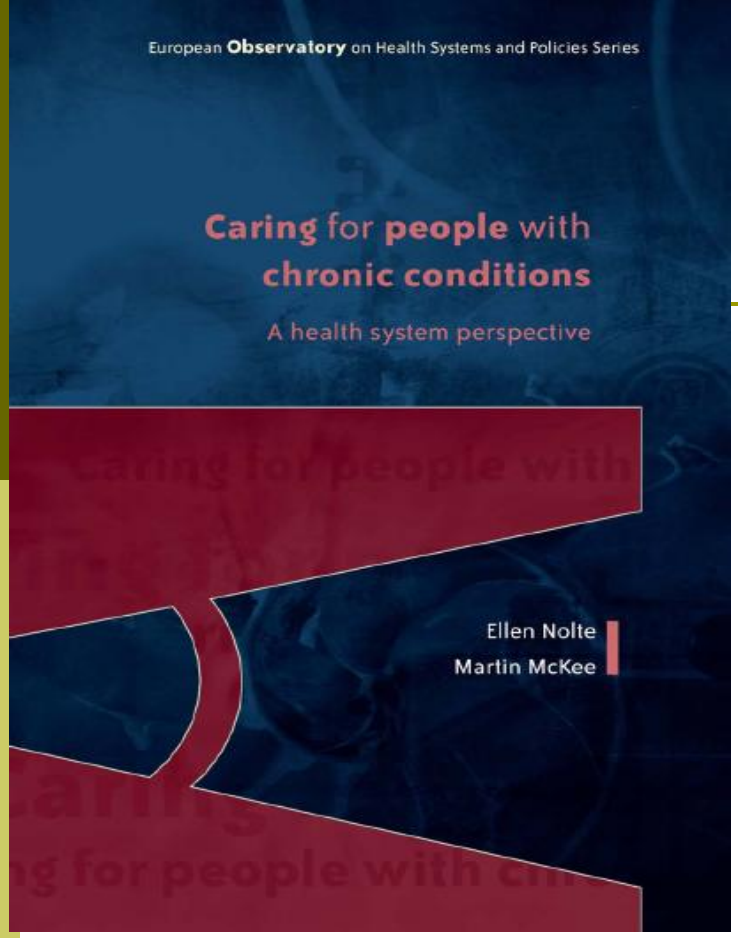
SIMPOSIO SIGG-AGE

Percorsi territoriali
delle Cronicità
e continuum assistenziale

La dimissione del paziente complesso: fra continuità assistenziale e discontinuità di cura



Population ageing and chronic disease

chapter two

The burden of chronic disease in Europe

Joceline Pomerleau, Cécile Knai and Ellen Nolte

Si tratta di una tipologia di utenza che

1. ricorre maggiormente ai servizi sanitari e all'ospedalizzazione
2. richiede spesso tempi di degenza più lunghi
3. ha maggiori bisogni assistenziali
4. spesso presenta problemi di perdita di autonomia
5. spesso necessita di integrazione tra prestazioni sanitarie e sociali

From bed blocking to delayed discharges

De Bey JS, Huijsman R, van der Cammen TJ

Delayed discharge of older patients from the Department of Geriatric Medicine of the Erasmus Medical Centre and factors affecting the length of stay; July 2001--June 2002
Ned Tijdschr Geneeskd. 2004 Dec 4;148(49):2438-42

**Sono pazienti in attesa di istituzionalizzazione,
che hanno problemi di delirium o di demenza,
che hanno perso delle autonomie in relazione al ricovero**

Jasinarachchi KH, Ibrahim IR, Keegan BC, Mathialagan R, McGourty JC, Phillips JR, Myint PK
Norfolk and Norwich University Hospital, Norfolk, UK.

Delayed transfer of care from NHS secondary care to primary care in England: its determinants, effect on hospital bed days, prevalence of acute medical conditions and deaths during delay, in older adults aged 65 years and over.
BMC Geriatr. 2009 Jan 22;9:4

Sono pazienti per i quali il prolungamento del ricovero è legato a problemi clinici : instabilità clinica, riacutizzazioni, mortalità.

