SER
SISTEMA EPIDEMIOLOGICO
REGIONE DEL VENETO

XXXIX Congresso AIE

Alimentazione e salute nell’era della globalizzazione

REGIONE DEL VENETO

Impatto dell’intensità e della tempestività di attivazione delle Cure Domiciliari Palliative Oncologiche (CDPO) sul luogo del decesso

Eliana Ferroni
Servizio Epidemiologico Regionale, Veneto
Milano, 30 Ottobre 2015

SISTEMA EPIDEMIOLOGICO REGIONE DEL VENETO

Percentuale di deceduti in ospedale per tipo di tumore. Veneto 2007-2013

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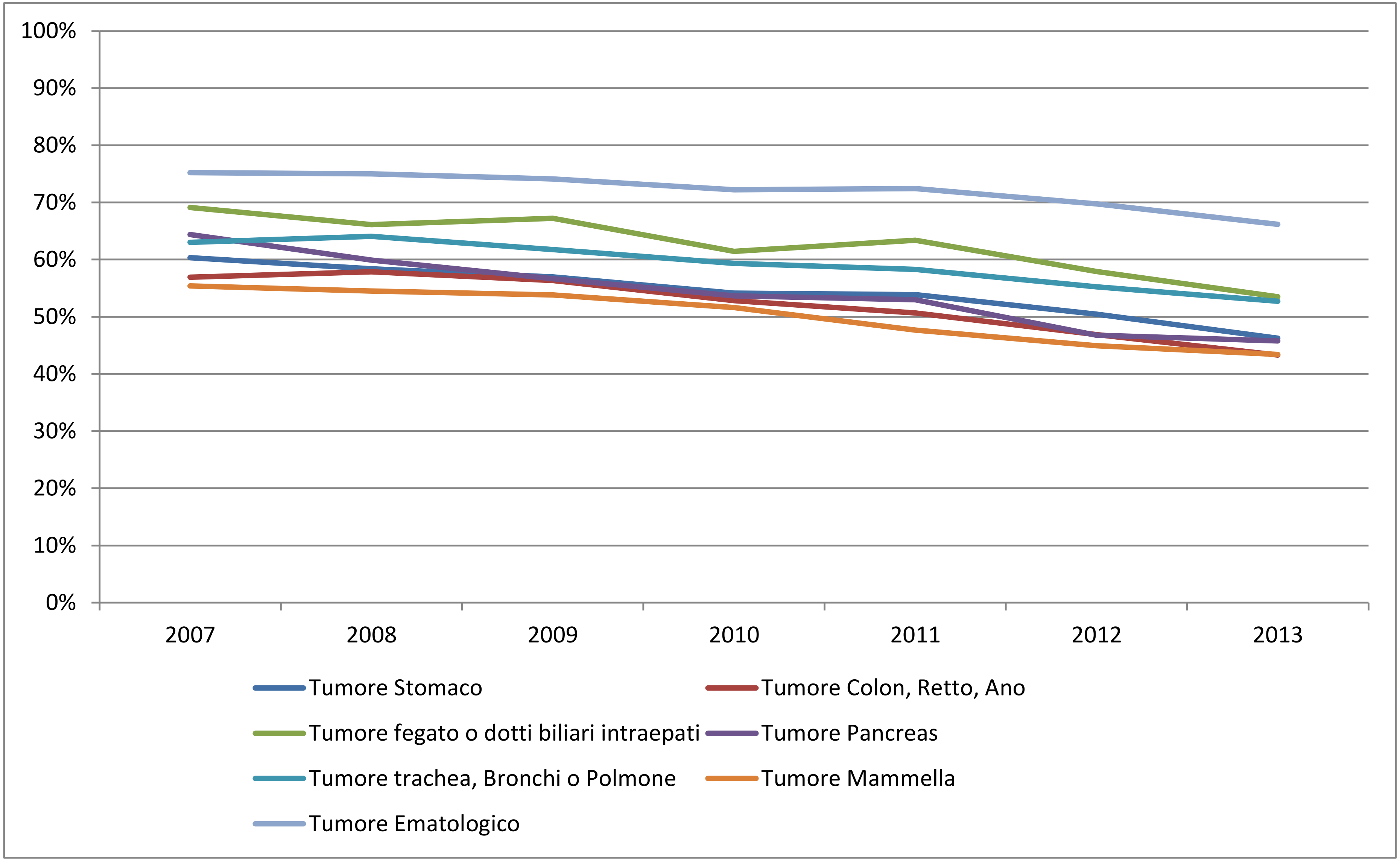
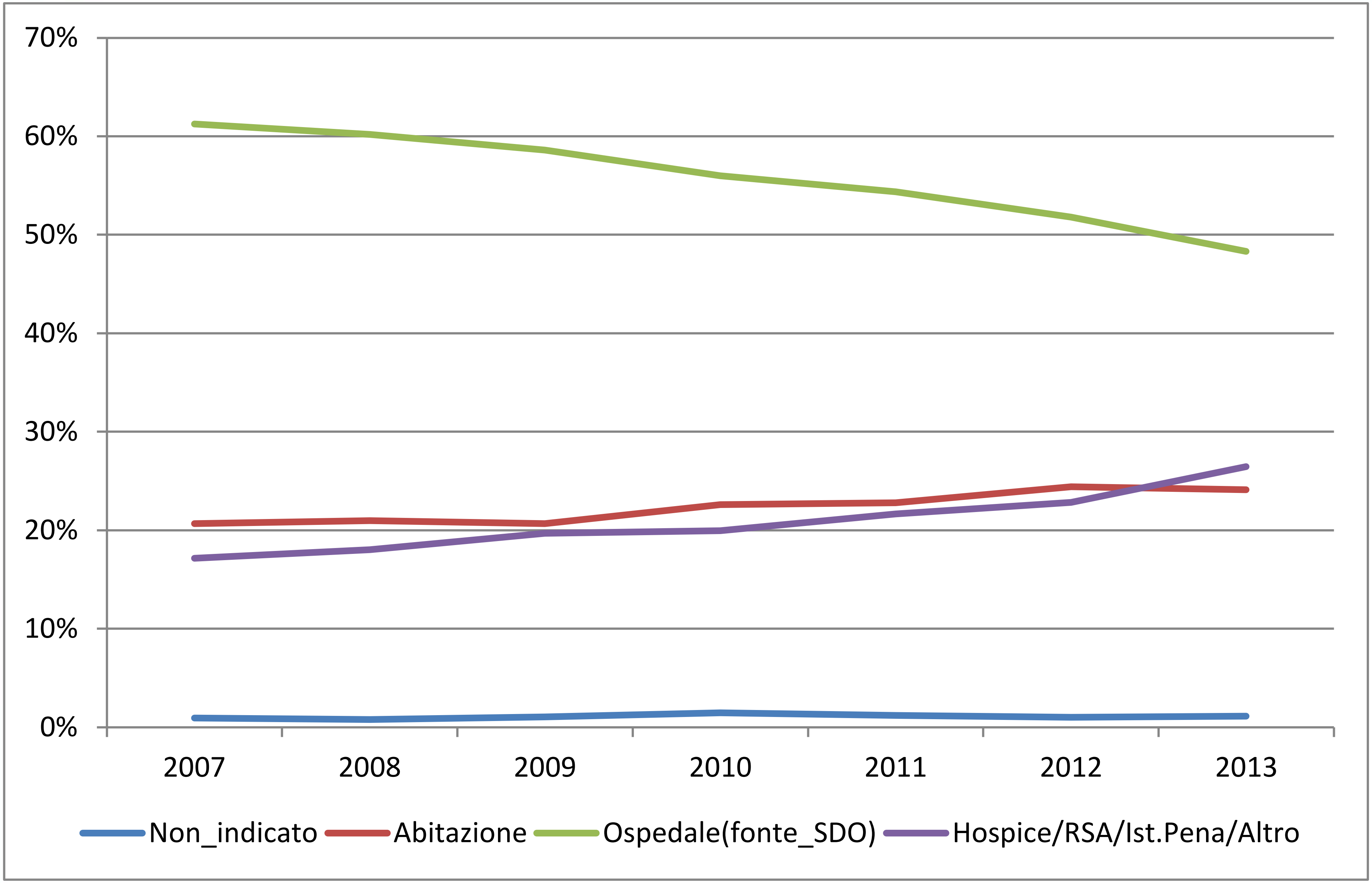
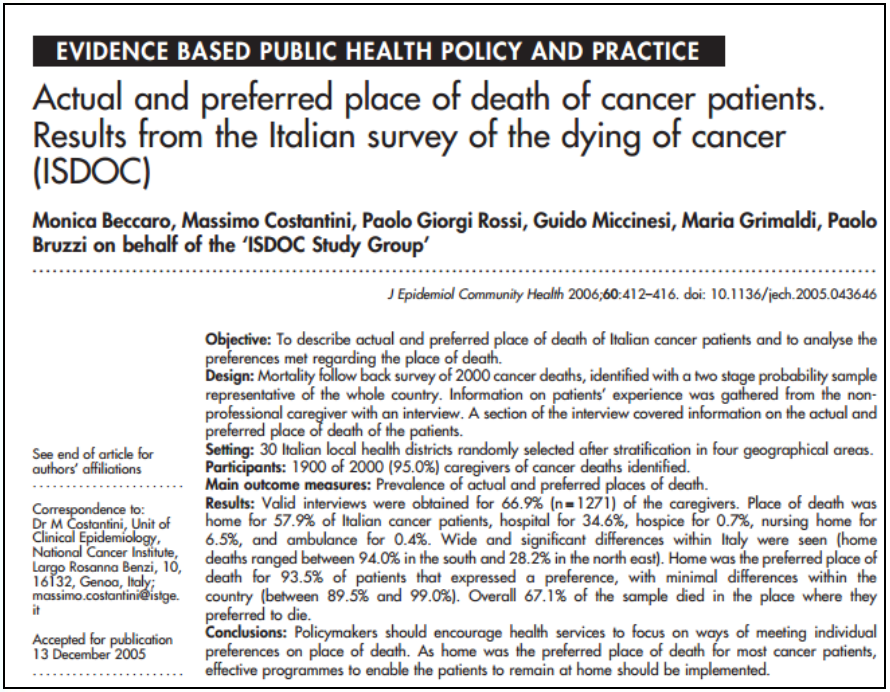


