Burdensome Transitions of Care: How Can You Help

Marianne M Holler, MSW DO FAAHPM, FACOI
Chief Medical Officer
VNA Health Group

Disclosure

- I have nothing to disclose

Goals

- Understand the issues surrounding medically fragile patients receiving home care
- Learn to help patients and families make decisions about treatment based on goals of care
- Understand the transition to hospice and what level of care is appropriate when

What are the facts

- Patients receiving home health care are medically fragile and have a one year mortality of 20.5% and four year mortality of 49.2%

Burdensome transitions of care

- Change in location in the last 3 days of life
- having 2 or more hospitalizations in the last 90 days of life
- Homecare patients are at particular risk for burdensome transitions of care

Homecare patient characteristics

- Majority female
- Majority single/widow
- majority 85+years
- Majority died of diseases other than cancer
- May take a targeted approach

Table 1. Descriptive Profile of Older Homecare Recipient (*N* = 7,866).

Variable	*n*	%
Sex		
Male	3,609	45.9
Female	4,257	54.1
Age (in years)		
65-74	1,355	17.2
75-84	3,037	38.6
85+	3,474	44.2
Marital status		
Single/widowed/divorced	4,915	62.5
Married	2,951	37.5
Income quintiles		
Q1 (lowest)	1,989	25.3
Q2	1,696	21.6
Q3	1,524	19.4
Q4	1,017	12.9
Q5 (highest)	887	11.3
Not assignable	753	9.6
Cause of death		
Died of neoplasms	2,205	28.0
Died of other diseases	5,661	72.0

Homecare Patients and transitions

52% had at least one hospitalization in the last 90 days of life

Among Older Homecare Recipients (N = 7,866).

Number of transitions or hospitalizations	Transitions in the last 30 days of life		Hospitalizations in the last 90 days of life	
	n	%	*n*	%
0	3,434	43.7	2,072	26.3
1	3,437	43.7	4,142	52.7
2	615	7.8	1,276	16.2
3	306	3.9	307	3.9
4-7	74	1.0	69	0.9

Note. Percentages do not add up to 100% because of rounding.

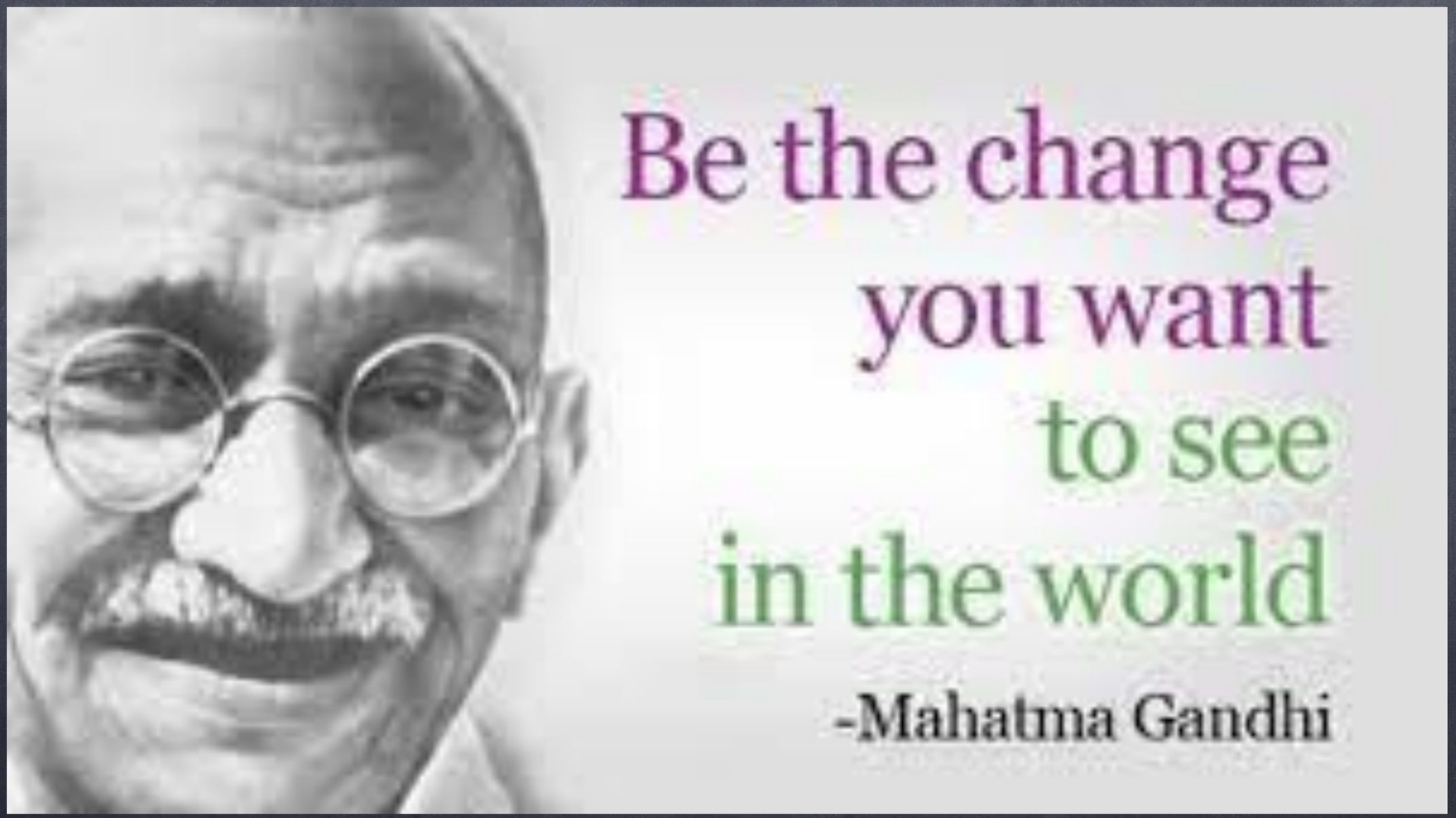
Table 3. The Most Common Transition Patterns in the Last 30 Days of Life Among Older Homecare Recipients.