Le Cure intermedie

"Gamma di Servizi integrati volti a promuovere una più rapida guarigione, prevenire i ricoveri non necessari, fornire assistenza nei casi di dimissioni tempestive e favorire l'autosufficienza"

DH, National Service Framework for older people
Intermediate Care: Moving Forward. 2002

Criteri per la definizione di cure intermedie

Servizi finalizzati a quei soggetti altrimenti necessitanti di lungo ricovero ospedaliero o a rischio di inappropriato ricovero ospedaliero o necessitanti di assistenza residenziale	Servizi imperniati sull'approccio globale finalizzato alla messa a punto di un percorso di cura individuale (PAI)	Servizi aventi l'obiettivo primario del massimo recupero funzionale e del rientro al domicilio	Servizi erogati per un periodo di norma non superiore a 6 settimane	Servizi che adottano il metodo del lavoro interprofessionale nell'ambito di un unico processo valutativo con protocolli condivisi

British Geriatrics Society 2008

Le Strutture Intermedie

Specificità metodologica e organizzativa

- Separatezza ambientale e funzionale dall'area di degenza ordinaria

- Spazi adeguati a consentire la mobilizzazione e garanzia di poter fruire dell'alzata dal letto quotidiana e di un tempo minimo di deambulazione assistita

- Non obiettivi esclusivamente clinici/ più funzionali:
  Forte tensione riabilitativa
  "Progetto struttura"

- Modello assistenziale basato sul lavoro in team e sulla figura dell'infermiere case-manager:
  Adozione del PAI
  Forti competenze rivolte al "processo dimissione" con addestramento dei care-givers

Salsi A., Calogero P.
Le cure intermedie
Italian Journal of Medicine (2010) 4, 57-62

Le Strutture Intermedie

Appropriatezza di utilizzo:

right care
right time
right place

Importanza della valutazione :

1. bisogni del paziente
2. caratteristiche dell' offerta della Struttura

Dalla continuità assistenziale al rischio di discontinuità di cura

La specializzazione delle cure in setting differenti, per quanto appropriati, non pone al riparo dal rischio di frammentazione: dall'obiettivo di continuità assistenziale si rischia di produrre discontinuità di cura

- **Il Chronic care Model**
- **La pianificazione della dimissione**
- **La transitional care**

Continuity of care matters

Three types of continuity of care

Informational continuity

Formally recorded information is complemented by tacit knowledge of patient preferences, values, and context that is usually held in the memory of clinicians with whom the patient has an established relationship

Management continuity

Shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in future care for both patients and providers

Relationship continuity

Built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in formal records and interpersonal trust based on experience of past care and positive expectations of future competence and care

BMJ 2008;337:a867

Regione Emilia-Romagna

Agenzia sanitaria e sociale regionale
Area Accreditamento e Qualità

Regione Emilia-Romagna
Giunta Regionale
Direzione Generale Sanità e Politiche Sociali

Servizio Politica del Farmaco

RACCOMANDAZIONE REGIONALE

Sicurezza nella terapia farmacologica
"Processo di ricognizione e di riconciliazione farmacologica per una prescrizione corretta e sicura"

A cura del Gruppo Regionale sul Rischio clinico da farmaci
Regione Emilia - Romagna