Percentuale di deceduti per tumore per luogo di decesso. Veneto 2007-2013



«Valore» del luogo di decesso



EVIDENCE BASED PUBLIC HEALTH POLICY AND PRACTICE

Actual and preferred place of death of cancer patients. Results from the Italian survey of the dying of cancer (ISDOC)

Monica Beccaro, Massimo Costantini, Paolo Giorgi Rossi, Guido Miccinesi, Maria Grimaldi, Paolo Bruzzi on behalf of the 'ISDOC Study Group'

J Epidemiol Community Health 2006;**60**:412–416. doi: 10.1136/jech.2005.043646

Objective: To describe actual and preferred place of death of Italian cancer patients and to analyse the preferences met regarding the place of death.
Design: Mortality follow back survey of 2000 cancer deaths, identified with a two stage probability sample representative of the whole country. Information on patients' experience was gathered from the non-professional caregiver with an interview. A section of the interview covered information on the actual and preferred place of death of the patients.
Setting: 30 Italian local health districts randomly selected after stratification in four geographical areas.
Participants: 1900 of 2000 (95.0%) caregivers of cancer deaths identified.
Main outcome measures: Prevalence of actual and preferred places of death.
Results: Valid interviews were obtained for 66.9% (n = 1271) of the caregivers. Place of death was home for 57.9% of Italian cancer patients, hospital for 34.6%, hospice for 0.7%, nursing home for 6.5%, and ambulance for 0.4%. Wide and significant differences within Italy were seen (home deaths ranged between 94.0% in the south and 28.2% in the north east). Home was the preferred place of death for 93.5% of patients that expressed a preference, with minimal differences within the country (between 89.5% and 99.0%). Overall 67.1% of the sample died in the place where they preferred to die.
Conclusions: Policymakers should encourage health services to focus on ways of meeting individual preferences on place of death. As home was the preferred place of death for most cancer patients, effective programmes to enable the patients to remain at home should be implemented.

See end of article for authors' affiliations

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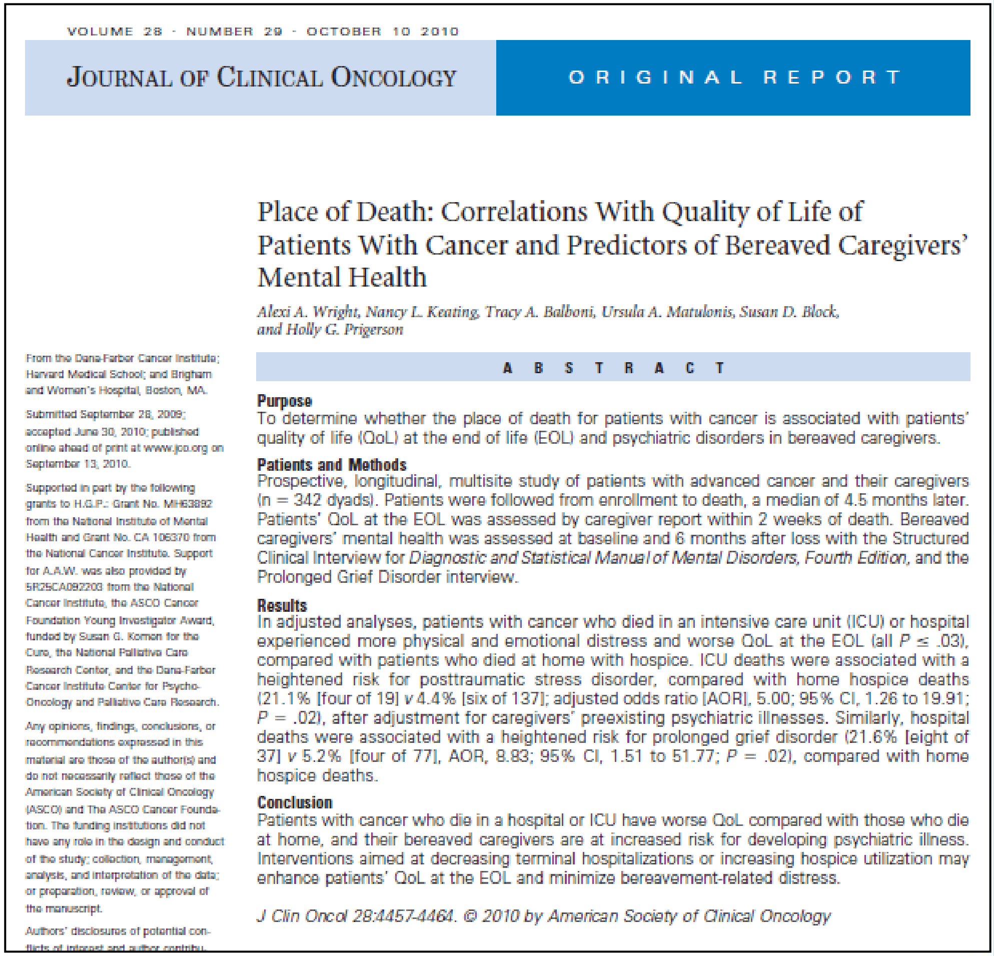

