



Multidisciplinary care's and integration concerning patients affested by SLA

(Side Amyotrophic Sclerosis)

Specific aims

- Opening a specific outpatient's clinic (Outpatient's department SLA)
- Increasing the quantity and quality of the health personnel updating on the SLA problem
- Participating to the collection and elaboration project of the epidemiological data on regional base;
- Raising the rapidity and ability of "listening" the demands expressed from the sick person;
- Decreasing of the waiting list (for medical examination, treatments, psychological consultation, ordinary or day hospitalization).
- Making contacts with the most important establishments interested (ASL) and also the specific Associations
- Programming Periodic Accesses (for disbursement cares and checks) coordinated between Neurology and Pneumatology
- Activation domiciliary visits from Medical staff: Neurologist, Pneumologist
- Activation domiciliary care from Nursing personnel by Neurology, Pneumology
- Extention the duration of the prescription of the specific medicine from 2 to 6 months.
- Organizing a Public Meeting /Conference about SLA

Not rarely, after the dramatic communication of the diagnosis, the patient and also close relatives have got a feeling of forsaking and isolation in front of one important list of problems (health, psychological, ethics, working, economic, social, etc.).

Finding
A CURE
Begins With
Hope
AMYOTROPHIC LATERAL SCLEROSIS AWARENESS

Results until now :

1. Opening up a specific clinic for the neuromuscular disorders diseases to fortnightly list ;
2. Activation a devoted telephone number with specific preparation answers, for booking of medical and instrumental examinations, for information and suggestions;
3. Reduction of the waiting list; the patients come as a rule revalued every two months, if necessary, after telephone contact, in the briefest possible time;
4. Rationalization of the access to the specific therapies furnished by the Business Pharmaceutical Service (medicines in H band);
5. Insertion of all new diagnosed patients into Regional Register
6. Integration either the appraisal pathway or multidisciplinary care between Pneumatology Ward and Intensive Care Unit in order to program:
 - evaluation of the respiratory function,
 - evaluation of the respiratory insufficiency risk,
 - activation of the program for management of the phase of the advanced respiratory insufficiency within the regional guide lines for the management of the mechanical ventilation for a long time term (program of respiratory domiciliary assistance (ADR)
 - prosecution of the research program (Pneumology and Intensive Respiratory Unit)
 - Making easier the access to the benefits of law (invalidity, aids, communicators and economic assistance);

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"Multidisciplinary care's quality and integration concerning patients affected by SLA"

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