XI congresso nazionale
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ROMA 24-26 MAGGIO 2018

Implementazione di una rete clinico assistenziale per il trattamento dell'ictus ischemico: risultati del progetto ANGELS EUROPE nel bacino d'utenza dell'A.O. San Camillo

Antonella Urso – Luca Casertano

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QUALITÀ DELLE CURE: COSA SAPPIAMO?

La letteratura indica:

- **Carenza di effettuazione sistematica di valutazione dell' esito assistenziale**
- **Carenza di valutazione delle risorse per la promozione della qualità assistenziale per specifiche patologie**
- **Persistenti variazioni nelle cure (tra diversi soggetti erogatori) rivolte a pazienti con caratteristiche simili**

Chassin MR, Galvin RW. The urgent need to improve health care quality. Institute of Medicine National Roundtable on Health Care Quality. *J Am Med Assoc* 1998; 280: 1000–1005.

President's Advisory Commission on Consumer Protection and Quality First. *Better Health Care for All Americans. Final Report to the President of the United States*. Washington, DC: President's Advisory Commission on Consumer Protection and Quality First, 2000.

Mainz J, Bartels PD, Laustsen S *et al*. The National Indicator Project for monitoring and improving medical technical care [in Danish]. *Ugeskr Laeger* 2001; 163: 6401–6406

QUALITÀ DELLE CURE: COSA SAPPIAMO?

"...l'individuazione di strategie efficaci per il miglioramento della qualità in ospedale rappresenta una problematica ancora irrisolta a livello internazionale..."

"...ci sono scarse evidenze in letteratura riguardo l'efficacia delle strategie per migliorare la qualità assistenziale..."

"...tale carenza di conoscenze non suggerisce che le strategie utilizzate sono inefficaci ma che esiste una notevole difficoltà nel valutare gli interventi di miglioramento e nel dimostrare che i risultati ottenuti siano dovuti alla strategia per la qualità utilizzata piuttosto che ad altri fattori..."

Øvretveit J. What are the best strategies for ensuring quality in hospitals? WHO Europe – November 2003

STRUMENTI PER IL CAMBIAMENTO

1. Coinvolgere i clinici
2. Sviluppare le capacità di leadership dei clinici
3. Fornire ai professionisti:
    - tempo
    - risorse
    - informazioni
    - competenze necessarie

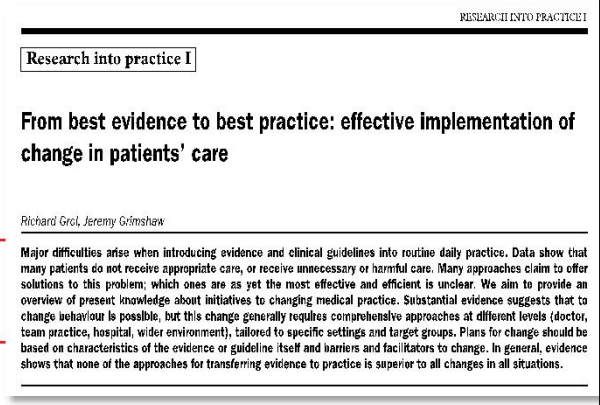
(McNulty T. Ferlie E. Reengineering health care. Oxford University, 2002)

INTERVENTI PER IL CAMBIAMENTO IN SANITÀ

- Formazione
- Audit
- Supporto informatico
- Sostituzione delle mansioni
- Collaborazione multiprofessionale
- Campagne informative (mass media)
- Interventi finanziari
- Interventi combinati

(R. Grol, J.Grimshaw – From best evidence to best practice: effective implementation of change in patients' care - Lancet 2003)

INTERVENTI: POSSIBILI CRITICITÀ



RESEARCH INTO PRACTICE I

Research into practice I

From best evidence to best practice: effective implementation of change in patients' care

Richard Grol, Jeremy Grimshaw

Major difficulties arise when introducing evidence and clinical guidelines into routine daily practice. Data show that many patients do not receive appropriate care, or receive unnecessary or harmful care. Many approaches claim to offer solutions to this problem; which ones are as yet the most effective and efficient is unclear. We aim to provide an overview of present knowledge about initiatives to changing medical practice. Substantial evidence suggests that to change behaviour is possible, but this change generally requires comprehensive approaches at different levels (doctor, team practice, hospital, wider environment), tailored to specific settings and target groups. Plans for change should be based on characteristics of the evidence or guideline itself and barriers and facilitators to change. In general, evidence shows that none of the approaches for transferring evidence to practice is superior to all changes in all situations.

