Les RCP sont-elles utiles?

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Missions du Centre de Référence (CR)
PRISE EN CHARGE DES IOA COMPLEXES (Circulaire 27/12/10)

- Chaque CR met en place une organisation permettant de répondre aux appels des patients, des médecins traitants ou **des services de chirurgie** (site internet, numéro de téléphone dédié, secrétariat, etc.).
- Chaque CR a une mission de recours et d'expertise.
- **Le CR organise et centralise les RCP** pour tous les patients (ceux qu'il a pris en charge et ceux qui ont été adressés par un établissement de santé ou un centre « correspondant »).
- Le CR valide le caractère complexe de l'IOA et définit le lieu de prise en charge ainsi que la stratégie de prise en charge.
- **Chaque CR a une mission d'évaluation, de recherche et d'enseignement**.
- Il établit et diffuse, en partenariat avec les établissements de santé « correspondants», des procédures pour la prise en charge d'une IOA au stade initial et contribue à la rédaction de **guides de bonnes pratiques** au niveau national.

Les critères de qualité des RCP: Plan cancer et la circulaire du 22 février 2005

- La **pluridisciplinarité :** présence d'au moins **trois** spécialités différentes
- Leur **fonctionnement** doit être **formalisé**
- Avant la réunion, une **fiche standardisée** est remplie par le médecin
- **Tous les nouveaux cas** doivent être présentés avant mise en route du traitement.
- **Si le dossier répond à une situation clinique faisant l'objet d'une procédure standard , il est possible de ne pas le discuter**
- Les propositions thérapeutiques sont fondées sur des **référentiels de pratique**
- Les possibilités d'inclusion dans des essais thérapeutiques sont connues
- **L'avis de la RCP comporte la proposition thérapeutique ainsi que les participants**.
- Il est intégré dans le dossier du patient (Dossier communicant en cancérologie).
- Si le traitement diffère de la RCP, les raisons doivent être argumentées
- **« L'évaluation régulière des RCP** (fonctionnement, pluridisciplinarité...) permet une amélioration continue de leur qualité et, *in fine*, du service rendu aux patients. »
- **La RCP (8-10/an) valide l'EPP**

La RCP présente des avantages évidents!

- **Multidisciplinarité** (Chirurgiens, Microbiologistes, Hygiénistes et Infectiologues, Imageurs, MPR, AS, Psychologue….)
- Travail **en** équipe
- **Moment formalisé de réflexion et de décision**
- Outil théoriquement puissant d'autoévaluation, de critiques positives (EPP) et de progrès
- Dans le contexte actuel, à privilégier pour les « vrais » cas complexes

Mais que dit la littérature?

Plusieurs types de recherche Medline en fonction des Key-Words du MesH

Multidisciplinary team-comparative studies-evaluation studis

Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes (Review) 2009 The Cochrane Collaboration

Poor interprofessional collaboration (IPC) can negatively affect the delivery of health services and patient care.

Objectives

- To assess the impact of practice-based interventions designed to change IPC, compared to no intervention or to an alternate intervention, on one or more of the following primary outcomes: patient satisfaction and/or the effectiveness and efficiency of the health care provided. Secondary outcomes include the degree of IPC achieved.

Search methods

- We searched the Cochrane Effective Practice and Organisation of Care Group Specialised Register (2000-2007), MEDLINE (1950-2007) and CINAHL (1982-2007). We also handsearched the Journal of Interprofessional Care (1999 to 2007) and reference lists of the five included studies.

Selection criteria

- Randomised controlled trials of practice-based IPC interventions that reported changes in objectively-measured or self-reported (by use of a validated instrument) patient/client outcomes and/or health status outcomes and/or healthcare process outcomes and/or measures of IPC.

Data collection and analysis

- A meta-analysis of study outcomes was not possible given the small number of included studies and their heterogeneity in relation to clinical settings, interventions and outcome measures. Consequently, we summarised the study data and presented the results in a narrative format.