VOLUME 28 · NUMBER 29 · OCTOBER 10 2010

JOURNAL OF CLINICAL ONCOLOGY   ORIGINAL REPORT

Place of Death: Correlations With Quality of Life of Patients With Cancer and Predictors of Bereaved Caregivers' Mental Health

Alexi A. Wright, Nancy L. Keating, Tracy A. Balboni, Ursula A. Matulonis, Susan D. Block, and Holly G. Prigerson

ABSTRACT

Purpose
To determine whether the place of death for patients with cancer is associated with patients' quality of life (QoL) at the end of life (EOL) and psychiatric disorders in bereaved caregivers.

Patients and Methods
Prospective, longitudinal, multisite study of patients with advanced cancer and their caregivers (n = 342 dyads). Patients were followed from enrollment to death, a median of 4.5 months later. Patients' QoL at the EOL was assessed by caregiver report within 2 weeks of death. Bereaved caregivers' mental health was assessed at baseline and 6 months after loss with the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, and the Prolonged Grief Disorder interview.

Results
In adjusted analyses, patients with cancer who died in an intensive care unit (ICU) or hospital experienced more physical and emotional distress and worse QoL at the EOL (all $P \leq .03$), compared with patients who died at home with hospice. ICU deaths were associated with a heightened risk for posttraumatic stress disorder, compared with home hospice deaths (21.1% [four of 19] *v* 4.4% [six of 137]; adjusted odds ratio [AOR], 5.00; 95% CI, 1.26 to 19.91; $P = .02$), after adjustment for caregivers' preexisting psychiatric illnesses. Similarly, hospital deaths were associated with a heightened risk for prolonged grief disorder (21.6% [eight of 37] *v* 5.2% [four of 77], AOR, 8.83; 95% CI, 1.51 to 51.77; $P = .02$), compared with home hospice deaths.

Conclusion
Patients with cancer who die in a hospital or ICU have worse QoL compared with those who die at home, and their bereaved caregivers are at increased risk for developing psychiatric illness. Interventions aimed at decreasing terminal hospitalizations or increasing hospice utilization may enhance patients' QoL at the EOL and minimize bereavement-related distress.

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From the Dana-Farber Cancer Institute; Harvard Medical School; and Brigham and Women's Hospital, Boston, MA.

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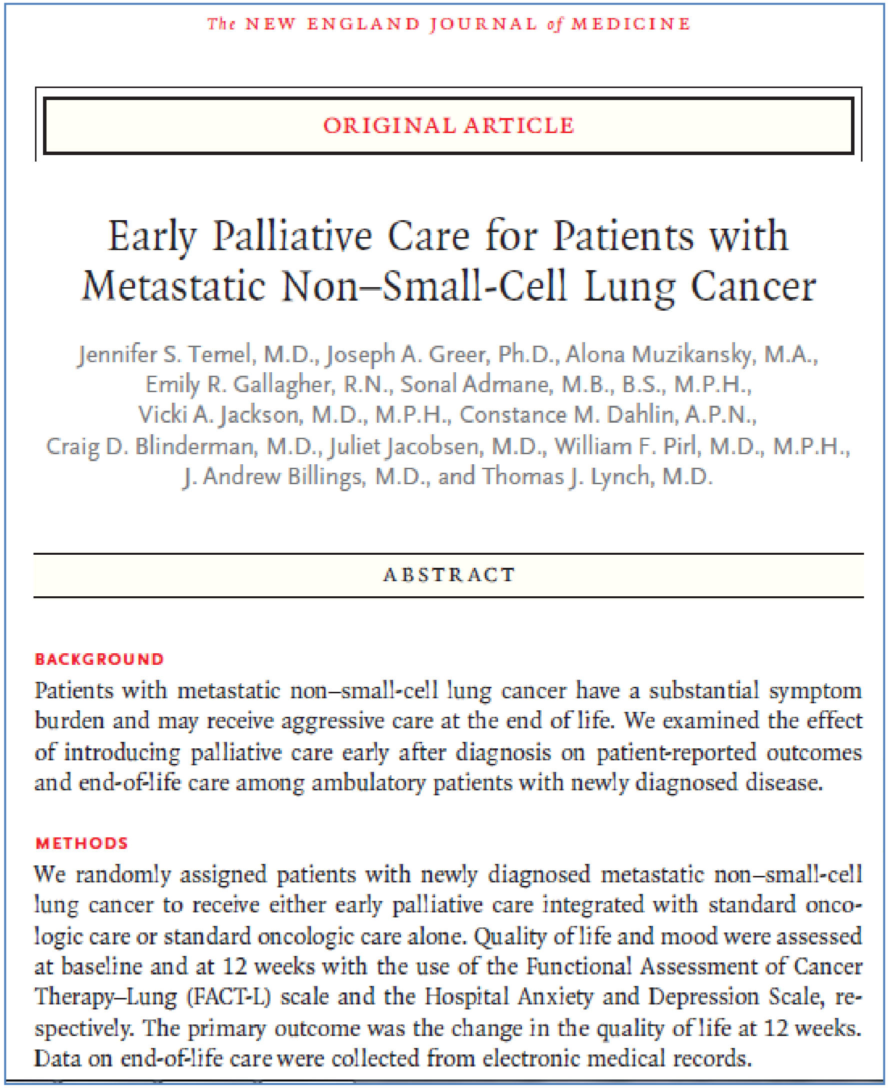
Any opinions, findings, conclusions, or recommendations expressed in this material are those of the author(s) and do not necessarily reflect those of the American Society of Clinical Oncology (ASCO) and The ASCO Cancer Foundation. The funding institutions did not have any role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript.