DISINCENTIVI ECONOMICI (es. mancanza di rimborso)

CRITICITÀ ORGANIZZATIVE (es. mancanza di tempo)

RESPONSABILITÀ (es. rischio di contenzioso)

ASPETTATIVE DEI PAZIENTI (es. richieste esplicite rispetto prescrizioni)

PRATICHE STANDARDIZZATE (es. routine)

OPINION LEADERS (es. persone chiave non sono d'accordo con le evidenze)

FORMAZIONE (es. conoscenze obsolete)

SELF CONFIDENCE (es. competenza)

INFORMATION OVERLOAD (es. incapacità di tenere in dovuta considerazione le evidenze)

Richard Grol,Jeremy Grimshaw : From best evidence to best practice: effective implementation of change in patients ' care. THE LANCET • Vol 362 • October 11,2003

INTERVENTI: POSSIBILI CRITICITÀ

La COLLABORAZIONE MULTI-PROFESSIONALE può essere di particolare interesse nei contesti che, come le reti tempo dipendenti, sono fortemente influenzati dal clima e dalla cultura organizzativa.

Le "relazioni e dinamiche sociali" possono influenzare il funzionamento dei servizi sanitari, determinando differenze significative nel funzionamento e nell'accesso al servizio e alle cure.

Methods of Implementation of Evidence-Based Stroke Care in Europe

European Implementation Score Collaboration

Antonio Di Carlo, MD; Francesca Romana Pezzella, MD; Alec Fraser, MA; Francesca Bovis, MSc; Juan Baeza, PhD; Chris McKevitt, PhD; Annette Boaz, PhD; Peter Heuschmann, MD; Charles D.A. Wolfe, MD; Domenico Inzitari, MD; on behalf of the European Implementation Score Collaboration Study Group*

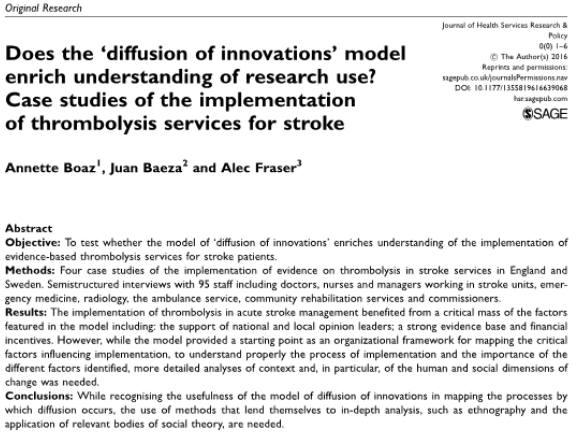
Background and Purpose—Differences in stroke care and outcomes reported in Europe may reflect different degrees of implementation of evidence-based interventions. We evaluated strategies for implementing research evidence into stroke care in 10 European countries.

Methods—A questionnaire was developed and administered through face-to-face interviews with key informants. Implementation strategies were investigated considering 3 levels (macro, meso, and micro, eg, policy, organization, patients/professionals) identified by the framing analysis, and different settings (primary, hospital, and specialist) of stroke care. Similarities and differences among countries were evaluated using the categorical principal components analysis.

Results—Implementation methods reported by ≥7 countries included nonmandatory policies, public financial incentives, continuing professional education, distribution of educational material, educational meetings and campaigns, guidelines, opinion leaders', and stroke patients associations' activities. Audits were present in 6 countries at national level; national and regional regulations in 4 countries. Private financial incentives, reminders, and educational outreach visits were reported only in 2 countries. At national level, the first principal component of categorical principal components analysis separated England, France, Scotland, and Sweden, all with positive object scores, from the other countries. Belgium and Lithuania obtained the lowest scores. At regional level, England, France, Germany, Italy, and Sweden had positive scores in the first principal component, whereas Belgium, Lithuania, Poland, and Scotland showed negative scores. Spain was in an intermediate position.

