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Les coûts de la phase palliative chez les patients atteints de cancer

TIMC
Techniques de l'Ingénierie Médicale et de la Complexité
Informatique, Mathématiques et Applications, Grenoble

CHU GRENOBLE ALPES

Contexte

PLOS | ONE

RESEARCH ARTICLE

Financial distress in patients with advanced cancer

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Abstract

Purpose

We examined the frequency and severity of financial distress (FD) and its association with quality of life (QOL) and symptoms among patients with advanced cancer in France.

Design

In this cross-sectional study, 143 patients with advanced cancer were enrolled. QOL was assessed using the Functional Assessment of Cancer General (FACT-G) and symptoms assessed using Edmonton Assessment System (ESAS) and Hospital Anxiety and Depression Scale (HADS). FD was assessed using a self-rated numeric scale from 0 to 10.

Results

Seventy-three (51%) patients reported having FD. Patients reported having FD were most likely to be younger (53.8 (16,7SD) versus 62 (10.5SD), p<0.001), single (33 (62%) versus 40

- 51% (73) déclaraient une détresse financière
- 17% (25) déclaraient que les coûts des traitements étaient responsables de leur détresse financière
- 9% (13) déclaraient prendre en compte les coûts des traitements dans leurs choix
- 1,4% (3)déclaraient renoncer aux traitements à cause du prix

The Oncologist®

Symptom Management and Supportive Care

Inequalities in Financial Distress, Symptoms, and Quality of Life Among Patients with Advanced Cancer in France and the U.S.

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Disclosures of potential conflicts of interest may be found at the end of this article.

Key Words. Financial distress • Palliative care • Advanced cancer • Symptom distress • Quality of life

Abstract

Background. Financial distress (FD) is common among patients with advanced cancer. Our purpose was to compare the frequency and intensity of FD and its associations with symptom distress and quality of life (QOL) in these patients in France and the U.S.

Materials and Methods. In this secondary analysis of two cross-sectional studies, we assessed data on 292 patients who received cancer care at a public hospital or a comprehensive cancer center in France (143 patients) or the U.S. (149 patients). Outpatients and hospitalized patients over 18 years of age with advanced lung or breast or colorectal or prostate cancer were

Results. The average patient age was 59 years, and 144 (49%) were female. FD and high intensity were reported more frequently in U.S. patients than in French (respectively 129 [88%] vs. 74 [52%], $p < .001$; 100 [98%] vs. 48 [34%], $p < .001$,). QOL was rated higher by the U.S. patients than by the French (69 [SD, 18] vs. 63 [SD, 18], $p = .003$). French patients had more psychological symptoms such as anxiety (8 [SD, 4] vs. 6 [SD, 5], $p = .008$). Associations were found between FD and U.S. residence, FD and single status (0.907, $p = .023$), and FD and metastasis (1.538, $p = .036$). In contrast, negative associations were found between FD and older age (−0.052

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- Population française avec une plus mauvaise qualité de vie
- Population française avec plus de symptômes psychiques
- Population française avec plus de traitements spécifiques oncologiques

Techniques de l'Ingénierie Médicale et de la Complexité — Informatique, Mathématiques et Applications, Grenoble

CHU GRENOBLE ALPES

PLOS ONE

The association between palliative care team follow-up and aggressiveness of cancer care near the end of life

--Manuscript Draft--

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Article Type:	Research Article
Full Title:	The association between palliative care team follow-up and aggressiveness of cancer care near the end of life
Short Title:	Agressive cancer care and palliative care team follow-up
Corresponding Author:	cecile barbaret, M.D Centre Hospitalier Universitaire de Grenoble LA TRONCHE, FRANCE
Keywords:	cancer; palliative care; end of life care; Quality of Life; cancer treatment protocol; quality indicators
Abstract:	Purpose : Some studies have found an association between aggressive cancer care and a lower quality of end of life. This study aimed to evaluate the association between a palliative care team follow-up and aggressive cancer care, and to find predictors of aggressive cancer care. Design: 561 inpatients with solid tumors or haematological malignancies were enrolled in this observational retrospective study in a teaching hospital in France. Patients followed by a palliative care team at least one month before death were included in the palliative care group. Aggressive cancer care included hospitalizations and/ or a new line of chemotherapy within the last month of life, location of death, the use of chemotherapy in the last two weeks, and hospice admission within the last 3 days of life. Results: 89 (16%) patients were followed by a palliative care team for one month or more before death. 124 (22%) patients received chemotherapy in the last two weeks, 110 (20%) died in an acute care unit. 395 patients (71%)

- 22% (124) avaient reçu un traitement oncologique dans les 15 derniers jours de vie
- 20% (110) étaient décédés dans des unités de soins aigus
- 16% (89) étaient suivis par une équipe de soins palliatifs
- Association entre suivi par une équipe de soins palliatifs et diminution des critères « d'agressivité » des soins (50.6% versus 74.7%, $p<0.0001$

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CHU Grenoble Alpes

Research protocol on early palliative care in patients with acute leukaemia after one relapse

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ABSTRACT

Objectives According to the American Society of Clinical Oncology palliative care referrals are made within the last 3 weeks of patients' lives and most frequently when oncological treatments have ceased especially for patients with haematological malignancies. Recent publications indicate that patients with acute leukaemia are prone to symptoms, an indication for which a close collaboration between the patient's haematologist and a palliative care team might result in improved symptom management. The object of this pilot study is to evaluate the feasibility of a clinical research trial to assess the effect of early palliative care in patients with acute leukaemia after one relapse.

