Ruolo delle Reti di Nutrizione Clinica

Andrea Pezzana

SC Nutrizione Clinica
ASL Città di Torino

Agenda

Le reti in sanità: un po' di storia, quale ruolo e quale eredità

Tempi moderni

Reti in Nutrizione Clinica: facile per tematica, difficile per formazione

Quali ruoli: verso i cittadini/pazienti
verso gli operatori
verso le organizzazioni/enti

Alcuni principi

OSPEDALI E RETI. IL MEDIOEVO*

MARINA GAZZINI
Università degli Studi di Parma

UNA METAFORA E LA SUA APPLICAZIONE

Fuori da ogni retorica, posso sinceramente affermare che è per me un grande onore essere stata invitata a tenere la relazione inaugurale del VI incontro degli «Abrils de l'Hospital». Il simposio internazionale quest'anno è stato dedicato al tema delle reti ospedaliere, indagate sotto l'aspetto storico, economico e sociologico-sanitario. Condivido appieno l'adozione della metafora della «rete» perché ritengo che essa sia una stimolante chiave di lettura per comprendere la complessa realtà degli ospedali di ogni tempo e luogo.

L'ospedale, inteso sia come ente sia come comunità di persone, non costituisce infatti un'isola, ma si trova inserito in un fitto intrico di connessioni reticolari. Fin dalle loro antiche origini, gli ospedali risultano essere stati nodi di reti differenti attraverso le quali sono circolati uomini, merci, denaro, ma anche idee e modelli: di assistenza, di sanità, di architettura, di gestione amministrativa e aziendale, di relazione sociale. La metafora della rete ci invita allora da un lato a riflettere su come e quanto la fisionomia di questi modelli, idee, uomini, merci, denari circolanti sulla rete ospedaliera risulti condizionata dalla struttura della medesima e, viceversa, su come e quanto le reti ospedaliere vengano influenzate dal quadro politico, culturale, economico all'interno del quale esse si dipanano.

Scambio di informazioni sanitarie e non

Libera circolazione di idee: confronto, innovazione, modelli relazionali e culturali

Modelli “a confronto”

Reti di religiosità, potere, idee, economia

Accessibilità (ponti, acquedotti, cammini) e ruolo dei “cittadini/utenti”

Ospedali Ospitali (... dei cammini e dei ponti…)

Venezia: la rete contro la peste (1575/6 - 1630/1)

Contaminazione virtuosa di saperi
Innovazione creativa
Pragmatismo e coraggio
Scientificità
Anticipazione

“L’Italia fu un laboratorio per comprendere come le infrastrutture e l’ambiente avessero un ruolo fondamentale nella diffusione delle malattie. A cominciare da Venezia, dove per la prima volta si sperimentò un approccio “epidemiologico” di rete. Grazie ai Lazzaretti si svilupparono concetti e procedure che poi si sarebbero rivelati essenziali nel controllo delle malattie diffusive.” (Ilaria Capua, 2020)

Venezia ha una sua storia nei confronti delle epidemie. Tra i primi luoghi d’Europa, Venezia ha sviluppato una politica sanitaria per poter affrontare il manifestarsi della peste. Non c’è dubbio che nella storia della sanità e delle emergenze epidemiche l’esperienza della Serenissima rimane estremamente significativa. Fu all’ avanguardia nella gestione della crisi, come si è visto durante le pestilenze del 1576 e del 1630, e fu molto efficace nel dopo 1630, sia nell’attuare strategie di profilassi sia nel realizzare una vera e propria rete di difesa sanitaria, soprattutto rispetto ai domini marittimi nel Mediterraneo, i quali confinavano con l’impero ottomano, un’area dove la peste era endemica, un focolaio che spaventava più di una guerra. (Ivetic, 2025)

Nos Supra Prouisores, Adiuncti, & Prouisores Salutis Venetiarum

G R A T I S.