Number of transitions	Transition pattern	*n*	%
1	Homecare to hospital	2,126	27
1	Homecare to palliative care	454	5.8
1	Nursing home to hospital	273	3.5
1	"Other" to hospital	168	2.1
1	Hospital to nursing home	133	1.7
2	Hospital to homecare to hospital	132	1.7
3	Homecare to hospital to homecare to hospital	173	2.2

Note. The last care setting in each transition pattern is the place of death; for example, homecare to hospital means that the individual

Most common pattern of transition in the last 30 days of life

***27% go from receiving home care to dying in the hospital


Be the change
you want
to see
in the world
-Mahatma Gandhi

Newton's First Law

(law of inertia)

Law of Inertia

- If Newton's First Law of Motion is called the Law of Inertia, we must first define Inertia….
  - **Inertia** is the **tendency** of **object** to **keep** doing what they are doing. If an object is **resting**, it will tend to keep **resting**. If an object is moving, it will tend to keep moving. This property is called inertia.

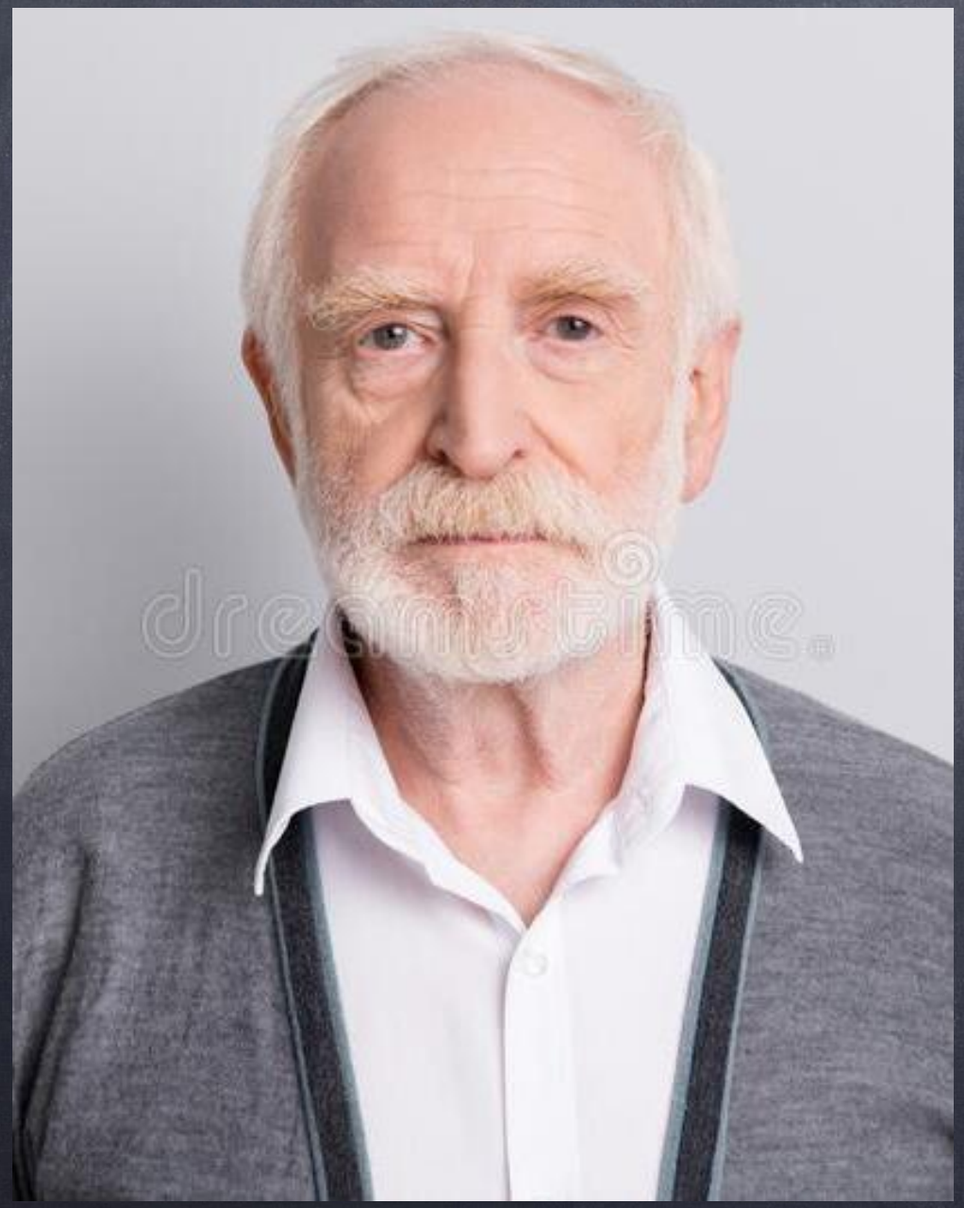
Inertia

- Is it time for us to talk about protecting our patients from the "inertia" of the medical system?

Consider Esther….

- 94 yo
- Homecare services 4 occasions over the past 2 years
- CHF/DM/Gait Dysfunction/Aspiration Pna
- A little confused but wants very much to be home