Conclusions—We developed a novel method to assess different domains of implementation in stroke care. Clear variations were observed among European countries. The new tool may be used elsewhere for future contributions. **(*Stroke*. 2015;46:2252-2259. DOI: 10.1161/STROKEAHA.115.009299.)**

Key Words: decision making ■ disease management ■ health services research ■ research science ■ stroke



Original Research

Journal of Health Services Research & Policy
0(0) 1–6

DOI: 10.1177/1355819616639068
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Does the 'diffusion of innovations' model enrich understanding of research use? Case studies of the implementation of thrombolysis services for stroke

Annette Boaz[1], Juan Baeza[2] and Alec Fraser[3]

Abstract

Objective: To test whether the model of 'diffusion of innovations' enriches understanding of the implementation of evidence-based thrombolysis services for stroke patients.

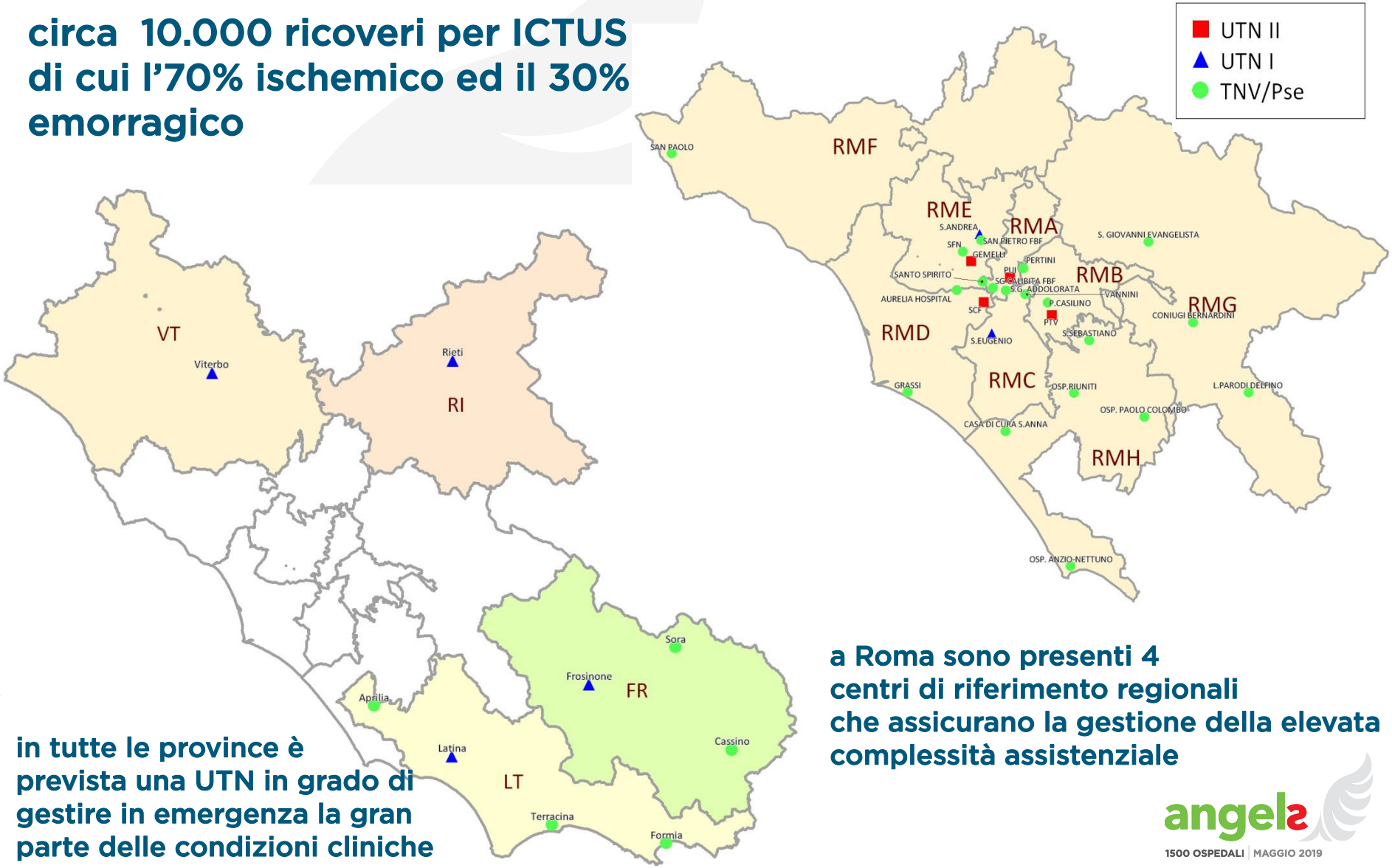
Methods: Four case studies of the implementation of evidence on thrombolysis in stroke services in England and Sweden. Semistructured interviews with 95 staff including doctors, nurses and managers working in stroke units, emergency medicine, radiology, the ambulance service, community rehabilitation services and commissioners.