SI parte da questa Dominante sana (Iddio lodato) & libera da ogni sospetto di mal Contaggio le gl'infrascritti, con robbe, ò con mercantie, ò senza, come qui sotto sarà notato, a' quali in cadaun luogo oue capiteranno, se li potrà dar libera, e sicura prattica. In quorum fidem, &c.

Dat. dall'Officio della Sanità di Venetia. Adi

Anni	Pelo	Statura
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Agenda

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verso gli operatori
verso le organizzazioni/enti

Reti cliniche, percorsi e strutturazione organizzativa

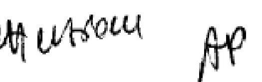
Possiamo riconoscere l'esistenza di tre diversi livelli di strutturazione organizzativa in campo sanitario: macrosistema, mesosistema e microsistema.

MICRO: GRUPPO INDIPENDENTE DI OPERATORI che lavora insieme su basi regolari per fornire assistenza a specifici gruppi di pazienti, ad esempio in un reparto od in un ambulatorio, piuttosto che nell'assistenza domiciliare integrata, ecc. Il microsistema è, quindi, il luogo fisico dove viene effettivamente erogata l'assistenza al paziente

MACRO: Le RETI CLINICHE, intese come un sistema integrato di setting ospedalieri e territoriali volti a dare una risposta ad una data patologia, sono invece, in quest'ottica, da considerarsi un MACROSISTEMA CLINICO, ossia un'impalcatura che dovrebbe permettere di far muovere il paziente attraverso le varie prestazioni sanitarie erogate nei diversi micro-sistemi clinici (che costituiscono, quindi i nodi della rete), garantendo equità, appropriatezza ed efficacia senza lasciare soluzioni di continuità

MESO: i PERCORSI ASSISTENZIALI (PDTA) che, guidando il contenuto tecnico ed organizzativo delle prestazioni, forniscono ai microsistemi quegli elementi di guida all'appropriatezza del loro contenuto e alla rete lo strumento operativo in grado di coordinare tra di loro i singoli microsistemi. Azione di MESOSISTEMA CLINICO, che in una rete costituisce l'impalcatura operativa dei percorsi, vero e proprio sistema connettivo in grado di veicolare l'Evidence Based Medicine (EBM), insieme alla migliore organizzazione, all'interno della pratica clinica.

Nelson EC, Godfrey MM, Batalden PB, Berry SA, Bothe AE, McKinley KE, Melin CN, Muething SE, Moore LG, Wasson JH, Nolan TW. 2008. Clinical Microsystems, Part 1. The Building Blocks of Health Systems. The Joint Commission Journal on Quality and Patient Safety. Volume 34 Number 7. July 2008.



Ufficio di Gabinetto

Ministero della Salute
GAB
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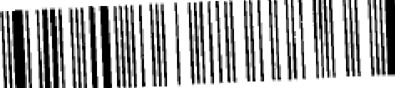
Presidenza del Consiglio dei Ministri
DAR 0016560 A-4.37.2.10
del 25/10/2017



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Alla Presidenza del Consiglio dei Ministri
Segreteria della Conferenza permanente per i rapporti tra lo Stato, le regioni e le province autonome di Trento e Bolzano
statoregioni@mailbox.governo.it

e p.c.

Al dott. Francesco Bevere
Direttore generale dell'Agenzia nazionale per i servizi sanitari regionali

Al dott. Andrea Urbani
Direttore generale della programmazione sanitaria

OGGETTO: Percorso di revisione delle Reti clinico-assistenziali in attuazione del punto 8.1 dell'allegato 1 al decreto ministeriale n. 70/2015. Trasmissione del documento "Linee guida per la revisione delle reti cliniche – Le reti tempo dipendenti"

http://www.quotidianosanita.it/allegati/allegato9561525.pdf

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RESEARCH ARTICLE Open Access

What are the reasons for clinical network success? A qualitative study

Elizabeth McInnes[1,2*], Mary Haines[3,4], Amanda Dominello[3], Deanna Kalucy[3], Asmara Jammali-Blasi[1,2], Sandy Middleton[1,2] and Emily Klineberg[5,6]

Abstract

Background: Clinical networks have been established to improve patient outcomes and processes of care by implementing a range of innovations and undertaking projects based on the needs of local health services. Given the significant investment in clinical networks internationally, it is important to assess their effectiveness and sustainability. This qualitative study investigated the views of stakeholders on the factors they thought were influential in terms of overall network success.