Authors' disclosures of potential conflicts of interest and author contribu-

Evidenze sperimentali delle Cure Palliative

Effetti sulla qualità della vita



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A.,
Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H.,
Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N.,
Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H.,
J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

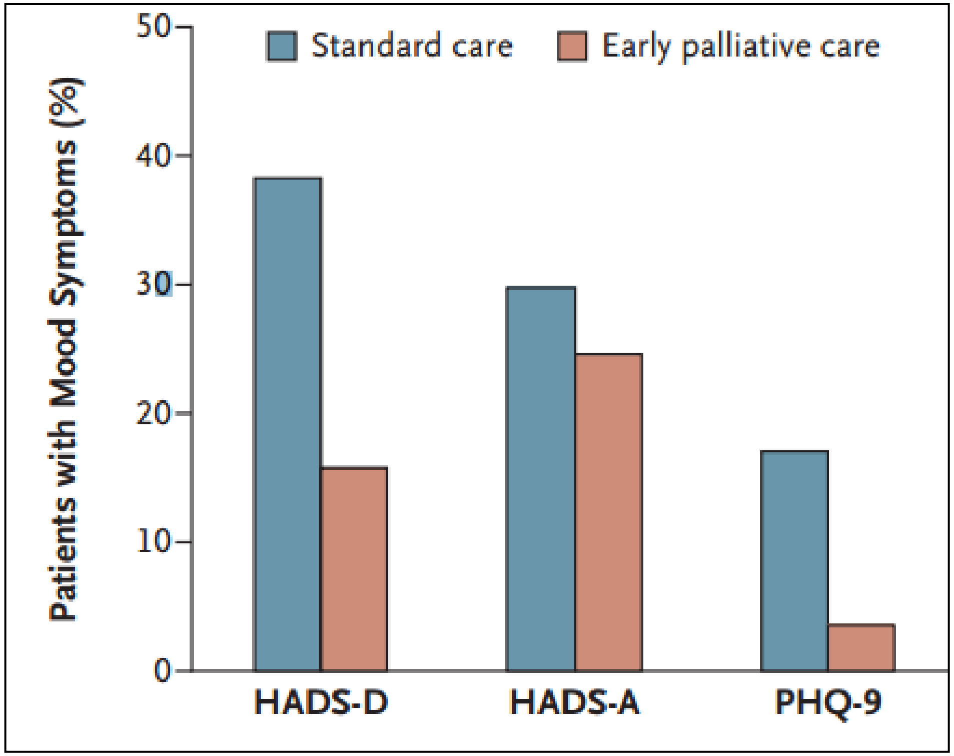
ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

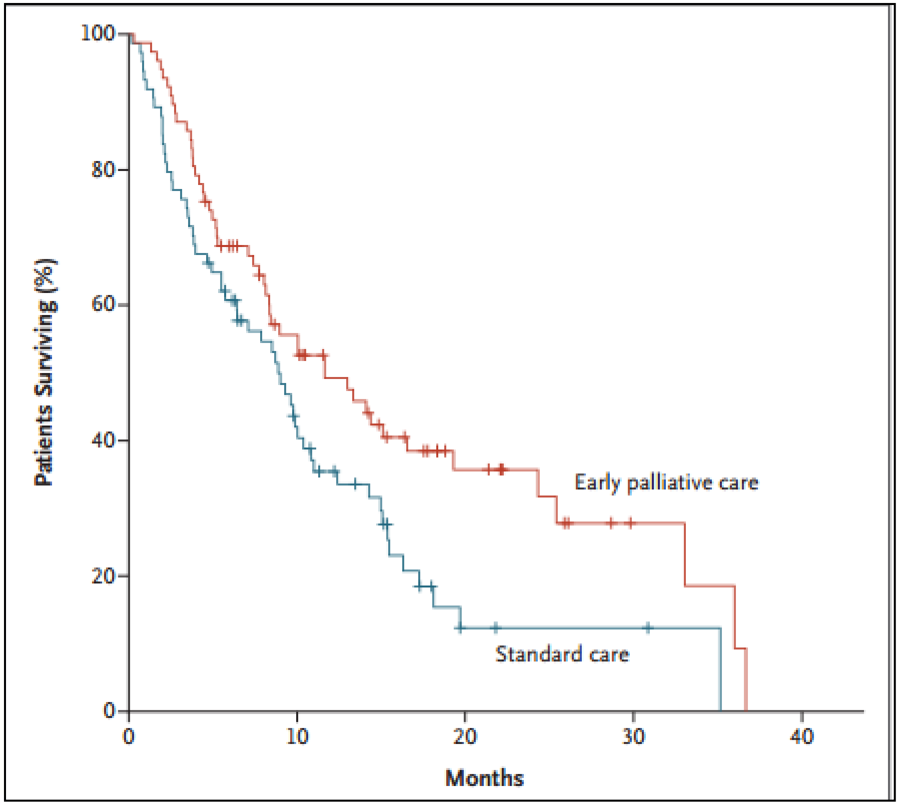
We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.



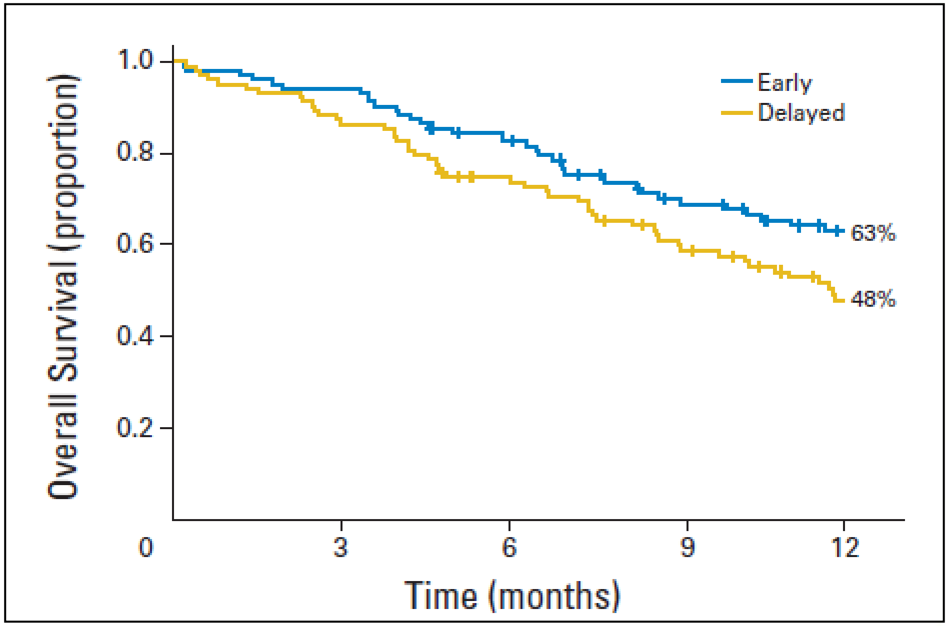
Temel et al. 2010 N Engl J Med;363:733-42.

Evidenze sperimentali delle Cure Palliative

Effetti sulla sopravvivenza



Temel et al. 2010 N Engl J Med;363:733-42.



