EXPOSANITA'
MED • CARE • INNOVATION

Bologna Fiere

18-19-20 Aprile 2018

La corretta informazione sanitaria in rete "Dr.Google" opportunità e rischi

Orientarsi tra i sistemi di valutazione della qualità e sicurezza delle cure, un' impresa difficile

GRC
Gestione Rischio Clinico
e Sicurezza del Paziente

WHO Collaborating Centre
in Human Factors and Communication
for the Delivery of Safe and Quality care

Riccardo Tartaglia, MD, Eur-Erg

European Commission

Patient Safety in the EU: 2014

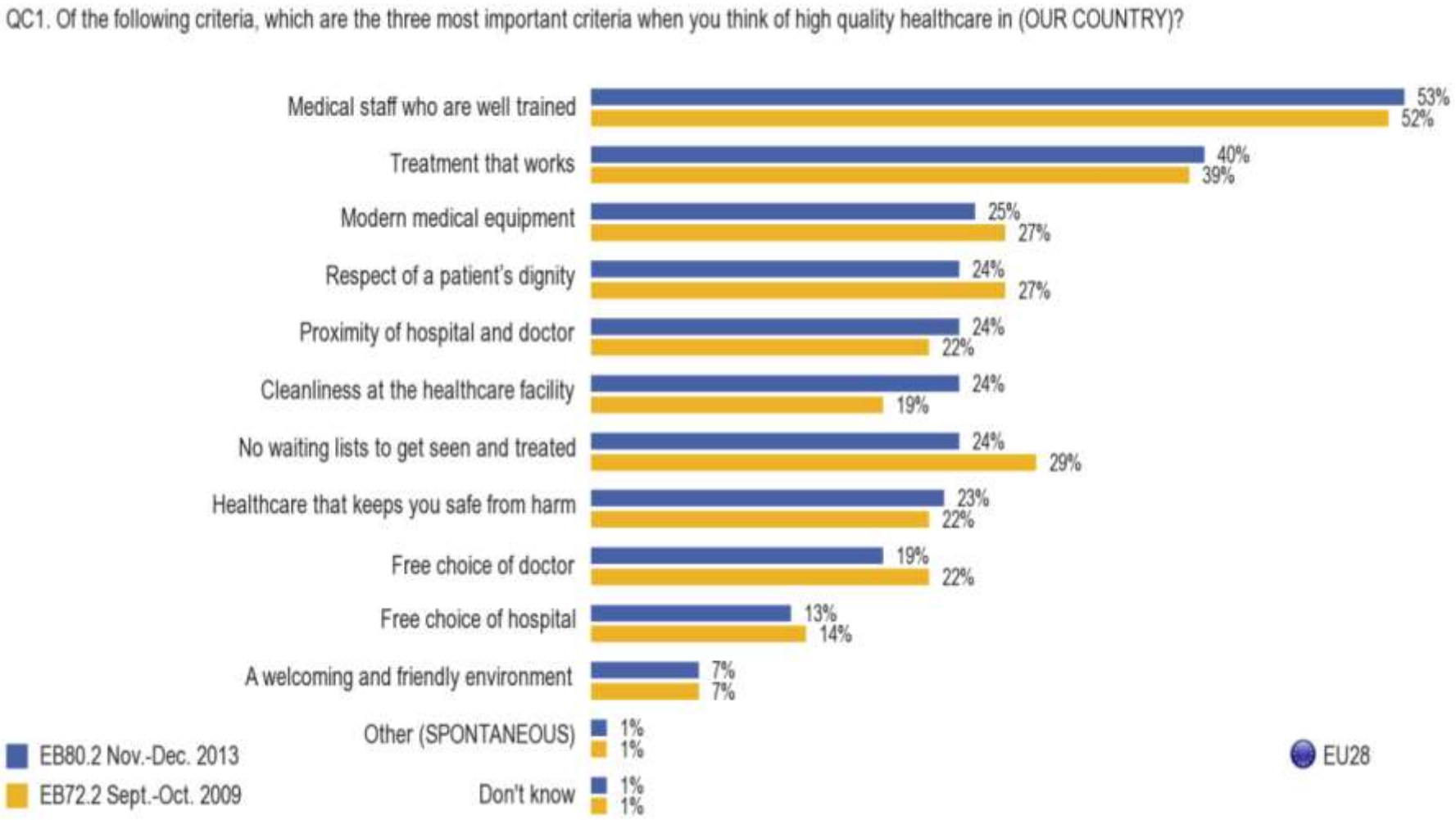
Patients think they can be harmed

EU citizens who think that **patients could be harmed by hospital care**

91%

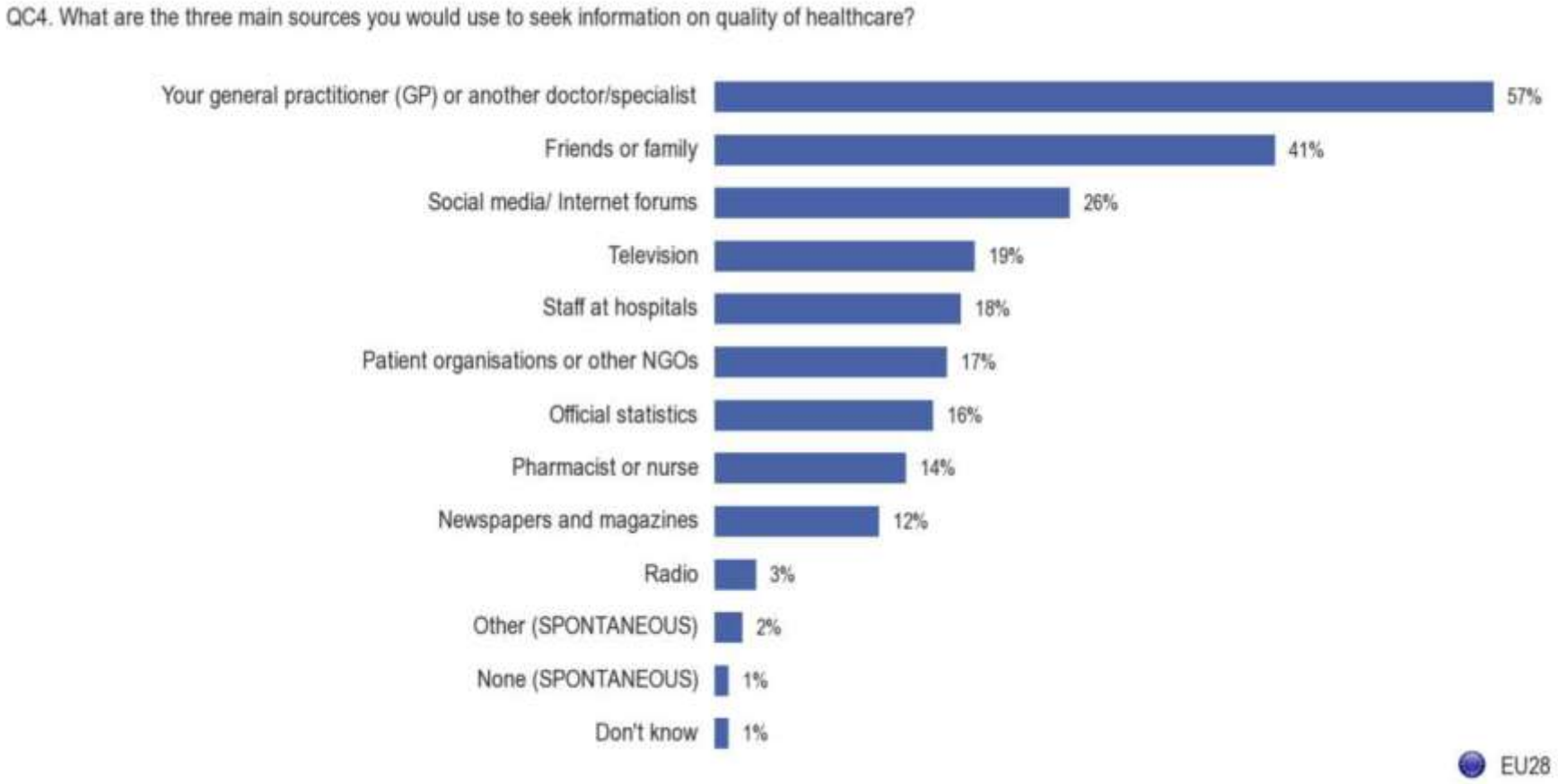
of STAKEHOLDERS think patient safety is an issue

