



1° Corso per Fisioterapisti  
e Terapisti Occupazionali

29 - 30 novembre



52°

## *La specificità della riabilitazione geriatrica*

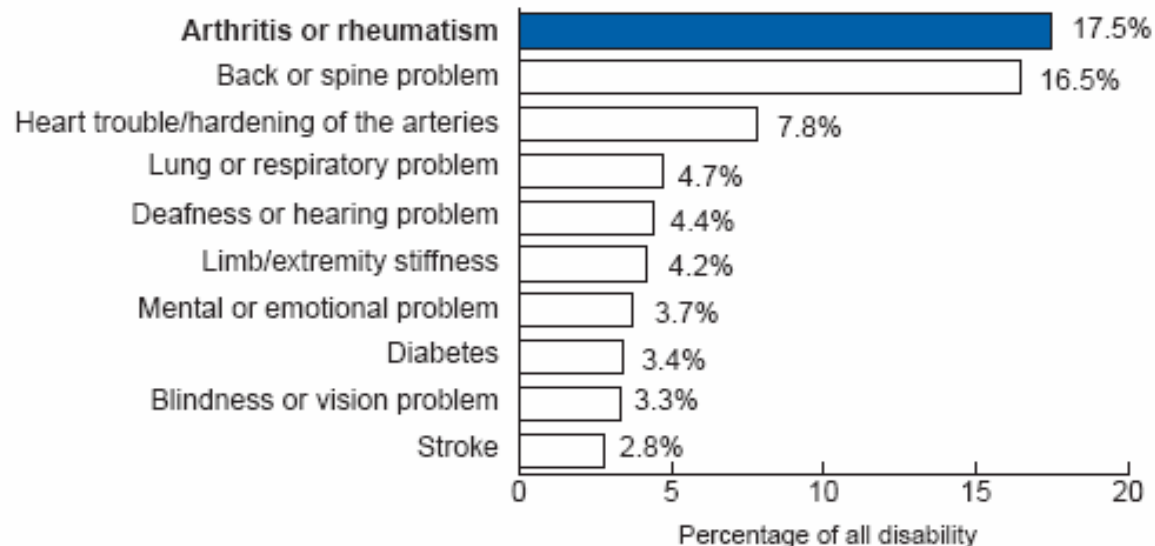


**Bruno Bernardini**

SC Recupero Funzionale  
EO Ospedali Galliera, Genova

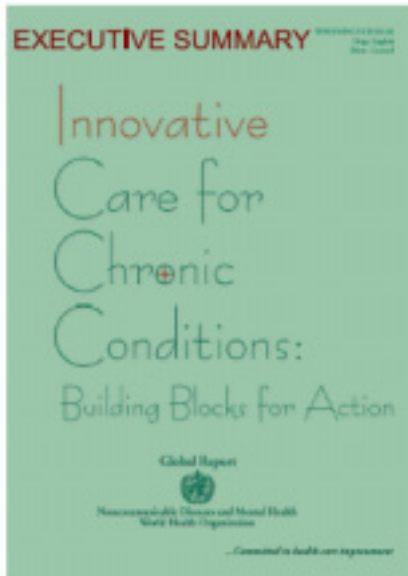


## Most Common Causes of Disability\* Among U.S. Adults, 1999



\* People were considered to have a disability if they had difficulty with any one of a wide range of activities—for example, being able to lift or carry 10 lbs, climb a flight of stairs without resting, walk three city blocks, get in and out of bed, bathe, dress, prepare meals, or do light housework. In addition, people were considered to have a disability if they used a wheelchair, crutches, cane, or walker for more than 6 months, were limited in the ability to work at a job, or had any one of a number of other limitations. For the full definition of disability, see the source below.

Source: CDC. Prevalence of disabilities and associated health conditions among adults—United States, 1999. *MMWR* 2001;50:120–5.