Main results

- Five studies met the inclusion criteria;

Authors' conclusions

- The review **suggests** that practice-based IPC interventions can improve healthcare processes and outcomes, but due to the limitations in terms of the small number of studies, sample sizes, problems with conceptualising and measuring collaboration, and heterogeneity of interventions and settings, **it is difficult to draw generalisable inferences about the key elements of IPC and its effectiveness.**

Effects of interdisciplinary team care interventions on general medical wards. A systematic review

S.Pannick, et al. JAMA 2015.

Background

- The effect of interdisciplinary team interventions on general medical ward care has not been systematically reviewed.

Objectives

- To describe the range of objective patient outcomes used in studies of general medical ward interdisciplinary team care, and to evaluate the performance of interdisciplinary interventions against them.

Evidence Review

- We searched EMBASE,MEDLINE, and PsycINFO from January1,1998, through December 31,2013, for interdisciplinary team care interventions in adult general medical wards using an objective patient outcome measure.
- Reference lists of included articles were also searched.
- The last search was conducted on January 29,2014,and the narrative and statistical analysis was conducted through December1,2014.
- Study quality was assessed using the Cochrane Effective Practice and Organization of Care group'stool..

Results

- 30/6934 articles met the selection criteria.
- The studies included **66548 patients**, with a mean age of 63 years.
- 63% studies reported length of stay, readmission, or mortality rate as their primary outcome
- The most commonly reported objective patient outcomes were length of stay (77%), complications of care (33%), in-hospital mortality rate (27%), and 30-day readmission rate (27%).
- Of 23 interventions,70% had no effect on length of stay, 80% did not reduce readmissions, and 93% did not affect mortality.
- 50% interventions reduced complications of care.
- All studies had a medium or high risk of bias.

CONCLUSIONS AND RELEVANCE

- Current evidence suggests that interdisciplinary team care interventions on general medical wards have **little effect on traditional measures of health care quality.**

Dans le domaine de l’infection

Ann Phys Rehabil Med. 2010 Jun;53(5):306-18. doi: 10.1016/j.rehab.2010.04.001. Epub 2010 May 26.

Evaluation of a multidisciplinary consultation of diabetic foot.

[Article in English, French]

Hamonet J[1], Verdié-Kessler C, Daviet JC, Denes E, Nguyen-Hoang CL, Salle JY, Munoz M.

Author information

Abstract

OBJECTIVES: To evaluate the effectiveness of a **multidisciplinary** consultation of diabetic foot in terms of ulcer healing rate and podiatric complications prevention.

METHODS: A longitudinal observational study was conducted on 78 patients consulting **multidisciplinary** clinic of diabetic foot between the 1st January 2005 and the 31th December 2006. There were two evaluations: the first one in June 2008, the second one in January 2010, at a medium follow-up of 48 months.

RESULTS: 30.8% of diabetic patients were addressed in primary prevention, 53.8% for treatment of foot ulcer, and 15.4% in secondary prevention. The global healing rate was 76.19% after a medium follow-up of 29 months, and the recurrence rate at a medium follow-up of 48 months was 9.52%. Healing was achieved in 63.6% of patients with off-loading shoes versus 81.8% of whom with fiberglass cast boot.

CONCLUSION: Care and follow-up of diabetic patients with foot at risk in **multidisciplinary** consultation seem to be effective not only in curative treatment, but also in primary and secondary prevention. The economic benefits need to be evaluated.

Solomon et al, *Arch Intern Med* 2001; 161: 1897-1902.