Bakitas et al. 2015 J Clin Oncol 33:1438-1445.

Impatto delle CP in Veneto
METODI

Popolazione

Adulti residenti in Veneto e deceduti per tumore nel periodo marzo-dicembre 2013

Criteri di esclusione

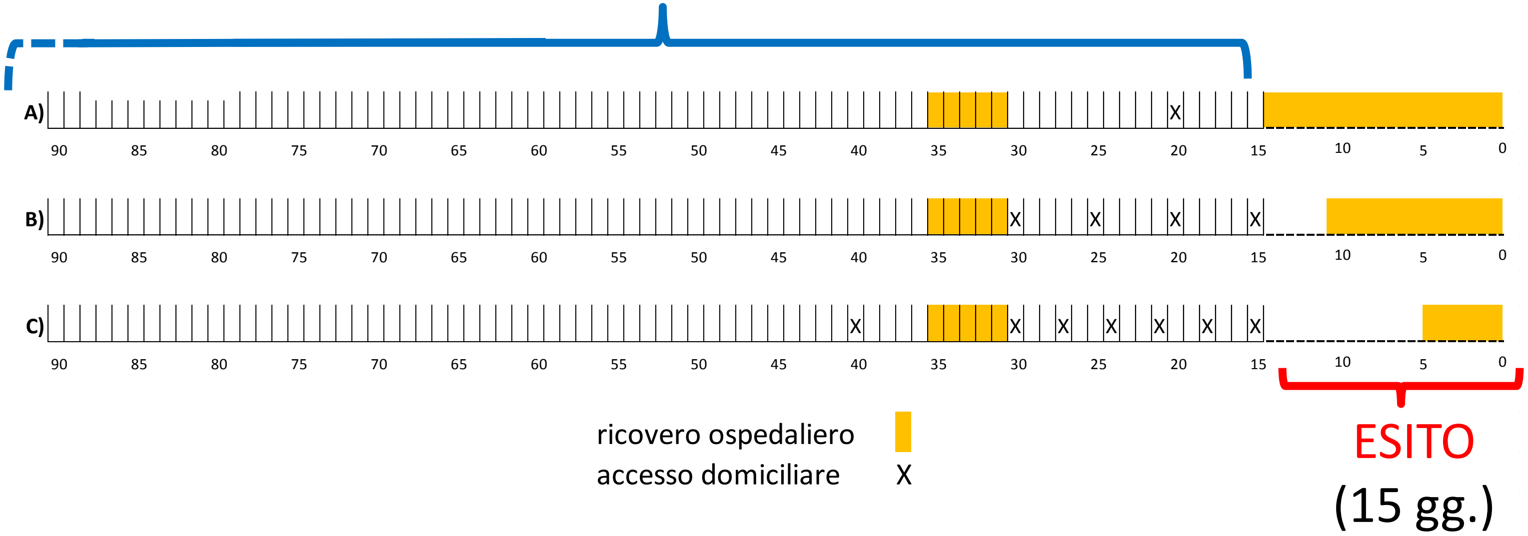
- Tumori ematologici
- > 85 anni
- Pazienti entrati direttamente in hospice
- Pazienti a domicilio <50% del periodo di esposizione
- Pazienti residenti in 6 ULSS (su 21 totali) dove la registrazione delle date di accesso domiciliare risultava meno accurata

Impatto delle CP in Veneto
METODI

Esposizione alle Cure Palliative

Finestra tra 90-16 giorni prima del decesso

- Intensità
- Tempestività



ricovero ospedaliero ▮
accesso domiciliare X

ESITO
(15 gg.)

Esito

Decesso in ospedale, *giorni di ricovero*

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Deceduti per tumore eleggibili per le CP

(15 aziende ULSS della Regione Veneto,
Periodo Marzo –Dicembre 2013)

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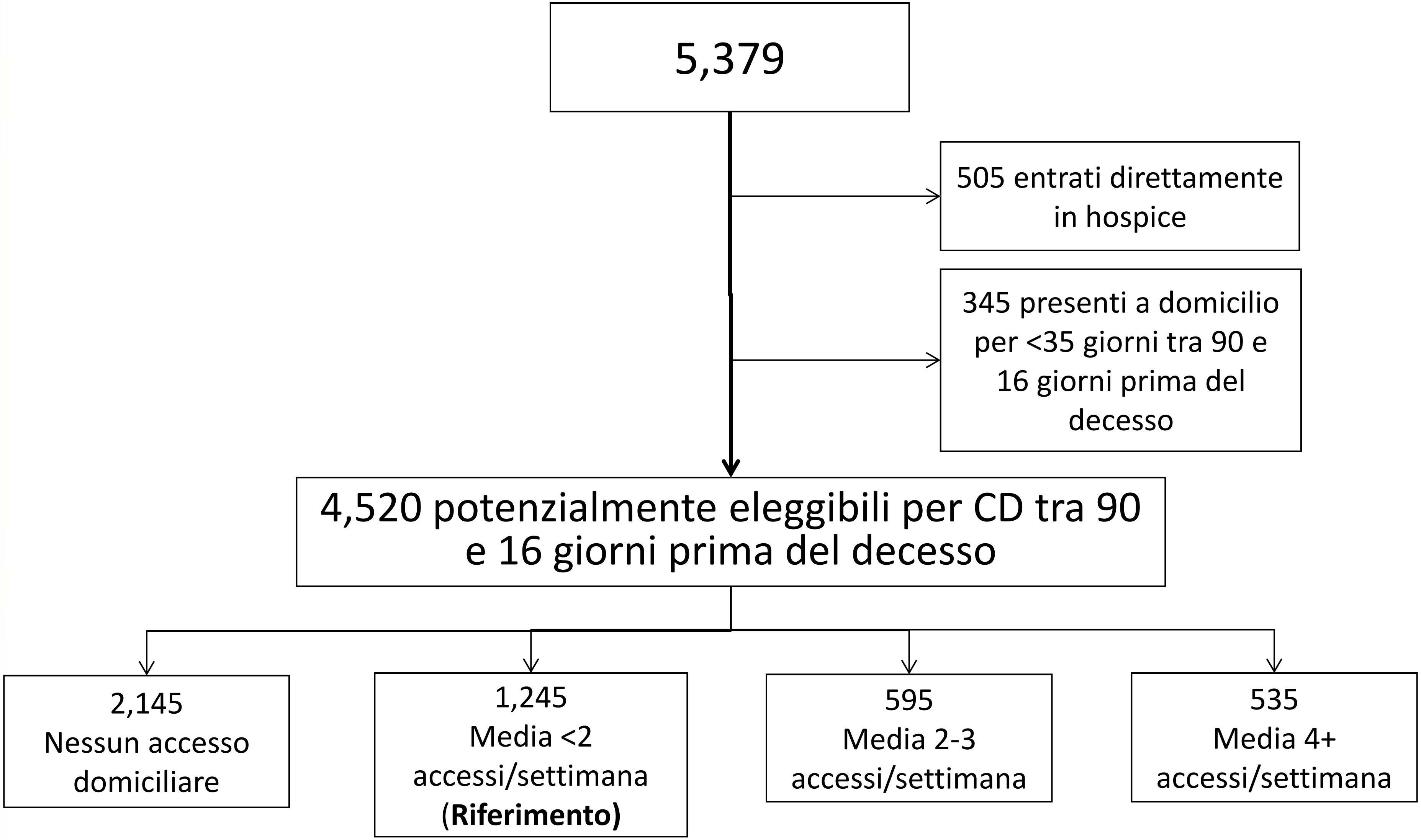

