La fragilità nello spazio fra ospedale e territorio

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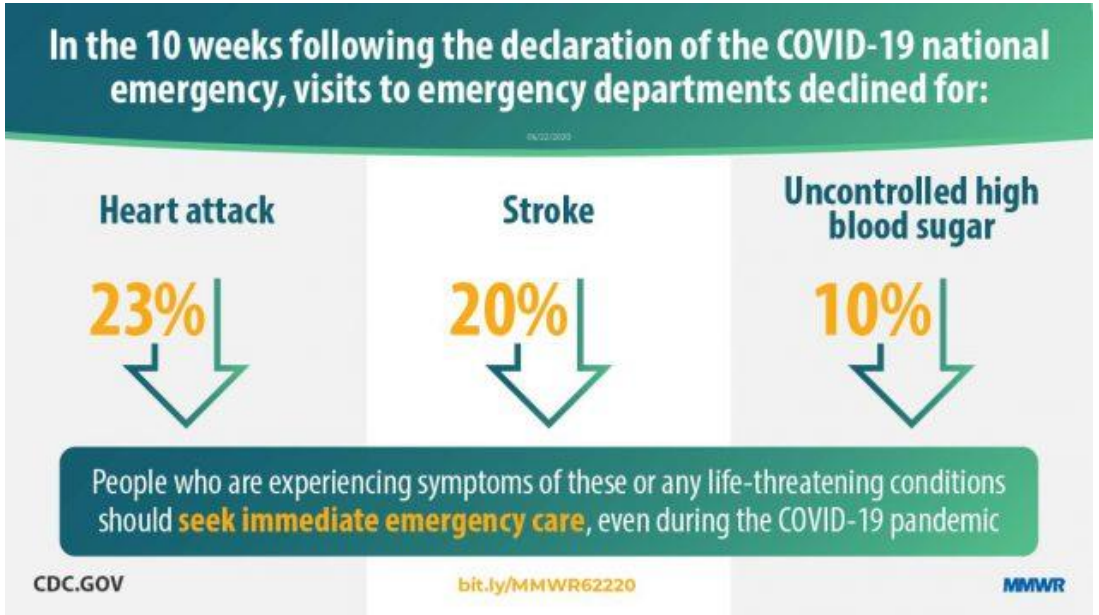
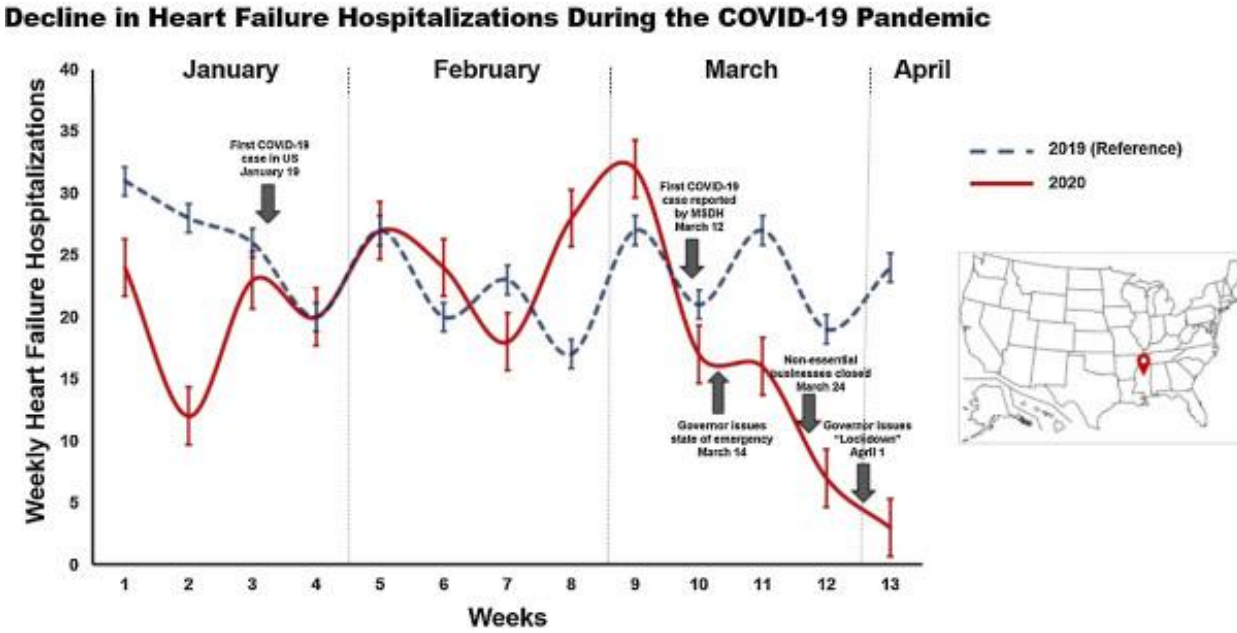
Riduzione delle ospedalizzazioni per patologia acuta durante la pandemia

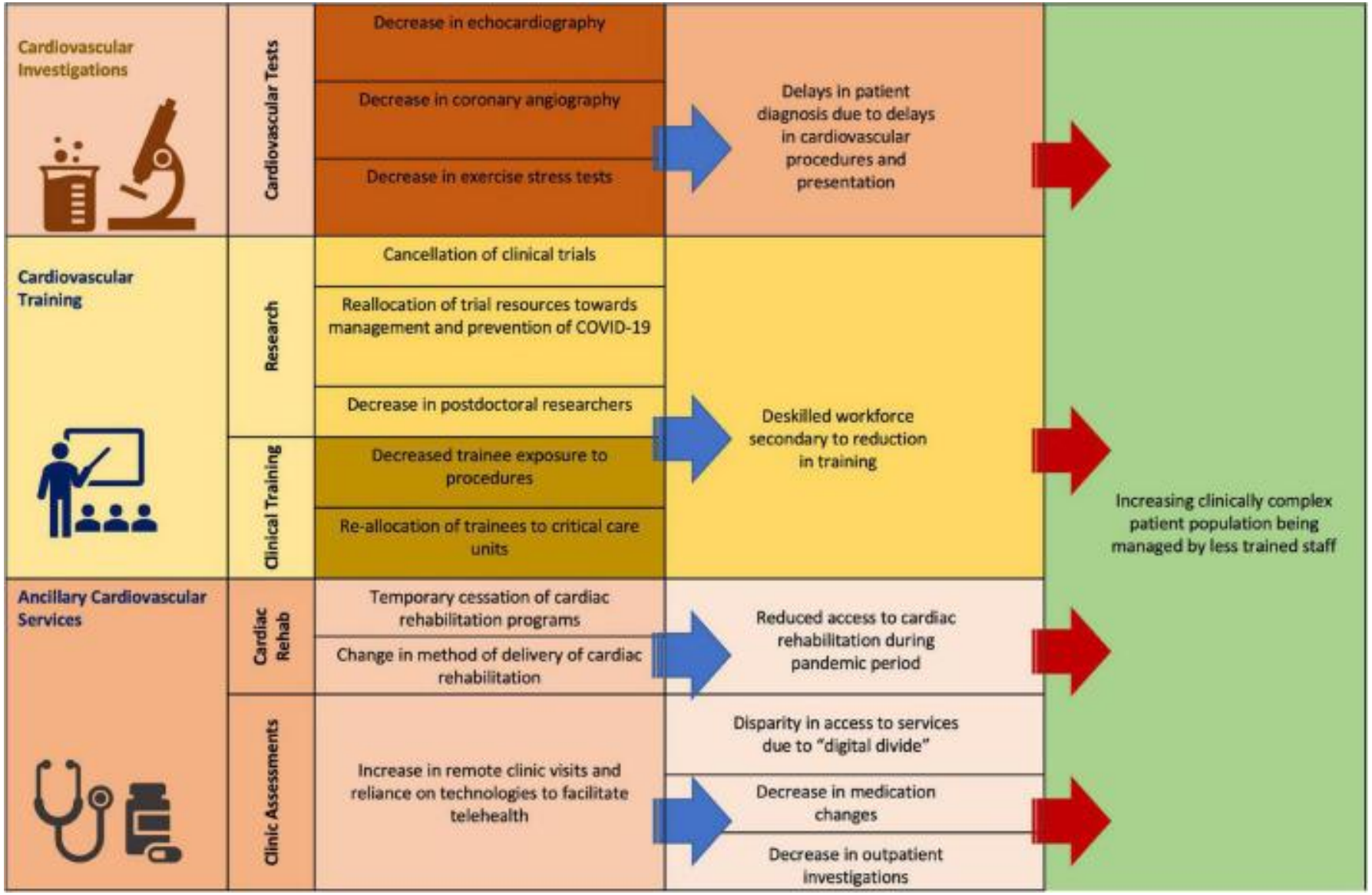




Lange SJ et al., MMWR Morb Mortal Wkly Rep 2020

Hall ME et al., J Card Fail. 2020

Riduzione delle prestazioni ambulatoriali e riabilitative durante la pandemia



Kodsi M, Bhat A.,
Front Cardiovasc Med. 2022

Impatto negativo della pandemia sulle cure primarie

- Ridotta capacità di fornire cure

  Carico dei pazienti COVID; carenza di personale; inizialmente riduzione degli accessi e scarsa disponibilità di DPI

- Ridotto accesso alle cure

  Minor supporto sociale; paura del contagi; trascurati gli interventi di prevenzione

- Ridotta qualità delle cure

  Minori occasioni di comunicazione, in contesti e con strumenti tecnologicamente non adeguati; minor attenzione a diagnosi e prevenzione delle malattie croniche

- Peggiore prognosi degli anziani con malattia cronica e con fragilità

  Riduzione dell'attività fisica; il caso della demenza – somma di condizioni di rischio

Lim J et al., Eur J Gen Pract, 2021

Effetti della «sindemia» sulle malattie croniche: aumento di mortalità per demenza nel 2020