Single university- affiliated academic medical center (USA)

Patients for whom levofloxacin or ceftazidime was requested unnecessarily

Multidisciplinary antimicrobial utilization team (**physician- educator, infectious disease physician, and clinical pharmacist)**
Systematic screening for unnecessary antibiotic prescriptions followed by educational intervention to prescriber "Academic detailing," one-on- one, interactive educational outreach delivered by a professional trained to discuss prescribing decisions in a manner likely to induce evidence- based practice change

Medium: intervention predominantly delivered in person, including to another member of the team if intern unavailable . Education includes discussion of local microbiological data and clinical publications. Intervention typically took 10 min on each occasion. Follow-up by telephone or email if primary team members not available to meet in person. Final drug choice left to original prescriber. Secondary outcomes assessed for every patient admitted to a study service, not just those receiving targeted antibiotics

LOS; 30-d readmissions; in-hospital deaths; and transfer to the ICU (all secondary)

Cluster randomized trial

Results: No change in any end point

Camins et al, *Infect Control Hosp Epidemiol* 2009; 30: 931-38.

Single-center (internal medicine service), university- affiliated, urban public teaching hospital (USA)

Patients receiving a combination of piperacillin and tazobactam, vancomycin hydrochloride, or levofloxacin

Multidisciplinary antimicrobial utilization team **(infectious disease physician and specialist pharmacist)**

Systematic screening for unnecessary antibiotic prescriptions followed by educational intervention

Results: shorter median LOS; no differences in mortality rates

Fine et al, *Am J Med* 2003; 115: 343-351.

Multicenter; 1 university teaching hospital, 3 community teaching hospitals, and 3 community nonteaching hospitals ; Cluster randomized trial (USA)

Patients with community-acquired pneumonia and hospital stay ≥2d

Specialist nurse input to facilitate antibiotic management

Screening for patient stability sufficient to allow conversion from IV to oral antibiotic therapy or discharge

Direct communication with primary team to discuss recommendations

Medium: daily patient assessment by specialist nurse until patient is stable (from day 3 of hospitalization); written and verbal recommendations; assistance with oral antibiotic prescription and discharge arrangements

Ultimate decision remained with initial prescriber

Results: No change in LOS; no differences in mortality or readmission

Korbkitjaroen et al, *Am J Infect Control* 2011; 39: 471-76.

Single-center, tertiary care university hospital (Thailand)

Patients hospitalized for > 48 h

Multidisciplinary infection control team (infectious disease physician and infection control nurse) identifying **risk factors for hospital-acquired infection, with feedback to the treating team**

Feedback included observations regarding adherence to infection control measures

No change in LOS or mortality

Reduction of HAI rate (pneumonia and catheter associated urine tract infections)

Dans le domaine hors de l’infection

Coory M et al. **Systematic review of multidisciplinary teams in the management of lung cancer.** The University of Queensland, Brisbane , Australia. 2008

BACKGROUND:

- In several countries, clinical practice guidelines for lung cancer recommend that **multidisciplinary** (MD) **teams** should be used to plan the management of all lung cancer patients. We conducted a systematic **review** to evaluate and critically appraise the effectiveness of **multidisciplinary teams** for lung cancer.

MATERIALS AND METHODS:

- Medline searches were carried out for the period 1984 to July 2007.

RESULTS:

- Sixteen **studies** met the criteria for inclusion.
- **Evidence of the effect of MD teams was stronger for changing patient management than for affecting survival.**

CONCLUSION:

This does not mean that MD **teams** do not improve survival, merely that currently available evidence of this is limited.

It seems intuitively obvious that MD **teams** should improve outcomes for lung cancer patients, but there are difficulties in conducting randomised trials to show this.

O'Leary KJ **Interdisciplinary teamwork in hospitals: a review and practical recommendations for improvement.** J Hosp Med. 2012 7:48-54. Division of Hospital Medicine, Feinberg School of Medicine, Chicago, Illinois.

- Measurement of teamwork is essential to understand baseline performance, and to demonstrate the utility of resources invested to enhance it and the subsequent impact on patient care.

- Interventions designed to improve teamwork in hospitals include **localization of physicians, daily goals of care forms and checklists, teamwork training**, and **interdisciplinary** rounds.

- **Though additional research is needed to evaluate the impact on patient outcomes, these interventions consistently result in improved teamwork knowledge, ratings of teamwork climate, and better understanding of patients' plans of care.**

Koshman SL, et al **Pharmacist care of patients with heart failure: a systematic review of randomized trials.** Arch Intern Med. 2008 ;168:687-94- Division of Cardiology, Alberta, Canada.