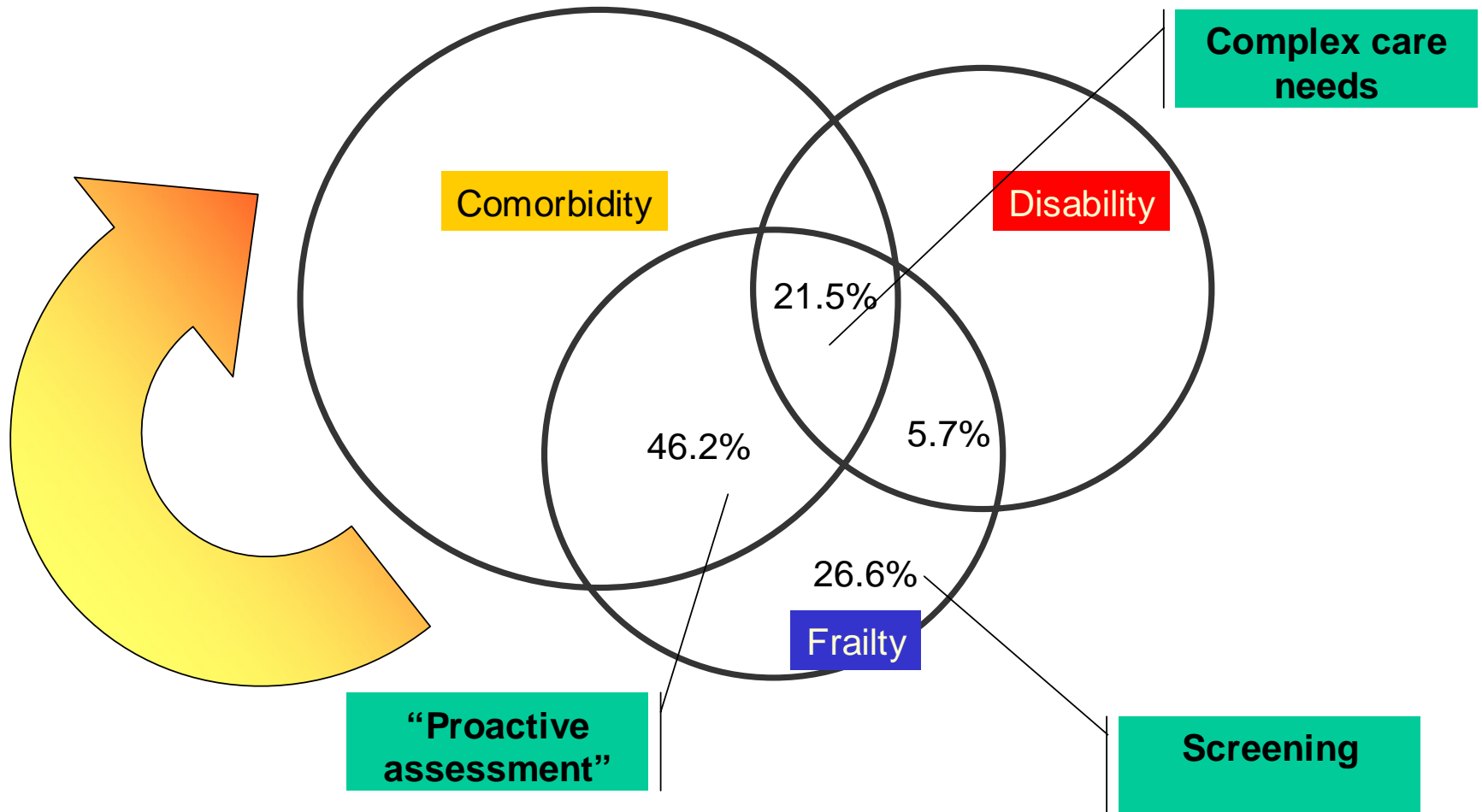
## 1 SUPPORT A PARADIGM SHIFT

Health care is organized around an acute, episodic model of care that no longer meets the needs of many patients, especially those with chronic conditions.