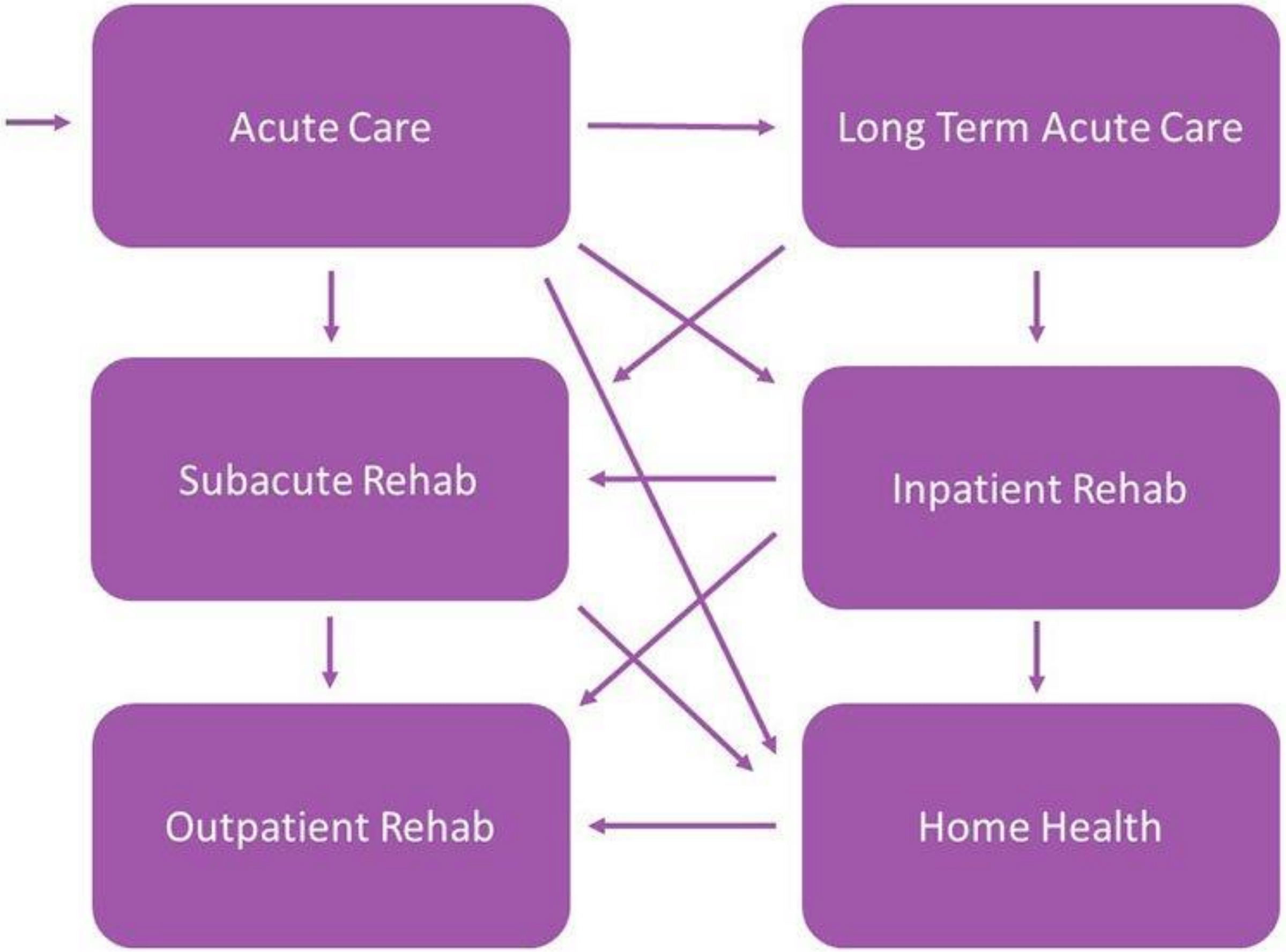
Esther continued…

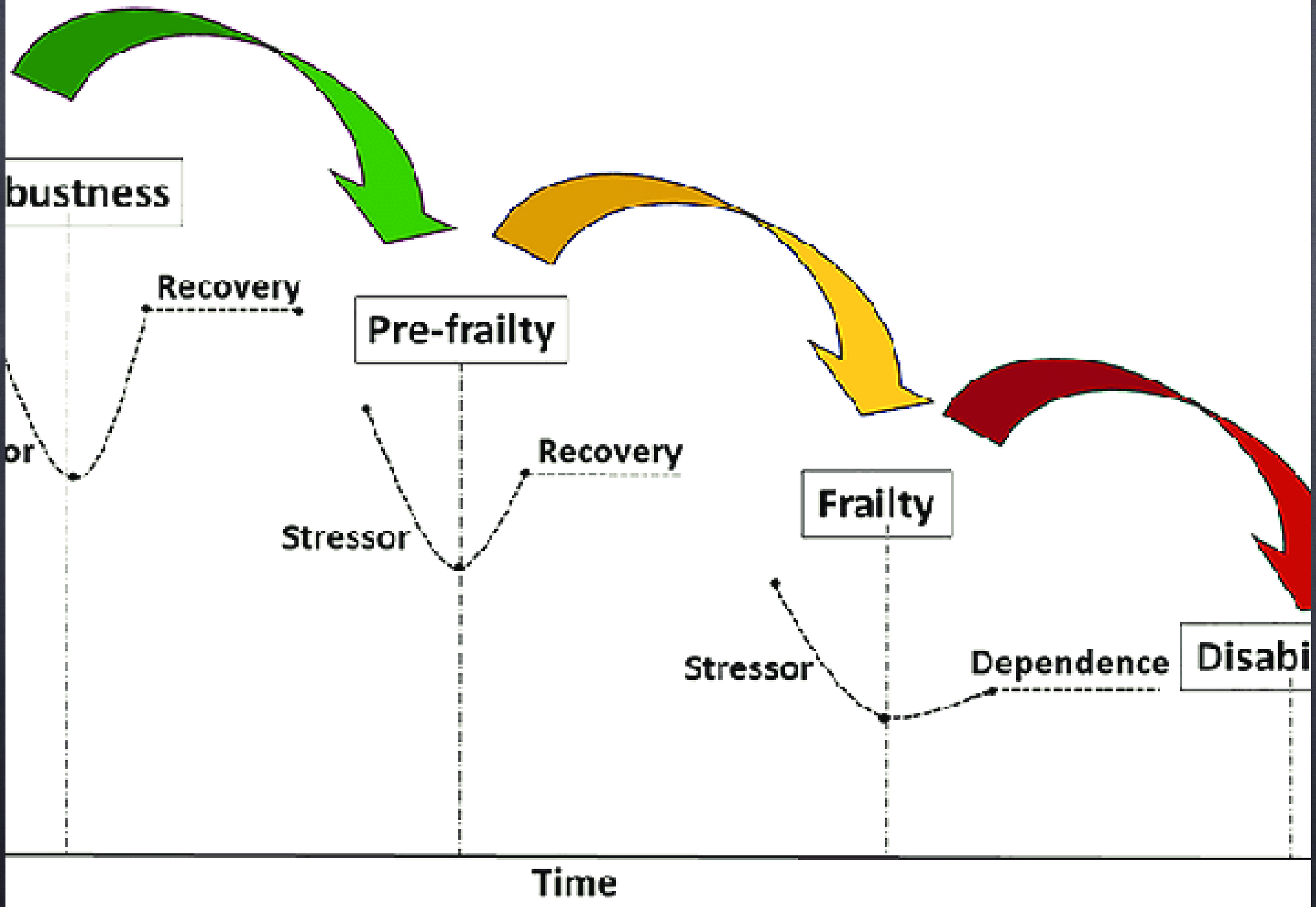


- Cared for by her husband of 62 years, George
- Health is relatively good
- 93 yo

Esther…

- Each time Esther is hospitalized her daughter, Nancy, encourages her with "Mom, a couple of weeks in rehab and you will be as good as new"


Acute Care
Long Term Acute Care
Subacute Rehab
Inpatient Rehab
Outpatient Rehab
Home Health