5,379

505 entrati direttamente in hospice

345 presenti a domicilio per <35 giorni tra 90 e 16 giorni prima del decesso

4,520 potenzialmente eleggibili per CD tra 90 e 16 giorni prima del decesso

2,145
Nessun accesso domiciliare

1,245
Media <2 accessi/settimana
(**Riferimento)**

595
Media 2-3 accessi/settimana

535
Media 4+ accessi/settimana

Deceduti per tumore eleggibili per le CP

(15 ULSS Veneto, 2013)

		N	%
Totale		4.520	100,0%
Sesso	Maschi	2.752	60,9%
	Femmine	1.768	39,1%
Classe d'età	18-44	98	2,2%
	45-64	996	22,0%
	65-74	1480	32,7%
	75-84	1946	43,1%
Coniugato	Non coniugato/a	1458	32,3%
	Coniugato/a	3062	67,7%
Residenza in comuni con azienda ospedaliera	No	3.940	87,2%
	Si	580	12,8%
Indice di comorbidità di Charlson a 90gg dal decesso (escluso punteggio tumore)	0	3314	73,3%
	1	691	15,3%
	2	274	6,1%
	3+	241	5,3%
Giorni di ricovero ordinario durante il periodo di esposizione	1 terzile (0 gg)	2.008	44,4%
	2 terzile (1-6 gg)	579	12,8%
	3 terzile (7-35 gg)	1.933	42,8%

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Deceduti per tumore eleggibili per le CP

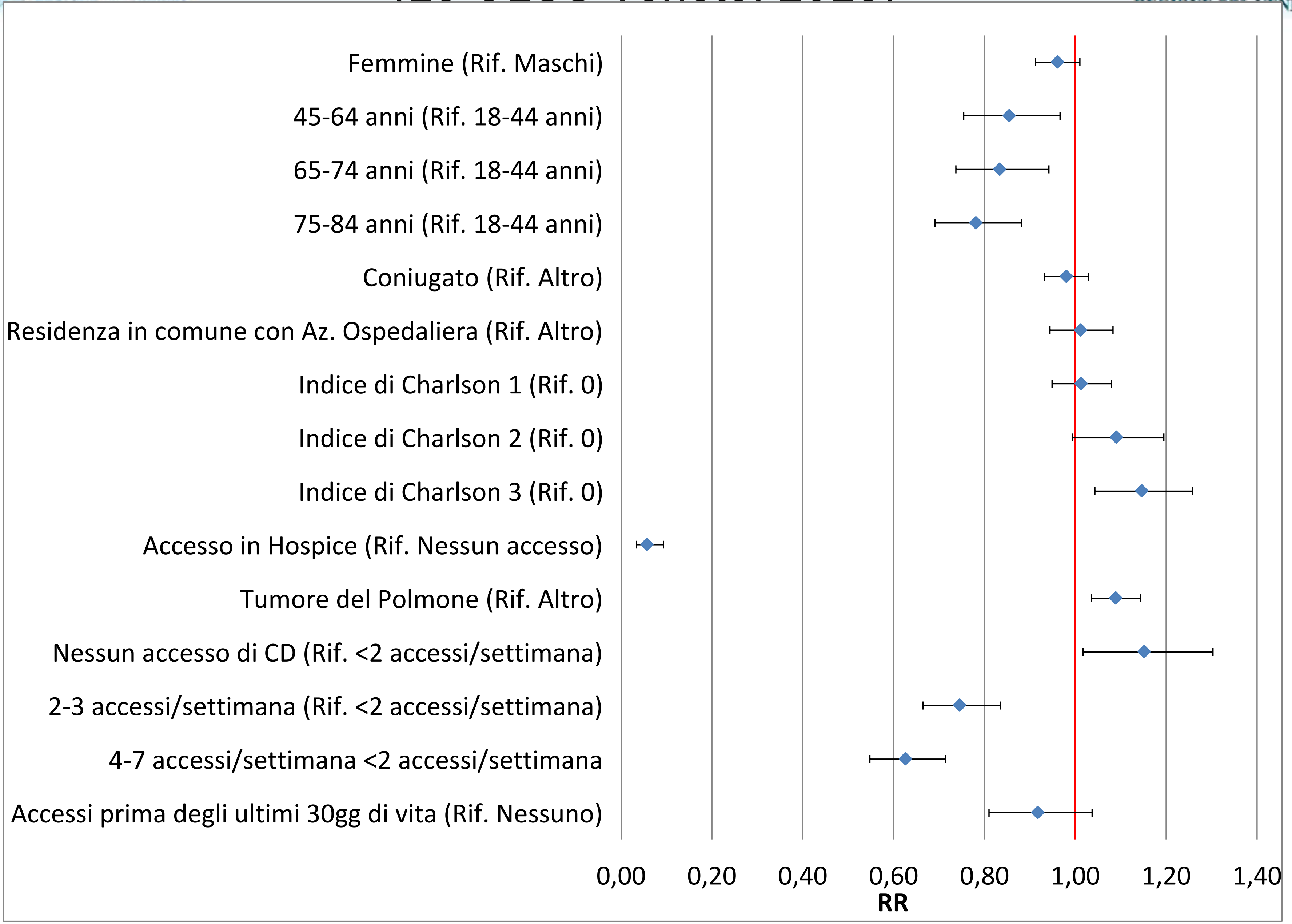
(15 ULSS Veneto, 2013)