I tre criteri per definire la Q&S



Special eurobarometer, EC 2014

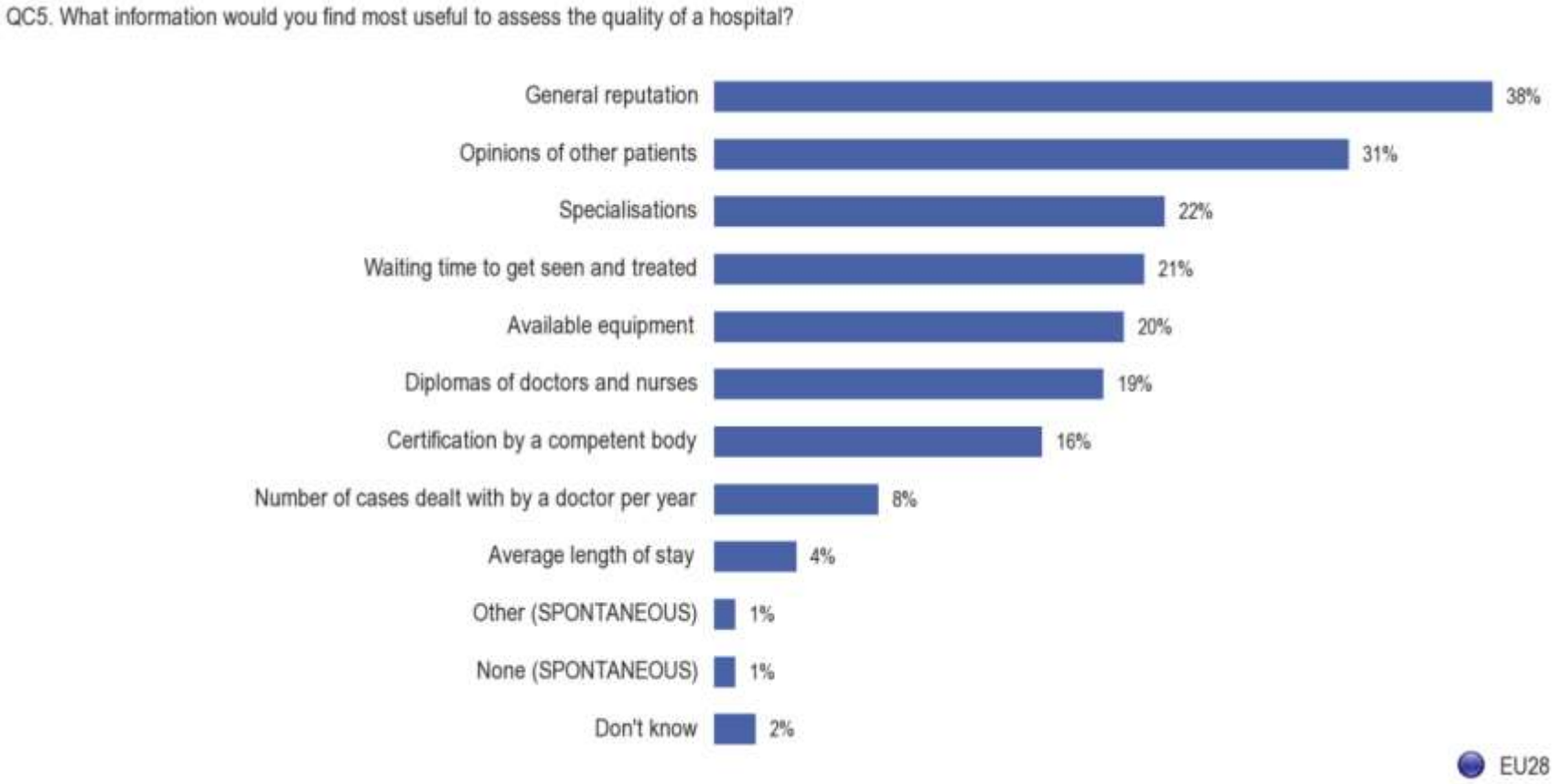
Le principali sorgenti d'informazione



Special eurobarometer, EC 2014

Le informazioni più utili per valutare la Q&S di un ospedale

REGIONE TOSCANA GRC Gestione Rischio Clinico SICUREZZA DEL PAZIENTE



Special eurobarometer, EC 2014

Volume based vs value based system

REGIONE TOSCANA GRC Gestione Rischio Clinico SICUREZZA DEL PAZIENTE

… the only way to control the costs of health care lis to improve the outcomes in a value based system

….. The achievement and the manteinance of results have to be evalutated on the whole clinical pathways

Volume based system vs value based system

Sylvia M. Burwell
N Engl J Med 2015; 372: 897-899 5 Marzo 2015

….il 30% dei pagamenti Medicare correlati alla qualità o al valore attraverso modelli di pagamento alternativi dal fine del 2016 e il 50% dei pagamenti entro la fine del 2018. Modelli di pagamento alternativi, accordi di pagamento in bundle in base ai quali i fornitori di assistenza sanitaria sono responsabili della qualità e dei costi dell'assistenza che forniscono pazienti.