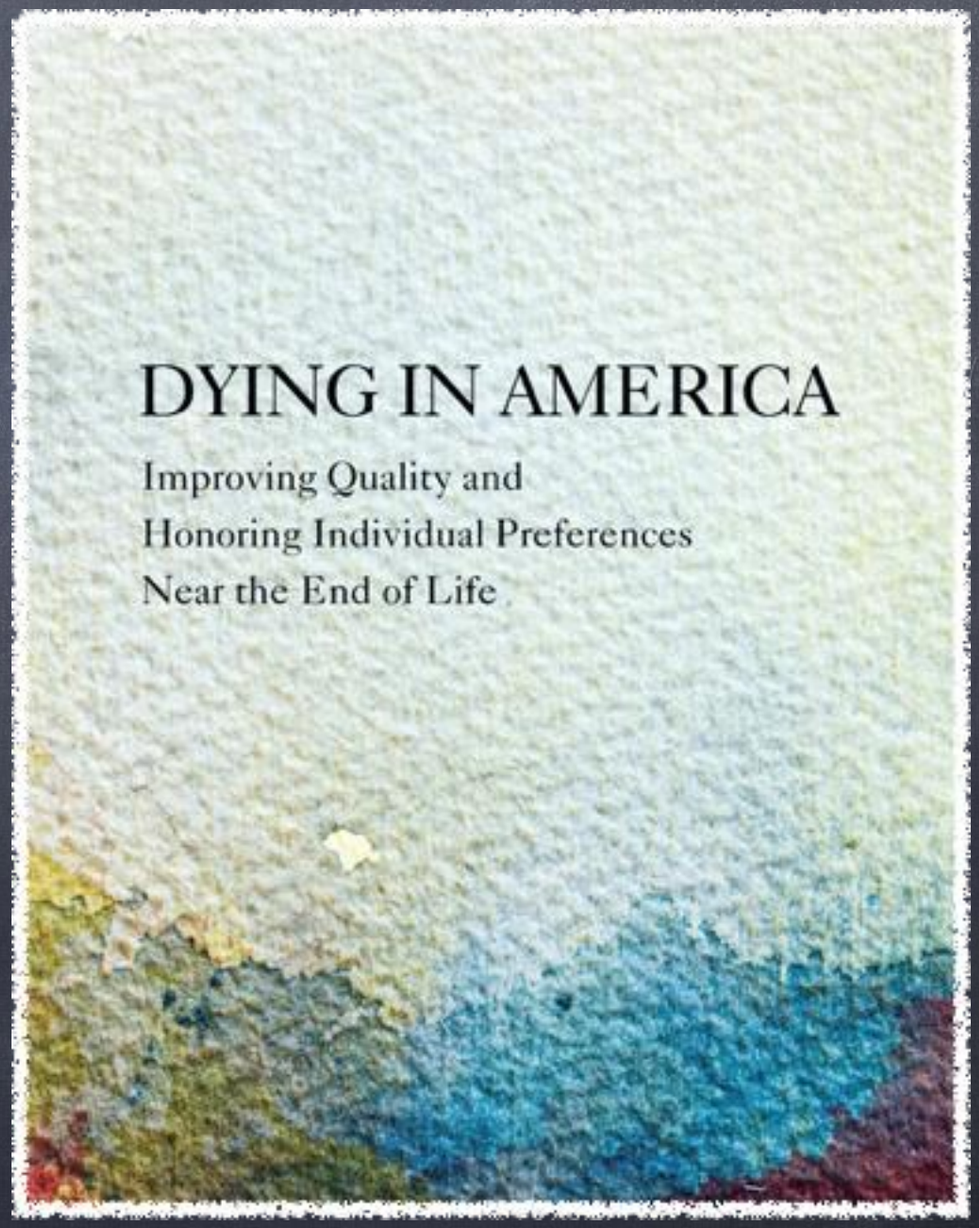

bustness
Recovery
or
Pre-frailty
Recovery
Stressor
Frailty
Stressor
Dependence
Disabi
Time

Medical Education System (RN/MD/DPT, etc)

- We were all taught patient has "A" we do "B"

Today's reality

- The patient has "A"
- Before going forward we must ask: What is the Goal? What treatment/interventions will get us to the goal?



End of Life Care

- Like learning a new language, a new skill set
- Not impossible, harder for some
- But necessary if you need to get around effectively and efficiently in this healthcare environment

AARP Study

- Nearly all doctors agree they should discuss end of life care with their patients
- 50% of Docs are unsure what to say, are concerned patients will give up hope
- 75% think they should initiate the talk (only 14% have billed medicare for it)
- We all need to own the conversation

Why do we do these things

- As practitioners we are taught HOW to do but not WHEN to use that HOW judiciously
- Problem A=Solution B
- It makes us feel better and more comfortable that we DID something

Why talk about this?