REGIONE DEL VENETO

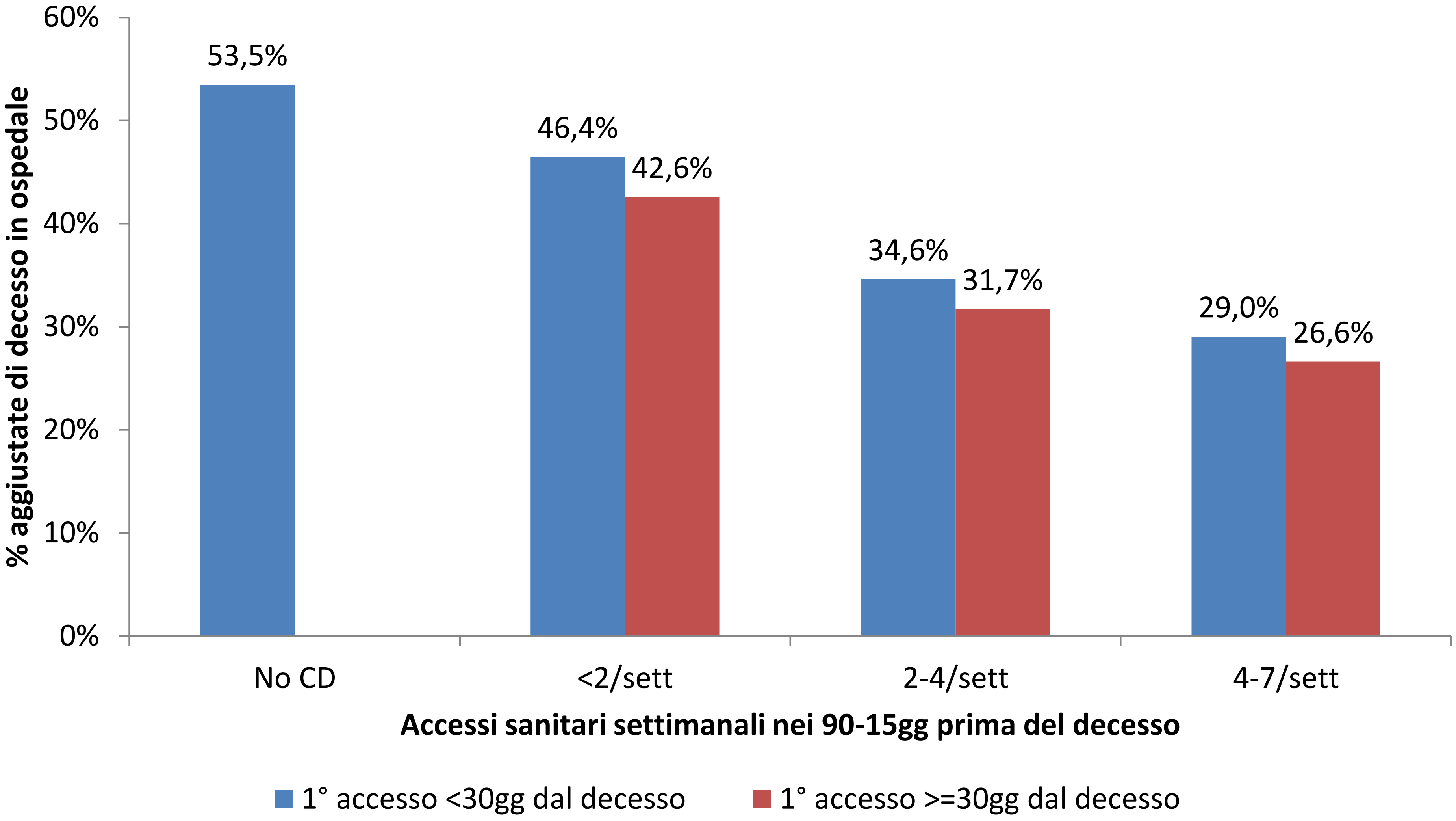
		N	%
Accesso in Hospice	No	4.007	88,7%
	Si	513	11,3%
Sede del tumore primitivo	Altro	3.473	76,8%
	Polmone	1.047	23,2%
Intensità delle CD nei 90-15gg prima del decesso	No CD	2.145	47,5%
	<2 accessi/settimana	1.245	27,5%
	2-3 accessi/settimana	595	13,2%
	4-7 accessi/settimana	535	11,8%
Tempestività della presa in carico in CD in giorni dalla morte	No CD	2.145	47,5%
	16-30 giorni dal decesso	368	8,1%
	31-89 giorni dal decesso	825	18,3%
	90+ giorni prima del decesso	1.182	26,2%

CD oncologiche e decesso in ospedale

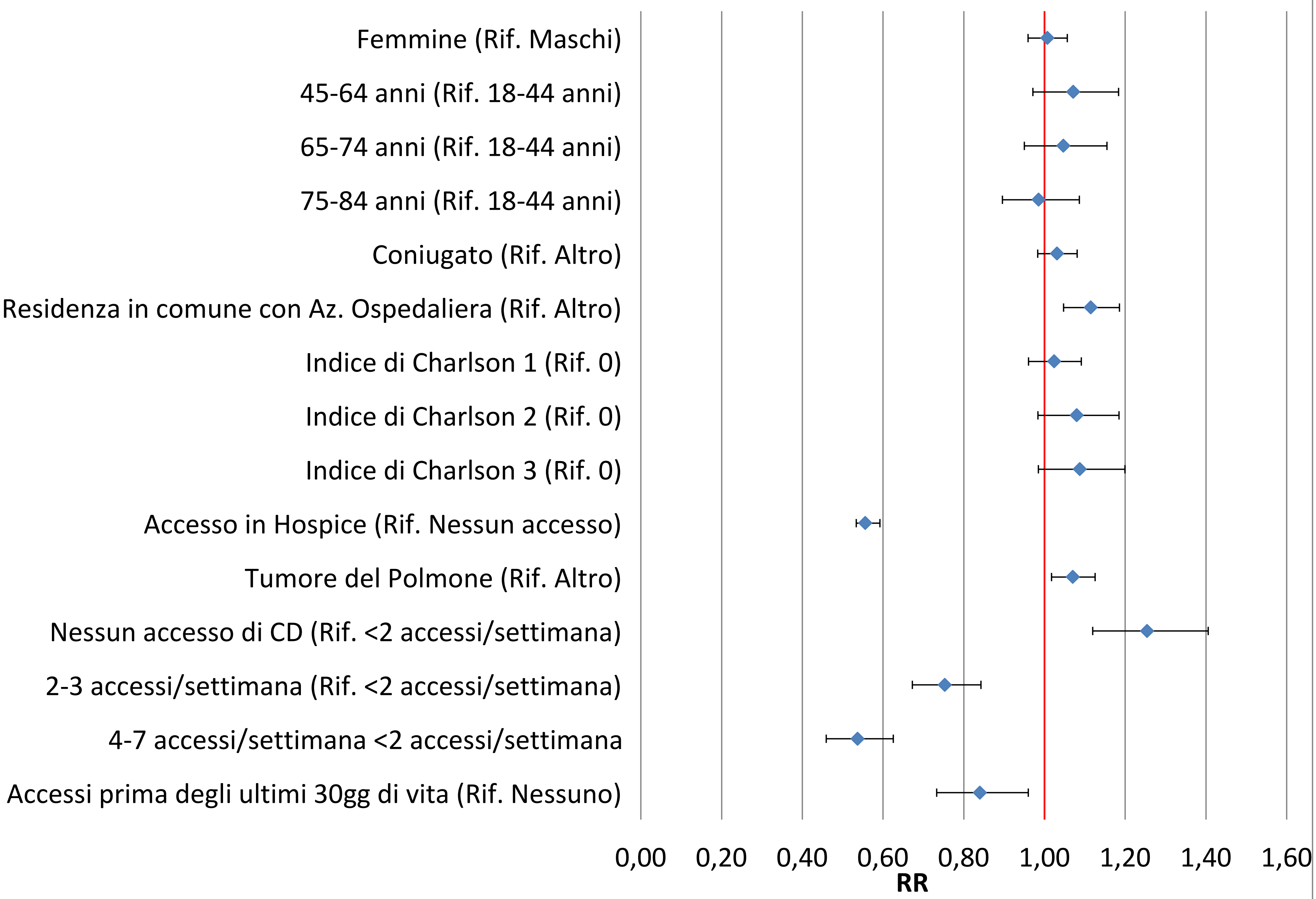
(15 ULSS Veneto, 2013)