Systems to assess Q&S

AHRQ patient safety indicators

EHCI Outcome indicators

NHS Safety Thermometer

Safety score Leapfrog group

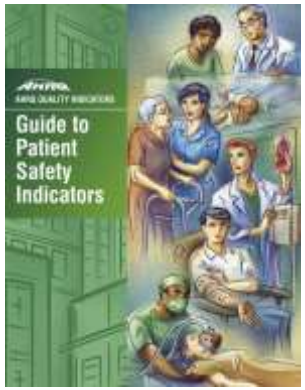
Agenas Programma Nazionale Esiti

MeS Sistema bersaglio

Tartaglia, Vannucci, Springer 2014

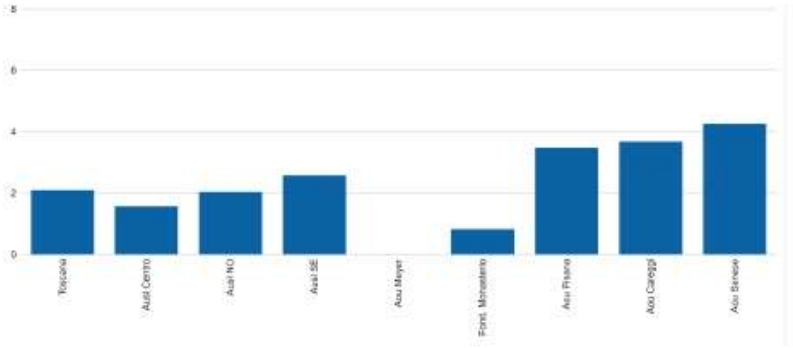
AHRQ Patient Safety Indicators

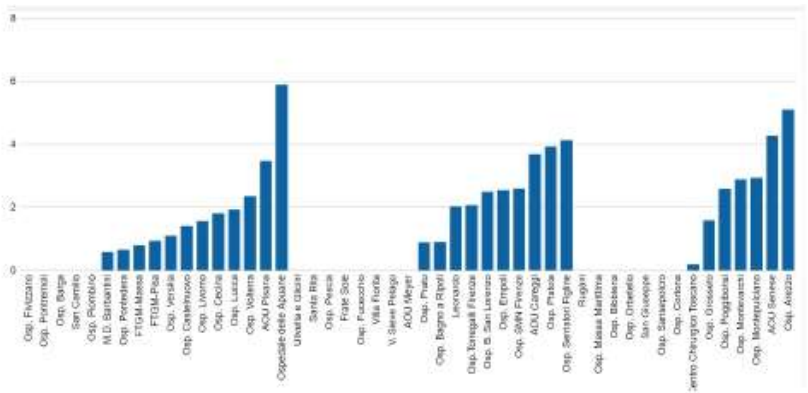
REGIONE TOSCANA GRC Gestione Rischio Clinico SICUREZZA DEL PAZIENTE

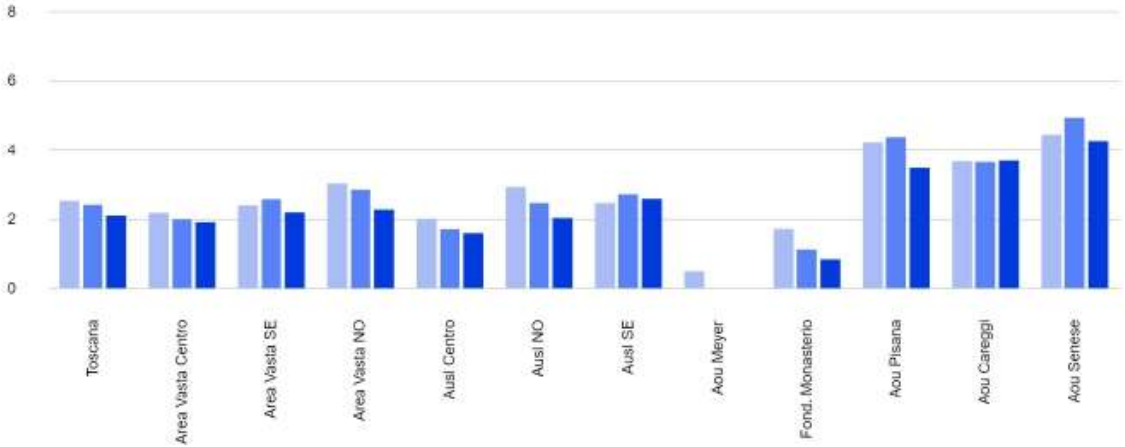


- Complications of Anesthesia
- Death in Low-Mortality DRGs
- Decubitus Ulcer
- Failure to Rescue
- Foreign Body Left During Procedure
- Iatrogenic Pneumothorax
- Selected Infections Due to Medical Care
- Postoperative Hip Fracture
- Postoperative Hemorrhage or Hematoma
- Postoperative Physiologic and Metabolic Derangements
- Postoperative Respiratory Failure
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis
- Postoperative Sepsis
- Postoperative Wound Dehiscence
- Accidental Puncture or Laceration
- Transfusion Reaction
- Birth Trauma – Injury to Neonate
- Obstetric Trauma – Vaginal with Instrument
- Obstetric Trauma – Vaginal without Instrument
- Obstetric Trauma – Cesarean Delivery

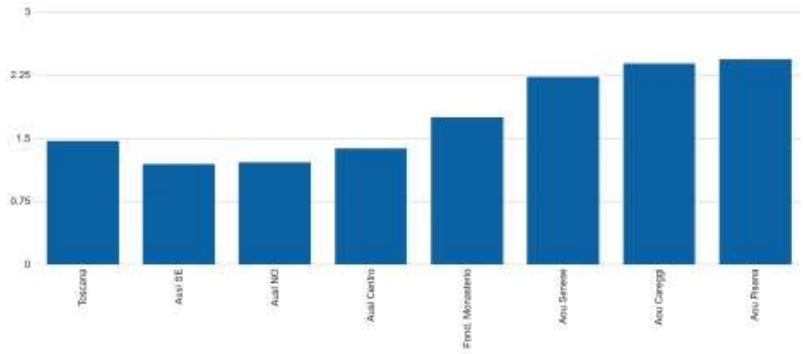
Indicatore di osservazione ***C.6.4.1 Sepsi post-operatoria per chirurgia d'elezione***