Results: The implementation of thrombolysis in acute stroke management benefited from a critical mass of the factors featured in the model including: the support of national and local opinion leaders; a strong evidence base and financial incentives. However, while the model provided a starting point as an organizational framework for mapping the critical factors influencing implementation, to understand properly the process of implementation and the importance of the different factors identified, more detailed analyses of context and, in particular, of the human and social dimensions of change was needed.

Conclusions: While recognising the usefulness of the model of diffusion of innovations in mapping the processes by which diffusion occurs, the use of methods that lend themselves to in-depth analysis, such as ethnography and the application of relevant bodies of social theory, are needed.

REGIONE LAZIO

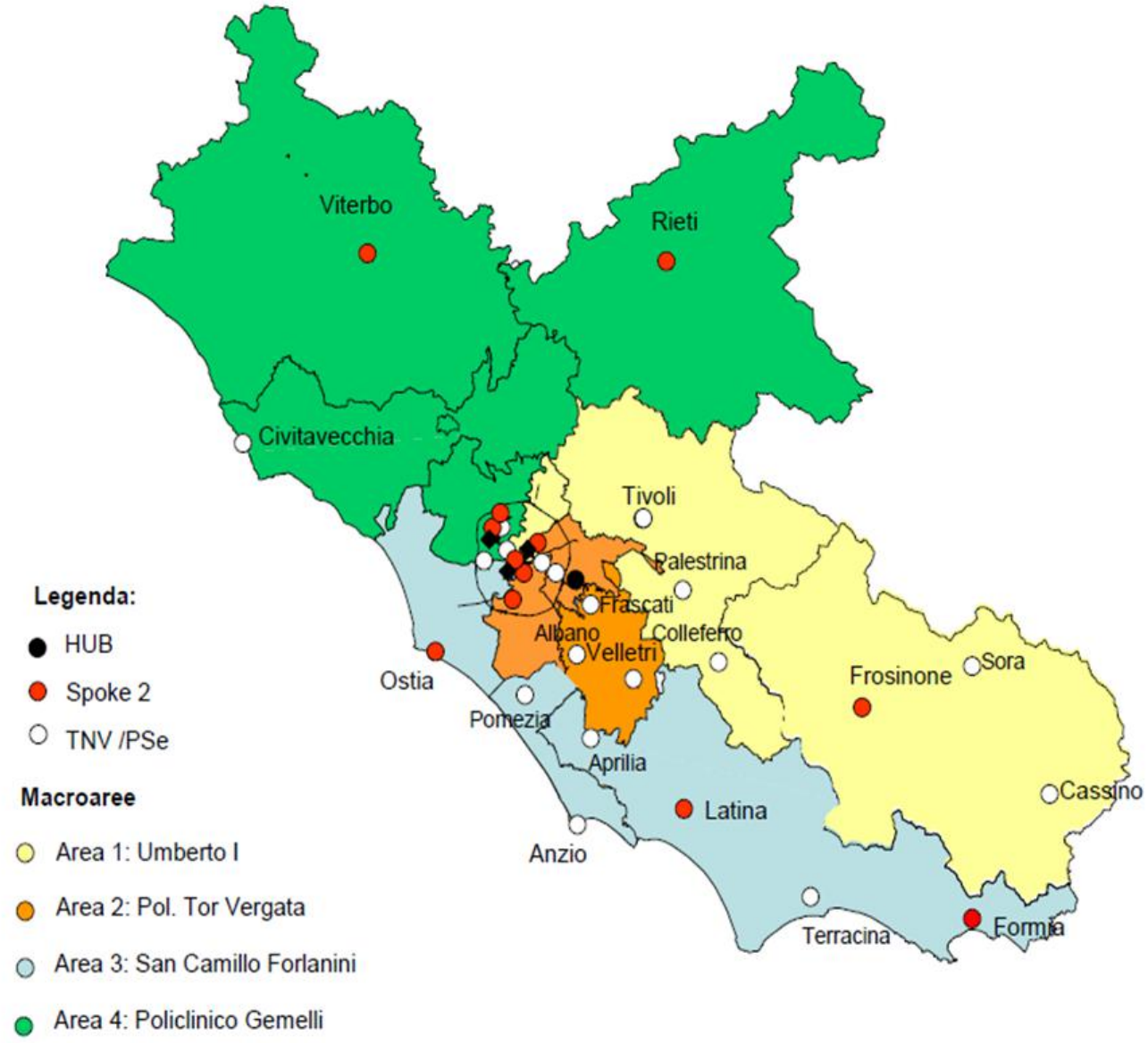
circa 10.000 ricoveri per ICTUS di cui l'70% ischemico ed il 30% emorragico