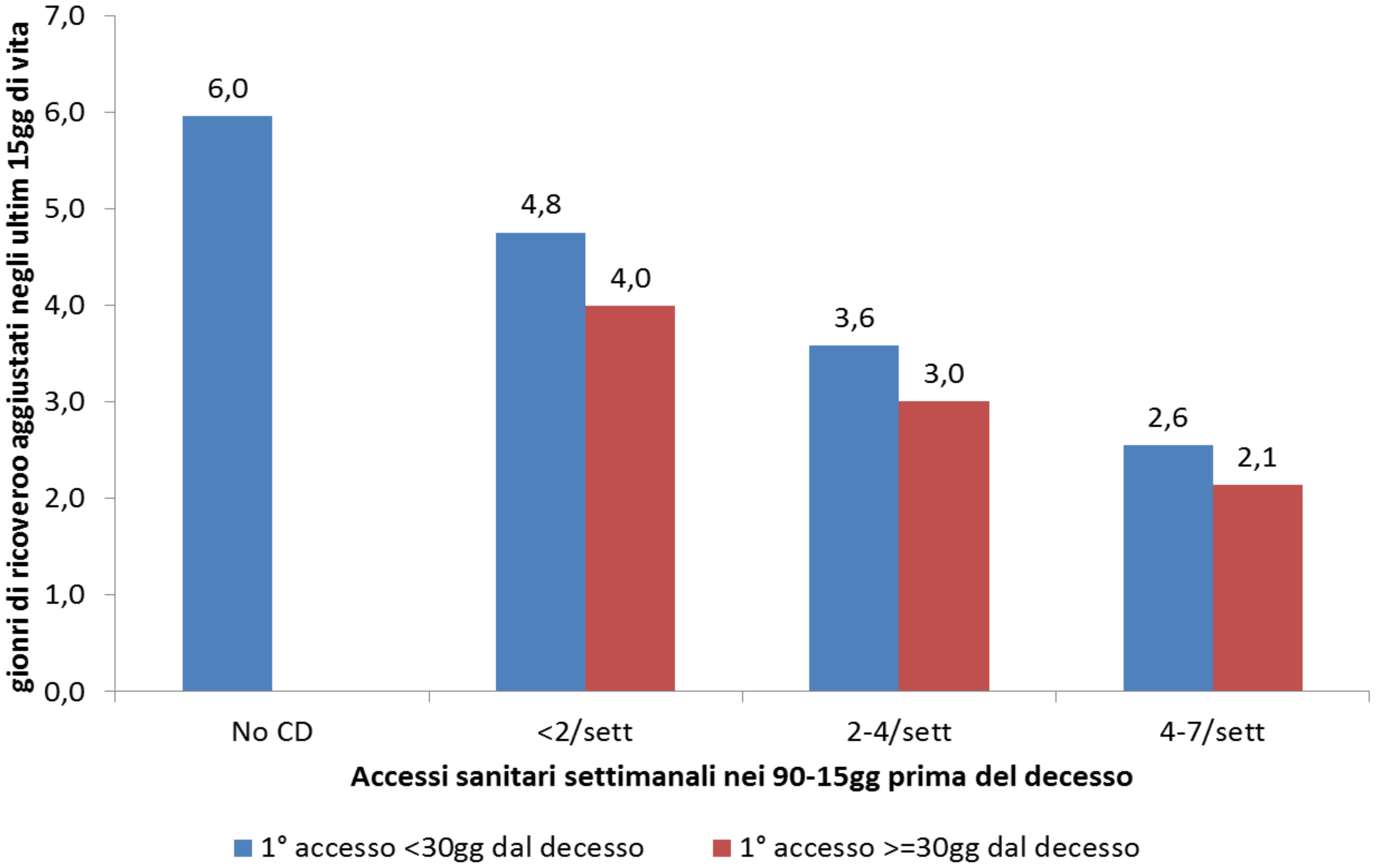
CD oncologiche e % decessi in ospedale
(15 ULSS Veneto, 2013)



CD oncologiche e numero giorni di ricovero (15 ULSS Veneto, 2013)



CD oncologiche e numero giorni di ricovero (15 ULSS Veneto, 2013)



Limiti/prospettive

Disegno dello studio

- Retrospettivo

Selezione dei pazienti e delle famiglie

- Performance fisica
- Presenza di dolore e dei sintomi stressanti
- Supporto assistenziale e disponibilità economica
- Consapevolezza di malattia e preferenze di cura del paziente e della famiglia

Altri outcome rilevanti

- Terapie attive nel fine vita
  - Chirurgia
  - chemioterapie orali e infusionali
  - terapia intensiva

Conclusioni

- L’intensità delle CD si associa in maniera rilevante e con una relazione dose-risposta sia al luogo di decesso sia al numero di giorni di ricovero

- La tempestività delle CD si associa in maniera significativa ad una riduzione del numero di giorni di ricovero

BMJ 2015;351:h4855 doi: 10.1136/bmj.h4855 (Published 7 October 2015)

ANALYSIS

Is home always the best and preferred place of death?

The current orthodoxy is that home is the best and preferred place of death for most people. **Kristian Pollock** questions these assumptions and calls for greater attention to improving the experience of dying in hospital and elsewhere

Kristian Pollock *principal research fellow*

Nottingham University, School of Health Sciences, Queen's Medical Centre, Nottingham NG7 2HA, UK

Place of death has become a key indicator of the quality of end of life care,[1,2] underpinned by the conviction that most people would prefer to die at home.[3,4] The institutional environment of acute hospital wards is considered an inappropriate and undesirable place in which to die,[5,6] and there are concerns about poor quality of care.[7-9] The need to reduce costs is a further incentive for reducing deaths in hospital.[6,10,11] However, the evidence on patients' preferences is unclear and conflicting. Regardless of preference, hospital will remain the most common place of death for the foreseeable future.[6,12] Far from neglecting and disregarding the hospital as a site of terminal care, much greater thought and adequate resources must be directed to enabling hospitals to provide excellent support for dying patients and their families.

Is place of death a public priority?

often hope for a quick and unexpected—and certainly a pain free—death.[13,20-22]

What matters most to patients?

Patient surveys also find that home is the most commonly expressed option,[23] although often respondents do not record a preference.[8,15] It is widely stated that many more people die in hospital than wish to do so. However, a recent systematic review concludes that the evidence for this assertion is not as strong as previously thought, particularly if changes in preference throughout an illness are recorded.[3] Preferences for place of care are rarely clearly differentiated from place of death.[15] When they are, preference for care at home is greater than for death at home.[6,10,13,24]

Ringraziamenti

- Mario Saugo
- Michele Pellizzari

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- Veronica Casotto

CONFLITTO DI INTERESSE

“What conflict of interest?!
I work here in my spare time.”