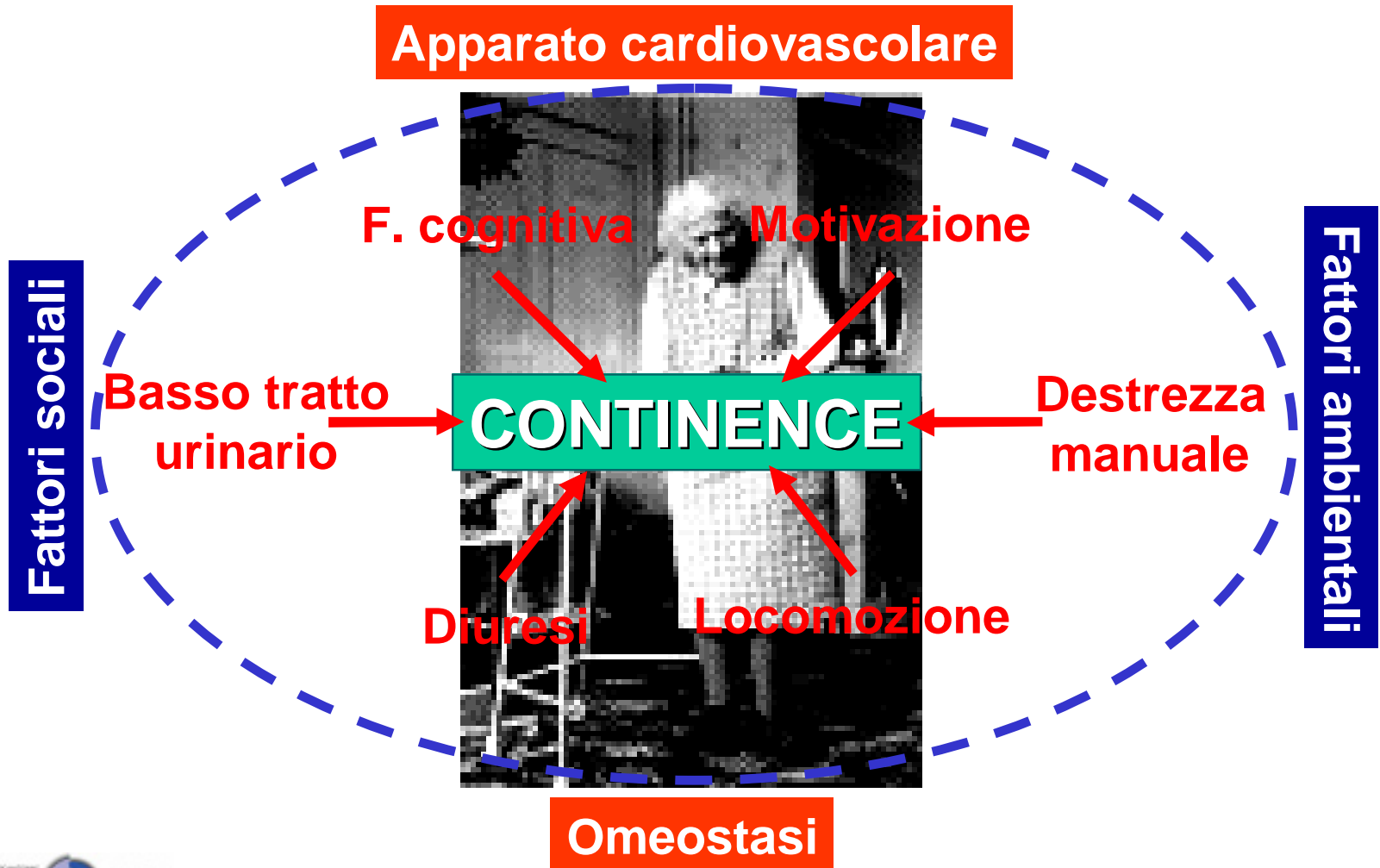
Decreases in communicable diseases and the rapid ageing of the population have produced this **mismatch between health problems and health care, and chronic conditions are on the rise**. Patients, health care workers, and most importantly, decision-makers must recognize that **effective chronic condition care requires a different kind of health care system**.

The most prevalent health problems such as diabetes, asthma, heart disease, and depression **require extended and regular health care contact**. A new paradigm will dramatically advance efforts to solve the problem of managing diverse patient demands given limited resources.

# Prevalence and overlaps of comorbidity, disability and frailty



# Determinanti della Continenza



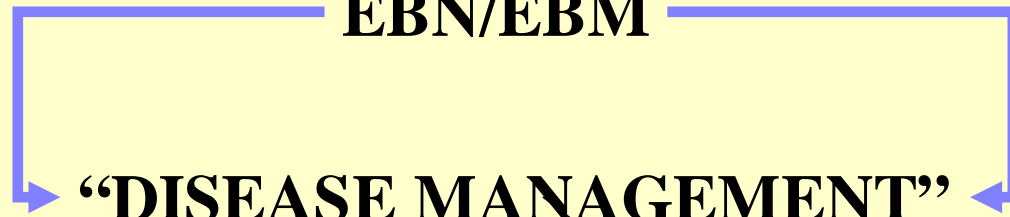
# *Che strumenti abbiamo per trasferire nella pratica questi principi?*