Method: Ten participants were interviewed using face-to-face, audio-recorded semi-structured interviews about critical factors for networks' successes over the study period 2006–2008. Respondents were purposively selected from two stakeholder groups: i) chairs of networks during the study period of 2006–2008 from high- moderate- and low-impact networks (as previously determined by an independent review panel) and ii) experts in the clinical field of the network who had a connection to the network but who were not network members. Participants were blind to the performance of the network they were interviewed about. Transcribed data were coded and analysed to generate themes relating to the study aims.

Results: Themes relating to influential factors critical to network success were: *network model principles; leadership; formal organisational structures and processes; nature of network projects; external relationships; profile and credibility of the network.*

Conclusions: This study provides clinical networks with guidance on essential factors for maximising optimal network outcomes and that may assist networks to move from being a 'low-impact' to 'high-impact' network. Important ingredients for successful clinical networks were visionary and strategic leadership with strong links to external stakeholders; and having formal infrastructure and processes to enable the development and management of work plans aligned with health priorities.

Keywords: Clinical networks, Outcomes, Stakeholder views, Qualitative

Background

Clinical networks have been established in several countries to improve patient outcomes and processes of care by implementing a range of innovations and undertaking projects based on local health needs. In Australia, a number of states have now established clinical networks and all aim to engage clinicians in improving patient care and making system-wide changes [1, 2]. The term clinical network describes many different models of networks, from those focused on service delivery systems to informal communities of practice [3–6]. In this study, the term clinical networks refers to voluntary multidisciplinary networks of clinicians that aim to improve clinical care and service delivery using a collaborative approach to identify patient and health service need and to implement strategies to improve quality of care and patient outcomes [1].

In the state of New South Wales, clinical networks are funded by the Agency for Clinical Innovation which sits within the state-based Ministry of Health. These networks, which are multidisciplinary in composition, have a single clinical or disease focus (for example burn injury, nuclear medicine, aged care, stroke) and largely rely on

* Correspondence: Liz.McInnes@acu.edu.au
[1]Nursing Research Institute – St Vincents Health Australia (Sydney) and Australian Catholic University, DeLacy Building, 379 Victoria Road, Darlinghurst, NSW 2010, Australia
[2]School of Nursing, Midwifery & Paramedicine (NSW & ACT), Australian Catholic University, North Sydney 2060 NSW, Australia
Full list of author information is available at the end of the article

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Research

Improving the quality of healthcare: a cross-sectional study of the features of successful clinical networks

Mary M Haines[a,b,l], Bernadette Brown[a], Catherine A D'Este[c,d], Elizabeth M Yano[e,f], Jonathan C Craig[b], Sandy Middleton[g], Peter A Castaldi[b], Carol A Pollock[b], Kate Needham[h*], William H Watt[i], Elizabeth J Elliott[b], Anthony Scott[j], Amanda Dominello[a], Emily Klineberg[k], Jo-An Atkinson[a], Christine Paul[d] and Sally Redman[a], on behalf of the Clinical Networks Research Group