METHODS:

- We searched PubMed, MEDLINE, EMBASE, International Pharmaceutical Abstracts, Web of Science, Scopus, Dissertation Abstracts, CINAHL, Pascal, and Cochrane Central Register of Controlled Trials for controlled **studies** from database inception to August 2007.

RESULTS:

- A total of 12 randomized controlled trials (2060 patients) were identified. Extent of pharmacist involvement varied among **studies**, and each study intervention was categorized as pharmacist-directed care or pharmacist collaborative care using a priori definitions and feedback from primary study authors.

- Pharmacist care was associated with significant reductions in the rate of all-cause hospitalizations (11 **studies** [2026 patients]) (OR, 0.71; 95% CI, 0.54-0.94) and HF hospitalizations (11 **studies** [1977 patients]) (OR, 0.69; 95% CI, 0.51-0.94),and a nonsignificant reduction in mortality (12 **studies** [2060 patients])(OR, 0.84; 95% CI, 0.61-1.15). Pharmacist collaborative care led to greater reductions in the rate of HF hospitalizations (OR, 0.42; 95%CI, 0.24-0.74) than pharmacist-directed care (OR, 0.89; 95% CI, 0.68-1.17).

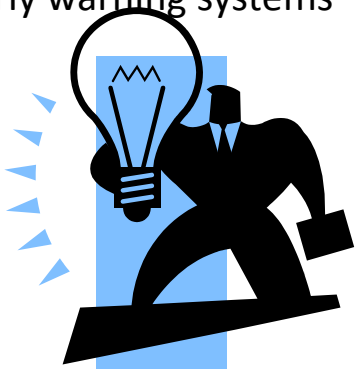
CONCLUSIONS: Pharmacist care in the treatment of patients with HF greatly reduces the risk of all-cause and HF hospitalizations. Since hospitalizations associated with HF are a major public health problem, the incorporation of pharmacists into HF care teams should be strongly considered.

McNeill G[1], Bryden D.

Do either early warning systems or emergency response teams improve hospital patient survival? A systematic review. Resuscitation. 2013 ;84:1652-67. Adult Intensive Care Unit, Nottingham, NG7 2UH, UK.

OBJECTIVES:

- To systematically **review** the available literature to assess whether either early warning systems or emergency response **teams** improve hospital survival.



METHODS:

- The Ovid Medline, EMBASE, CINAHL, Web of Science, Cochrane library and NHS databases were searched in September 2012

RESULTS:

- 43 **studies** meeting the **review** criteria were identified and included for analysis. 2 **studies** assessed single parameter scoring systems and 4 addressed aggregate weighted scoring systems. A total of 20 **studies** examined medical emergency **teams** and 22 **studies** examined **multidisciplinary** outreach **teams**.

CONCLUSIONS:

Much of the available evidence is of poor quality.

The response to deterioration appears most effective when a clinician with critical care skills leads it.

Mais que ne dit pas la littérature?

- Lien de subordination fréquent « dans et entre » les équipes médicales surtout en CHU
- Travailler **dans une** équipe ne signifie pas travailler **en** équipe
- « Poids » variable des personnalités en présence (le problème général de la communication de groupe)
- Dilution et déresponsabilisation possible
- Forte consommation de temps médical
- RCP IOA et urgence infectieuse?
- Le rapport Coût-Efficacité n'est pas ou rarement étudié
- **Les indicateurs de qualité**?