**Evoluzione dei sistemi di cura  
(Ultimi 15 anni)**

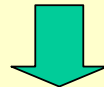
**“PATIENT-CENTERED” CARE**



**EBN/EBM**



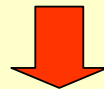
**“DISEASE MANAGEMENT”**



**Studi prospettici  
osservazionali**

**PDT-A**

**Linee-Guida**



**CPI (Continuous Processes Improvement)**

# Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases

## Implications for Pay for Performance

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Cynthia M. Boyd, MD, MPH

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Jonathan Darer, MD, MPH

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Chad Boulton, MD, MPH, MBA

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Linda P. Fried, MD, MPH

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Lisa Boulton, MD, MPH, MA

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Albert W. Wu, MD, MPH

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**Context** Clinical practice guidelines (CPGs) have been developed to improve the quality of health care for many chronic conditions. Pay-for-performance initiatives assess physician adherence to interventions that may reflect CPG recommendations.

**Objective** To evaluate the applicability of CPGs to the care of older individuals with several comorbid diseases.

**Conclusions** This review suggests that adhering to current CPGs in caring for an older person with several comorbidities may have undesirable effects. Basing standards for quality of care and pay for performance on existing CPGs could lead to inappropriate judgment of the care provided to older individuals with complex comorbidities and could create perverse incentives that emphasize the wrong aspects of care for this population and diminish the quality of their care. Developing measures of the quality of the care needed by older patients with complex comorbidities is critical to improving their care.

*JAMA.* 2005;294:716-724

[www.jama.com](http://www.jama.com)

## State-of-the-Science on Postacute Rehabilitation: Measurement and Methodologies for Assessing Quality and Establishing Policy for Postacute Care

*Pamela W. Duncan, PhD, PT, Craig A. Velozo, PhD, OT*

**ABSTRACT.** Duncan PW, Velozo CA. State-of-the-science on postacute rehabilitation: measurement and methodologies for assessing quality and establishing policy for postacute care. *Arch Phys Med Rehabil* 2007;88:1482-7.

We present an overview of commonly used postacute outcome measures and review new methodologies for postacute assessment. We question the impact that current measurement has had on improvement of quality of postacute care (PAC) and its utility in informing health policy. We suggest that Donabedian's model of health care quality should be endorsed for measurement. Specifically, measurement of outcomes and process should be used jointly in assessment of PAC.

**Key Words:** Health policy; Outcome and process assessment (health care); Rehabilitation.

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## **Assessing the Effectiveness of Postacute Care Rehabilitation**

*Robert L. Kane, MD*

**ABSTRACT.** Kane RL. Assessing the effectiveness of post-acute care rehabilitation. *Arch Phys Med Rehabil* 2007;88:1500-4.

This commentary reviews a number of issues related to determining the effectiveness of postacute care including what it is (in terms of type and site of care), how to tease out the critical elements (what components of this multifaceted process are essential), the role of research designs (given the logistic difficulties of doing randomized trials, how can nonexperimental designs be used to the greatest advantage), how to assess the relation between treatment and outcomes, measurement issues (what, when, how), correcting for case mix, and potential payment schemes.

**Key Words:** Insurance, health; Outcomes research; Rehabilitation; Reimbursement, incentives; Research design.

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# Another Look at Observational Studies in Rehabilitation Research: Going Beyond the Holy Grail of the Randomized Controlled Trial

*Susan D. Horn, PhD, Gerben DeJong, PhD, David K. Ryser, MD, Peter J. Veazie, PhD, Jeffrey Teraoka, MD*

This commentary compares randomized controlled trials (RCTs) and clinical practice improvement (CPI) approaches to study design, evaluates their relative advantages and disadvantages, and discusses their implications for rehabilitation research and evidence-based practice. Many argue that observational cohort studies are not sufficient as scientific evidence for practice change. We challenge this assertion by introducing the concept of a CPI study: a comprehensive observational paradigm structured to decrease biases generally associated with observational research. One strength of CPI studies is their attention to defining and characterizing the “black box” of clinical practice. CPI studies require demanding data collection, but by using bivariate and multivariate associations among patient characteristics, process steps, and outcomes, they can uncover best practices more quickly while achieving many of the presumed advantages of RCTs.

