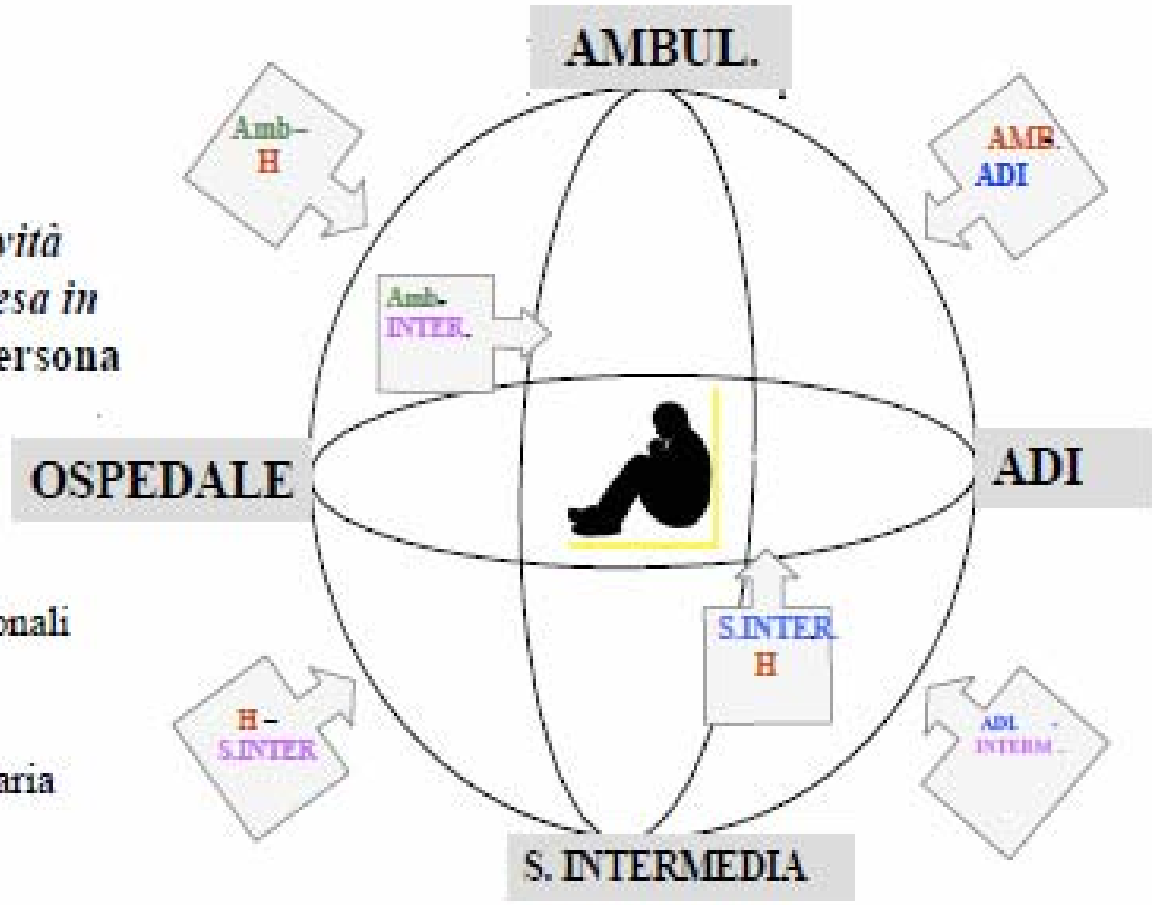
Rete, continuità, indicatori e ruolo del paziente

- Reti, nodi, link: quali indicatori e modalità di studio per un sistema di relazioni?
- Indicatori: informazione di esercizio o informazione di governo ?
- Rete sanitaria: strumento di partecipazione o di medicalizzazione ?

La *Rete* della continuità ospedale – territorio

L'integrazione di *attività complesse* verso la *presa in carico globale* della persona

Ospedale
Distretto
Medicina Generale
Medicina Specialistica
Nurse/team non professionali
Paziente/Famiglia
ADI/Cure Intermedie
Integrazione Socio-Sanitaria
Habitat
Volontariato



Informazione e Partecipazione

L'unità sanitaria locale come sistema

I nemici della partecipazione:

autorità*: vestiti i panni della competenza, separatasi nella tecnica, si pone quale esecutrice dei comandi di un potere che la sovrasta;*

efficienza*: domanda del potere che, in un sistema dato, la confonde con l'efficacia, come confonde la funzione, definita dai fini, con il funzionamento, definito dai modi;*

provvidenzialità*: modo paternalista di disporre risposte preformate che prescindono dalla formazione delle domande, consentendo solo la richiesta che si conforma all'offerta.*

G.A. Maccacaro 1976