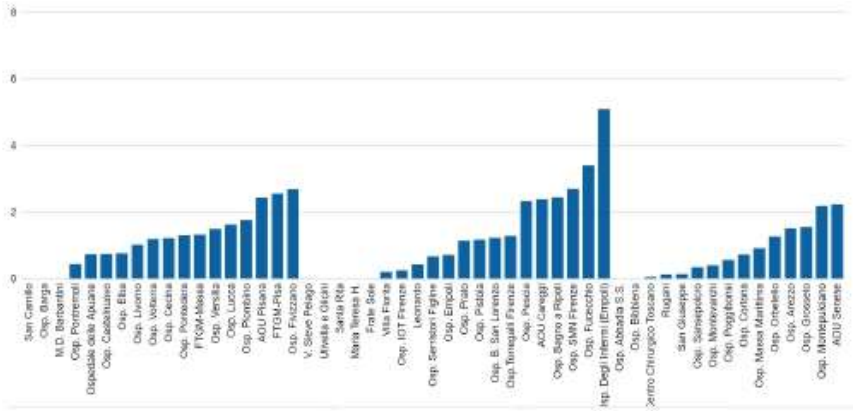


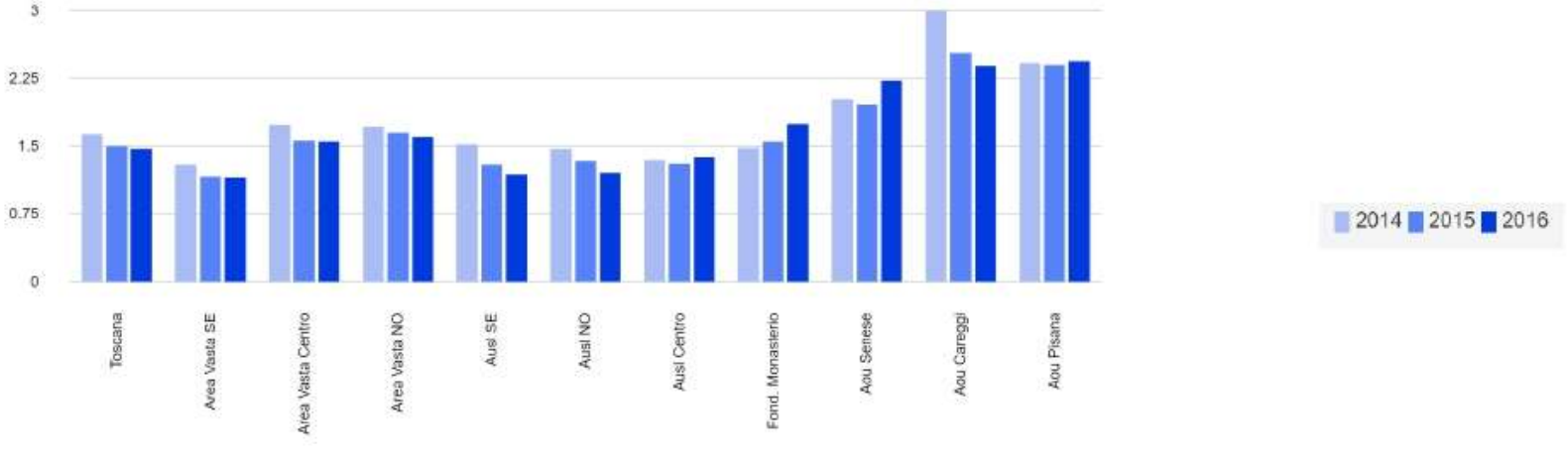




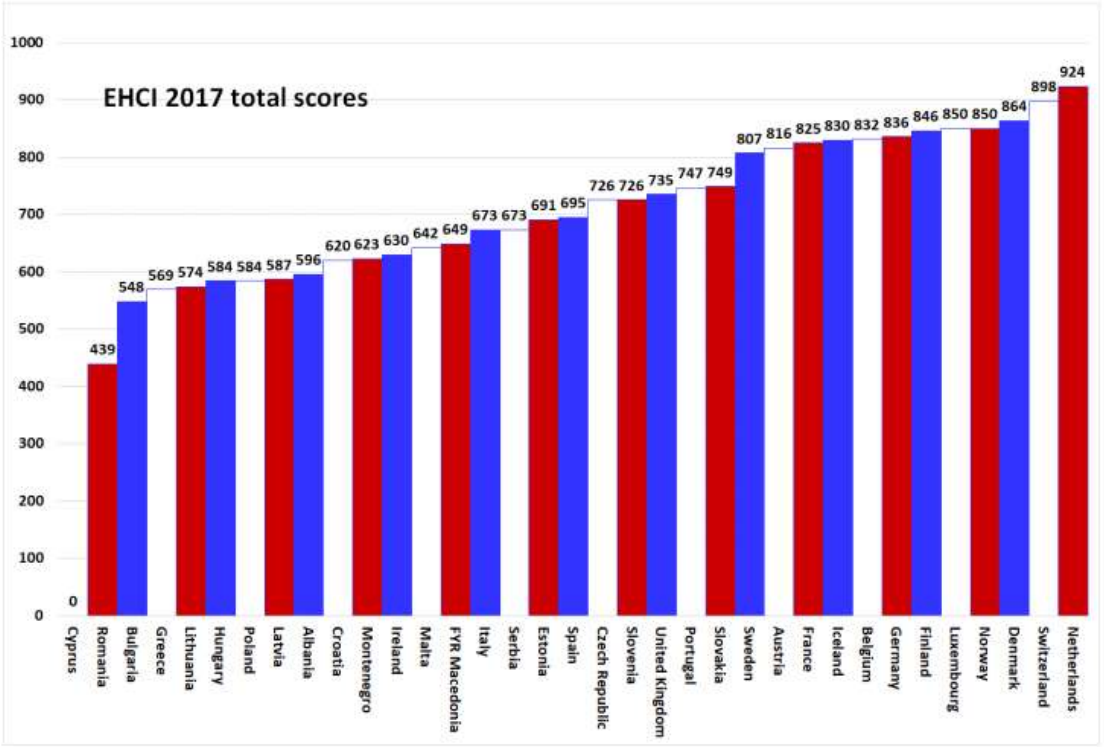
Indicatore di osservazione ***C.6.4.3 Embolia polmonare o trombosi venosa post-chirurgica***