Methods This project is a multicentre, non-blinded, randomised, controlled trial. Patients in group 1 will receive standard haematological care associated with palliative care (intervention group). Patients in group 2 will receive standard haematological care with palliative care only if requested by the haematologist (control

improve patients' quality of life through the relief of psychological and physical symptoms.[1–4] According to the American Society of Clinical Oncology (ASCO), referrals for PC are generally made within the last 3 weeks of a patient's life and more often when oncological treatments have ceased.[5] Despite clear guidelines to the effect that PC should be considered at any stage in the disease,[5–7] these tardy referrals indicate that PC is predominantly associated with end-of-life care and its representations.[8–11] In addition, it is difficult to define a prognosis for patients with cancer, especially for the oncologist who has been following the patient over a long period of time.[12 13] In view of the demonstrated improvements to quality of life (QOL), it would be more appropriate to refer patients for PC on the basis of their symptoms rather than their prognosis. Consequently, as it has also been shown that these patients

- Etude multicentrique en cours
- Même principe que Temel et al en 2010
- Évaluer les symptômes et la qualité de vie des patients suivis systémiquement ou non par une équipe de soins palliatifs

Constat

Résultats récents d'une enquête sur 351 personnes en situation de handicap ou de maladie:

-près de 90% ont des restes à charge

-reste à charge moyen de 1000 euros sur les 12 derniers mois

-plus de la moitié ont des difficultés financières

-70% renoncent à certains soins à cause des frais

-70% ont eu une diminution du revenu (arrêt/diminution TT/invalidité)

- Revue de littérature en cours: peu d'études, coûts directs médicaux principalement, à un moment donné et non sur une phase

- Aucune étude sur l'ensemble des coûts pour la phase palliative en cancérologie

- Pourtant cela permettrait de revoir:

  -Les aides sociales et financières dans leurs distributions et importances

  -Les pratiques : prescriptions/collaborations/ coordination/anticipation/formation

  -Les dépenses hospitalières: au niveau des médicaments, des soins, des prises en charge

L’avenir

Déterminer des indicateurs communs entre qualité des soins et économie de la santé

- Etude prospective multicentrique
- Coûts directs médicaux, non médicaux
- Coûts indirects
- Coûts intangibles
- Evaluation de la qualité de vie et des symptômes
- Evaluation de la coordination des soins et de la formation des soignants

Déterminer des indicateurs communs entre qualité des soins et économie de la santé :

- L'information au patient
- L'anticipation
- La formation des soignants
- La coordination des soins

Aider la recherche en soins palliatifs

- Financements
- Collaborations même dans les CHU

GSF Update on Evaluations and Evidence no 1 Sept 2016

the gold standards framework

1. Evidence that use of GSF improves early identification of patients in different settings.

Thomas K, Armstrong Wilson J A., Tanner T, National GSF Centre. Sept 2016

There is good evidence that use of the GSF Prognostic Indicator Guidance improves early recognition or identification of patients considered to be in their last year of life. However, this is only the first key step in the full GSF Quality Improvement Programme used in different settings (primary care, care homes, hospitals, domiciliary care, prisons hospices etc). Intrinsic comparative evaluations of teams progressing with the GSF programme demonstrates significant change towards current population-based estimates (eg 1%,30%,80%), and that high levels of early identification in line with can be achieved. The further steps of GSF, including use of Needs-based Coding, MDT discussions ,assessment and planning, all then work together to ensure more proactive care for patients in line with preferences.

1. Evidence from Intrinsic GSF Evaluation Audit

Early identification is GSF's first key step. The GSF training and coaching enables staff to increase their identification rate over time, supported by use of the GSF Prognostic Indicator Guidance and abbreviated forms of it (eg Mini-PIG, PIGLET) through teaching, , coaching , use of run-charts, workshop feedback ,peer-support etc. Over the course of the full GSF Programme (6-24 months), teams demonstrate increased identification rates for all patients, assessed regularly in a variety of ways. Before and after evaluations are assessed, plus Accreditation portfolio submissions includes clarification of consistency and sustainability, examined further at the Visit.

a) **Acute Hospital wards** -Cumulated data from 8 GSF Accredited Hospital wards in different hospitals ie wards that have undertaken GSF training and were successfully accredited.
Conclusion for these GSF wards – an average identification rate 32% of all patients (in line with Clarke study) – snapshot survey at one specific time cumulated

Percentage of patients identified in the first 8 GSF accredited

- Modification de la formation et de la coordination des soignants au domicile
- Diminution des hospitalisations
- Augmentation des décès au domicile
- Soignants moins angoissés par la fin de vie
- Meilleure prise en charge symptomatique

Merci pour votre attention

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