[a] Sax Institute, Sydney, NSW, Australia
[b] Sydney Medical School, University of Sydney, NSW, Australia
[c] College of Health and Medicine, Australian National University, Canberra, ACT
[d] School of Medicine and Public Health, University of Newcastle, NSW, Australia
[e] US Department of Veterans Affairs Health Services Research & Development Centre for the Study of Healthcare Innovation, Implementation and Policy, VA Greater Los Angeles Healthcare System, CA, US
[f] UCLA Fielding School of Public Health, Los Angeles, CA, US
[g] Nursing Research Institute, St Vincent's Health, and Australian Catholic University, Sydney, NSW
[h] Agency for Clinical Innovation, Sydney, NSW, Australia
[i] School of Medicine, University of Wollongong, NSW, Australia
[j] Melbourne Institute of Applied Economics and Social Research, University of Melbourne, VIC, Australia
[k] NSW Health, Sydney, Australia
[l] Corresponding author: mary.haines@saxinstitute.org.au
* Deceased 22 September 2016

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Key points

- Networks of clinical experts are being established internationally to help embed evidence based care in health systems, but there is little evidence about the most successful network design
- Few studies have investigated clinical networks that span multiple clinical disciplines across a health system
- This study provides quantitative evidence that clinical networks can improve quality of care and facilitate system-wide change
- Combining 'top down' (strategic planning, strong leadership) and 'bottom up' (supportive environment, multidisciplinary representation) organisational approaches is most effective

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verso gli operatori
verso le organizzazioni/enti

COMPLEXITY

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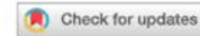

The Unmet Need for Nutrition Education: Results from Survey of Internal Medicine Residents at an Academic Training Medical Center

Courtney L. DeCan[a], Katie A. Thure[b], and Mina Ma[c]

[a]Division of Clinical Nutrition, Department of Medicine, University of California, Los Angeles, California, USA; [b]Department of Medicine, University of California, Los Angeles, California, USA; [c]Division of General Internal Medicine & Health Services Research, Department of Medicine, University of California, Los Angeles, California, USA

ABSTRACT

Objective: Despite the increasing prevalence of obesity and diet-related chronic diseases, nutrition education has been historically lacking in medical education. With increasing access to effective diet-related chronic disease treatments, physicians have an increasingly important role to play in nutrition counseling. We evaluated the attitudes and comfort related to nutrition and nutrition counseling among a cohort of internal medicine residents at a large academic training program.
Methods: An online survey was administered to internal medicine residents on nutrition attitudes and counseling practices using a previously validated questionnaire. The survey was open for responses following an outpatient didactic session in March 2023. Responses were captured using Qualtrics and analyzed using descriptive statistics.
Results: The survey was distributed to 70 trainees. Of the 40 residents from all levels of training who completed the survey 60% reported having received no prior nutrition training in their educational background. Residents generally strongly agreed that nutritional assessments and counseling should be included in any routine appointments, just like diagnosis and treatment of patients, and that physicians can have an effect on patient's dietary behavior if they take the time to discuss the problem. Residents also strongly agreed that most physicians are not adequately trained to discuss nutrition effectively with patients and had low comfort with nutrition counseling across all areas.

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KEYWORDS
Medical education; nutrition; residents; medical training; obesity

Mayo Clinic Care Network

Trinity Health
Altru Health System
Billings Clinic
St. Alexius Medical Center
CentraCare Coborn Cancer Center
Dartmouth-Hitchcock
Shriners Hospitals for Children – Twin Cities
ThedaCare
Sparrow Health System
OSF HealthCare
NorthShore University HealthSystem
Aspen Valley Hospital
Heartland Health
St. Elizabeth Healthcare
Pikeville Medical Center
Kingman Regional Medical Center
Palomar Health
Yuma Regional Medical Center
ASU Health Services
St. Francis Hospital
Baptist Health Care
NCH Healthcare
MEXICO
Médica Sur
Salus
Puerto Rico

- Mayo Clinic Care Network
- Mayo Clinic Health System
- Mayo Clinic

nutrients

Perspective

Toward a Pragmatic Multidisciplinary Management of Nutritional Risk in Hospitalized Patients: Initiatives and Proposals of the Clinical Nutrition Network of Lombardy Region