346 | Alzheimer's & Dementia®
THE JOURNAL OF THE ALZHEIMER'S ASSOCIATION

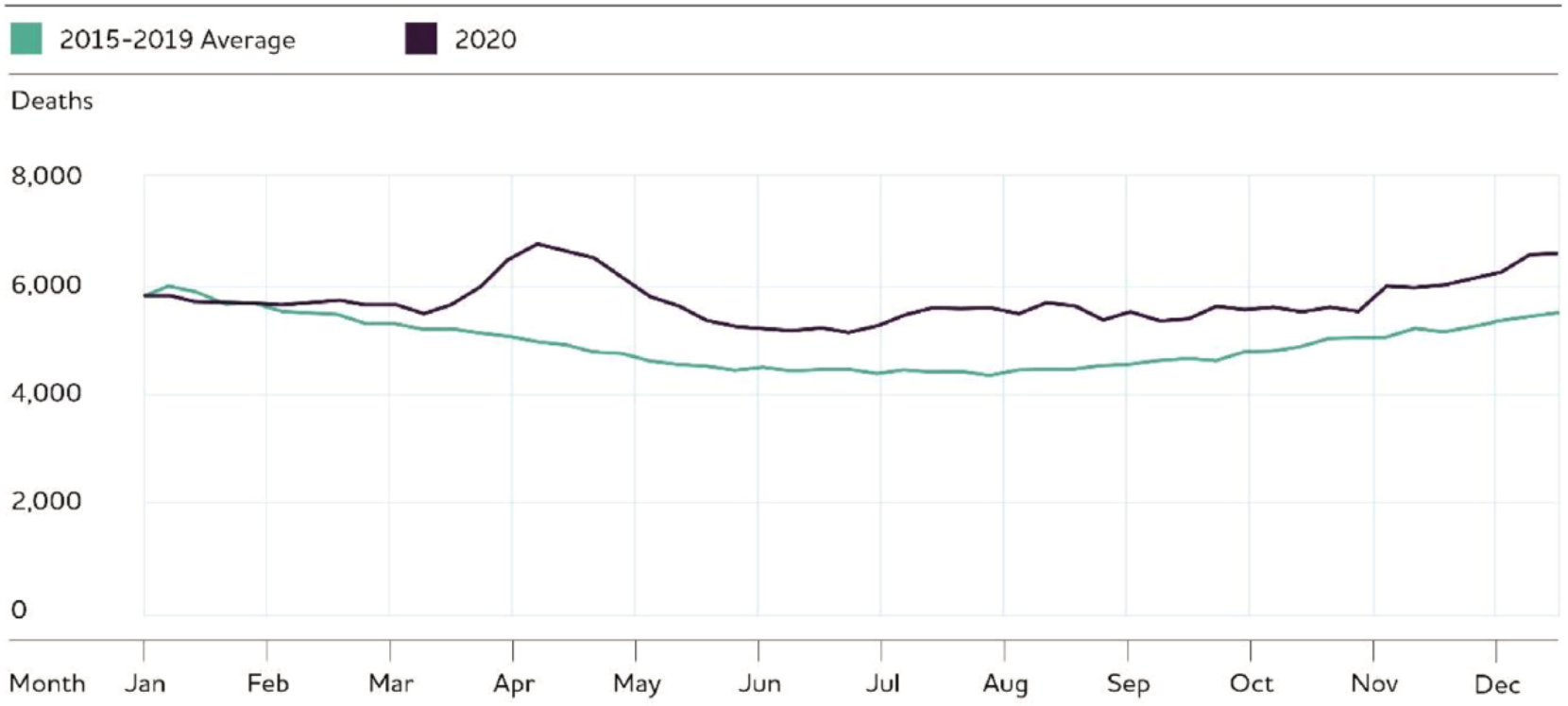
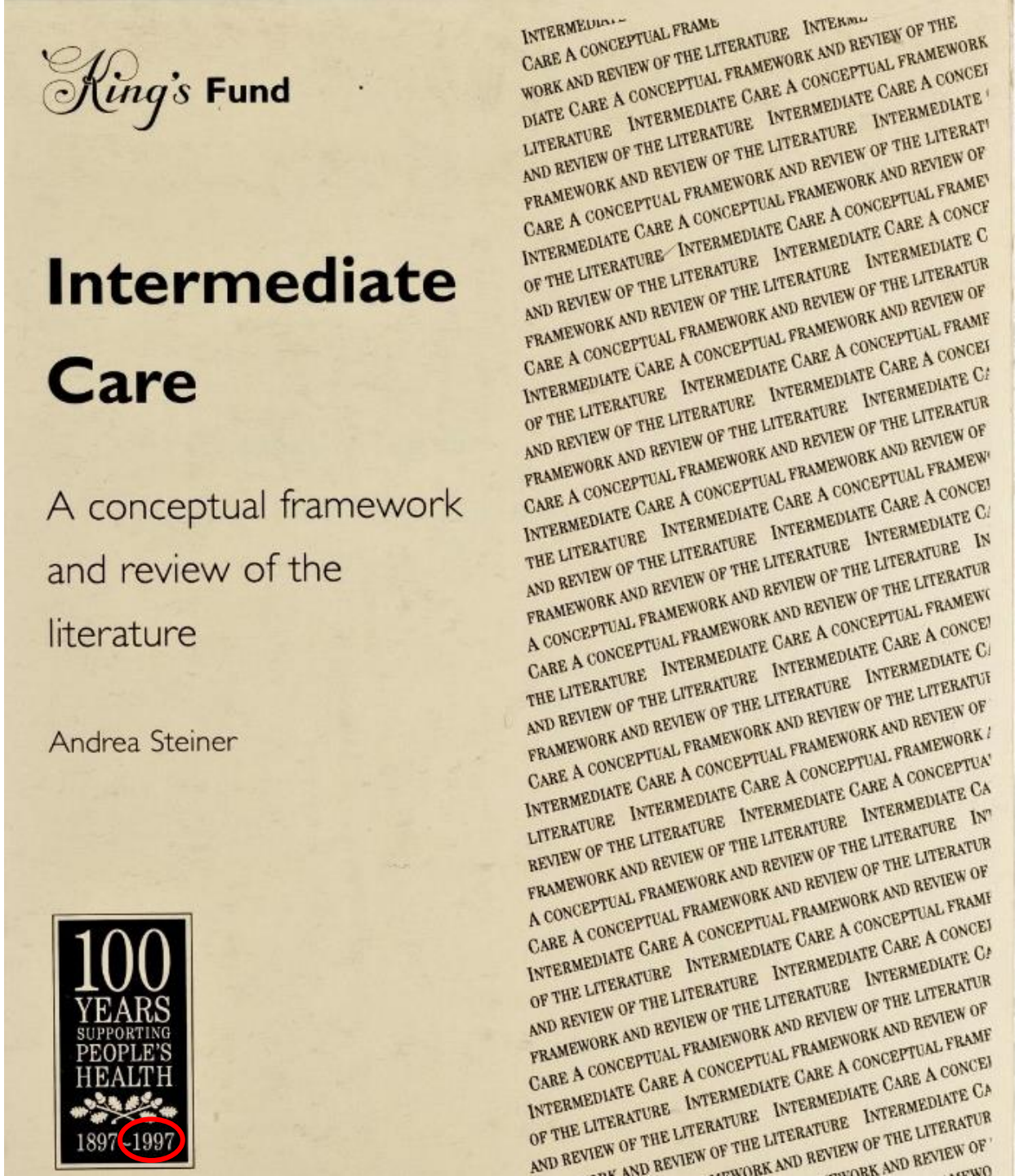


FIGURE 6 Deaths due to Alzheimer's and other dementias in the United States in 2020 compared with previous years. Data for 2020 are current as of February 3, 2021. Created from data from the National Center for Health Statistics.[328]

2021 Alzheimer's disease facts and figures. Alzheimers Dement, 2021

Tra la crisi degli ospedali e la crisi delle cure primarie e ambulatoriali…



…le cure intermedie!

Non un'idea nuova…

«Ospedale in RSA»: modello fiorentino di cure intermedie in epoca COVID

Aging Clinical and Experimental Research
https://doi.org/10.1007/s40520-021-01959-z

ORIGINAL ARTICLE

Check for updates

Caring for nursing home residents with COVID-19: a "hospital-at-nursing home" intermediate care intervention

Enrico Benvenuti[1] · Giulia Rivasi[2] · Matteo Bulgaresi[1] · Riccardo Barucci[1] · Chiara Lorini[3] · Daniela Balzi[4] · Antonio Faraone[5] · Giacomo Fortini[1] · Gabriele Vaccaro[3] · Ilaria Del Lungo[1] · Salvatore Gangemi[1] · Sante Giardini[1] · Cecilia Piga[1] · Eleonora Barghini[1] · Serena Boni[1] · Giulia Bulli[1] · Paolo Carrai[5] · Andrea Crociani[5] · Aldo Lo Forte[5] · Letizia Martella[1] · Simone Pupo[1] · Irene Marozzi[2] · Giulia Bandini[6] · Primo Buscemi[3] · Claudia Cosma[3] · Lorenzo Stacchini[3] · Lorenzo Baggiani[7] · Andrea Ungar[2] · Enrico Mossello[2] · Guglielmo Bonaccorsi[3] · Giancarlo Landini[8]