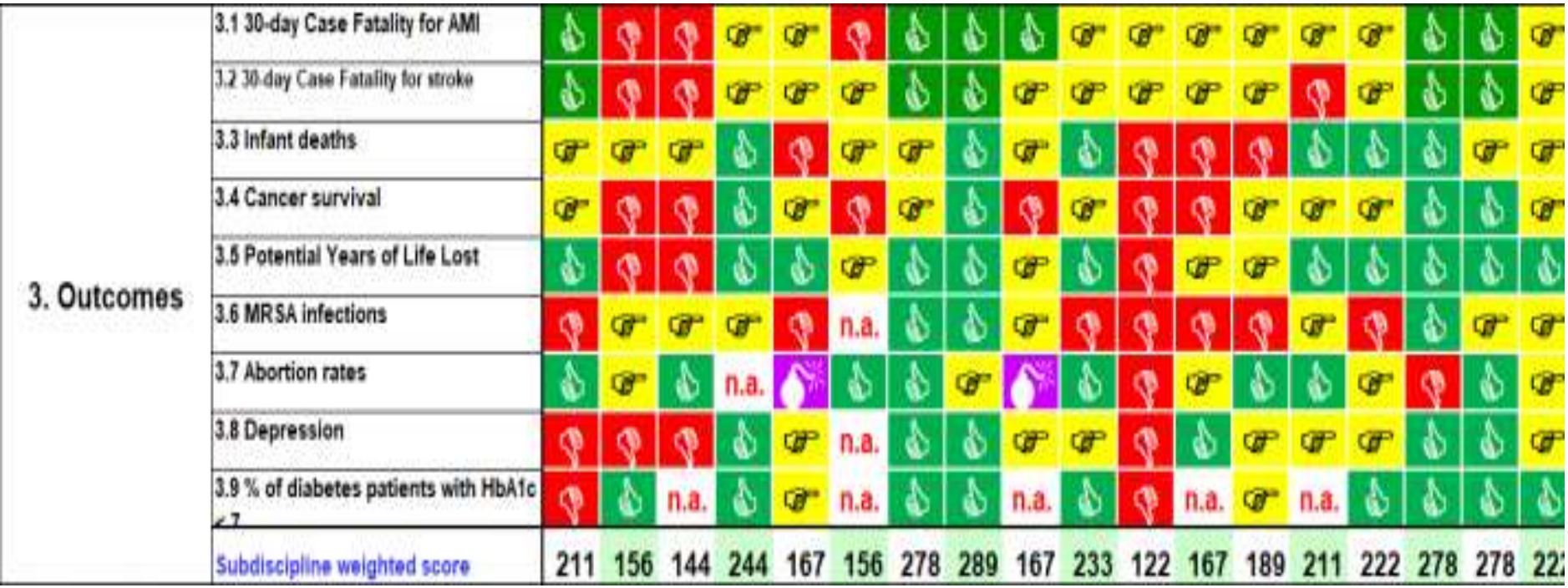


European experience EHCI



European experience EHCI

REGIONE TOSCANA
GRC Gestione Rischio Clinico
SICUREZZA DEL PAZIENTE



NHS Safety Thermometer

Hospital Safety Score

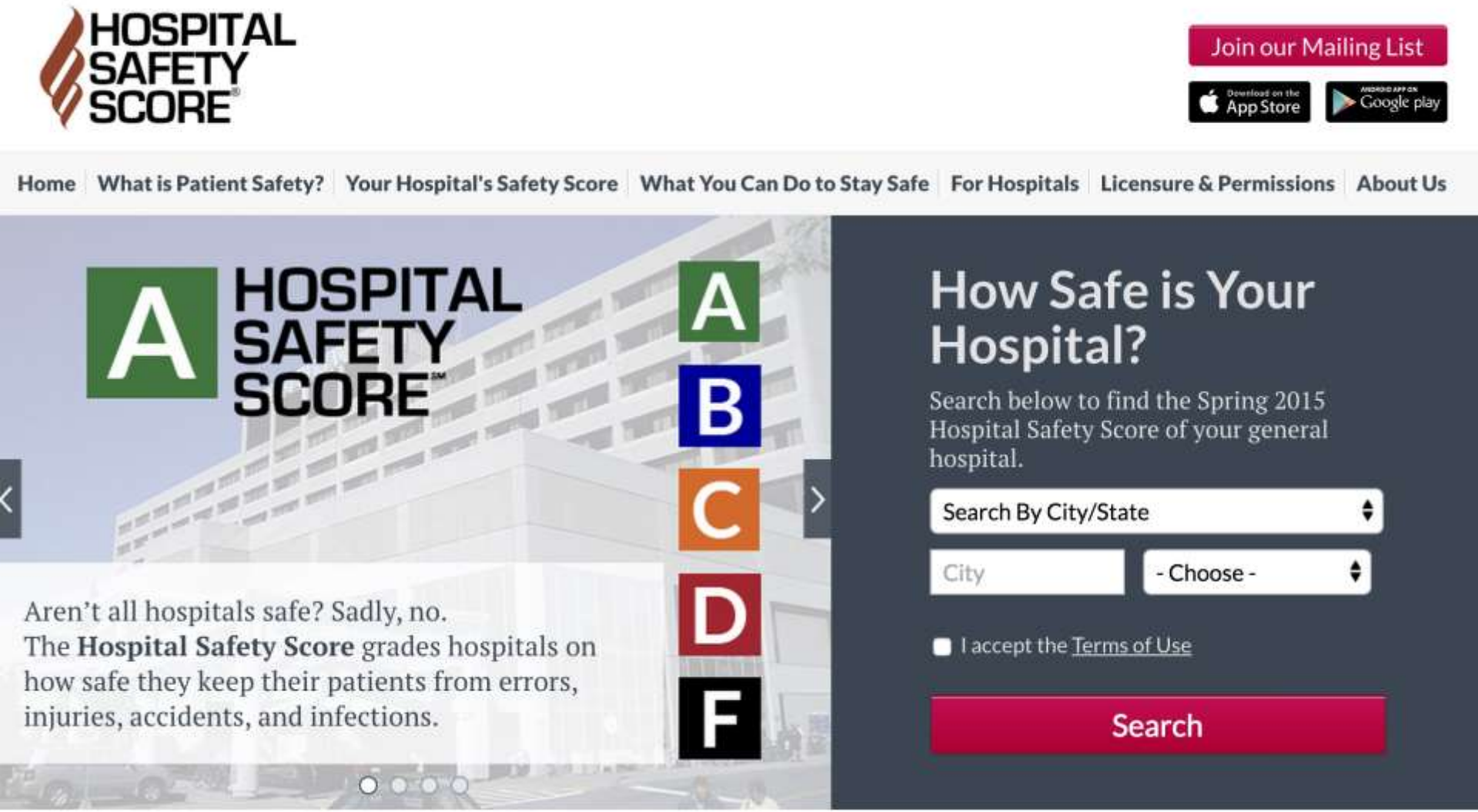
J Patient Saf • Volume 9, 2013

ORIGINAL ARTICLE

Safety in Numbers: The Development of Leapfrog's Composite Patient Safety Score for U.S. Hospitals

J. Matthew Austin, PhD[1], Guy D'Andrea, MBA[2], John D. Birkmeyer, MD[3], Lucian L. Leape, MD[4], Arnold Milstein, MD[5], Peter J. Pronovost, MD, PhD[6], Patrick S. Romano, MD[7], Sara J. Singer, MBA, PhD[8], Timothy J. Vogus, PhD[9], and Robert M. Wachter, MD[10]

Hospital Safety Score



Hospital Safety Score

REGIONE TOSCANA GRC Gestione Rischio Clinico EL PAZIENTE

PROCESS AND STRUCTURAL MEASURES (15)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	HIT Supplement[ii]	2014
ICU Physician Staffing (IPS)	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	AHA Annual Survey[i]	2014
Safe Practice 1: Leadership Structures and Systems	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A
Safe Practice 3: Teamwork Training and Skill Building	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A
Safe Practice 4: Identification and Mitigation of Risks and Hazards	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A
Safe Practice 9: Nursing Workforce	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A
Safe Practice 17: Medication Reconciliation	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	N/A	N/A

OUTCOME MEASURES (15)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2011-06/30/2013	N/A	N/A
Air Embolism	CMS	07/01/2011-06/30/2013	N/A	N/A
Falls and Trauma	CMS	07/01/2011-06/30/2013	N/A	N/A
CLABSI	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	CMS	04/01/2014-03/31/2015
CAUTI	2015 Leapfrog Hospital Survey	01/01/2014-06/30/2015	CMS	04/01/2014-03/31/2015
SSI: Colon	CMS	04/01/2014-03/31/2015	N/A	N/A
MRSA	CMS	04/01/2014-03/31/2015	N/A	N/A
C. Diff.	CMS	04/01/2014-03/31/2015	N/A	N/A
PSI 3: Pressure Ulcer	CMS	07/01/2012-06/30/2014	N/A	N/A
PSI 4: Death Among Surgical Inpatients	CMS	07/01/2012-06/30/2014	N/A	N/A
PSI 6: Iatrogenic Pneumothorax	CMS	07/01/2012-06/30/2014	N/A	N/A