Raccomandazione Regionale per la Sicurezza nella terapia farmacologica n.2

Maggio 2011

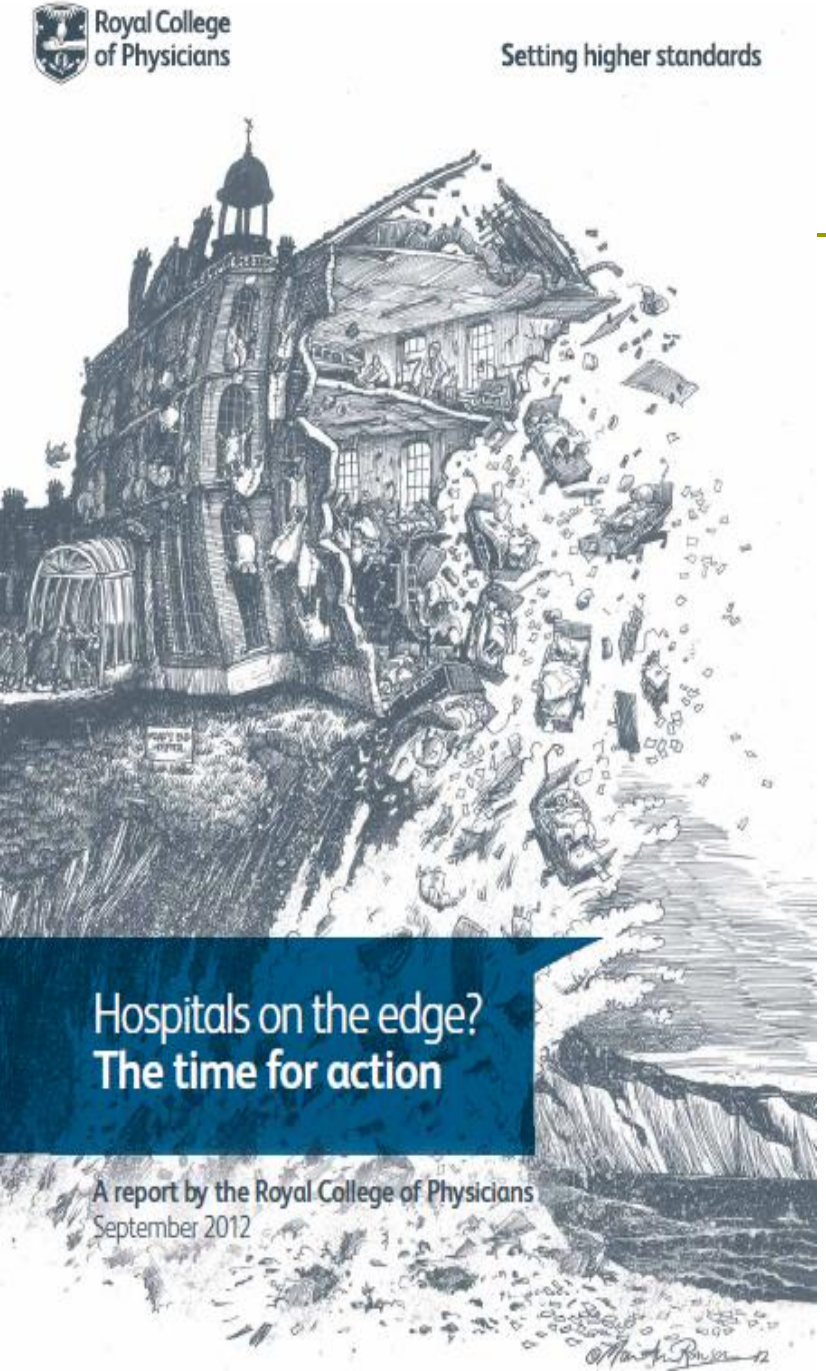
Ricognizione e Riconciliazione

La Ricognizione è un processo sistematico eseguito dal personale sanitario che consiste nella raccolta di informazioni complete e accurate su farmaci e altri prodotti (anche non convenzionali) assunti dal paziente.

La Riconciliazione è il processo nell'ambito del quale si confrontano i farmaci assunti dal paziente, così come evidenziati nella Ricognizione, con quelli indicati per la cura nella particolare circostanza, in funzione di una decisione prescrittiva corretta e sicura.

Il percorso di Riconciliazione prevede che il medico prescrittore, nell'eseguire il confronto, valuti attentamente l'opportunità del prosieguo del trattamento farmacologico in atto e la sua compatibilità con quello che ritiene indicato nella specifica circostanza.

Gli Ospedali sul baratro della frammentazione



Fractured care

Hospital doctors ranked continuity of care as their greatest concern in the current health landscape.[6] A quarter of RCP fellows and members rated their hospital's ability to deliver continuity of care as poor or very poor.[17]

Continuity of care

Lack of clinical continuity detracts from the overall quality of care experienced in hospital, particularly in patients aged 70 and over with multiple health problems. A report from The King's Fund shows that older patients are more likely than others to be readmitted to hospital within a short time of discharge and are often moved around in hospital.[5] Conversations with hospital doctors reveal a worrying picture:

- It is 'common for patients to move four or five times during their stay, particularly afflicting elderly patients moved to outlying wards during the night'.
- Many patients on specialty wards may be 'inappropriate' general medical admissions who are 'often moved between wards during their admission with no consultant taking overall responsibility for their care'.
- Patients can be 'moved four times because of the need for a bed in a particular specialty'.
- Decisions are often 'made by bed managers' and patient care is 'often transferred to a new consultant without any formal handover'.
- Patients who do not fall neatly into any organ-based specialist remit may become 'lost' in the system or at least 'neglected'.[7]

It is common for patients, particularly older patients who do not fit neatly into a specialty, to be moved multiple times during a hospital stay, each time changing their ward nursing team and often their medical team.[5] This is not good care. It also lengthens hospital stays: studies show that every ward move puts at least one day on a length of stay. Patients rate continuity of care highly.

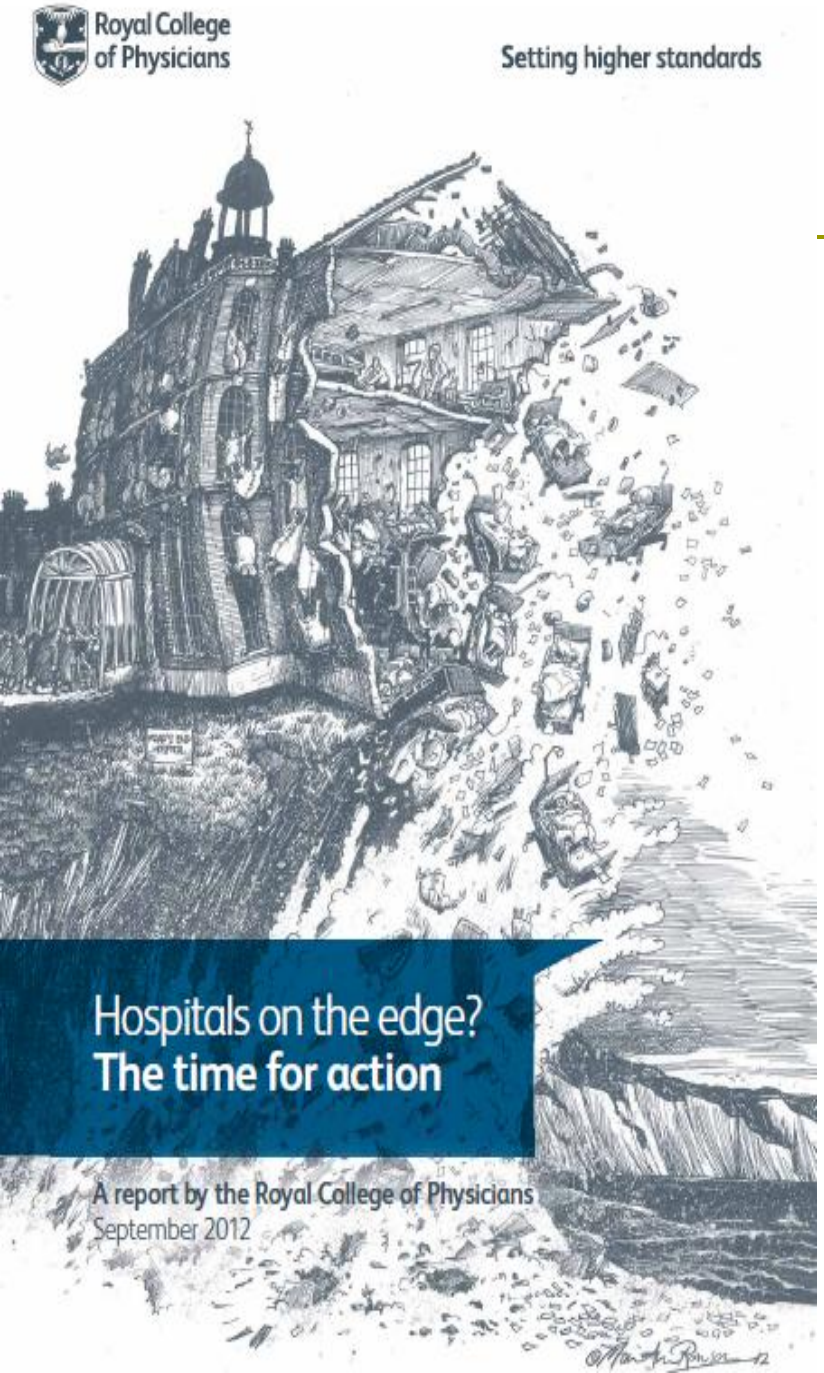
Holistic and appropriate care for patients