Les indicateurs de qualité en France Rapport Hôpital IGAS 2012

- Le modèle français de régulation de la qualité a d'abord accordé une part limitée au pilotage par indicateurs.
- Centré depuis 1996 sur l'accréditation devenue certification en 2004, il a privilégié **initialement l'évaluation du respect de référentiels de pratiques et de management**, dans une démarche qui se voulait incitative.
- Ainsi les RCP sont bien datées, signées, incorporées au dossier patient, etc……
- La France s'est engagée plus tardivement dans la mise en place d'indicateurs de qualité
- En 2003, un accord-cadre regroupant la DGOS (alors la DHOS), la HAS (alors l'ANAES) et la DREES a engagé le projet COMPAQH de **recherche d'indicateurs de qualité** capables de mesurer de façon comparative la performance des établissements de santé en France.

- Certaines informations recueillies favorisent une appréciation de la qualité : les résultats de la certification, le score ICALIN (Indicateur composite d'activité de lutte contre les infections nosocomiales)
- Et de récents indicateurs sur la pratique clinique (Réévaluation de l'antibiothérapie à H72, prises en charge des escarres, des AVC, douleur,…)
- S'y ajoutent des éléments sur la tenue du dossier patient, dits QUALHAS (lettre du MG, courrier de sortie < 72H,….)

- En dépit des avancées les plus récentes, la confrontation de l'expérience française aux démarches étrangères met en lumière **une relative timidité des démarches** engagées pour objectiver la qualité des soins et un moindre volontarisme des pouvoirs publics en termes de suivi.

- **Absence d'unité de pilotage et faiblesse des moyens mobilisés**

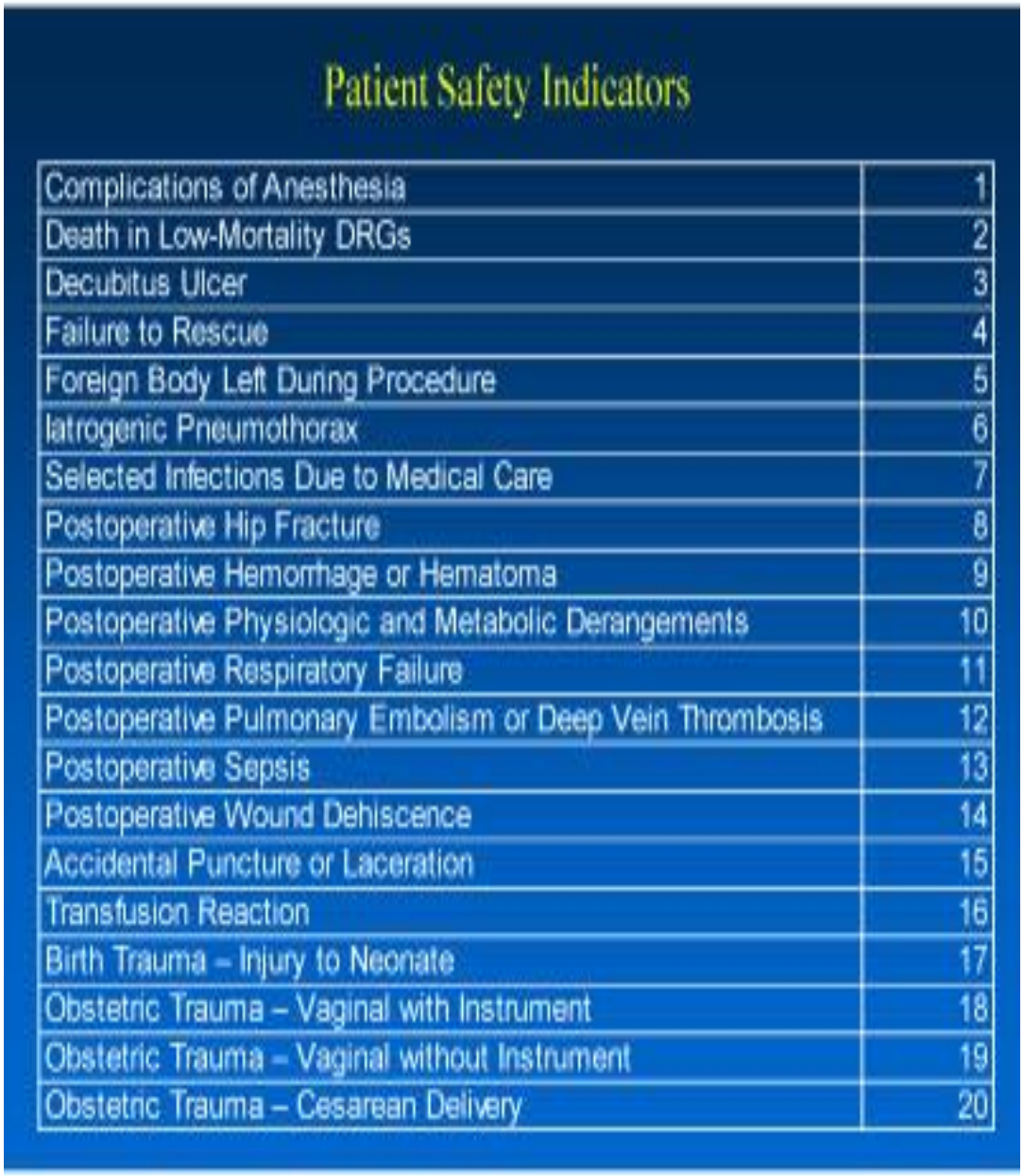
- **Faute de volonté forte, les débats scientifiques sur la validité des indicateurs et les craintes de mésusage des professionnels l'ont longtemps emporté sur la logique de pilotage et de transparence sur la qualité des soins dans les établissements de santé.**