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GIROT

Gruppo di Intervento Rapido Ospedale Territorio

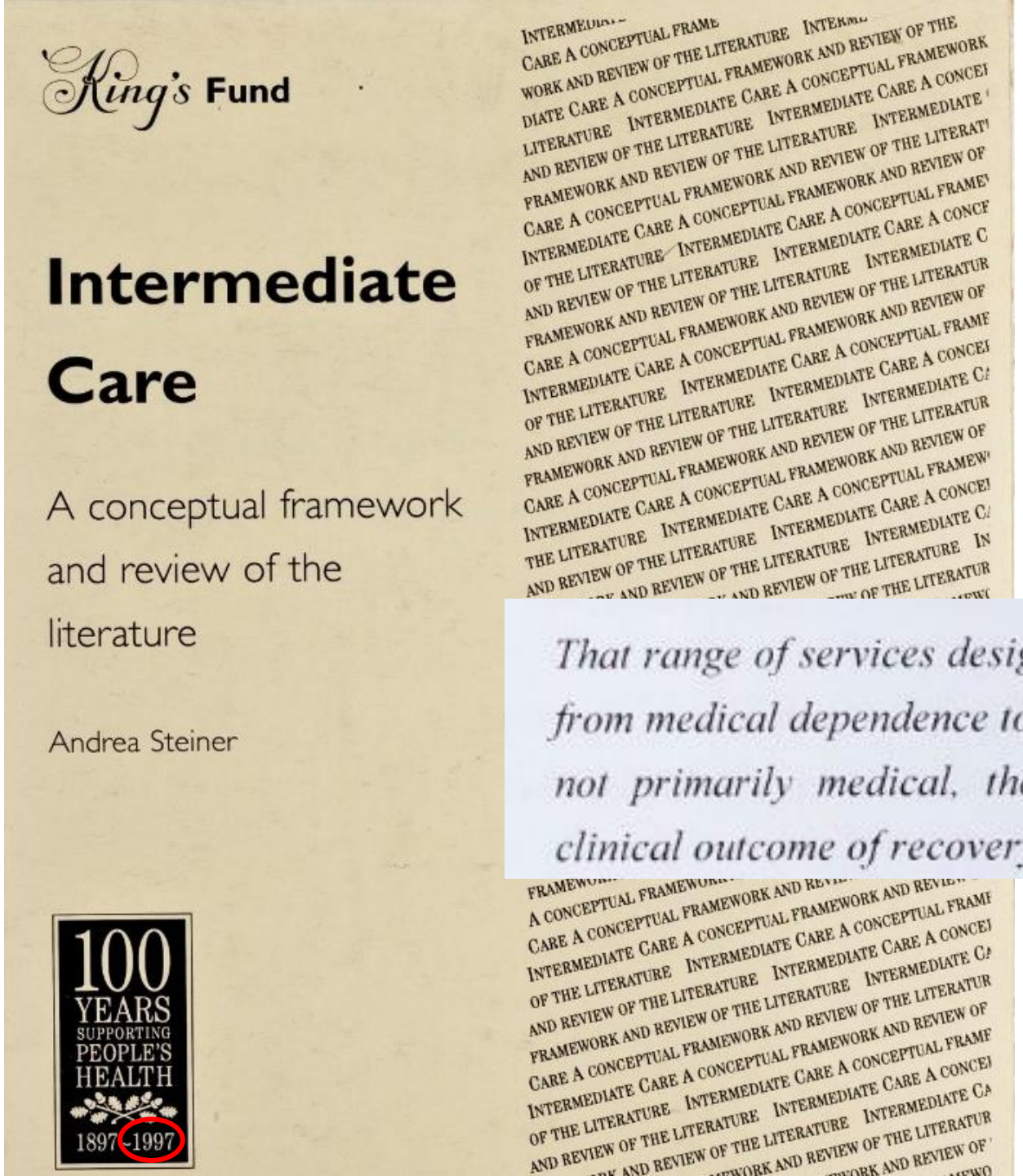
Risultati dell'intervento

	First wave March 1st 2020–April 30th 2020	Second wave October 1st 2020–January 31st 2021
Number of nursing homes	21	43
Number of residents	1159	2448
Mean age (years)	83.9	82.8
Female residents	830 (71.6%)	1728 (70.6%)
Number of COVID-19-positive residents	450	1578
% of COVID-19-positive residents*	38.8%	64.5%
Number of deaths	140	369
Number of residents admitted to hospital	262	160
Hospitalization rate among COVID-19-positive residents†	58.2%	10.1%
Lethality rate among COVID-19-positive residents ‡	31.1%	23.4%

*Chi2 test (1df): 210.0; $p < 0.001$

†Chi2 test (1df): 491.2; $p < 0.001$

‡Chi2 test (1df): 11.1; $p < 0.001$



…le cure intermedie!

Non un'idea nuova…

That range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired.

Cure intermedie e *transitional care*: definizioni

How are these models of care defined?

1. Intermediate care is are a broad range of time-limited services, from crisis response to support for several weeks or months, that aim to ensure continuity and quality of care and promote recovery at the interface between hospital and home, care home, primary care and community services
2. Intermediate care, at home or in intermediate care beds, aims to enable recovery, restore independence and confidence, or prevent a decline in functional ability at times of change in health
3. Transitional care services are a subset of intermediate care designed to enable safe, coordinated and timely transfers between care settings

Who may benefit?

4. These services may particularly benefit persons who have complex needs or circumstances, are vulnerable to a decline in health status or functional ability, or are at increased risk of (re)admissions to hospital or institutionalisation

What is the approach to care?

5. Intermediate care is based on principles of holistic comprehensive assessment; person-centred care planning; education for patients, family and caregivers; support for self-management (including nutrition and medication management); and continuity and coordination of care. The use of a reablement approach and interdisciplinary rehabilitation has a specific role for persons who have experienced a decline in functional ability
6. The nature, duration and intensity of the multi-dimensional interventions are tailored to the needs of the individual, in collaboration with their family and caregivers, and may involve a case management approach for the duration of the episode
7. Health professionals should adopt relational approaches, creative solutions and simple technologies that enable and support patients, their families and caregivers to be fully involved in care planning, goal setting and monitoring from the earliest stages

How should services be organised?

8. Intermediate care is best delivered by an interdisciplinary team within an integrated health and social care system that links different providers and levels of care in a collaborative network of care and support that includes partners from community and voluntary sectors
9. A single point of contact helps to optimise service access, communication and coordination of care
10. To be effective, intermediate care services should have sufficient capacity and responsiveness, appropriate expertise, clear governance arrangements, and opportunities for education and training to support team members to work collaboratively and to continually improve service quality and outcomes for people and care systems

Segzin D et al., Aging Clin Exp Res, 2020

Modelli di cure intermedie e *transitional care*

Revisione di 133 studi (N=703 523)

Pre-discharge stage | **Post-discharge stage**

Transitional care interventions delivered only in hospital

- *Co-ordination and hospital-based education for patients and/or caregivers*
- *Implemented discharge planning (multidisciplinary)*

Agenzia di Continuità Ospedale-Territorio

Interventions delivered at discharge and up to 30 days after discharge

a) Service provider and approach

- *Outreach by hospital professional(s)*
- *Community based or in-reach models*
- *Transitional care clinics*

b) Focus of the interventions

- *Telephone follow-up*
- *Patient and caregiver education or coaching*
- *Decision support systems*

Transitional care dopo la dimissione

Intermediate care in a community hospital, care home or post-acute facility

- *Needs assessment and rehabilitation*
- *Rapid transfer from acute care*
- *Education and training for existing staff*

Cure intermediie in struttura

Intermediate care at home

a) Professionals delivering the interventions

- *Interdisciplinary support with/without rehabilitation*
- *Single profession led interventions*

b) Approach to care

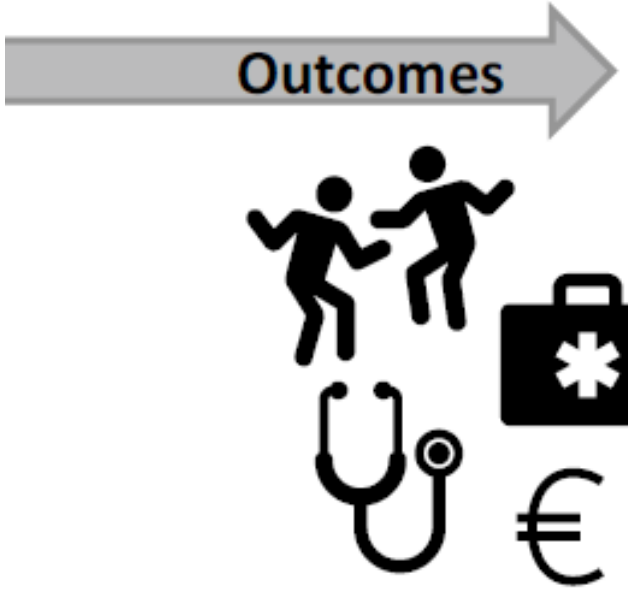
- *Crisis response or hospital admission avoidance*
- *Home visits for follow-up*

Cure intermedie a domicilio – *hospital at home*

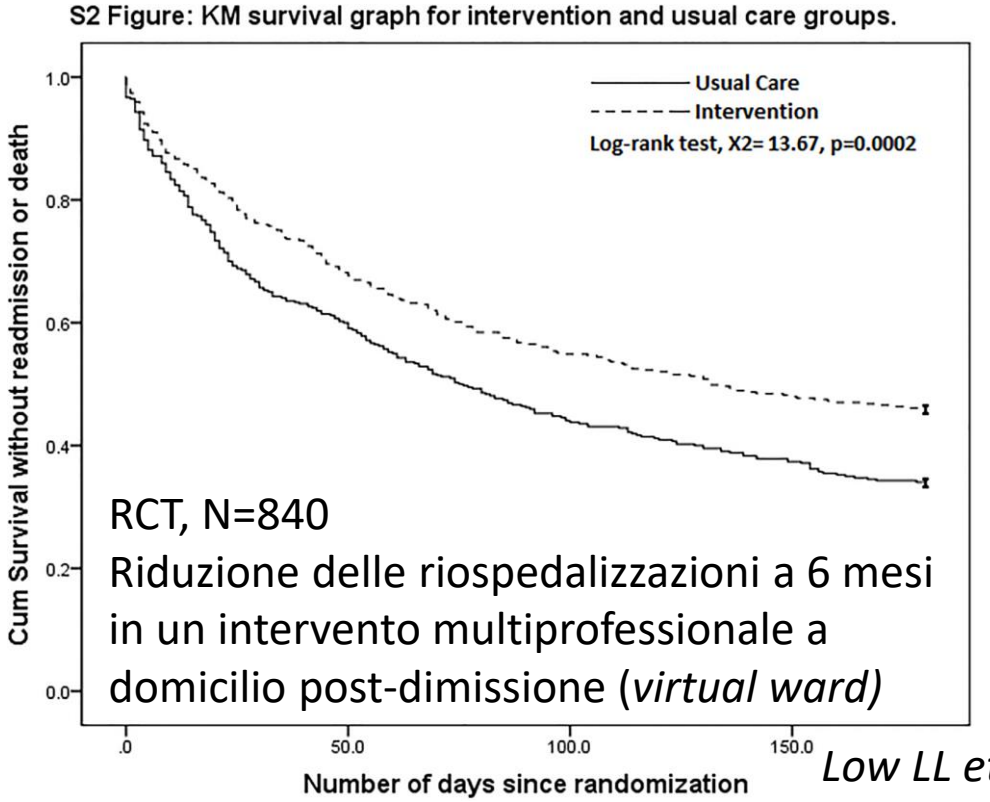
Segzin D et al., Eur Geriatr Med, 2020

Cure intermedie e *transitional care:* benefici osservati

Revisione di 133 studi (N=703 523)



Improved function or ADL
Reduced hospital readmissions
Delayed transfers to institutional care
Reduced costs



RCT, N=840
Riduzione delle riospedalizzazioni a 6 mesi in un intervento multiprofessionale a domicilio post-dimissione (*virtual ward)*

Low LL et al., PLoS One, 2017

Studi e risultati non sempre concordanti

Segzin D et al., Eur Geriatr Med, 2020

Hospital-at-home

Benefici attesi:

- Per il paziente
  - Minor rischio di complicanze ospedaliere (ipomobilità, delirium, infezioni)
  - Obiettivi individualizzati nel proprio ambiente → miglior qualità della vita
  - Miglior recupero funzionale
  - Minor rischio di istituzionalizzazione
- Per il sistema
  - Minor occupazione dei posti letto
  - Minori costi

Possibili rischi per la sicurezza del paziente (mortalità)