**Key Words:** Cerebrovascular accident; Clinical practice variations; Rehabilitation; Treatment outcomes.

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# Geriatric Syndromes: Clinical, Research, and Policy Implications of a Core Geriatric Concept

*Sharon K. Inouye, MD, MPH,\*† Stephanie Studenski, MD,‡§ Mary E. Tinetti, MD,|| and George A. Kuchel, MD¶*

This article reviews criteria for defining geriatric syndromes and proposes a balanced approach of developing preliminary criteria based on peer-reviewed evidence. Based on a review of the literature, four shared risk factors—older age, baseline cognitive impairment, baseline functional impairment, and impaired mobility—were identified across five common geriatric syndromes (pressure ulcers, incontinence, falls, functional decline, and delirium). Understanding basic mechanisms involved in geriatric syndromes will be critical to advancing research and developing targeted therapeutic options, although given the complexity of these multifactorial conditions, attempts to define relevant mechanisms will need to incorporate more-complex models, including a focus on synergistic interactions between different risk factors. Finally, major barriers have been identified in translating research advances, such as preventive strategies of proven effectiveness for delirium and falls, into clinical practice and policy initiatives. National strategic initiatives are required to overcome barriers and to achieve clinical, research, and policy advances that will improve quality of life for older persons. *J Am Geriatr Soc* 55:780–791, 2007.

# Modello indicatori del percorso clinico

## STATO

### Rischio specifico:

Natura e potenziale  
patologico  
della malattia principale



### Rischio Generico

#### Fattori non modificabili

- Età / sesso
- Disabilità premorbose
- Comorbilità cronica
- Fragilità sociale

#### Fattori modificabili

- Disabilità Comunicativa
- Instabilità clinica
- Delirium
- Malnutrizione
- Infezioni
- Catetere
- Ulcere da pressione



## TRANSIZIONE

### Fattori interni

- Risorse e competenze
- Organizzazione



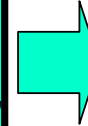
### TRATTAMENTO

- **Riabilitativo:** tipo, contenuti, intensità, durata.
- **Medico:** instabilità clinica.
- **Nursing riabilitativo:** processi critici



### Fattori esterni

- Supporto familiare
- Servizi di comunità
- Regole del sistema Sanitario e Sociale