- Le législateur a cependant confié dans le cadre de la loi de financement de la sécurité sociale pour **2012**, une nouvelle mission à la **HAS** : « **coordonner l'élaboration et assurer la diffusion d'une information adaptée sur la qualité des prises en charge dans les établissements de santé à destination des usagers et de leurs représentants ».**

Patients Safety Indicators

La mise à disposition rapide des premiers «patient safety indicators» (PSI) encore en phase de test serait appréciable, comme la consolidation d'indicateurs de mortalité généraux et spécifiques.

Ils permettraient d'atténuer la durable prépondérance en France des indicateurs en lien avec les problèmes infectieux.



Satisfaction des patients

- Le projet I-Satis , qui devrait débuter en 2013, viendra combler une lacune française dans l'association des usagers à l'appréciation de la qualité.
- Il permettra de mesurer de façon désormais systématique et homogène la satisfaction sur une base annuelle, une société extérieure recueillant l'avis des patients par téléphone 5 à 6 semaines après leur sortie

Rapport Coût/Efficacité

- Le passage des instruments (CREA, TCCM) à l'analyse des processus concrets de soins n'est en rien évident et nécessite des explorations supplémentaires.
- **Il est difficile de construire un lien contrôlable entre organisation et efficacité économique**.
- La diffusion d'analyses nationales sur les coûts à partir des indicateurs existants ou à partir de travaux spécifiques peut aider les établissements dans leurs démarches

En conclusion

- Si l'on oppose le travail isolé (historique?) de certains chirurgiens en IOA à une RCP, l'amélioration liée à la RCP parait peu discutable
- Il serait plus difficile de montrer qu'une confrontation simple téléphonique ou en présentiel infectiologue-chirurgien est inférieure à une RCP pour les cas les plus fréquents
- Etre aussi très conscient des limites sus-décrites des RCP et d'un Rapport Coût/Efficacité probablement médiocre


Merci pour votre attention
FACULTÉ DE MÉDECINE

Back-Up

Berber R et al. **A new approach to managing patients with problematic metal hip implants: the use of an Internet-enhanced multidisciplinary team meeting: AAOS exhibit selection.** J Bone Joint Surg Am. 2015 United Kingdom.

BACKGROUND:

- Over one million patients worldwide are estimated to have a metal-on-metal hip arthroplasty. To improve the management of these patients and reduce surgeon uncertainty regarding decision-making, we designed an **Internet-enhanced multidisciplinary team** (iMDT) working approach.