Hospital Safety Score

REGIONE TOSCANA
GRC Gestione Rischio Clinico
SICUREZZA DEL PAZIENTE

Cape Cod Hospital

PO Box 640, 27 Park Street
Hyannis, MA 02601
Map and Directions

This Hospital's Grade

STRAIGHT A'S

A

SINCE 2012

Learn how to use the Hospital Safety Score

▶ Show Past Grades

Detailed table view

Safety Problems with Surgery | Staff Follows Steps to Make Surgery Safer | Infections and Safety Problems | Right Staffing to Prevent Safety Problems | Hospital Uses Standard Safety Procedures

Click Each Measure to Learn More

Hospital Performs Below Average — Above Average

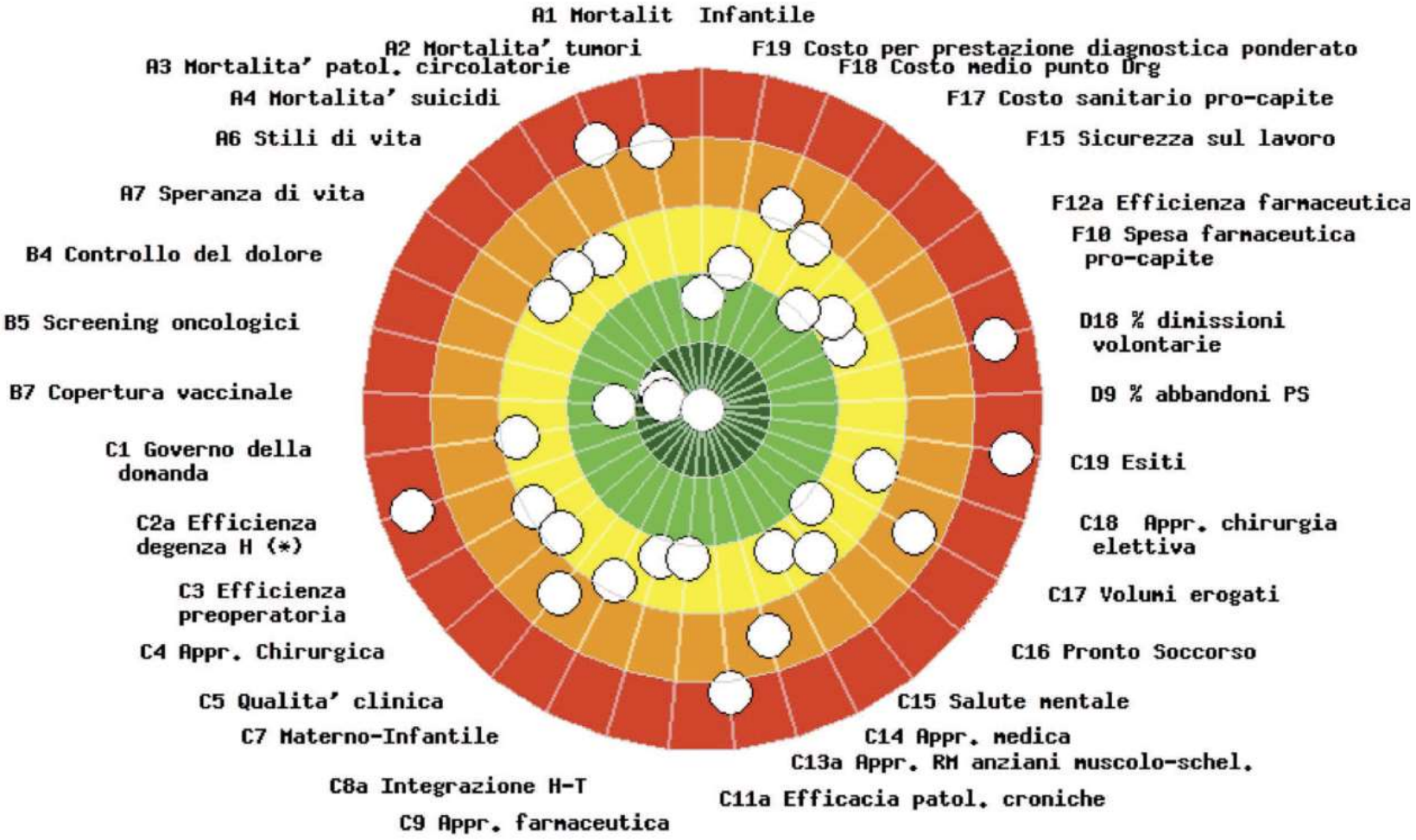
Use antibiotics right before surgery	Use correct antibiotics before surgery	Stop antibiotics soon after surgery	Remove catheter soon after surgery	Take steps to prevent blood clots