Increasing specialisation in medicine has contributed to increasing survival rates for single conditions. However, the fragmentation of acute care services (eg stroke, acute myocardial infarction, respiratory failure) has removed many consultants from the general medical admitting role and certain specialties (eg neurology, dermatology) effectively provide no junior- or consultant-level staffing for this activity in the majority of hospitals. Only 19% of consultants reported having a formalised acute team in their hospital.[18]

There has been increasing specialisation in medicine and nursing with a proliferation of disease and organ based specialties. There are 61 approved medical specialties in the UK compared to 30 in Norway, which has also rendered the provision of continuity of care increasingly difficult.[19] While specialisation can undoubtedly improve clinical quality and safety, it has negative consequences when the care from specialists is poorly coordinated. This is particularly apparent for older people with complex and multiple needs.

Leadership is needed to clarify the roles and inputs to the team of each individual in order to coordinate the contributions of different healthcare professionals involved in the care of the patient. There must be clarity around who is accountable. There must also be the ability to assemble reliable information, provide good records and transfer care rapidly but safely (clinical functional integration). This problem is equally apparent on medical and surgical wards. A National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, concerning elective and emergency surgery in the elderly, indicated that routine daily input from medicine for the care of older people should be available to elderly patients undergoing surgery and is integral to the patient care pathways in this population.[20]

Studies suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there.[21,22] Less than 20% of people die in their own homes even though most people would prefer to do so.[22] It is clear that we must review the mechanisms for admitting patients, and the organisation of care for those that would be better served by care in alternative settings. ■



Gli Ospedali sul baratro della frammentazione

1. Durante una degenza molti pazienti subiscono 4 o 5 spostamenti

2. Spesso cambia non solo lo staff infermieristico ma anche quello medico

3. Manca una leadership generalista, cioè una responsabilità di presa in carico da parte di un professionista che segua tutti gli aspetti

4. Oggi il 65% dei ricoverati in ospedale è over 65 ma ai professionisti manca una formazione geriatrica

5. Il carico di lavoro dei medici è tale per cui non riescono a fare formazione

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Perspectives

Continuity of care: betrayed values or misplaced nostalgia

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Il paradosso

So we have a paradox. Our patients are getting older, more with complex comorbidities that require a personal physician to help coordinate and integrate their care. At the same time, doctors are less able to provide that care. In response to this, health care systems are employing a new generation of healthcare workers whose job appears to be to do what the GP used to do. In the UK, these new workers have titles such as 'case managers' or 'community matrons'. It is in fact impossible for a single person to provide high quality care for people with multiple complex problems, but that does not mean that the family physician should not be at the core of coordinating and integrating a patient's care. So do doctors value continuity of care? And if so, are they prepared to organise they clinical practice accordingly, albeit within a context where care will also be provided by other members of the team? [13]. Maybe

Care is better coordinated when doctors have personal responsibility for their patients.

Il punto di vista del paziente

Martin Gulliford, Smriti Naithani, and Myfanwy Morgan
What is 'continuity of care'?
J Health Serv Res Policy ***October 2006 11:248;***

Nell'esperienza del paziente la continuità di cura coincide nella relazione continuativa con la stessa figura sanitaria in contrasto rispetto a quanto offrono i sistemi di erogazione dei servizi che, in ragione della necessità di interventi plurispecialistici, tutt' al più possono perseguire l'integrazione e il coordinamento delle figure che erogano il servizio

Uijen AA, Schers HJ, Schellevis FG, Mokkink HG, van Weel C, van den Bosch WJ.
Measuring continuity of care: psychometric properties of the Nijmegen Continuity Questionnaire.
Br J Gen Pract. 2012 Jul;62(600):e949-57.

It aims to measure continuity of care from the patient perspective across primary and secondary care settings.

Initial pilot testing proved promising.

Improving the Quality of Transitional Care for Persons with Complex Care Needs

American Geriatrics Society (AGS) Position Statement

Position 1. Clinical professionals must prepare patients and their caregivers to receive care in the next setting and actively involve them in decisions related to the formulation and execution of the transitional care plan.