in tutte le province è prevista una UTN in grado di gestire in emergenza la gran parte delle condizioni cliniche

a Roma sono presenti 4 centri di riferimento regionali che assicurano la gestione della elevata complessità assistenziale

RETE ICTUS AFFERENTE HUB SAN CAMILLO



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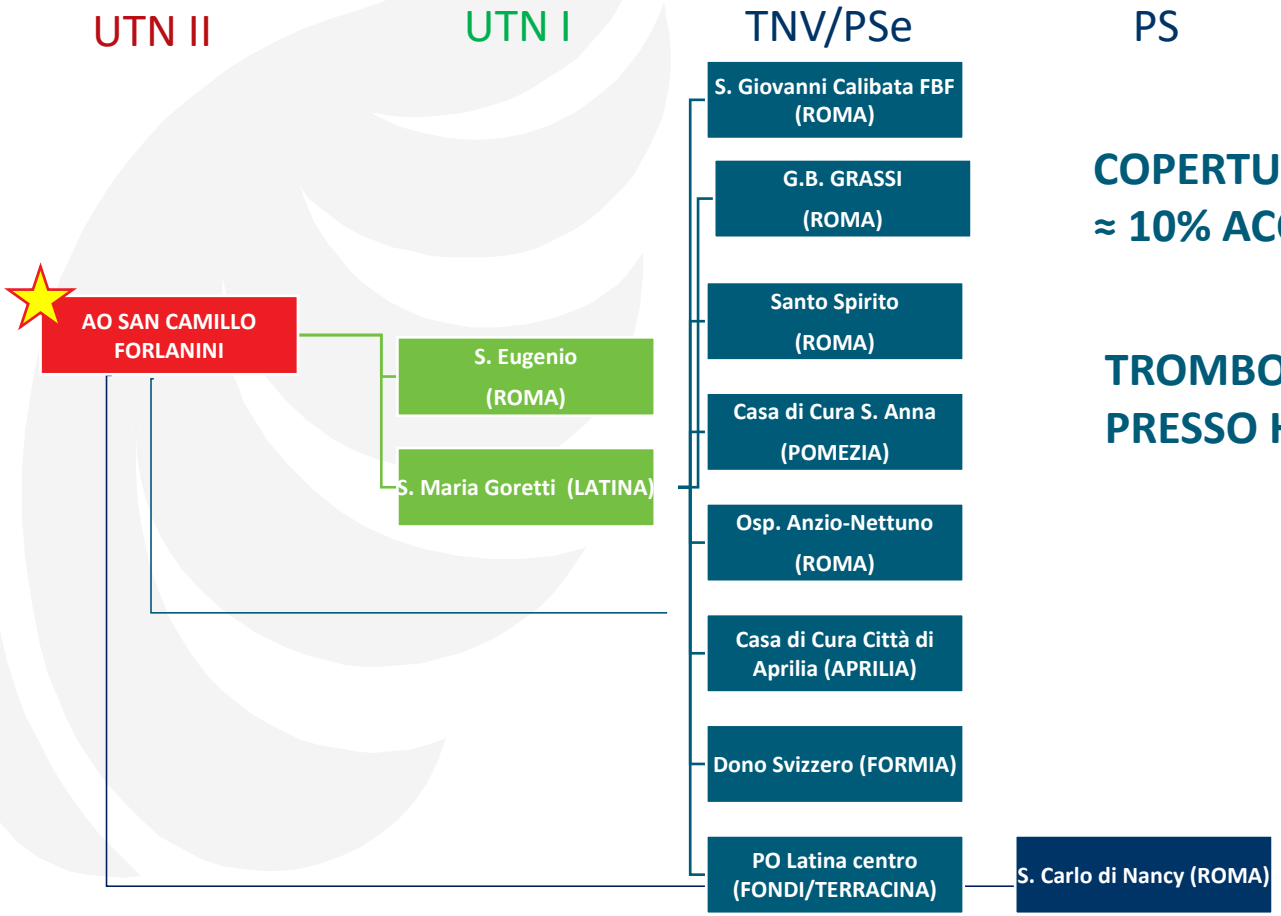