Necessità di supporto domiciliare adeguato

Shepperd F et al., Cochrane Datab Syst Rev, 2016

Hospital-at-home (HaH): revisioni di efficacia per patologia indice

Strategy and Condition	Systematic Review	Mortality		Return Hospital Admissions	
		Summary	Details	Summary	Details
HaH					
Heart failure	Qaddoura et al,[20] 2015	↔	RR for HaH compared with inpatients was 0.94 (3 studies; 95% CI, 0.67-1.32); mortality was 3.8% in HaH and 9.7% in inpatients in a prospective cohort study ($P < .05$)	↔	RR for HaH compared with inpatients was 0.68 in RCTs (2 studies; 95% CI, 0.42-1.09); return admissions were significantly lower in prospective cohort trials (2 studies)
Various medical conditions (eg, pneumonia, urosepsis, cellulitis)	Varney et al,[21] 2014	↔	No difference between HaH and inpatient care (5 studies)	↔	No difference between HaH and inpatient in RCTs (3 studies); 0%-15% in observational studies (5 studies)
Various medical conditions (eg, COPD, stroke, pulmonary embolism)	Caplan et al,[22] 2012	↓	OR for HaH compared with inpatients was 0.79 (23 studies; 95% CI, 0.65-0.97)	↓	OR for HaH compared with inpatients was 0.76 (18 studies; 95% CI, 0.60-0.97)
Various medical conditions (eg, COPD, stroke, cellulitis, pneumonia)	Shepperd et al,[23] 2009	↓	Hazard ratio for HaH compared with inpatients at 3 mo was 0.77 (5 studies; 95% CI, 0.54-1.09); at 6 mo it was 0.62 (3 studies; 95% CI, 0.45-0.87)	↔	RR for HaH compared with inpatients was 1.35 (5 studies; 95% CI, 0.97-1.87); patient-level meta-analysis had hazard ratio of 1.49 (3 studies; 95% CI, 0.96-2.33)
COPD	Jeppesen et al,[24] 2012	↔	RR for HaH compared with inpatients was 0.65 (7 studies; 95% CI 0.40-1.04)	↓	RR for HaH compared with inpatients was 0.76 (8 studies; 95% CI, 0.59-0.99)
	McCurdy,[25] 2012	↔	RR for HaH compared with inpatients was 0.85 (2 studies; 95% CI, 0.45-1.62)	↔	RR for HaH compared with inpatients was 0.79 (2 studies; 95% CI, 0.43-1.45)

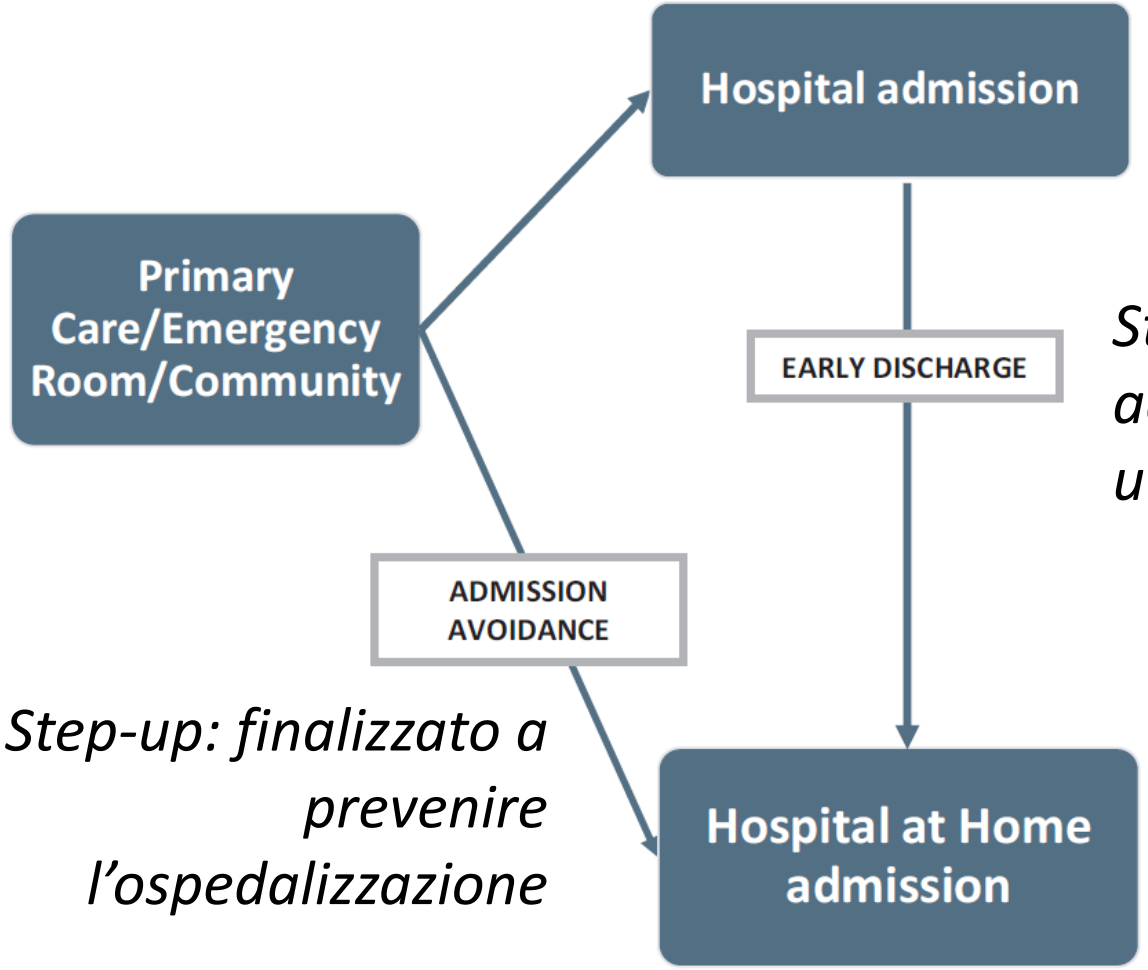
Conley J et al., JAMA Intern Med, 2016

Hospital-at-home (HaH): soddisfazione e costi per patologia indice

Strategy and Condition	Systematic Review	Patient Satisfaction		Costs of Care	
		Summary	Details	Summary	Details[a]
HaH					
Heart failure	Qaddoura et al,[20] 2015	NA	96% Of patients were very satisfied or satisfied with HaH care (1 study)	↓	Significantly reduced costs in outpatients in RCTs (3 studies; 2008, 2007, 2005); costs at 12 mo remained significantly lower in 1 RCT and were lower in another RCT but not statistically significant
Various medical conditions (eg, pneumonia, urosepsis, cellulitis)	Varney et al,[21] 2014	↑	Satisfaction was greater in HaH compared with inpatients in RCTs (3 studies); 1 RCT reported high HaH satisfaction; 95% of patients were satisfied in observational studies (2 studies)	↓	Significantly reduced costs in HaH in RCTs (3 studies; 2000, 1997); other studies reported savings without a *P* value (2 studies; 1999, 1998)
Various medical conditions (eg, COPD, stroke, pulmonary embolism)	Caplan,[22] 2012	↑	Satisfaction was greater in HaH compared with inpatients in all but 1 study, in which satisfaction was equal (10 studies)	↓	Cost savings favored HaH with mean difference of −1821.69 in RCTs (5 studies; 2008; 95% CI, −2591.89 to −1051.49)
Various medical conditions (eg, COPD, stroke, cellulitis, pneumonia)	Shepperd et al,[23] 2008	↑	Higher satisfaction in HaH compared with inpatients: cellulitis ($P < .001$) and CAP (40% more); elderly patients with various medical conditions also reported significantly higher satisfaction in HaH (2 studies); in 1 study, 6% of patient refused HaH care	↓	Significant and nonsignificant cost savings were found in HaH when compared with inpatient care (6 studies; 2003, 2000, 1998, 1996)
COPD	Jeppesen et al,[24] 2012	↔	Risk ratio of HaH compared with inpatients was 1.06 (2 studies; 95% CI, 0.96-1.17)	↓	Significant reduction in direct costs for HaH in 2 studies, and 1 other study showed a trend toward lower cost without significance (3 studies; 2005, 2000)
	McCurdy,[25] 2012	↔	95% Of patients completely satisfied with care in HaH (1 study); 94% of patients in HaH and 88% of inpatients rated care as very good/excellent (1 study)	NA	NR

Conley J et al., JAMA Intern Med, 2016

Hospital-at-home: modelli



Step-down: finalizzato ad accelerare la dimissione degli utenti ricoverati

Step-up: finalizzato a prevenire l'ospedalizzazione

Coloma E, Nicolás D. Eur J Clin Invest, 2020

Modello 1: *Hospital at home – early supported discharge (step down)*

Metaanalisi di 32 studi (ictus, patologie mediche, patologie chirurgiche)

Risultati incerti

- Nessun effetto sulla mortalità
- Effetto incerto sui re-ricoveri (possibile beneficio nella BPCO)
- Riduzione del rischio di istituzionalizzazione
- Riduzione dei giorni di degenza
- Costi probabilmente inferiori, ma stima dubbia

Gonçalves-Bradley DC et al., Cochrane Database Syst Rev. 2017; Echevarria C et al., COPD, 2016; Williams S et al., BMC Geriatr, 2022

Modello 2: *Hospital at home – admission avoidance (step-up)*

Metaanalisi di 16 studi

Meno studi, ma effetto complessivamente più positivo

- Effetto protettivo o neutro sulla mortalità
- Dati disomogenei con effetto neutro sui re-ricoveri
- Riduzione del rischio di istituzionalizzazione
- Maggior soddisfazione dei pazienti
- Costi probabilmente inferiori, ma stima dubbia

Shepperd F et al., Cochrane Datab Syst Rev, 2016 Leong MQ et al., BMJ Open. 2021

Step-up vs. step-down nel mondo reale

N=688 pazienti seguiti in hospital-at-home a Barcellona per 4-6 settimane dal 2018 al 2021, alcuni step-down (prevalenti all'inizo), altri step-up (prevalenti in pandemia)

	Total, n= 688	Step-up, n=307	Step-down, n=351	p-value
Age, mean (SD)	82.7 (9.2)	85.0 (8.3)	81.0 (10.0)	**<0.001**
Female, % (n)	56.5(372)	58.7 (148)	55.7 (243)	0.445
Social situation				
Living with				0.193
Family	85.2 (561)	82.9 (209)	86.9 (379)	
Caregiver	10.8 (71)	11.5 (29)	10.1 (44)	
Nursing home	4.0 (26)	5.6 (14)	3.0 (13)	
Formal caregiver, % (n)	32.4 (212)	40.6 (102)	26.3 (114)	**<0.001**
Comorbidities				
Cardiovascular[a], % (n)	83.9 (552)	88.1 (222)	81.4 (355)	**0.022**
Diabetes mellitus, % (n)	31.0 (204)	27.8 (70)	32.6 (142)	0.190
Cerebrovascular, % (n)	20.1 (132)	18.7 (47)	20.9 (91)	0.483
Chronic Renal Failure, % (n)	28.9 (190)	32.5 (82)	27.3 (119)	0.145
Dementia or Cognitive impairment, % (n)	28.4 (187)	34.5 (86)	24.8 (108)	**0.009**
Depression, % (n)	19.2 (126)	17.5 (44)	20.9 (91)	0.278
COPD, % (n)	19.9 (131)	24.6 (62)	16.3 (71)	**0.008**
Neoplasia, % (n)	13.5 (89)	11.5 (29)	14.7 (64)	0.241
Charlson Index, mean (SD)	2.2 (1.8)	2.2 (1.6)	2.2 (1.9)	0.985
Diagnosis at admission, % (n)				
Post-surgery	1.8 (12)	0.8 (2)	2.3 (10)	0.148
Orthogeriatric	32.2 (212)	13.5 (34)	45.0 (196)	**<0.001**
Medical event	51.5 (339)	70.6 (178)	38.8 (169)	**<0.001**
Stroke	6.1 (40)	4.4 (11)	6.9 (30)	0.179
Pressure/vascular ulcers	5.5 (36)	9.9 (25)	3.0 (13)	**<0.001**
COVID-19/ post-COVID-19	2.9 (19)	0.8 (2)	4.1 (18)	**0.012**
Functional assessment, means (S.D.)				
Barthel I. pre-admission	76.4 (24.9)	67.7 (27.8)	81.3 (21.6)	**<0.001**
Barthel I. (admission)	53.2 (23.5)	51.7 (25.9)	54.0 (21.9)	0.230