Agenas – Programma Nazionale Esiti

30 days mortality in aortocoronary bypass

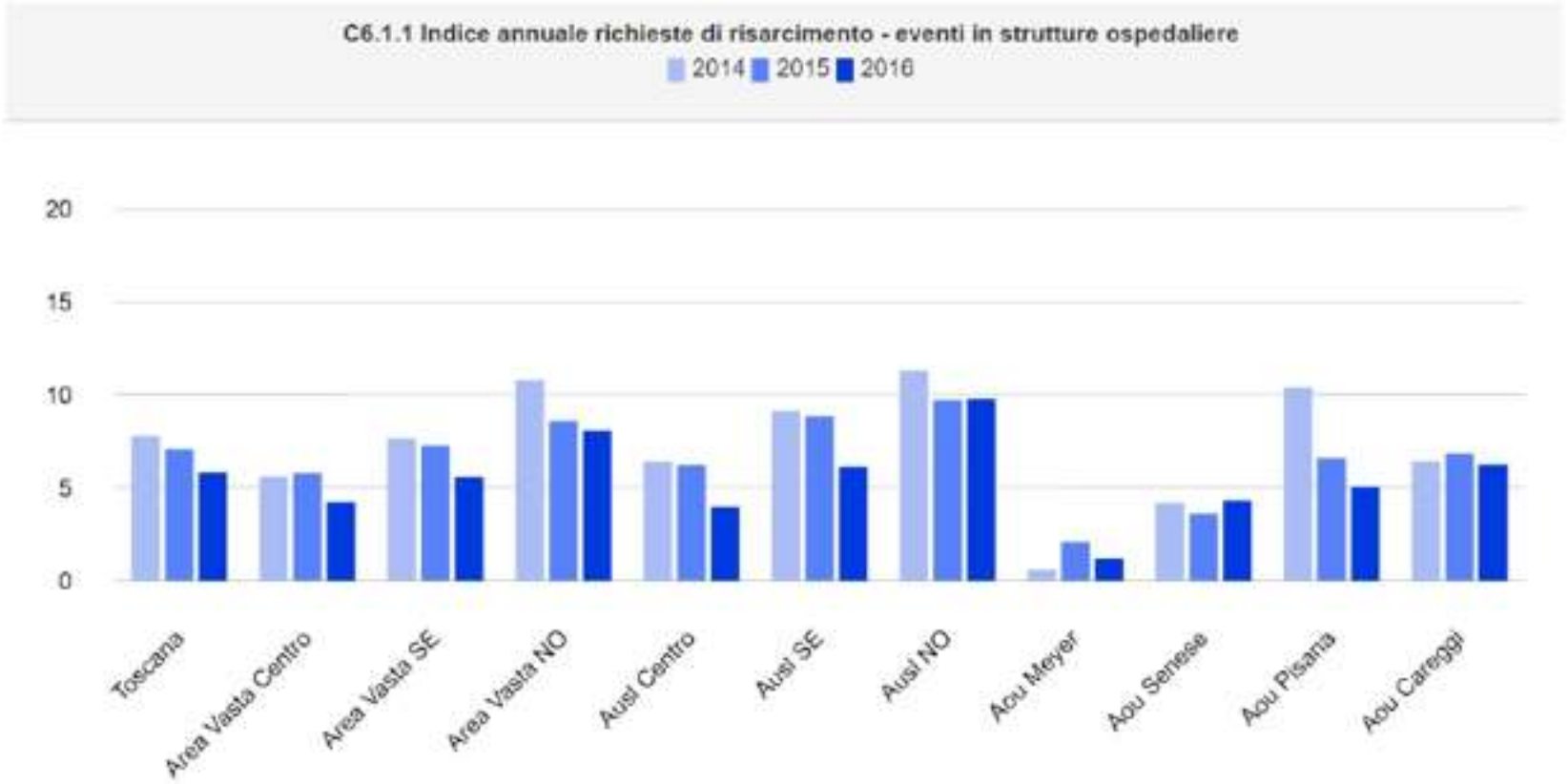
STRUTTURA	PROVINCIA	REGIONE	N	% GREZZA	% ADJ	RR ADJ	P
Italia		Italia	29651	2.43	-	-	-
A.O.U.U. Senese - Siena	SI	Toscana	140	0.00	-	-	-
A.O.U.U. Pisana - Pisa	PI	Toscana	227	5.29	4.72	1.94	0.026
A.O.U.U. Careggi - Firenze	FI	Toscana	471	1.91	1.78	0.73	0.363
CCA Villa Maria Beatrice Hospital SRL - Firenze	FI	Toscana	271	1.85	2.36	0.97	0.950
E.R. Ospedale del Cuore G. Pasquinucci - Pisa	PI	Toscana	408	0.98	0.89	0.37	0.049

MeS – Target based system

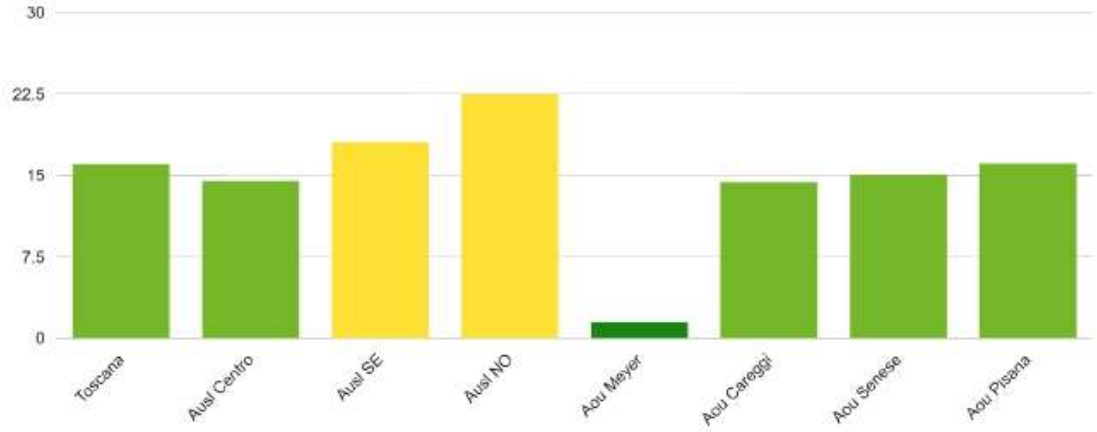


MeS – Target based system

C6	**Rischio clinico e sicurezza del paziente**
C6.1	Indice di richieste di risarcimento
C6.1.1	*Indice di richieste di risarcimento - eventi in strutture ospedaliere*
C6.1.2	*Indice di richieste di risarcimento - eventi in strutture territoriali*
C6.1.3	*Capacità di gestione del risarcimento*
C6.2	Sviluppo del sistema di incident reporting:
C6.2.1	Indice di diffusione degli audit
C6.2.2	Indice di diffusione delle rassegne di Mortalità e Morbilità
C6.4	***Sicurezza del paziente:***
C6.4.1	*Sepsi post-operatoria per chirurgia d'elezione*
C6.4.2	*Mortalità intraospedaliera nei dimessi con Drg a bassa mortalità*
C6.4.3	*Embolia polmonare o trombosi venosa post-chirurgica*
C6.5	Livello di diffusione delle buone pratiche
C6.6	Capacità di controllo delle cadute dei pazienti


C6.1.1 Indice annuale richieste di risarcimento - eventi in strutture ospedaliere
2014
2015
2016
20
15
10
5
0
Toscana
Area Vasta Centro
Area Vasta SE
Area Vasta NO
Ausl Centro
Ausl SE
Ausl NO
Aou Meyer
Aou Senese
Aou Pisana
Aou Careggi

Indicatore di valutazione **C6.1.5 Indice triennale richieste di risarcimento – eventi in strutture ospedaliere**



Nel 2015 l'indicatore era di osservazione ed era denominato **Indice di sinistrosità**

Codice	Azienda	Valutazione 2016	Valore 2016	Numeratore 2016	Denominatore 2016
90	Toscana	3,29	16,03	855	533.211
901	Aou Pisana	3,28	16,08	102	63.423
902	Aou Senese	3,49	15,05	50	33.229
903	Aou Careggi	3,63	14,35	103	71.775
904	Aou Meyer	5,00	1,50	5	33.338
931	Ausl NO	2,01	22,47	258	114.795
932	Ausl Centro	3,61	14,45	194	134.276
933	Ausl SE	2,90	18,02	140	77.696

Definizione

Indice triennale richieste di risarcimento - eventi in strutture ospedaliere

Numeratore

N. richieste di risarcimento x 10000

Denominatore

N. ricoveri

Note

Sono incluse le richieste di risarcimento per lesioni personali e/o decesso correlato a prestazioni ospedaliere riferite ad eventi occorsi nell'anno solare 2014 e giunte entro i due anni successivi (2015-2016).