- WW II to Mid 70s
- Explosion of medical advancements
- Heart Surgery, pacemakers, ICUs, ventilators, CPR, 911

The Rise of the “Treatment Train”

Berlin 2016

Treatment Train

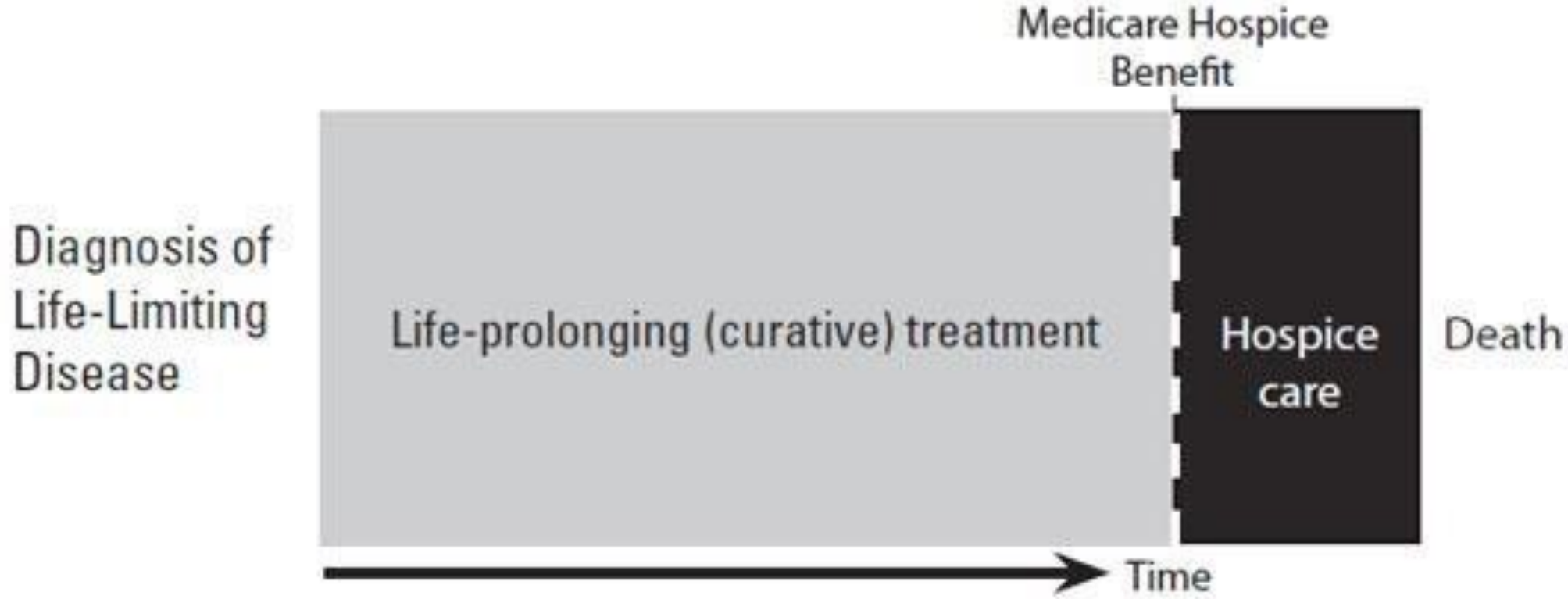
- Who is the conductor? (patient vs family vs doctor vs system)
- What is the destination?
- When is it time to re-route?
- How do we stop, redirect