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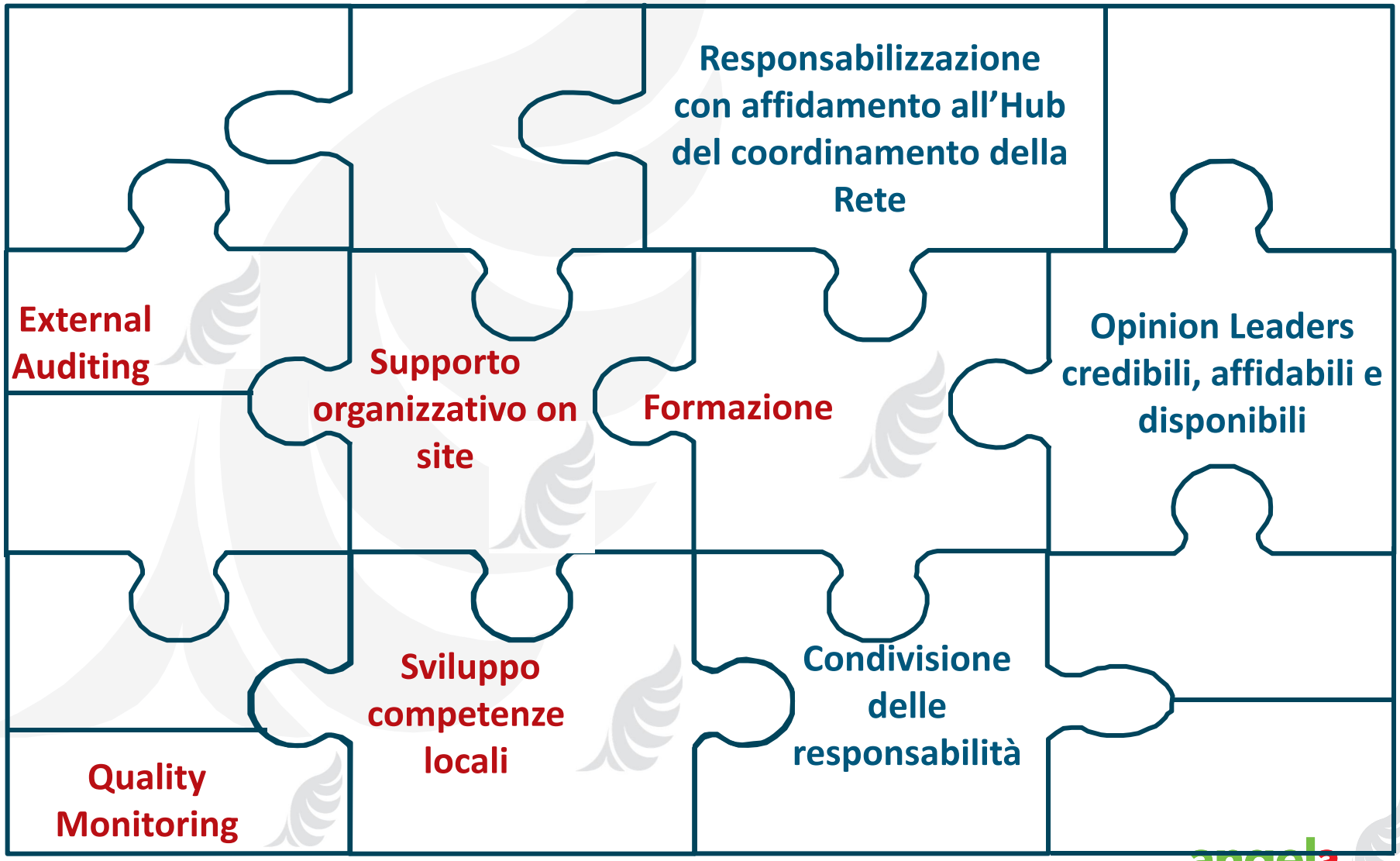
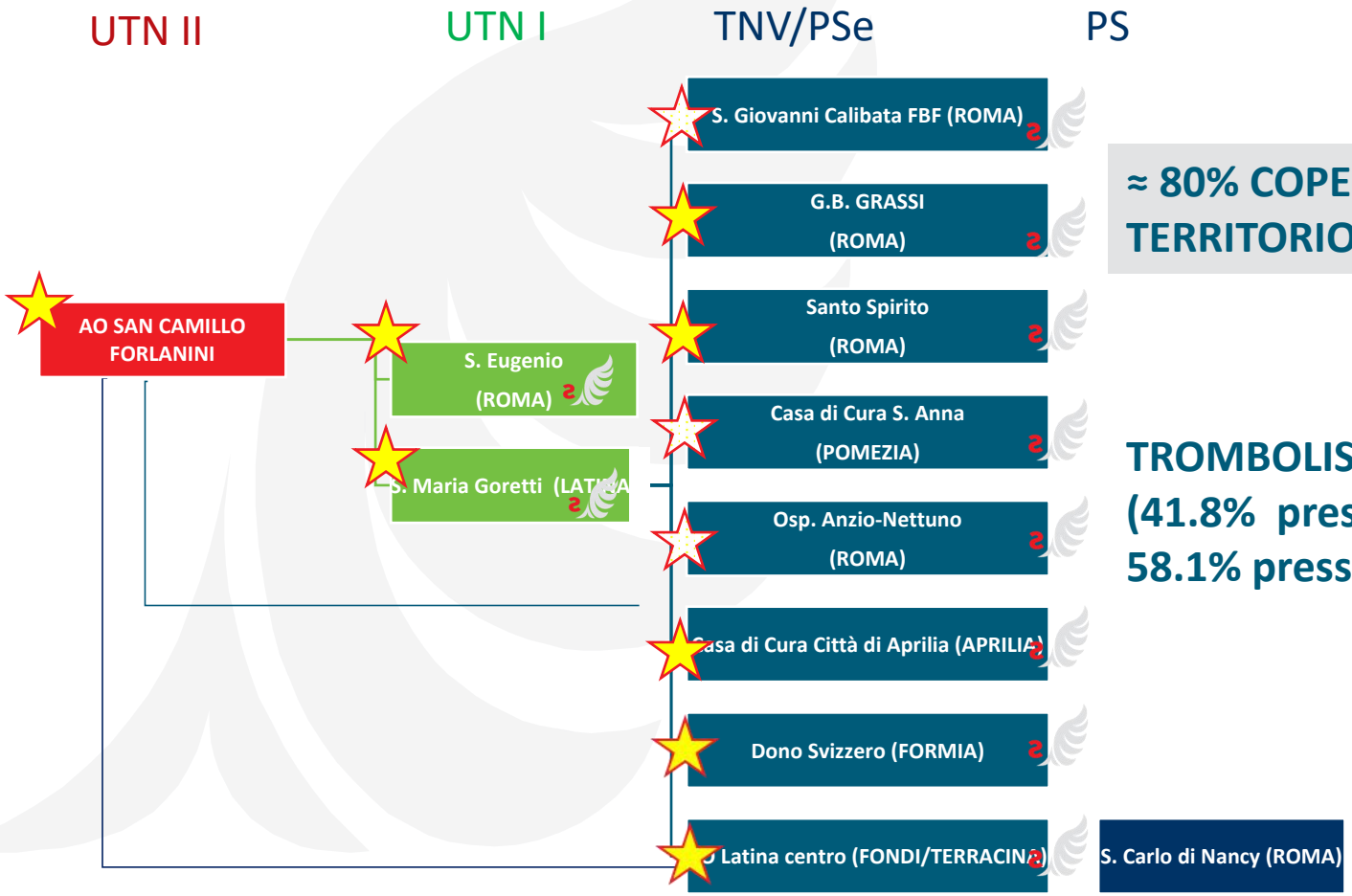
STRUMENTI PER IL CAMBIAMENTO



ASSETTO RETE ICTUS 2018



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GRAZIE!

"...a meno che non facciamo progressi ogni anno, ogni mese, ogni settimana, credetemi, stiamo tornando indietro." (Florence Nightingale)

... I professionisti della sanità hanno un ampio grado di controllo...

(H. Mintzberg, 1979)

In sanità l'unica variabile indipendente correlata con gli esiti è la competenza degli operatori

(OMS)

Segreteria Nazionale:

Via Valprato, 68 - 10155 Torino
c.f. 91206690371
p.i. 02272091204

Contatti:

tel +39 02 67077483
fax +39 02 89959799
segreteria@simeu.it