Esito al termine dell'intervento

	Barthel improvement			Death		
REGRESSION MODELS	**Linear regression**			**Logistic regression**		
	ß	**95% C.I.**	**p-value**	**OR**	**95% C.I.**	**p-value**
Unadjusted						
Step-up	ref					
Step-down	7.45	5.03 ; 9.86	**<0.001**	0.19	0.09 ; 0.42	**<0.001**
Adjusted						
Step-up	ref			ref		
Step-down	4.12	1.44 , 6.82	**0.003**	0.46	0.18 ; 1.15	0.098
Age	-0.05	-0.19 ; 0.08	0.452	1.07	1.00 ; 1.13	**0.036**
Female	2.99	0.54 ; 5.43	**0.017**	0.99	0.42 ; 2.34	0.987
Formal caregiver	-1.67	-4.37 ; 1.04	0.226	0.88	0.38 ; 2.04	0.759
Cardiovascular disease [a, b]	-1.52	-4.68 ; 1.63	0.343	1.53	0.33 ; 7.11	0.585
Dementia or Cognitive impairment [b]	1.84	-4.59 ; 0.91	0.189	0.80	0.32 ; 1.98	0.625
Orthogeriatric [c]	4.45	0.167 ; 7.24	**0.002**	0.28	0.06 ; 1.37	0.116
Falls (past six months)	1.09	-1.43 ; 3.60	0.397	0.78	0.33 ; 1.82	0.561
Barthel pre-admission	0.05	0.01 ; 0.111	**0.046**	0.98	0.97 ; 0.99	**0.028**

Barthel Index improvement: Barthel Index at discharge minus Barthel Index at admission

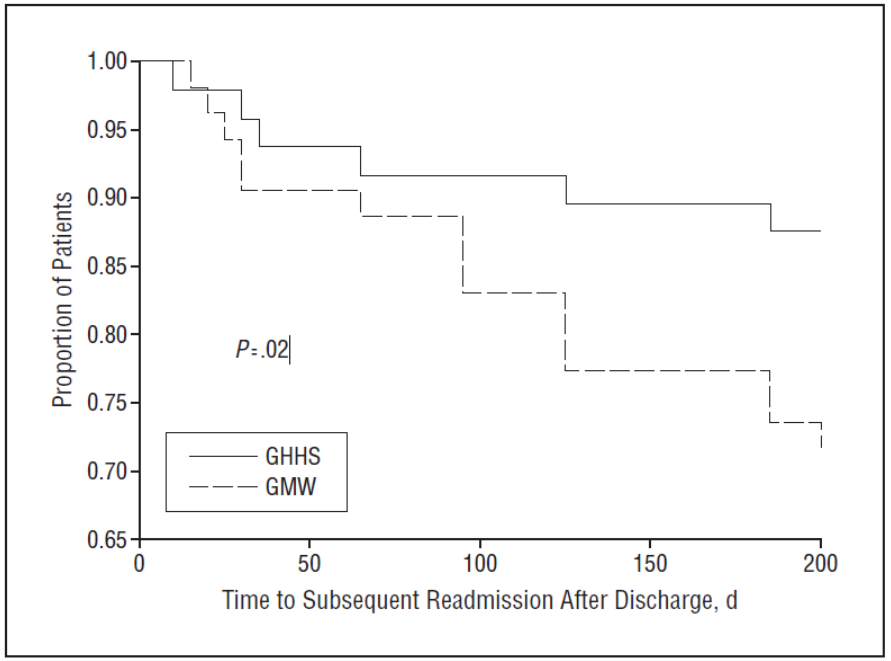
Inzitari M et al., J Am Med Dir Assoc, 2022

Journal Pre-proof

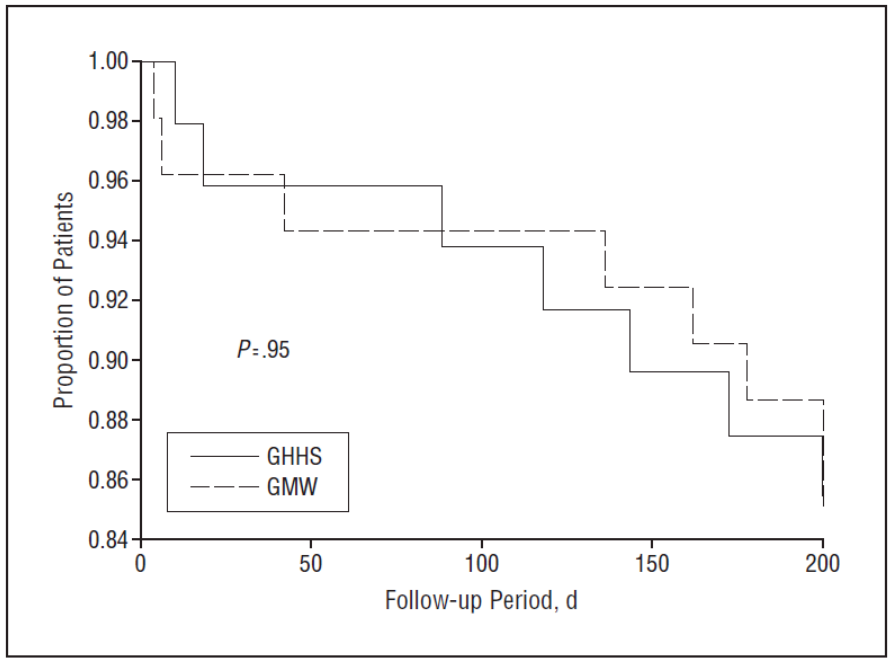
Hospital at home-AA nello scompenso cardiaco

N=101 anziani 75+ (età media 81) ricoverati per scompenso cardiaco nel PS dell'Ospedale di Torino e randomizzati a ospedalizzazione domiciliare geriatrica (GHHS) vs. ricovero in reparto medico per acuti (GMW) → f/u a 6 mesi

Successivo ricovero in ospedale



Mortalità



…con maggior beneficio su depressione, stato nutrizionale, qualità della vita nel gruppo GHHS

Tibaldi M et al., Arch Intern Med, 2009

Annals of Internal Medicine 2021

ORIGINAL RESEARCH

Is Comprehensive Geriatric Assessment Admission Avoidance Hospital at Home an Alternative to Hospital Admission for Older Persons?

A Randomized Trial

Sasha Shepperd, MSc, DPhil; Chris Butler, FMedSci; Andrea Cradduck-Bamford, BSc; Graham Ellis, MD; Alastair Gray, PhD; Anthony Hemsley, BMedSci, MD; Pradeep Khanna, MBBS; Peter Langhorne, PhD; Sam Mort, PGCert; Scott Ramsay, MD; Rebekah Schiff, BSc, MBBS; David J. Stott, MD; Angela Wilkinson, MD, MBChB; Ly-Mee Yu, DPhil; and John Young, MSc

N=1055 older subjects (mean age 83, ADL disability 37%) referred for a hospital admission, randomized to acute hospital vs. hospital at home (HAH) with CGA.

Similar 6-month survival, **lower long term care admission**, **lower delirium rate after 1 month**.

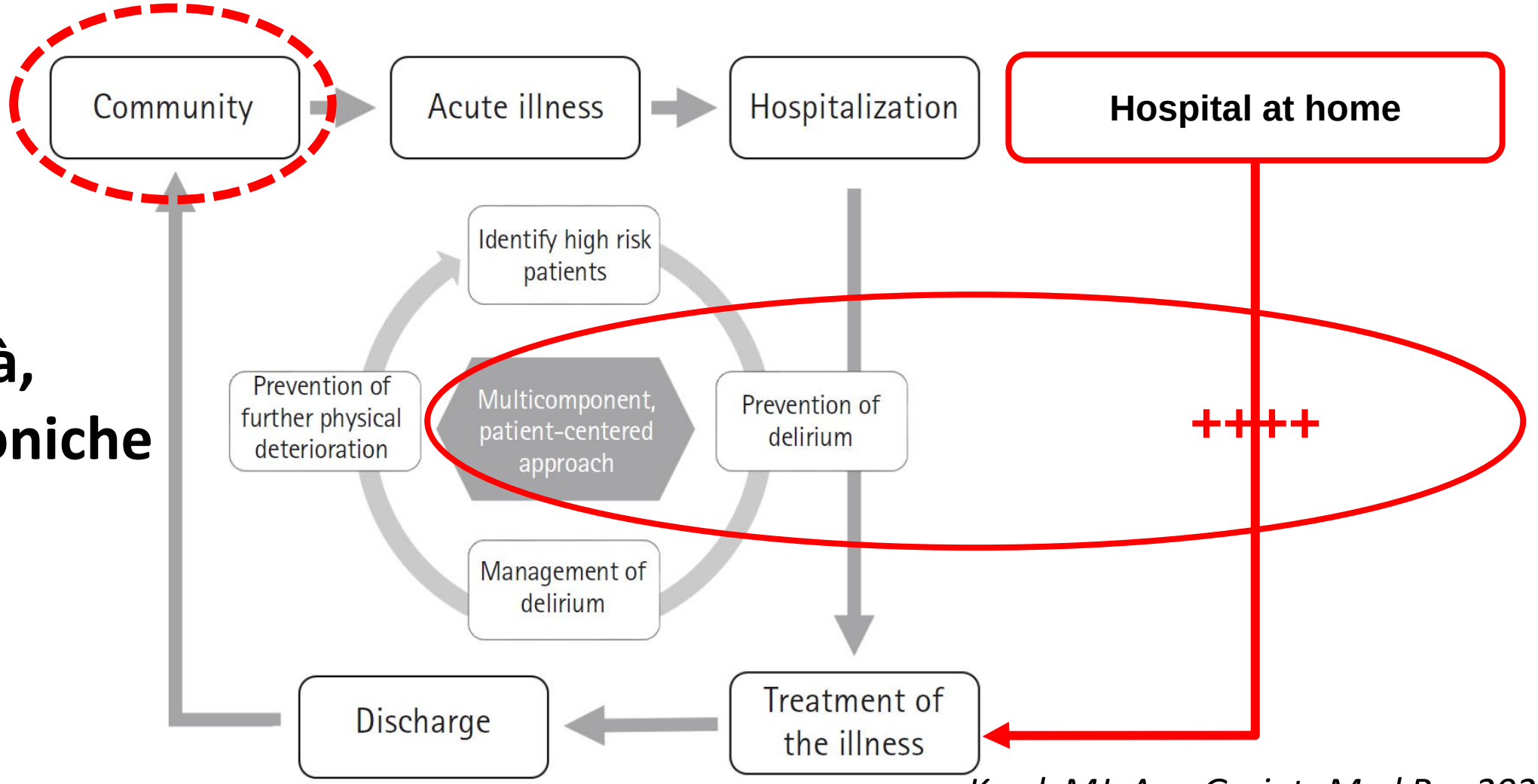
Table 3. Presence of Delirium* Measured by CAM at 3 Days, 5 Days, and 1 Month