## ESITO

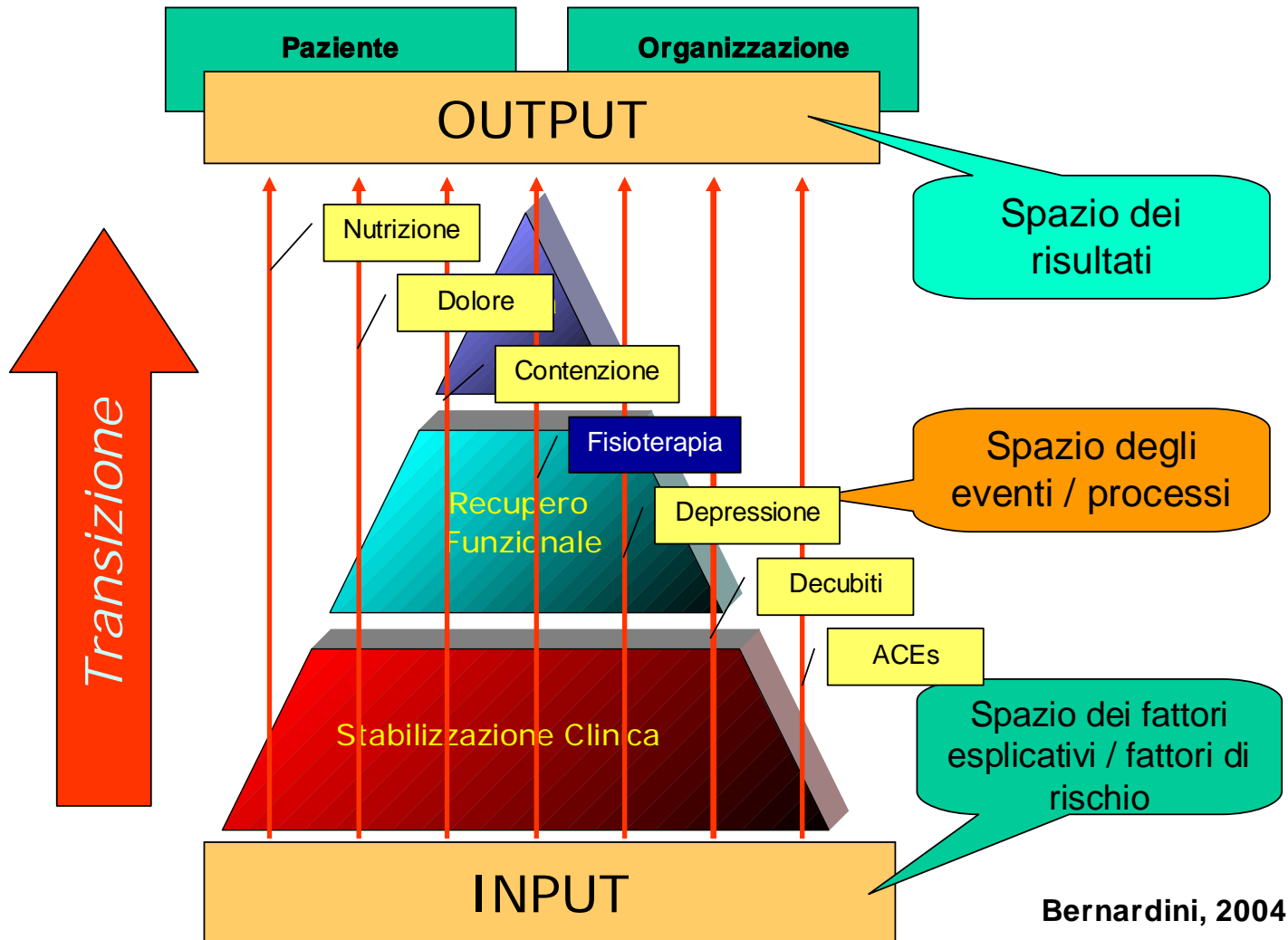
### Paziente-orientati

- Cammino indipendente
- Potenziale riabilitativo
- Non catetere
- Continenza
- Non ulcere da pressione