Position 2. Bidirectional communication between clinical professionals is essential to ensuring high-quality transitional care.

Position 3. Policies should be developed that promote high-quality transitional care.

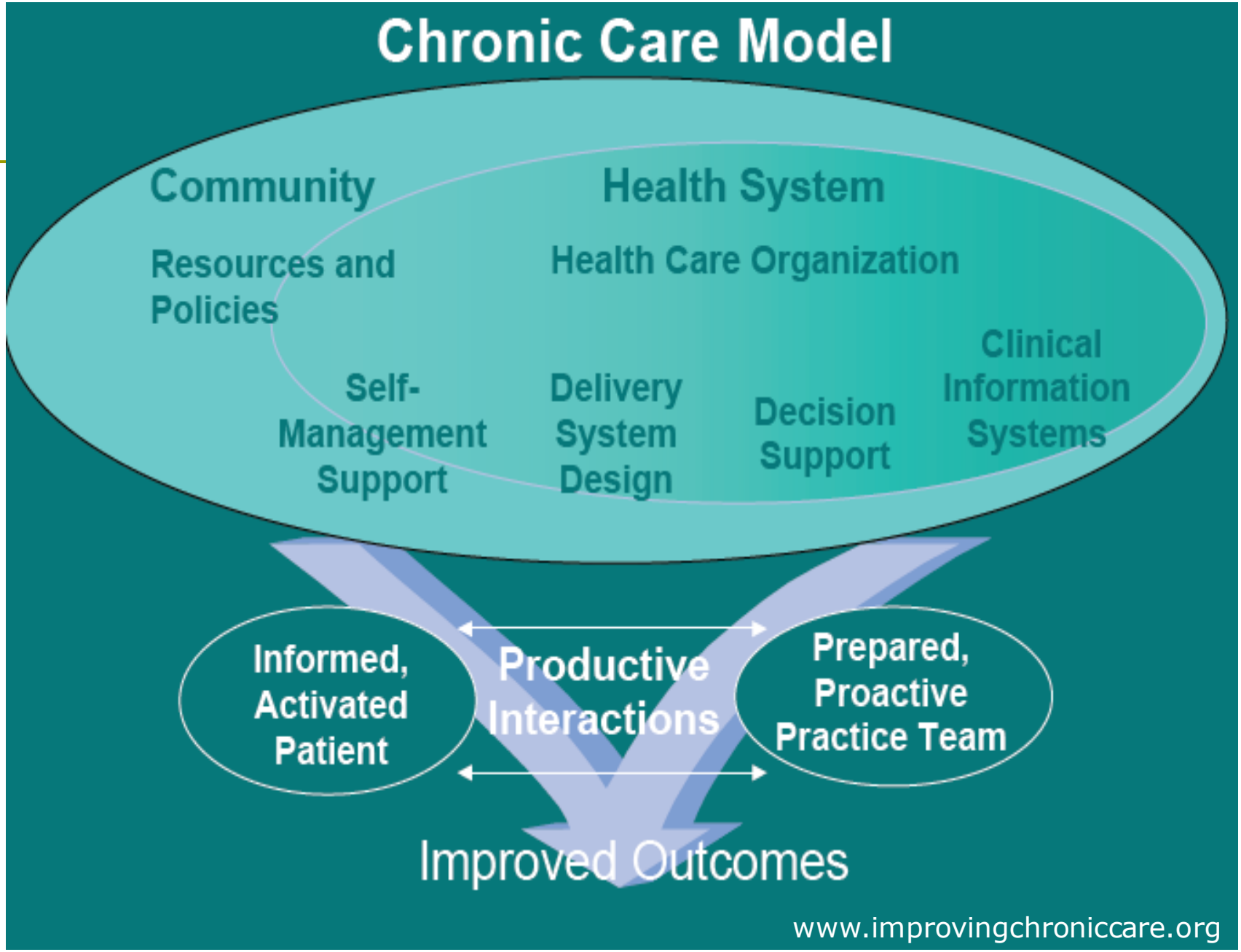
Position 4. Education in transitional care should be provided to all healthcare professionals involved in the transfer of patients across settings.