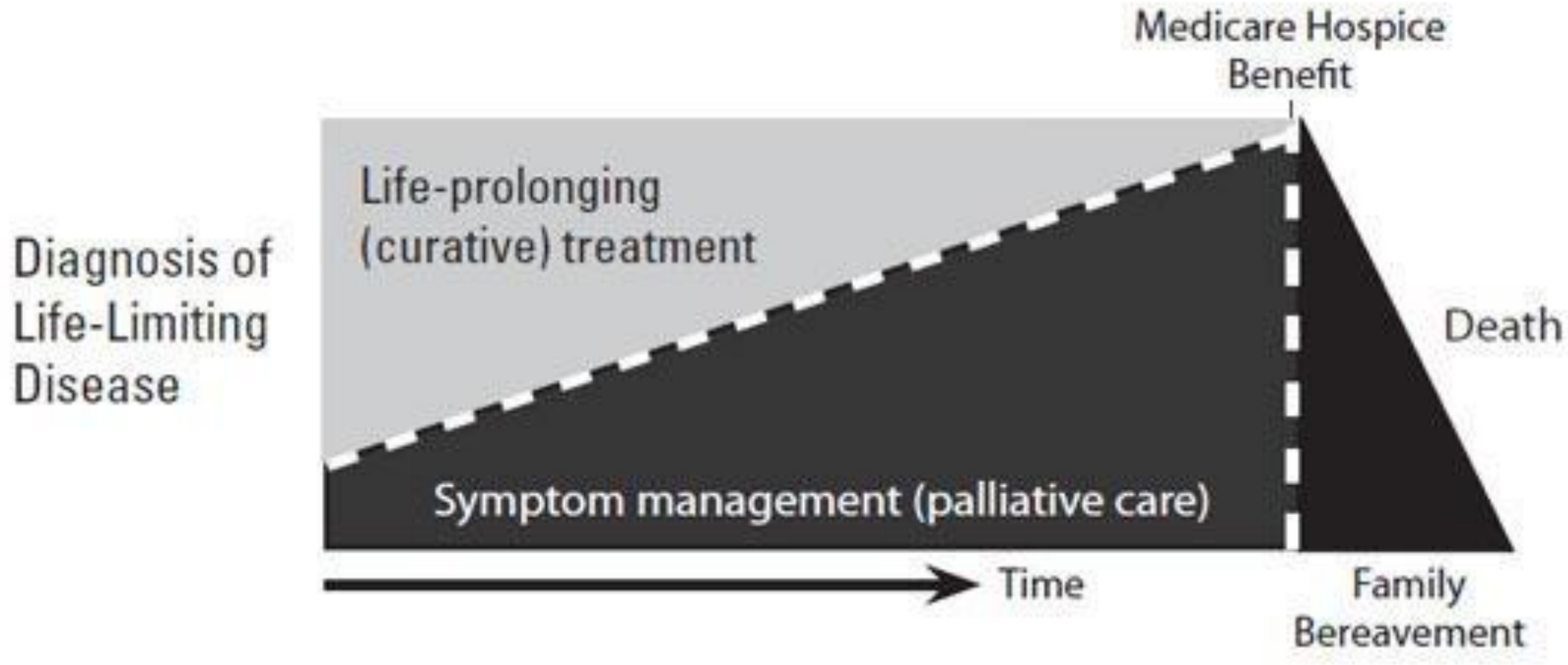
New Paradigm

- BECAUSE A DOCTOR CAN DO SOMETHING NEVER MEANS THEY SHOULD!
- CMS: "Choosing Wisely Campaign"

CMS Choosing Wisely Campaign

- Right Patient
- Right Treatment
- Right Time
- Based on 70 medical societies consensus on treatments and interventions


Medicare Hospice Benefit
Diagnosis of Life-Limiting Disease
Life-prolonging (curative) treatment
Hospice care
Death
Time


Medicare Hospice Benefit
Diagnosis of Life-Limiting Disease
Life-prolonging (curative) treatment
Death
Symptom management (palliative care)
Time
Family Bereavement


HUDSON
15

Dartmouth Atlas Study
2006 vs 2014

Factor	NJ 2006	NJ 2014	US Avg. 2006	US Avg. 2014	NJ Rank among 50 states (incl. DC) 2006	NJ Rank among 50 states (incl. DC) 2014
Hospital days per decedent during last 6 months of life	15.2	10.6	11.7	7.9	49	50
ICU days per decedent during last 6 months of life	4.6	5.7	3.2	3.5	50 (tie)	51
Physician visits per decedent during last 6 months of life	41.5	40.1	29.0	26.5	51	51
% deaths associated with admission to intensive care	25.1	20.2	18.5	14.7	51	51
% enrolled in hospice	23.5	47.8	27.2	52.0	32 (tie)	39
Days spend in hospice	12.7	19.6	17.0	23.3	42	31
Medicare spending & resource inputs during last 2 years of life	$39,810	$83,996	$29,199	$69,289	51	50

Discussing Goals in Advanced Illness

- What are the two most important questions that must be asked to start the conversation?

Question #1

- What is your understanding of what is happening with your (your family members') health at this time?
- (ASK-TELL-ASK)

What is known? (ASK)

- What is being said is not always what is being heard.
- Make no assumptions. Ask what they already know, ask about the last 3-6 months. Ask about one year ago
- How have things changed?

Medical Review (TELL)

- Present medical information
- Give details and how it relates to the big picture
- Speak slowly, deliberately, clearly
- NO JARGON
- Be aware of the difference between "good news" and "good information"

Medical Review (ASK)

- Do you have questions about what I just went over?
- Now everyone can be on the same page of the same book

Question #2

- Based on that information, what is the GOAL? Now and if your health worsens?

Make Recommendations

- Patients and families want help in making decisions
- Support the decision that is made but do not be afraid to express what concerns you about the decision
- "Wish/Worry technique"

Remember

- DYING is a process
- DEATH is the event
- If you do not understand the process your patient's and families will not be ready for the event
- Discuss code status in an honest way

- Try to remember: It is resuscitation, not resurrection that we are offering!

When Challenged

- "We want everything done for mom!"

When Challenged

- Majority of healthcare practitioners will walk out of the room and document on the chart: "Family wishes everything to be done" and go on to the next patient.
- The vast majority of us will also shake our heads and discuss it with a colleague how ridiculous these efforts are in this patients particular situation.

