What Are We Doing Here?

The Importance of Addressing Goals At Transitions of Care

Ascension

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Disclosures

I have no disclosures

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- B.S. Biology, Purdue University, 2009
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Experience:
- St. Vincent Medical ICU (RN) 2012-2018
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Objectives

- Learn how to identify patients with high 6-12 month mortality risk
- Recognize importance of addressing goals and expectations as environment of care changes and at key decision points
- Identify barriers to discussing goals and possible solutions
- Understand benefits of clear goals and expectations
- Become familiar with advance care planning (ACP) tools available to patients and clinicians

Case Study

- 88 year old female with PMH: HTN, Hypothyroidism, GERD and remote endometrial CA who lives in AL with her husband
- Fell at home, sent to hospital, found to have L hip fracture. Surgically repaired
- Uneventful hospitalization
- Presented to sub-acute rehab POD #5
- Full code - son and daughter involved making decisions together

Why Does It Matter?

More pain and suffering for patient

Families and patients get frustrated when expectations are not met

Provider and clinician moral distress and burnout

ACP doesn’t just happen in one conversation, so it’s never too early to start

Assessing Risks

Tools for Assessing Mortality

- ePrognosis.org:
  - Several tools for different settings - ambulatory, hospitalized, facility-dwelling
  - Takes frailty, nutrition, mobility, functional status, and symptoms into account
  - Result is estimate of 6-month mortality
  - Can be useful for hospice referral process if unsure of eligibility

- Charlson Comorbidity Index
  - Not specific to elderly
  - Provides 10-year mortality risk estimate
  - Based primarily on chronic conditions, does not account for frailty or functional status
  - Can be useful in early, primary care-based conversations

Assessing Mortality Risk (cont.)

- Recent hip fracture
  - Significant increase in all-cause mortality in first 3 months
  - Lowers but persists for at least 2 years
- Repeat hospitalization within 30 days
  - Estimated 2-3x 1-year mortality risk
- Cognitive impairment paired with hospitalization/heart disease/advanced age
- Poor Nutrition
- Decline in Functional status, increase in frailty

Ask yourself "Would I be surprised if this patient died in the next year?"

Case Study

- Within one week of reab admission, developed cough, dx with pneumonia via CXR
- Cognitive decline, became withdrawn
- Poor PO intake led to hypernatremia, electrolyte abnormalities, so fluids were given, ultimately IV antibiotics started
- Family maintained full code status

Case Study

Mitchell Index (ePrognosis.org): 18 points → 49-62% 6-month mortality

Charlson Comorbidity Index: 5 points → 21% estimated 10 year survival

When?

Key Decision Points

Short answer: Anytime you can!

- Especially important at transitions:
  - A new diagnosis
  - Prior to referral to specialist
  - When nearing the end of available treatments for chronic conditions
  - If possible, prior to hospitalization
  - Before surgery/procedure
  - Before discharge from hospital
  - On admission to SNF/LTAC
  - When Transitioning between community-dwelling, IL, AL, LTC/SNF
- Address expectations, priorities

Barriers

Barriers to Discussing ACP/Goals

- Time!
  - Does not have to be long, involved discussion
  - Most successful when occurs in multiple discussions over time
- Discomfort with Subject Matter
  - Ask patients their preferences for these conversations
  - Both patients and providers may be reluctant
- Reluctance to Start the Conversation
  - Patients expect providers to discuss prognosis, EOL issues
  - Providers wait for patients to ask
- Lack of Training/Experience

All of these factors lead to ACP/GOC conversations being crisis-oriented, which is more difficult for both providers and patients

Principles of End Of Life Communication

- Patients want the truth about prognosis.
- You will not harm your patient by talking about end-of-life issues.
- Anxiety is normal for both patient and clinician during these discussions.
- Patients have goals and priorities besides living longer.
- Learning about patient goals and priorities empowers you to provide better care.

*These apply often, but of course patient preferences and communication styles vary with individuals and with culture/experience.

Bernacki, R. E., Block, S. D., & American College of Physicians High Value Care Task Force (2014). Communication about serious illness care goals: a review and synthesis of best practices. *JAMA internal medicine*, *174*(12), 1994–2003. https://doi.org/10.1001/jamainternmed.2014.5271

Case Study

Barriers Preventing Effective ACP

- Family was unrealistic about her state - complicated by isolation/lockdown due to Covid-19
- Family felt beholden to prior conversations where she stated she wanted to live as long as possible
- Multiple small events that each feel “fixable” but tend to compound

Benefits

‘It’s not easy to talk about these things at all, but … information is power’

Anonymous Patient

Advance care planning discussions in advanced cancer: analysis of dialogues between patients and care planning mediators.

Barnes, K. A., Barlow, C. A., Harrington, J., Ornadel, K., Tookman, A., King, M., & Jones, L. (2011). Advance care planning discussions in advanced cancer: analysis of dialogues between patients and care planning mediators. *Palliative & supportive care*, *9*(1), 73–79. https://doi.org/10.1017/S1478951510000568

Benefits of Effective ACP and Discussion of Goals

- Improved patient quality of life
- increased patient satisfaction with care
- Empowerment of patient
- Decreased readmissions, utilization of expensive and limited resources
- Decreased moral distress and burnout for providers

Tools

Tools and Methods for ACP

- "What Matters?"
  - An easy place to start to assess values without explicitly discussing end of life/mortality

- Five Wishes
  - Simple advance directives in every day language
  - 1. The Person I Want to Make Health Care Decisions for Me When I Can't Make Them for Myself
  - 2. My Wish for the Kind of Medical Treatment I Want or Don't Want
  - 3. My Wish for How Comfortable I Want to Be
  - 4. My Wish for How I Want People to Treat Me
  - 5. My Wish for What I Want my Loved Ones and Health Care Team to Know

- Indiana POST form
  - Allows for more specificity than a traditional living will or DNR

Communication Tips

Table. Communication Tips

Do	Don't
Give a direct, honest prognosis[99,101]	Avoid responding to a patient request for information about prognosis[102]
Provide prognostic information as a range; acknowledge uncertainty, eg, "we think you have weeks to a small number of months, but it could be shorter or longer"[103]	Provide vague, eg, "incurable" or overly specific information, eg, "you have 6 months"
Allow silence[104]	Talk more than half the time[104]
Acknowledge and explore emotions[105]	Provide factual information in response to strong emotions
Focus on the patient's quality of life, goals, fears, and concerns[33]	Focus on medical procedures[106]

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Case Study

- Had 4 hospitalizations in next 60 days
  - Pneumonia, dehydration
  - Dehydration, while hospitalized, hip became dislocated, had revision surgery
  - Feeding tube placement when she continued to refuse food, fluids
  - Pulled feeding tube, dehydration/electrolyte abnormalities
- Admitted to hospice 60 days post fall, passed away 3 days later

Case Study, cont.

Interdisciplinary team all understood poor prognosis

Family struggling as patient could not participate in goals of care conversation

Last 60 days of life came with high cost, high level of intervention, and likely significant discomfort for the patient

Questions?

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