Facilitating Smooth Transitions: ICU → Home Hospice

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We have nothing to disclose
Objectives

• Provide definitions to themes
• State the common areas of patient care that are vulnerable to poor continuity
• Name the essential steps to promote seamless transitions in care settings
• List the benefits to the patient and family, provider, and health care system from a successful transition of care
Discharge is a family affair

https://www.youtube.com/watch?v=Un7As1R2-HU
Transitions of Care

• A set of actions to ensure patient coordination & continuity of care as patients transfer between different locations or levels
What are transitions of care?

• Transitions care occur
  – Within settings
  – Between settings
  – Across settings
  – Between providers

• Settings may include
  – Hospitals
  – Subacute/post-acute nursing facilities
  – Patient’s home
  – Primary/specialty care offices
  – Long-term care settings
Transition Issues Dramatically Impact Patient Care

OUTPATIENT:
- Home
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Care Giver

ER → ICU

In-Patient

SNF → ALF

Patient

Patient
Common vulnerabilities

• Ineffective delivery of team-based care
• Absence of evidence-based treatment decisions
• Lack of healthcare provider accountability
• Inaccurate medication reconciliation
• Unsuccessful communication
• Delayed transfer of critical information
• Non-standardized hand-off procedures
• Untimely follow-up
• Subpar patient/caregiver education
• Patients with multiple comorbidities

An unfortunate example of inaccurate medication administration...

SIR... THE BALDNESS PILL IS NOT A SUPPOSITORY.
Subpar patient/caregiver education...

“Giving raw egg enemas twice a day to your cat will cure any urinary tract infection. Instructions follow:”

Beware of internet advice: You don't know who's giving it.
Specific patient-related issues

• Not able to properly participate in active self-care
  – Lack skills, knowledge, confidence and tools
• Cognitive function
• Transportation, food access, finances
• Support Services, housing
• Medication utilization
• Accessing provider with questions
• Hospice de-enrollment *
• Access to palliative care services

Cost of suboptimal transitions

• Medicare spends $15-17 billion annually on unintentional hospital readmissions

• Polypharmacy and referrals to specialty clinics continue to rise → growing burden of costs

• Patient/Caregiver/family

• Safety

• Others?

What is necessary for success?

- Multimodal
- Multidisciplinary
- Begin before transition
- Continue throughout transition with long-term f/u
- Close collaboration & communication between inpatient & outpatient providers
- Patients & caregivers must be included in communication
- Effective strategies that improve education to patients and caregivers needed
- Discussion about goals of care in patients with serious illness

Case – Mr. B

• 47 y/o admitted with AMS, respiratory failure, UTI
• PMH: C5 incomplete tetraplegia in May 09, Botox injections for bladder, hands, & feet, neurogenic bladder, recurrent UTIs, OSA – wears CPAP, peripheral neuropathy, anxiety/depression
• PSH: diaphragmatic pacemaker, cervical spinal cord detethering, PEG, trach, C4 corpectomy with C3-5 fusion, Baclofen pump placement
Case – Mr. B

- ED → MICU
  - BiPAP → 2 liters NC
  - Ceftriaxone
  - Home opioids (methadone & oxycodone) held initially due to somnolence/AMS
  - Baseline achieved 1 day later
  - Palliative Care Service consulted for goals of care discussion on hospital day #2
Case – Mr. B

• Palliative Care Consult
  – Wife & paid caregiver present
  – Endorsed a deteriorating QOL following detethering procedure 2 years prior
    • Unrelenting pain, spasms, functional losses, insomnia, burden, isolation, depression, anger, frustration, sadness
  – Prior to procedure, patient described himself as “positive, motivational and active.”
“My day to day existence is full of suffering.”

Mr. B requested that his medical care be focused on comfort and quality of life enhancement versus life sustainment.
Comfort Care in Mr. B

• Discussed potential implications given respiratory fragility
  – No further hospitalizations, No 911 → POLST

• Detailed assessment of pain and other symptoms
  – Led to increase of frequency of oxycodone to q 3 hr prn from q 6 hr prn
  – Continue abx course, BiPAP, pacemaker, botox injections

• Holiday weekend
  – Planned hospice admission on following Tuesday *
  – Gave wife our 24/7 team contact information in the meantime should questions arise
Transition of Care - Coordination

- MICU Team
  - Attending, resident, RN, LCSW
- PMR Physician / Attending MD
- Pharmacist
- Case Management Team
- Insurance Provider *
- Hospice Team and Physician

Duration of total encounter: 3 hours
Question #1

• How often do you give/receive handoffs for hospice patients?

A. 0-15% of the time
B. 16-30% of the time
C. 31-45% of the time
D. more
Question #2

- When you do receive handoff, how helpful do you find them?

  A. not very helpful
  B. somewhat helpful
  C. extremely helpful
Question #3

• What’s the biggest barrier you face in providing/receiving handoffs?

A. Time
B. Don’t know who to call
C. Don’t find them helpful, so don’t do them
D. other (raise hand and comment)
Handoff

• Received call from Holli prior to patient’s admit
  – When complicated, often get heads up call a few days before, then again at day of discharge as we did with Mr. B

• What do I need to know from medical standpoint
  – Diaphragmatic pacer (what??), BiPAP
  – Baclofen pump
  – Insurance coordination (meds, outside visits)

• Reviewed his goals of care
Transition from hospital to home

• Medical personnel view this as an “event”*
• For the family, it is a “process”
  – Feels different to go home with hospice vs just going home
  – Doesn’t happen all at once for them
• DME, medications, hospice paperwork
• Family/friends visiting
• Hospice staff visiting
• When asked, most patients state they view the 1\textsuperscript{st} hospice visit as paperwork, not the start of care

Transitioning to home

• There’s a lot to learn!
• Family members are not trained caregivers
  – Can I leave to run errands?
  – Making a schedule
  – Teaching about wound care, hygiene, repositioning
• Symptom management
  – Recognizing and treating
  – Meds can be very intimidating
• Dispelling myths of hospice
“Hospice will take care of everything”

• Many patients are told this
• Is it true?
• Is it reassuring?
• Can it also be misleading?
1\textsuperscript{st} Hospice Visit with Mr. B

- Spent 2.5 hours with patient and his caregiver
- Called wife on speaker phone
- Patient c/o pain and insomnia, but felt the insomnia was 2/2 to pain
- Adjusted pain medications
- Simplified med regimen
- Detailed notes written for family, caregivers
- Make sure hospice RN present, as she is the continuity
How did the handoff from Palliative care team help me plan?

• Preparation
  – Research before the visit
  – Social workers, chaplain already updated
• Saying “I spoke with Holli from the University of Utah...” goes a long way
• Able to dive right in to symptom management, as this was the patient’s priority
• My own confidence, preparedness
2nd Hospice Visit with Mr. B

• Pain improved
• Still not sleeping well
• Another 2+ hour visit discussing sleep at length
  – Routine before bed
  – Caregivers
  – My “Ah Ha” moment regarding history of symptoms
• Coordinating care, social workers, chaplain, his own caregivers, called wife on speaker phone
Outcome

• Week after my last visit, patient with decreased responsiveness, died 2 days later comfortably and at home
• Family very thankful to have had lengthy discussions about his goals of care and desire to not return to hospital
• Were able to keep him comfortable, trusted his nurse, had peace with their decisions
Wrap Up

• Personal experience: handoffs are extremely helpful
• Evidence in the literature supports this
• Lack of standardized process major barrier
• Think about your own programs - how could you enhance how transitions of care occur, how might you, patient and their family benefit?
• Time!
Questions/Comments?

THANK YOU!