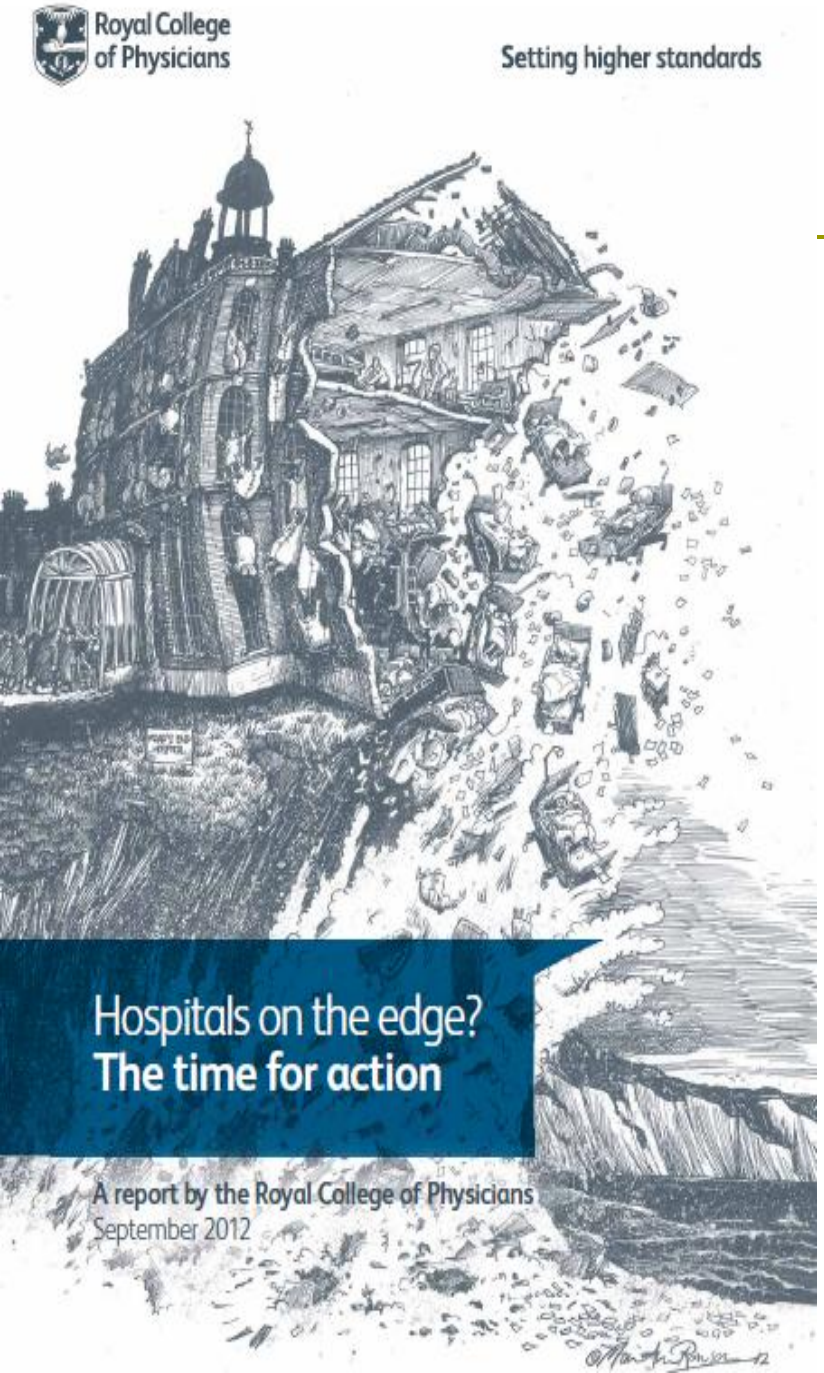
Position 5. Research should be conducted to improve the process of transitional care.