METHODS:

- From August 2012 to April 2014, the iMDT discussed 215 patients with 266 metal-on-metal hip arthroplasties. Of these, 236 primary arthroplasties (132 hip resurfacing and 104 total hip) were analyzed. The remaining thirty cases involved problematic revised hips and were therefore excluded. The possible recommendations of the iMDT were monitoring, further investigation, or surgery. The concordance between the recommendation and the actual management was used to assess the usefulness of this approach in reducing uncertainty in surgeon-level decision-making.

RESULTS:

- The median Oxford Hip Score was 35 (range, 4 to 48), and median cobalt and chromium levels in whole blood were 3.54 ppb (range, 0.18 to 161.46 ppb) and 3.17 ppb (range, 0.20 to 100.67 ppb), respectively. Magnetic resonance imaging revealed abductor muscle atrophy in ninety-two (39%) of the hips and a pseudotumor in eighty (34%). The iMDT recommended monitoring of 146 (61.9%) of the hips, further investigation of thirty (12.7%), and surgery in sixty (25.4%). The actual outcome was concordant with the recommendation in 211 (91.7%) of the hips.

CONCLUSIONS:

- Our iMDT approach to the metal-on-metal hip burden combines the tacit knowledge of an expert panel, regulatory guidance, and up-to-date evidence to improve decision-making among surgeons. The high level of concordance between the recommendation and the actual outcome, combined with the feasibility of the methods used, suggest that this method effectively reduces uncertainty among surgeons and may lead to improved patient outcomes.

Manuel et al, *J Hosp Inf 2010; 74: 326-331.*

Single-center (general internal medicine wards) university hospital (Switzerland)

Patients who receive an IV antibiotic for more than 3 d

Infectious disease specialist

Non randomized cluster trial (with crossover)

Systematic assessment of antibiotic prescription regarding need for antibiotic, choice of drug, route, and dose, with feedback to treating physician

Low: single review with standardized evaluation form and discussion with the treating physician

No difference in end-points: LOS and in-hospital mortality rate (secondary)

Lesprit et al *Clin Microb Inf* 2013; 19: 91-97.

Single-center Infectious disease

Patients receiving intermediate or broad-spectrum antibiotics for 3- 5 d, with expected survival >30 d

Systematic assessment of antibiotic prescription, with feedback to treating physician

No change in LOS, in- hospital mortality rates, or ICU admission

Fewer 60-d readmissions for relapsing infection in intervention group

- **Systematic review of interdisciplinary interventions in nursing homes.** J Am Med Dir Assoc. 2013;14:471-8.

- Nazir A et al. Division of General Internal Medicine and Geriatrics, Indiana, USA.

BACKGROUND:

- The role of **interdisciplinary** interventions in the nursing home (NH) setting remains unclear. We conducted a systematic evidence **review** to study the benefits of **interdisciplinary** interventions on outcomes of NH residents. We also examined the **interdisciplinary** features of successful trials, including those that used formal **teams**.

METHODS:

- Medline was searched from January 1990 to August 2011.
- Search terms included **residential facilities, long term care, clinical trial, epidemiologic studies, epidemiologic research design, comparative study, evaluation studies, meta-analysis and guideline**.
- We included randomized controlled trials (RCTs) evaluating the efficacy of **interdisciplinary** interventions. We used the Cochrane Collaboration tools to appraise each RCT

RESULTS:

- We identified 27 RCTs: 7 had no statistically significant effect , 2 had a statistically negative effect, and 18 demonstrated a statistically positive effect. Participation of residents' own primary physicians (all 6 trials were positive) and/or a pharmacist (all 4 trials were positive) in the intervention were common elements of successful trials. For interventions that used formal team meetings, presence of communication and coordination among team members were the most commonly observed elements.

CONCLUSION: Overall **interdisciplinary** interventions had a positive impact on resident outcomes in the NH setting. Participation of the residents' primary physician and/or a pharmacist in the intervention, as well as team communication and coordination, were consistent features of successful interventions.