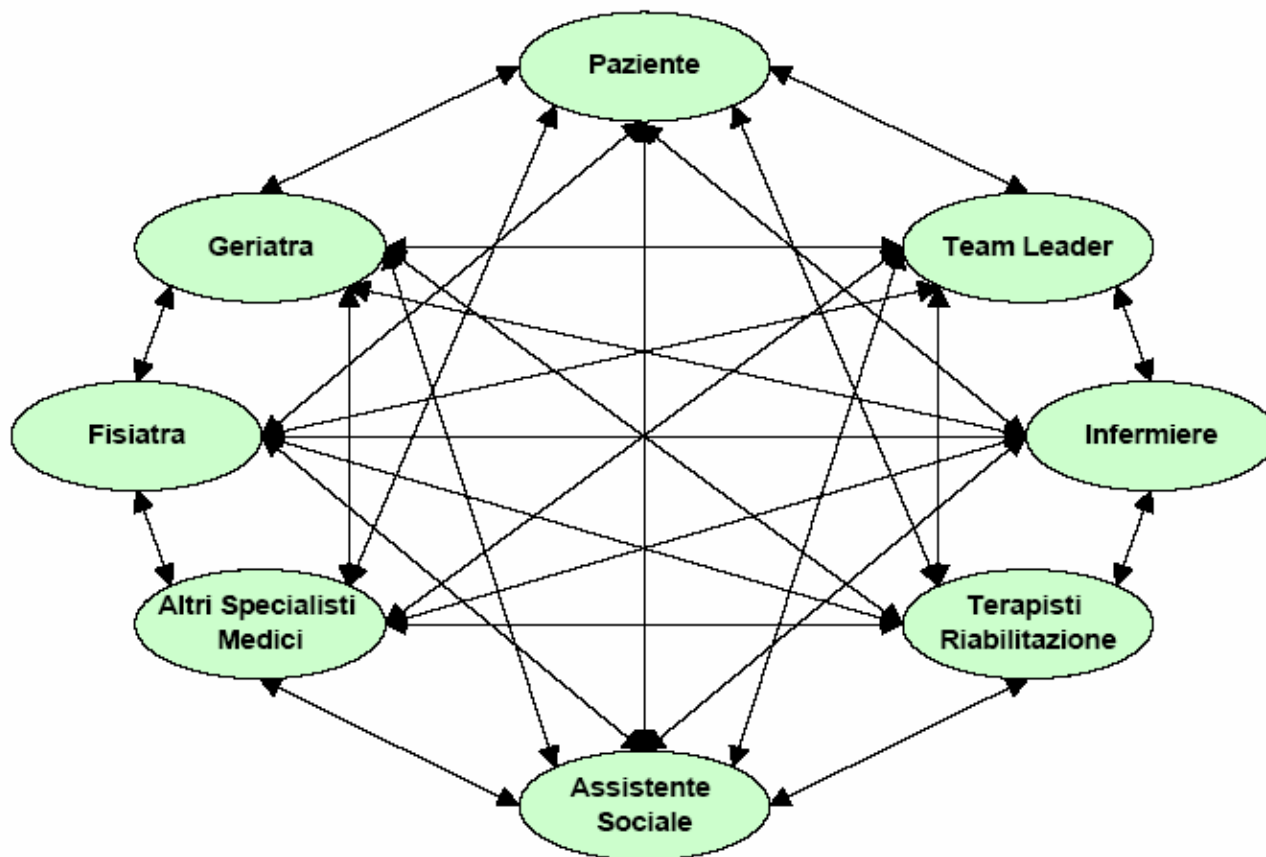
### Organizzazione-orientati

- Conclusa riabilitazione
- Istituzionalizzazione
- Traferimento acuti
- Mortalità
- Lunghezza degenza