Dalla continuità assistenziale alla continuità di cura

La Presa in carico

1. Dei problemi clinici
2. Dei bisogni assistenziali
3. **Qualità di vita**


Chronic Care Model
Community
Health System
Resources and Policies
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes
www.improvingchroniccare.org



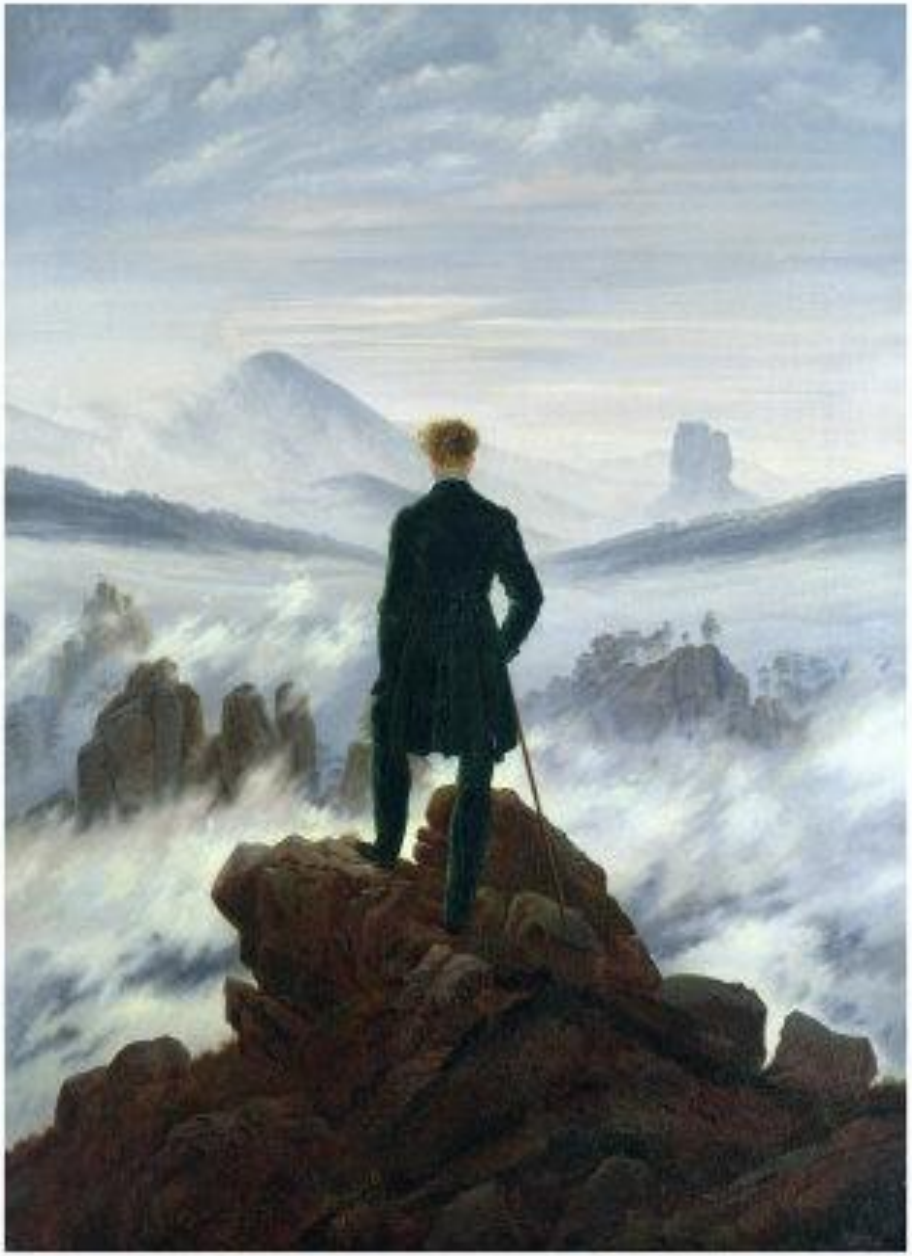
The time for action

1. Dobbiamo ridisegnare i servizi e la loro organizzazione

2. Dobbiamo rivedere la formazione e l'addestramento dei medici

3. Dobbiamo aumentare la disponibilità dei servizi delle cure primarie

4. Dobbiamo rivoluzionare i sistemi informativi affinchè siano di supporto alla decisione clinica



Il viaggio della Cura: punti chiave

Visione clinica prospettica

Ricognizione e riconciliazione clinica

Responsabilità del professionista

Responsabilità del curato

Il viaggio della Cura

Case management

Care management

Self care management

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

Continuity of care is the process by which the patient and the physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.

Grazie per l'attenzione