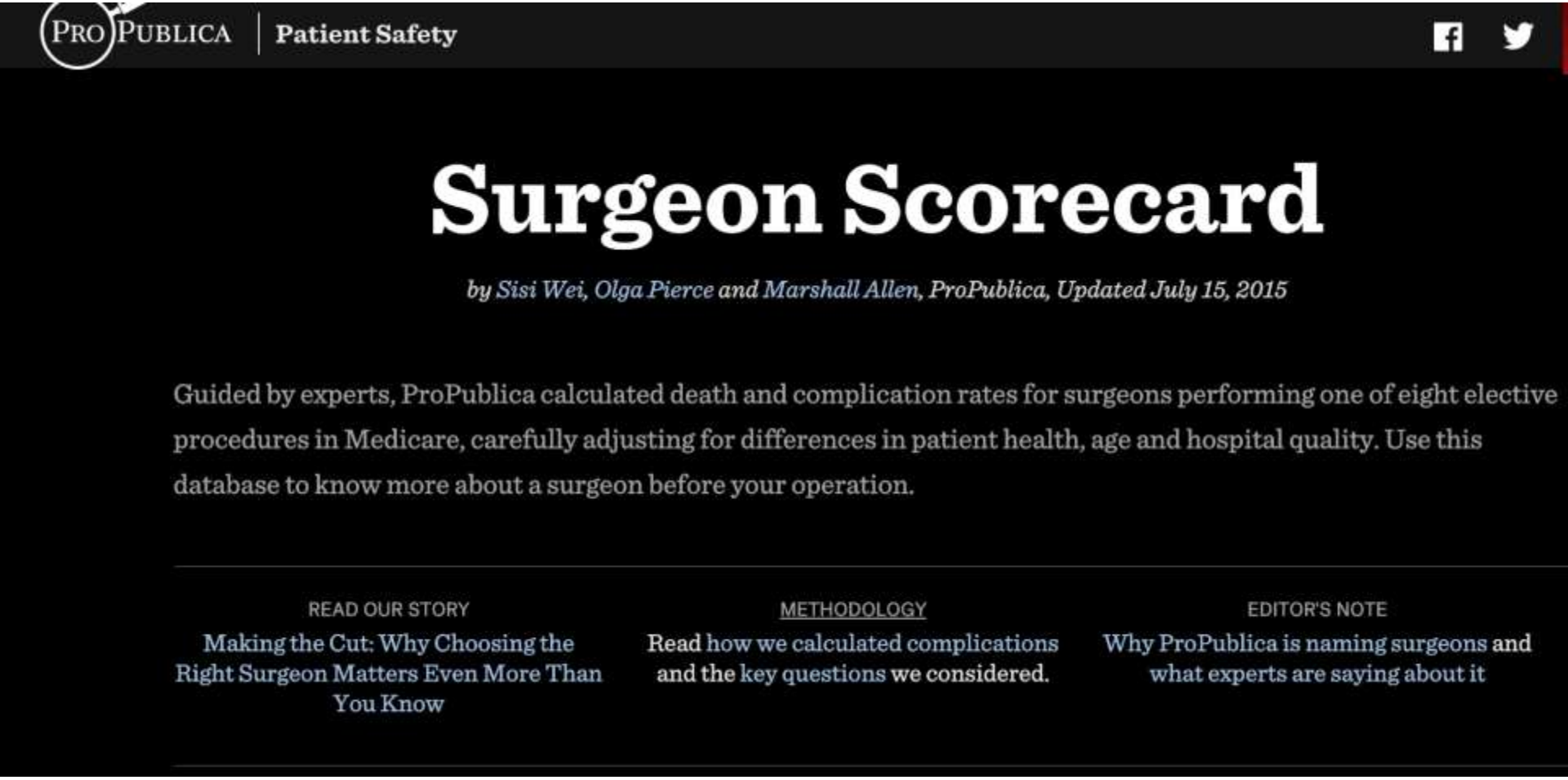
Al denominatore si considerano i ricoveri dell'anno 2014.

L'indicatore fino all'anno 2015 era di osservazione ed era denominato "Indice di sinistrosità-eventi in strutture ospedaliere"

Fonte

Sistema informatizzato Regionale per la Gestione dei Sinistri (SGRS) - Centro Gestione Rischio Clinico - Regione Toscana

ProPublica's Surgeon Scorecard



Da NEJM N Engl J Med. 2015 Settembre 2

Scoring No Goal — Further Adventures in Transparency

Lisa Rosenbaum, M.D.

ProPublica's Surgeon Scorecard

REGIONE TOSCANA GRC Gestione Rischio Clinico SICUREZZA DEL PAZIENTE

A. ROSENFIELD

4130 LA JOLLA VILLAGE DR, STE 306, LA JOLLA, CALIFORNIA 92037-1481 | 858-455-6460
(address information updated May 2, 2013)

Related Hospitals:
SCRIPPS MERCY HOSPITAL
SCRIPPS MEMORIAL HOSPITAL LA JOLLA

Knee Replacement

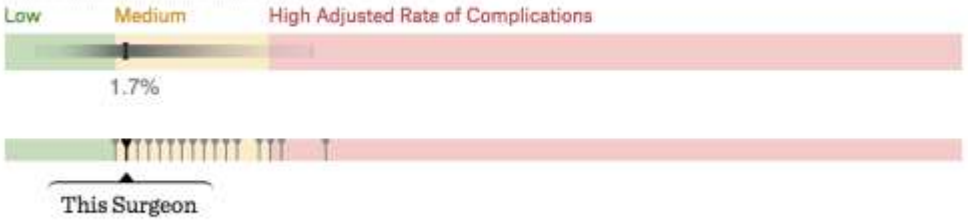
Total knee replacement (ICD-9-CM code 81.54)

Replace diseased knee joint with an artificial knee. The most common reason for a knee replacement is osteoarthritis, which is a breakdown of the cartilage in the joint. More information

This Surgeon

PERFORMED PROCEDURE	COMPLICATIONS	RAW COMPLICATION RATE
103 times	0	0*

ADJUSTED COMPLICATION RATE



SURGEONS PERFORMING THIS PROCEDURE WITHIN 25 MILES →
SEE AREA HOSPITALS »

A coach in operating theater

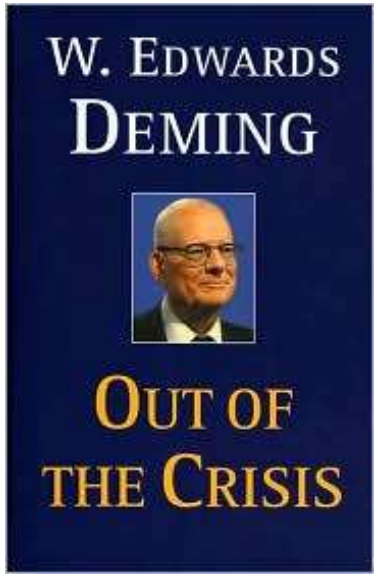
ANNALS OF MEDICINE | OCTOBER 3, 2011 ISSUE

PERSONAL BEST

Top athletes and singers have coaches. Should you?

BY ATUL GAWANDE

Thank you for your attention



In God we trust, all others must bring data

Edward Deming