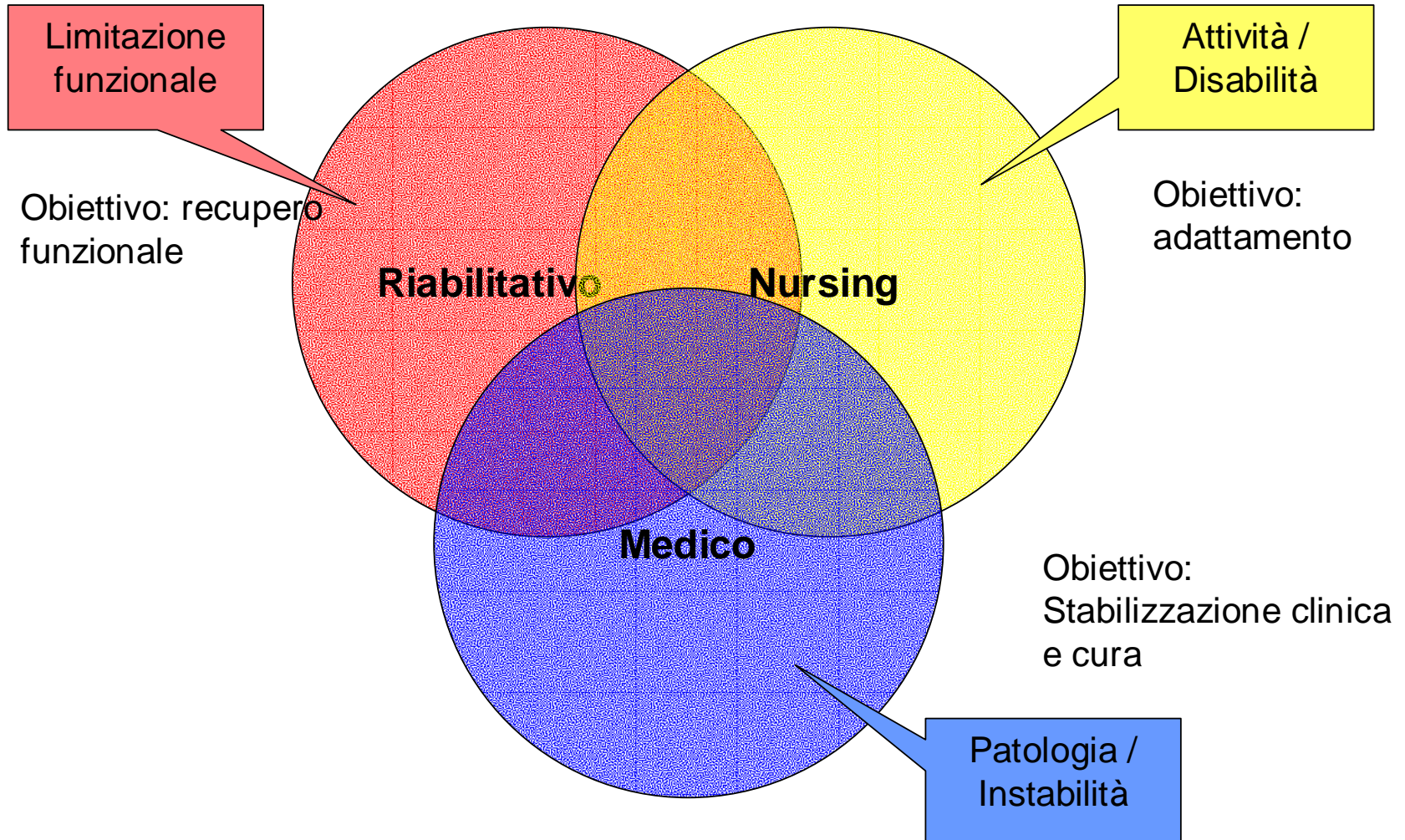
# MODELLO PER LA COSTRUZIONE DEL CORE-SET DI INDICI DI PROCESSO-ESITO



## Il team interdisciplinare



# Obiettivi e "drive" delle attività di cura



# STABILIZZAZIONE CLINICA: OBIETTIVI

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## PREVENIRE / TRATTARE

- ⇒ **La disidratazione e gli squilibri elettrolitici**
- ⇒ **La malnutrizione**
- ⇒ **Le infezioni**
- ⇒ **Il dolore**
- ⇒ **L'immobilità e le sue complicazioni**
- ⇒ **La comorbilità (malattie e limitazioni funzionali molteplici)**
- ⇒ **Gli eventi clinici avversi**

# RECUPERO FUNZIONALE: OBIETTIVI

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## RECUPERO:

- ⇒ **Funzione muscolare (trofismo, elasticità, forza)**
- ⇒ **Articolarità (ROM passivo ed attivo)**
- ⇒ **Coordinazione**
- ⇒ **Postura e cambi posturali**
- ⇒ **Stazione eretta e distribuzione del carico**
- ⇒ **Cammino**
- ⇒ **Autonomia nelle B-ADL**

# RITORNO AL DOMICILIO E QUALITA' DELLA VITA: OBIETTIVI

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## EDUCAZIONE/COUNSELING:

- ⇒ Del paziente sui rischi della propria condizione e sul significato della disabilità.
- ⇒ Dei familiari sui bisogni e le modalità di assistenza al parente.

## SUPPORTO:

- ⇒ Prescrizione ausili
- ⇒ Attivazione dei servizi territoriali
- ⇒ Modificazioni ambiente
- ⇒ Assistenza sociale

# CARTA DI MONITORAGGIO DELLA GESTIONE INFERMIERISTICA DEI PROCESSI CRITICI ASSISTENZIALI

Id. paziente

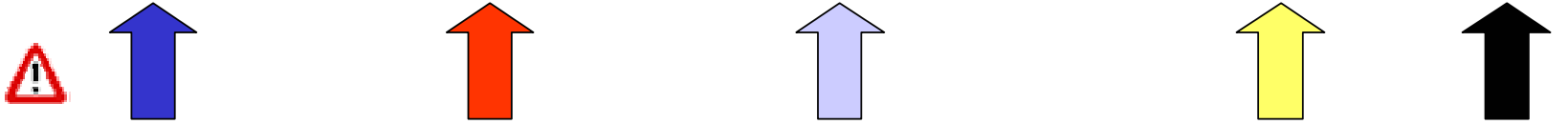
Data ammissione

Data dimissione

Giorni trattamento (episodi assistenziali)

PROCESSI	Data inizio	Giorni trattamento (episodi assistenziali)	Data fine	Presenza alla dimissione	
		+--+--+--+--+--+--+--+--+--+--+		No	Si
<b>ALIMENTAZIONE</b>					
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Supplementazione orale (MNA)	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sondino Nasogastrico / PEG	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>MOBILITA'</b>					
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Assistenza al cammino	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

B.S.B.



# CARTA DI CONTROLLO INTENSITA' ASSISTENZIALE (130 PAZIENTI CON ICTUS)