Elisa Mattavelli [1], Elvira Verduci [2,3], Annalisa Mascheroni [4], Ettore Corradi [5], Valentina Da Prat [1], Emanuela Ammoni [6], Danilo Cereda [6], Alessandro Scardoni [6], Alessandro Amorosi [6] and Riccardo Caccialanza [1,*,†] on behalf of the Clinical Nutrition Network of Lombardy

1 Clinical Nutrition and Dietetics Unit, Fondazione IRCCS Policlinico San Matteo, 27100 Pavia, Italy; e.mattavelli@smatteo.pv.it (E.M.); v.daprat@smatteo.pv.it (V.D.P.)
2 Metabolic Disease Unit, Department of Paediatrics, Vittore Buzzi Children's Hospital, University of Milan, 20154 Milan, Italy; elvira.verduci@unimi.it
3 Department of Health Sciences, University of Milan, 20142 Milano, Italy
4 Clinical Nutrition and Dietetics Unit, ASST Melegnano e Martesana, 20077 Melegnano, Italy; annalisa.mascheroni@asst-melegnano-martesana.it
5 Clinical Nutritional Unit, ASST Grande Ospedale Metropolitano Niguarda, 20162 Milano, Italy; ettore.corradi@ospedaleniguarda.it
6 Welfare General Directorate, Regione Lombardia, 20124 Milano, Italy; emanuela_ammoni@regione.lombardia.it (E.A.); danilo_cereda@regione.lombardia.it (D.C.); alessandro_scardoni@regione.lombardia.it (A.S.); alessandro_amorosi@regione.lombardia.it (A.A.)
* Correspondence: r.caccialanza@smatteo.pv.it
† Clinical Nutrition Network of Lombardy members are listed in the Acknowledgments.

Abstract: Malnutrition is a widespread problem in hospitalized patients, which significantly impacts clinical outcomes, quality of life, and healthcare costs. Despite its well-documented consequences, it remains underdiagnosed and inadequately managed in many healthcare settings. Even with recent progress, key challenges remain, including inconsistent use of standardized nutritional screening tools and practices, insufficient professional training, and resource limitations. A multidisciplinary approach involving physicians, dietitians, nurses, and pharmacists is crucial for early detection, timely intervention, and prevention

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NUTRITIONAL CARE NEEDS IN ELDERLY RESIDENTS OF LONG-TERM CARE INSTITUTIONS: POTENTIAL IMPLICATIONS FOR POLICIES

A. PEZZANA[1], E. CEREDA[2], P. AVAGNINA[3], G. MALFI[4], E. PAIOLA[5], Z. FRIGHI[1], I. CAPIZZI[3], E. SGNAOLIN[4], M.L. AMERIO[5]

1. Struttura Operativa Semplice Dipartimentale di Dietetica e Nutrizione Clinica – Ospedale San Giovanni Bosco, Torino, Italy; 2. Servizio di Dietetica e Nutrizione Clinica, Fondazione IRCCS Policlinico San Matteo, Pavia, Italy; 3. Struttura Semplice Dipartimentale di Dietetica e Nutrizione Clinica, Azienda Ospedaliero-Universitaria "San Luigi Gonzaga", Orbassano, Italy; 4. Struttura Complessa di Dietetica e Nutrizione Clinica dell'Ospedale Santa Croce di Cuneo, Cuneo, Italy; 5. Struttura Operativa Complessa di Dietetica e Nutrizione Clinica – Ospedale Cardinal Massaia, Asti, Italy. Corresponding author: Emanuele Cereda M.D., Ph.D. Fondazione IRCCS Policlinico San Matteo, Viale Golgi 19, 27100 Pavia, Italy. Tel.: +39 0382 501615 ; Fax: + 39 0382 502801, E-mail: e.cereda@smatteo.pv.it