Presence of Delirium (CAM)	CGA HAH (*n* = 687), *n* (%)	Hospital (*n* = 345), *n* (%)	Adjusted Relative Risk† (95% CI)	*P* Value
Baseline	46 (6.7)	24 (7.0)	–	–
Missing	1	2		
3 d	25 (3.9)	11 (3.5)	1.12 (0.54–2.29)	0.76
Missing	42	33		
5 d	17 (2.7)	9 (3.0)	0.93 (0.34–2.47)	0.87
Missing	49	37		
1 mo	10 (1.7)	13 (4.4)	0.38 (0.19–0.76)	0.006
Missing	85	48		

La transizione tra i setting di cura dell'anziano fragile: il modello del delirium

Scompenso clinico acuto

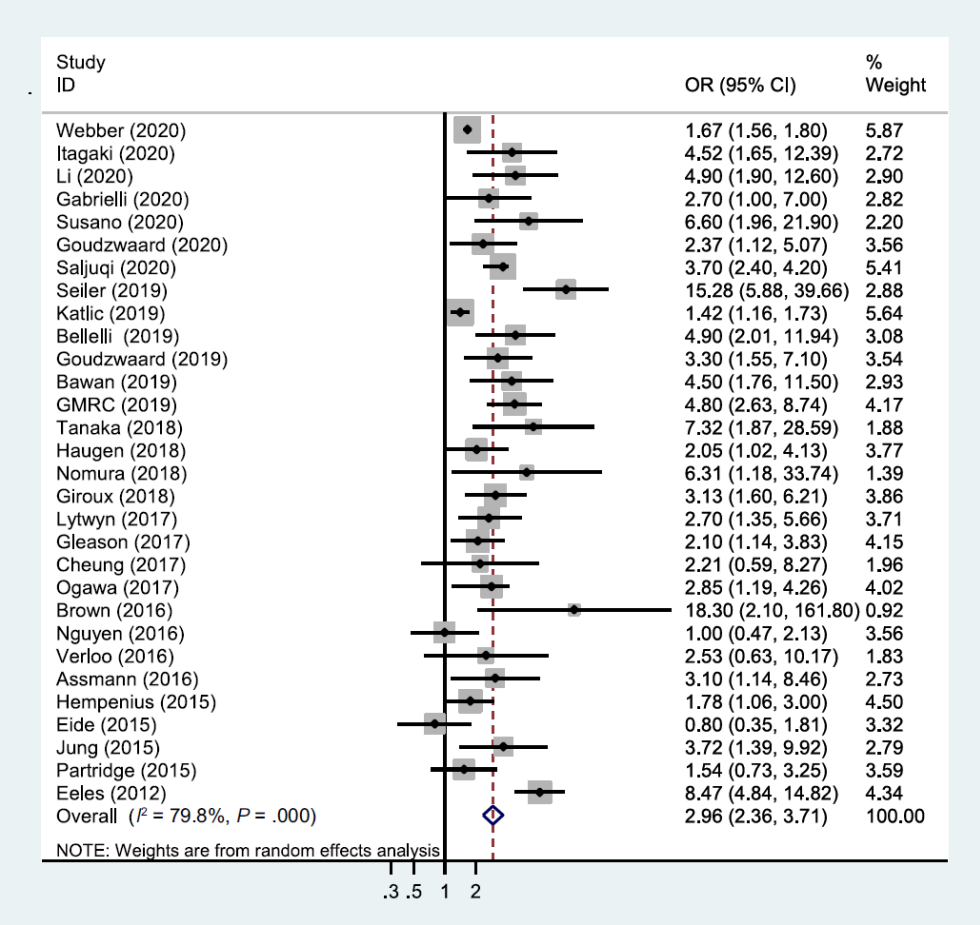
Fragilità, malattie croniche



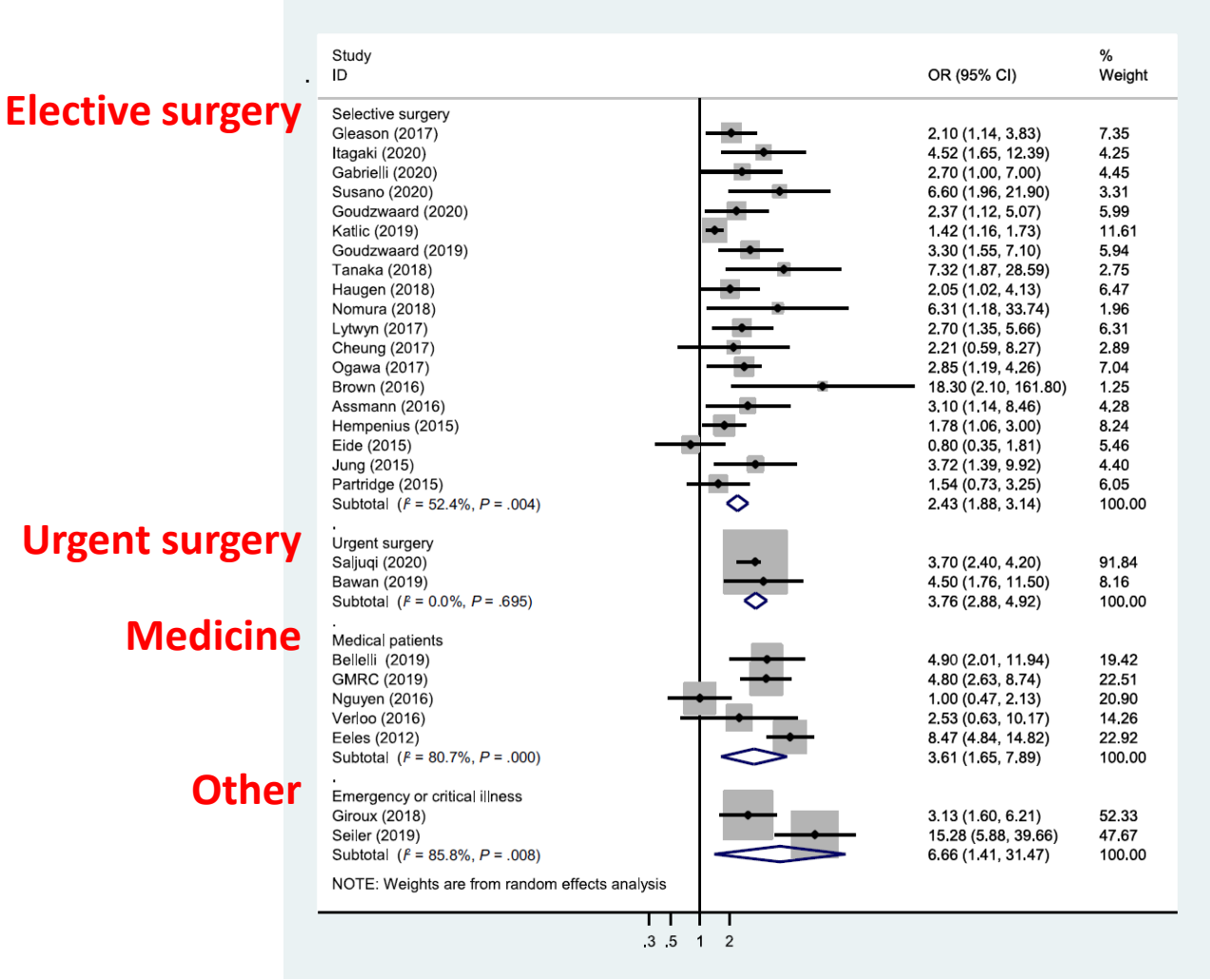
Kwak MJ, Ann Geriatr Med Res 2021

Fragilità come fattore di rischio di delirium

Metaanalysis: 20 studies, N=217 623



Irrespectively of clinical setting

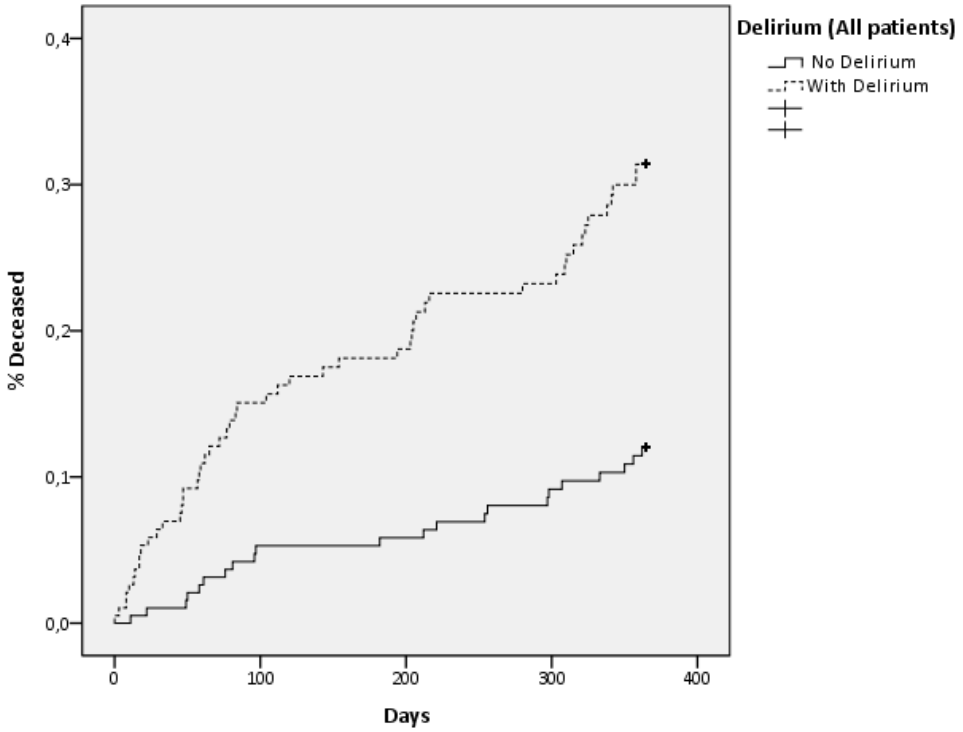


Zhang XM et al., J Am Med Dir Assoc, 2021

Delirium come generatore di disabilità

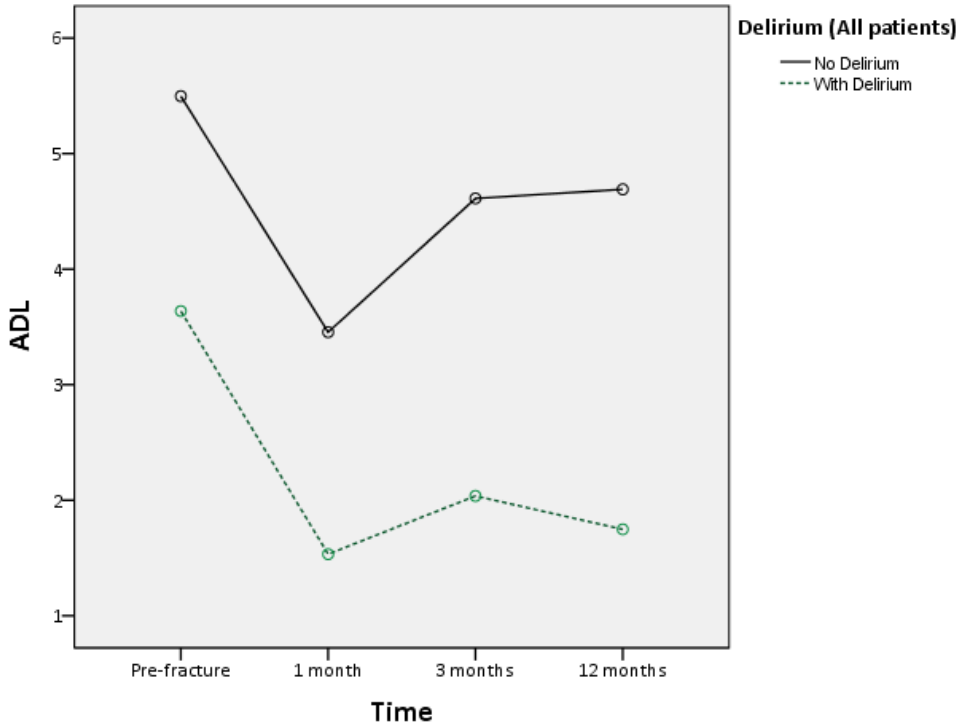
N=387 treated for hip fracture, mean age 82, dementia 46%, delirium 50%. 1-y follow-up

Effect on mortality…



…explained by comorbidity

Effect on ADL disability…

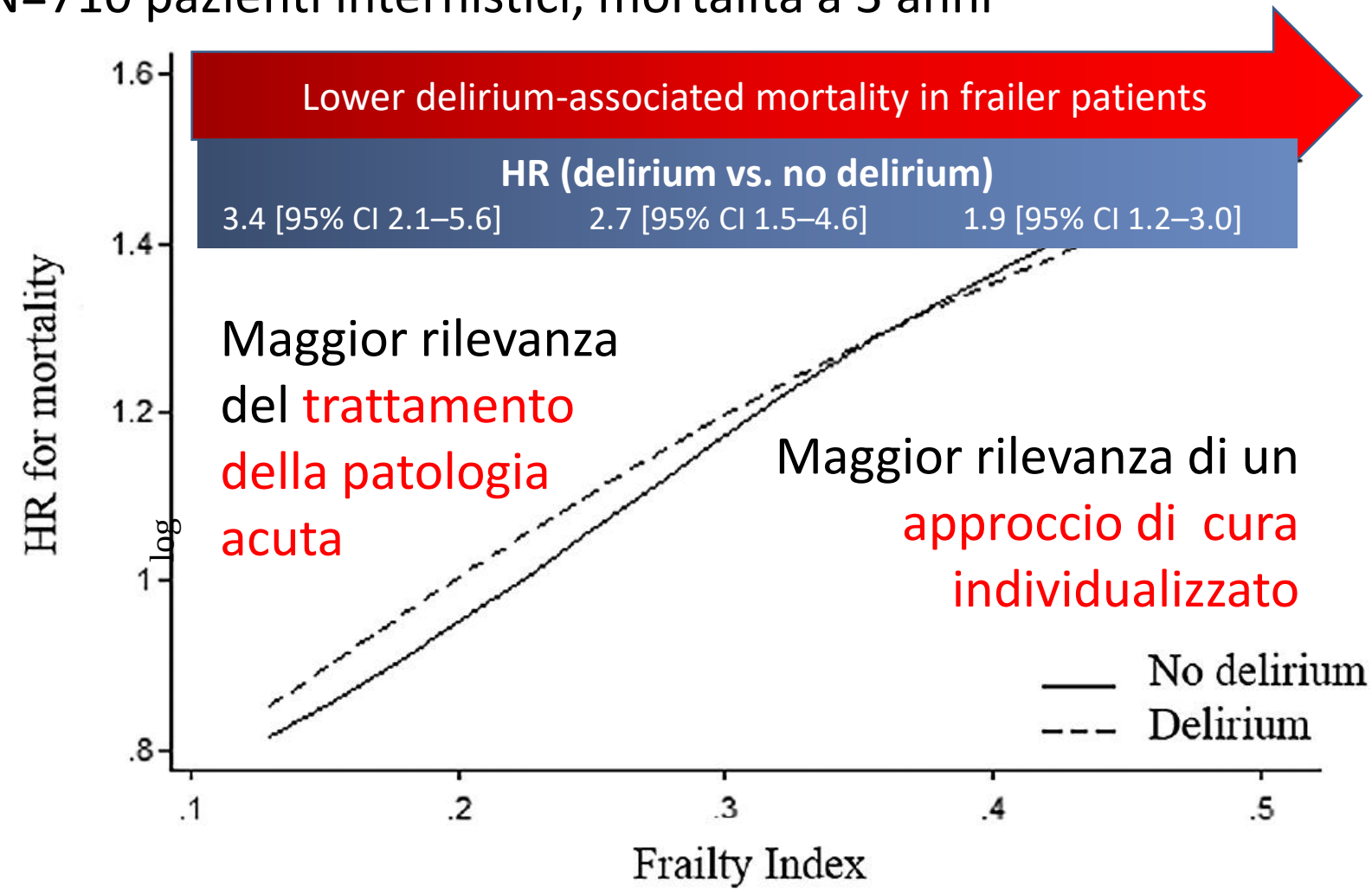


…independently associated with delirium

Cartei A et al., submitted, 2021

Mortalità associata al delirium stratificata per livello di fragilità: quale medicina dell'acuzie per i più fragili?

N=710 pazienti internistici, mortalità a 3 anni



Dani M et al., Gerontol A Biol Sci Med Sci, 2018

I livelli crescenti di fragilità in clinica: la Clinical Frailty Scale

B

1 – MOLTO IN FORMA

Persona forte, attiva, energica e motivata. Pratica regolare esercizio fisico e appartiene alla categoria di persone più in forma fra la propria fascia di età.

2 – IN FORMA