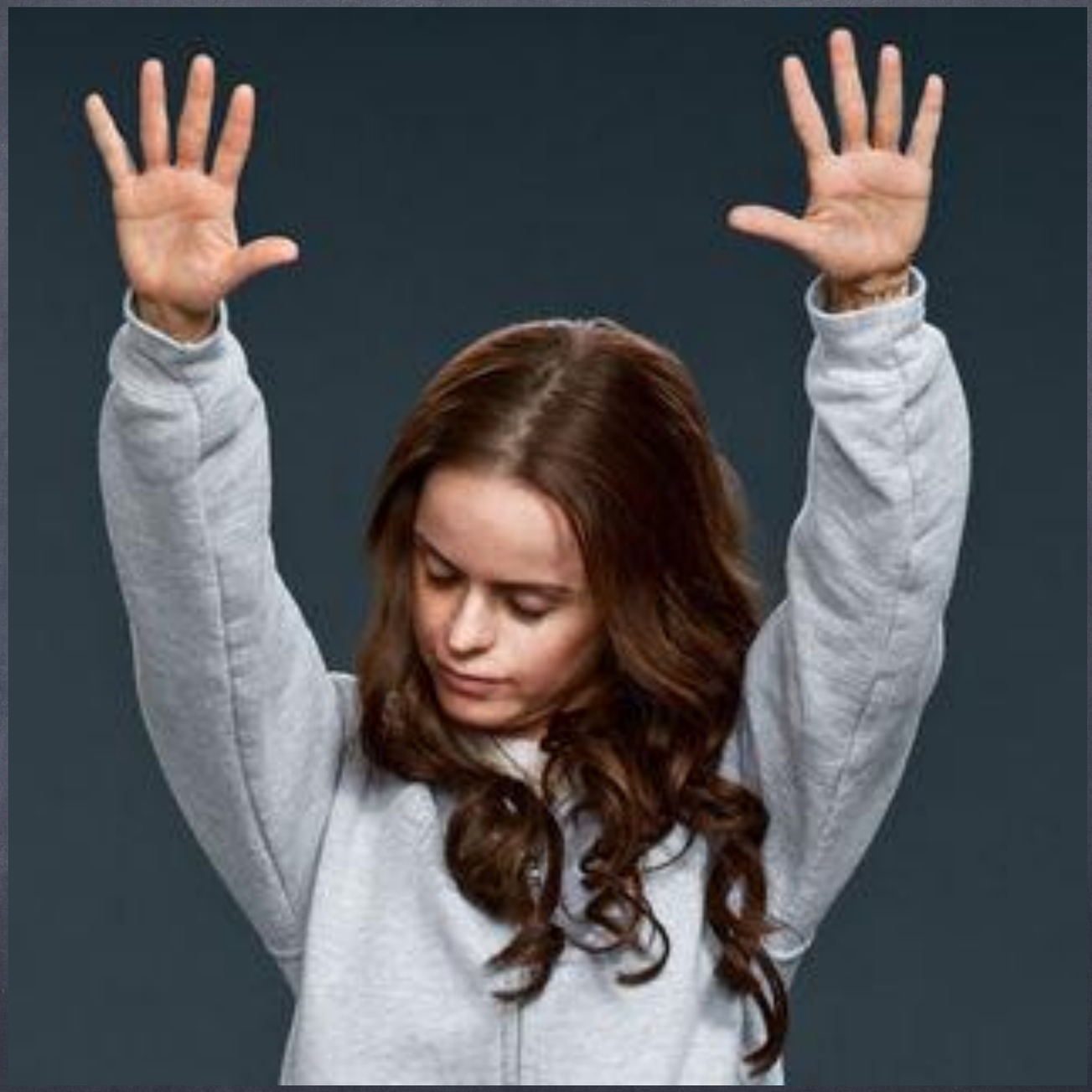
When Challenged

- "What concerns you that everything hasn't been done or isn't being done? I reviewed the records and I can assure you, in your mom's situation, everything has been done"
- Now you have the opportunity to have a detailed discussion about what is really happening.

Still Challenged?

- "What concerns you most about your mom's death?"

"God is Going to Heal Her"



Stop Seeing Religion and Faith as a Barrier

- What are families really saying when they say "God is Going to Heal Her?
- This is an opportunity, not an obstacle.

"We have Hope"

- Hope is a powerful asset
- Do not take hope away
- You may need to help families re-define what they are hoping for?
- Hope is not binary

She's a fighter!

What is a Fighter?

- Being a fighter is a mental, emotional and spiritual state
- When illness becomes advanced, despite a fighting spirit the body with continue to fail
- At that point, what is the goal?

"He was fine right before this"

Fine vs Not Fine

- Everyone who is "not fine" was "fine" at some point

Goals into Plan: Common Issues

- Future hospitalizations?
- Admission to ICU?
- Tests?
- Code status?
- Artificial Nutrition and Hydration? (Know the facts)
- Antibiotics?
- Blood Products? (benefits vs burdens)
- Home support? Hospice?

Know your strengths

- Not everyone has to be good at this
- Know who amongst your colleagues is good at this and when to refer your patients

Doing something "for" the patient

Doesn't always mean doing something "to" the patient

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