Abstract: *Objectives:* To collect information on actual nutritional intervention requirements in long-term care institutions and on the role of institutional factors in nutritional care. *Design:* A cross-sectional analysis of baseline data (collected between September 2011 and September 2013) within the context of a multicenter prospective cohort study. *Setting:* Nineteen long-term care institutions. *Participants:* Thirteen hundred and ninety-four resident elderly (age ≥60 years). *Measurements:* The prevalence of nutritional derangements (MNA-Short Form) and the need to introduce nutritional interventions on the residents. *Results:* Prevalence of malnutrition and risk of malnutrition were 35.2% [95%CI, 32.8-37.8] and 52.6% [95%CI, 50.0-55.2], respectively. Malnutrition was more frequent upon admission and in larger institutions (≥50 beds). Overall, 50% of the residents requiring an individualized nutritional care plan (any type) were not receiving it. Oral diet, the use of fluid thickeners and oral nutritional supplements had to be introduced in 306 (22.5%), 201 (15%) and 175 (13%) residents, respectively. The need to implement the oral diet was mainly due to inadequacy of texture according to chewing and swallowing capabilities. In gender and age-adjusted multivariable logistic regression models, nutritional interventions were associated with worse nutritional status (P<0.001 for all). Moreover, while the duration of stay was unrelated to the need for nutritional interventions, we observed that residents living in larger long-term care institutions (≥50 beds) were more likely to require improvement in nutrition care. *Conclusions:* In long-term care elderly residents nutritional derangements are very common, underdiagnosed and undertreated. Nutritional screening should be part of routine care. However, also the systematic involvement of a nutritional care specialist appears to be an urgent need, particularly in larger institutions where the standards of care are likely to be lower.

Key words: Long-term care, elderly, malnutrition, risk of malnutrition; treatment.

Introduction

It is known that malnutrition is underreported and undertreated in long-term care institutions. Poor nutritional status may have negative effects on prognosis (1, 2). Although estimates are inconsistent, pooled data analyses from available studies report that the prevalence of malnutrition and risk of malnutrition in institutionalised elderly is about 25% and 50%, respectively (3, 4). Aging appears to be intrinsecally associated with nutritional derangements due to multiple comorbidities, a reduction in food intake, changes in hormonal profile (e.g. insulin resistance) and susceptibility to acute diseases (2, 3, 5-9). However, also extrinsic factors should be considered. Among modifiable factors, a key role could be played by nutritional care practices (5-10) as they have proved to improve outcome (11).

In this perspective, several guidelines and recommendations for nutritional screening are now available, with positive screening being an indication for pertinent interventions (5-10). However, although a large body of data on the prevalence of nutritional derangements has been collected by systematic screening procedures (2-4), there is little information on actual nutritional intervention requirements and on the role of institutional factors in nutritional care.

We designed the present study to ascertain the prevalence of nutritional derangements and provide a picture of the type and frequency of new nutritional interventions required in a representative population of institutionalised elderly. In this perspective, the role of structural institutional factors was also investigated.

Methods

Study Design

The present study is part of a wider project taking place in the Italian Piedmont region, which is the one with the highest offer of residential care for people aged ≥65 years (4 beds every 100 inhabitants) (12). In the past nutritional care in this setting was left to the initiative of local healthcare professionals and the presence of an expert in nutrition among local staff never was a priority. In 2007, an expert panel started designing a regional policy for the prevention and treatment of malnutrition in elderly long-term care institutions residents (13). This guideline became operational in late 2010. The approved "global nutritional approach" to all elderly residents includes: 1) the implementation of nutritional screening procedures

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Assessorato alla Tutela della Salute e Sanità,
Programmazione Socio-Sanitaria
di concerto con l'Assessore al Welfare
per quanto attiene all'edilizia sanitaria.
di concerto con l'Assessore al Patrimonio
Ufficio di Comunicazione

Slow Food Italia

RACCOMANDAZIONI
ELABORATE A PARTIRE DAI RISULTATI DEL PROGETTO
"La ristorazione collettiva negli ospedali e nelle strutture assistenziali per anziani: sviluppo di buone pratiche"

10 GENNAIO 2011

Assessorato alla Tutela della salute e Sanità, Politiche sociali e Politiche per la famiglia
Direzione Sanità