Persone che **non hanno sintomi di malattia attivi**, ma che sono meno in forma rispetto alle persone della categoria 1. Praticano spesso esercizio fisico e sono a volte molto attive, a seconda della stagione.

3 – SE LA CAVA BENE

Persone i cui **problemi medici sono ben monitorati**, ma **non sono però regolarmente attive** al di fuori della normale deambulazione quotidiana esterna.

4 – SE LA CAVA ABBASTANZA BENE

Anche se non dipendenti dall'aiuto degli altri nella vita quotidiana, queste persone sono spesso limitate nelle loro attività **a causa di sintomi di malattia**. Spesso lamentano di sentirsi «rallentati» e/o stanchi durante il giorno.

5 – LEGGERMENTE FRAGILE

Persone spesso evidentemente rallentate nei **movimenti** e nelle **attività** più impegnative **della vita quotidiana** (es. gestione delle finanze, gestione dei farmaci) e **hanno bisogno di aiuto**. Sono in genere sempre più limitate nello shopping, nella deambulazione autonoma, nella preparazione dei pasti e nei lavori domestici.

6 – MODERATAMENTE FRAGILE

Queste persone hanno bisogno di **assistenza in tutte le attività esterne alla casa e nella gestione delle finanze**. Spesso hanno difficoltà a salire le scale, hanno bisogno di **aiuto per lavarsi** e possono avere bisogno di aiuto per vestirsi.

7 – MOLTO FRAGILE

Completamente dipendenti per la cura personale, per qualunque tipo di causa (fisica o cognitiva). Tuttavia, sembrano stabili e non ad alto rischio di morte (entro ⊠6 mesi).

8 – FRAGILITÀ MOLTO GRAVE

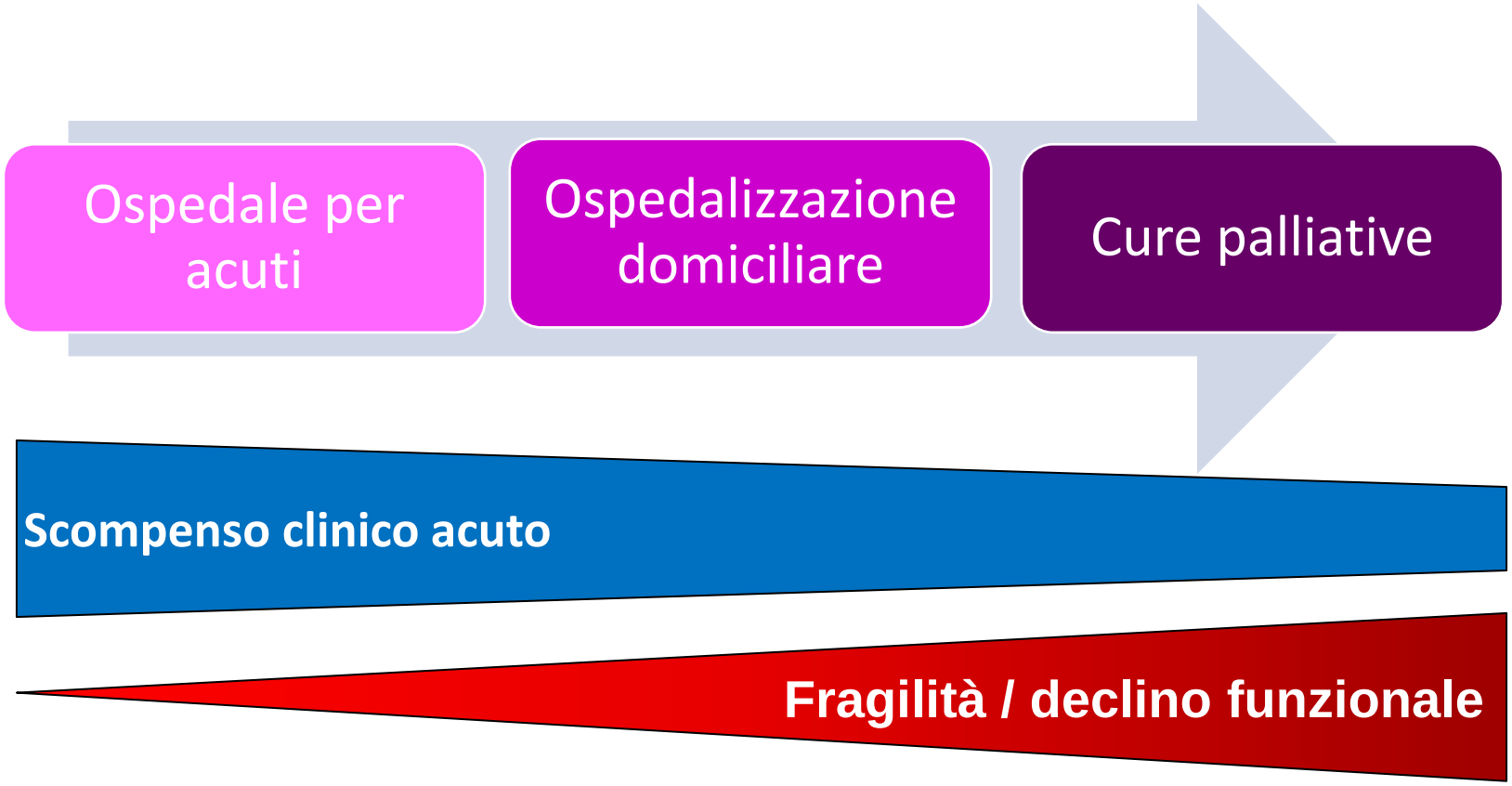
Queste persone **si avvicinano al decesso e sono completamente dipendenti dagli altri**. Se si ammalassero di qualsiasi malattia, molto probabilmente non riuscirebbero a riprendersi.