Settore Promozione della Salute e Interventi di Prevenzione Individuale e Collettiva

RETE REGIONALE DELLE STRUTTURE DI DIETETICA E NUTRIZIONE CLINICA

PRESENTAZIONE E REPORT ATTIVITÀ DEL 2008

EXPO MILANO 2015
NUTRIRE IL PIANETA
ENERGIA PER LA VITA

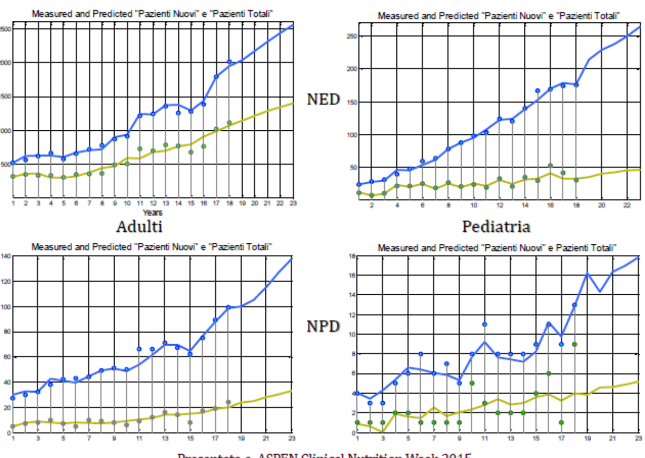
Slow Food

Qualita' quotidiana della ristorazione ospedaliera: monitoraggio degli scarti in 13 ospedali piemontesi

La Rete piemontese di Nutrizione Clinica ha promosso nel 2014 e 2015 un impegnativo percorso per conoscere l'entità e le cause degli scarti derivanti dalla ristorazione collettiva ospedaliera, attivando una task force di medici e dietisti, che per un periodo cumulativo di 48 settimane hanno effettuato 39545 rilevazioni monitorando gli scarti relativi a 8827 pasti in 13 ospedali della Regione. Se ne parla a:

Expo Milano 2015, Rho
Mercoledì 7 ottobre 2015 ore 16,30 al Teatro Slow Food

Pz Nuovi e Pz Totali NED ed NPD attesi negli anni 2013-2017



Presentato a ASPEN Clinical Nutrition Week 2015

Agenda

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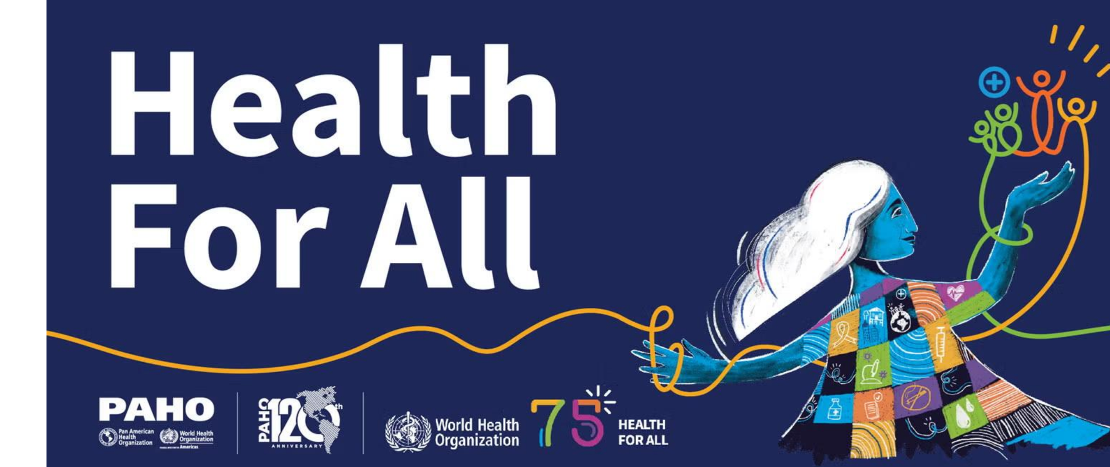
verso gli operatori
verso le organizzazioni/enti