9 – MALATO TERMINALE

Queste persone hanno un'**aspettativa di vita <6 mesi** e si avvicinano alla fine della vita, anche se la loro condizione non è così marcatamente visibile.

Rockwood K et al., CMAJ, 2005

Il peso di fragilità e scompenso clinico acuto nella scelta del setting di cura ottimale



Principi dell'intervento GIROT: oltre il COVID in RSA…

Intervento rapido con strumenti ospedalieri

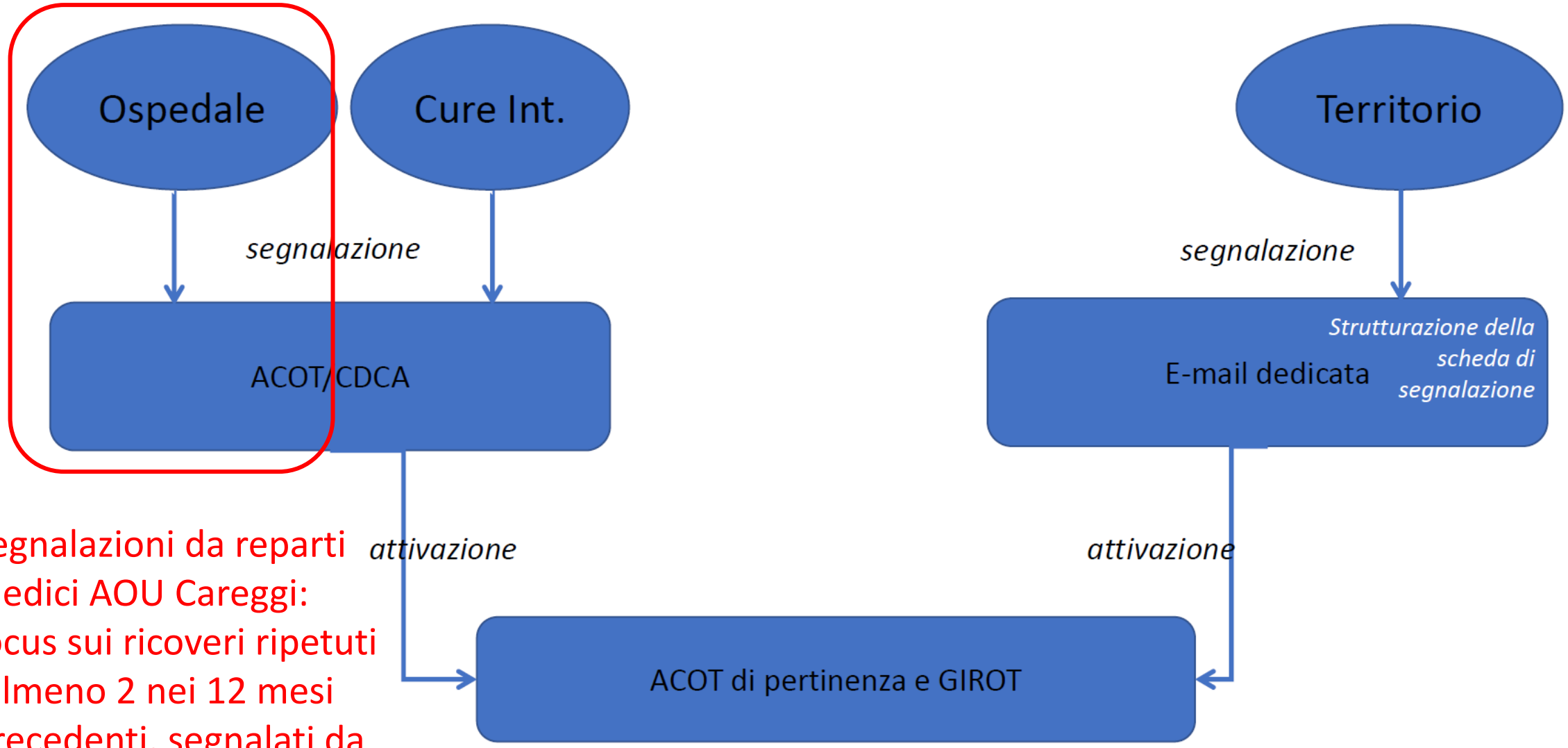
Mantenimento nel proprio ambiente

Prevenzione delle complicanze

Focus sulla qualità della vita

…con verosimili ricadute positive sui costi sanitari

Hospital at home a Firenze: Gruppo Intervento Rapido Ospedale-Territorio (GIROT, USL Toscana Centro)



Segnalazioni da reparti medici AOU Careggi: focus sui ricoveri ripetuti (almeno 2 nei 12 mesi precedenti, segnalati da cartella elettronica)

Benvenuti E, Convegno Nazionale Centri Diurni Alzheimer, 2022

Primi utenti GIROT Careggi: condizione socio-demografica e funzionale

		N=43
Età		86 [82, 89]
Sesso femminile		24 (56%)
Coniugati		20 (47%)
Vive	*Con la famiglia*	29 (67%)
	Con badante	12 (28%)
	Solo	2 (5%)
Caregiver principale	*Familiare*	23 (54%)
	Badante	17 (39%)
	Altro	3 (7%)
BADL pre- evento acuto		3 [2, 3]
Barthel Index pre- evento acuto	*>80%*	8 (19%)
	40-80%	19 (44%)
	<40%	16 (37%)

Primi utenti GIROT Careggi: condizioni croniche

	N=43	
Scompenso cardiaco	32 (74%)	*[27 con FE conservata]*
Fibrillazione atriale	21 (49%)	
BPCO	16 (37%)	
Insufficienza renale cronica	14 (33%)	
Diabete mellito	11 (26%)	
Ipertensione arteriosa	25 (58%)	
Malattia cerebrovascolare	6 (14%)	
Demenza	20 (46%)	*[7 con dist. comportamento]*
N ricoveri nell'anno precedente	2 [1, 3]	
Cadute (anno precedente)	14 (33%)	
Calo di peso non intenzionale (6 mesi)	18 (42%)	

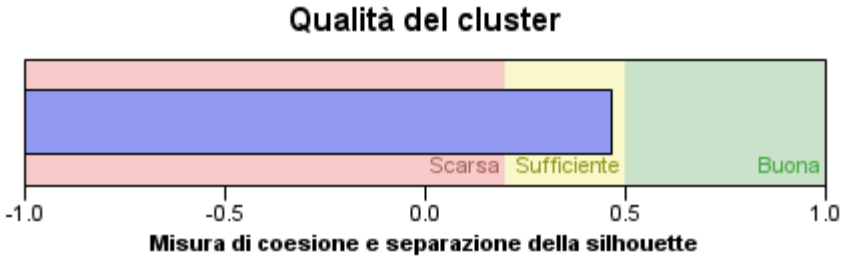
Primi utenti GIROT Careggi: condizioni cliniche alla presa in carico

	N=43	
BADL	1 [1, 2]	
Non deambulanti	18 (42%)	
Numero farmaci	10 (8, 12)	
Delirium	7 (16%)	
Lesioni da pressione	18 (42%)	
Catetere vescicale	17 (40%)	
O2 terapia	18 (42%)	*[13 precedente evento acuto]*
Disfagia	8 (19%)	
Dolore	13 (30%)	

Tipologia degli utenti GIROT Careggi: esplorazione cluster

		Cluster 1	Cluster 2	Cluster 3	Cluster 4
		N=12	*N=11*	*N=7*	*N=13*
Età		87±5	85±4	86±6	78±15
Scompenso cardiaco	***FE conservata***	12 (100%)	0	7 (100%)	8 (62%)
	FE ridotta	0	0	0	5 (38%)
BPCO		3 (25%)	6 (54%)	7 (100%)	0
Demenza		12 (100%)	8 (72%)	0	0
Delirium		5 (42%)	1 (9%)	1 (14%)	0

Two-step cluster analysis



Primi utenti GIROT Careggi: interventi e esito

	N=43	
Durata intervento (giorni)	16 [8, 22]	
N accessi domiciliari medico	3 [2, 4]	
N televisite	2 [0, 3]	
Fisioterapia	20 (47%)	
Idratazione parenterale	9 (21%)	
Farmaci parenterali	7 (16%)	
Ospedalizzazione	5 (12%)	
Attivazione cure palliative	8 (19%)	
Decesso	4 (9%)	
Non deambulanti alla dimissione (n=39)	10 (26%)	***p<0.001 vs. ingresso***
ADL (n=39)	1 [1, 2]	
N farmaci (n=39)	10 [6, 13]	

Messaggi principali

- La crisi parallela della risposta degli ospedali alla pandemia e dell'insufficienza del territorio rende necessario coltivare lo spazio intermedio (ciò che prima era virtuoso ora diviene obbligato)
- Le cure intermedie sono luogo di necessaria sinergia
  - ✓ tra ospedale e territorio
  - ✓ tra diverse specialità e professioni sanitarie
  - ✓ tra interventi sanitari e sociali
- *Hospital at home* come contesto in cui è possibile curare l'anziano fragile anche in fase di scompenso clinico, con tecnologia ospedaliera ma nel suo ambiente, con approccio personalizzato multiprofessionale e focus su recupero funzionale (quando possibile) e qualità della vita (sempre)
- Possibili esiti positivi per l'anziano (e la sua famiglia) e per la società nel suo insieme
- Percorso da strutturare e validare per costi e benefici

Grazie dell’attenzione

Images from www.helpguide.org and https://hopehospice.com