Open Access Review Article

Connecting for Success: The Role of Networking in Medical Education

Review began 09/09/2024
Review ended 11/27/2024
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Pinaki Wani [1]

1. Physiology, All India Institute of Medical Sciences, Raebareli, Raebareli, IND

Corresponding author: Pinaki Wani, pinakicureus@gmail.com

Abstract

Networking is a critical component of professional development in medical education, involving the establishment and maintenance of relationships that facilitate the exchange of information, resources, and opportunities. Defined as the process of creating and nurturing connections with peers, mentors, and collaborators, networking is essential for advancing research, enhancing career development, and improving clinical practice. This review explores the multifaceted role of networking in academia, emphasizing its importance for medical professionals who rely on collaborative efforts to drive innovation and improve patient care. Key benefits of strategic networking include access to interdisciplinary research opportunities, enhanced knowledge sharing, career advancement, and resource acquisition. However, networking in medical education is not without challenges. Time commitment and burnout, superficial relationships, exclusivity, ethical concerns, and professional jealousy are potential drawbacks that can hinder the effectiveness of networking efforts. Solutions to these challenges include balancing networking with other responsibilities, focusing on quality over quantity, ensuring inclusivity, and maintaining ethical standards in professional relationships. The review also provides practical tips for effective networking, such as engaging in formal and informal networking activities, leveraging technology, and building a professional online presence. By strategically participating in networking activities and overcoming common challenges, medical professionals can significantly enhance their academic growth, career opportunities, and contributions to the field. The overarching message is that investing in and nurturing professional networks is crucial for sustained success and advancement in medical education and research.

Categories: Medical Education
Keywords: career advancement, collaboration, medical education, networking, professional development, research opportunities

Personalised Nutrition, Sustainable Dietary Practices, Shared Food Protocols: The Future of Malnutrition Research

Cena H, 2024

MED/49 Food sciences and clinical nutrition
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MED

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SPS

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BIO/19 General microbiology

ING-INF/06 Electronic and informatics bioengineering

SPS/10 Urban and environmental sociology

Good news

I nuovi emendamenti sulla nutrizione clinica

Gli emendamenti alla Legge di Bilancio 2026 introducono misure concrete per rafforzare la gestione nutrizionale dei pazienti oncologici. Tra le novità, è previsto il sostegno alla costituzione e al funzionamento delle reti regionali di nutrizione clinica, con un fondo sperimentale di 5 milioni di euro. Viene inoltre prevista la possibilità di detrazione fiscale del 19% per gli alimenti a fini medici speciali (AFMS), l'introduzione di programmi strutturati di screening nutrizionale e misure volte a rendere più coerente e razionale il trattamento IVA sugli AFMS, adeguandolo al 10% per tutti i prodotti.

Parole chiave e THM's

Le reti in sanità: un po' di storia, quale ruolo e quale eredità

Tempi moderni

Reti in Nutrizione Clinica: facile per tematica, difficile per contenuti e formazione

Quali ruoli: verso i cittadini/pazienti
verso gli operatori
verso le organizzazioni/enti

Alcune suggestioni di parole chiave e THM's

Le reti in sanità: un po' di storia, quale ruolo e quale eredità
Medicina di iniziativa, coinvolgimento dei cittadini, innovazione creativa e pragmatica

Tempi moderni
Monitoraggio e manutenzione, esiti, studi clinici, perseveranza

Reti in Nutrizione Clinica: facile per tematica, difficile per formazione
Credibilità, competenza, integrazione, relazioni, analisi dei bisogni

Quali ruoli: verso i cittadini/pazienti flessibilità, equa accoglienza
verso gli operatori formazione, confronto, motivazione
verso le organizzazioni/enti professionalità non vicariabile

Grazie per l’attenzione