Go To The Hospital Or Stay Here? Having the Conversation

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Go To The Hospital Or Stay Here? A Decision Guide for Residents, Families, Friends and Caregivers

Throughout this session, we will be referring to the **Go To The Hospital Or Stay Here?** decision guide.

If you are not familiar with the guide and its contents, we recommend that you visit www.decisionguide.org or view the Alliant Health Solutions 5-minute video guide overview on the Alliant YouTube channel: Go to the Hospital Or Stay Here? A Decision Guide for Residents, Families, Friends and Caregivers – YouTube to familiarize yourself with the guide prior to viewing this module.

https://bit.ly/DecisionGuide_CMS

https://bit.ly/GototheHospitalorStayHere

Learning Objectives

- ✓ Understand the transfer experience from a patient or resident perspective.
- ✓ Recognize how implicit bias can impact transfer decisions.
- ✓ Learn how to incorporate risks and benefits into the conversation regarding transfer.

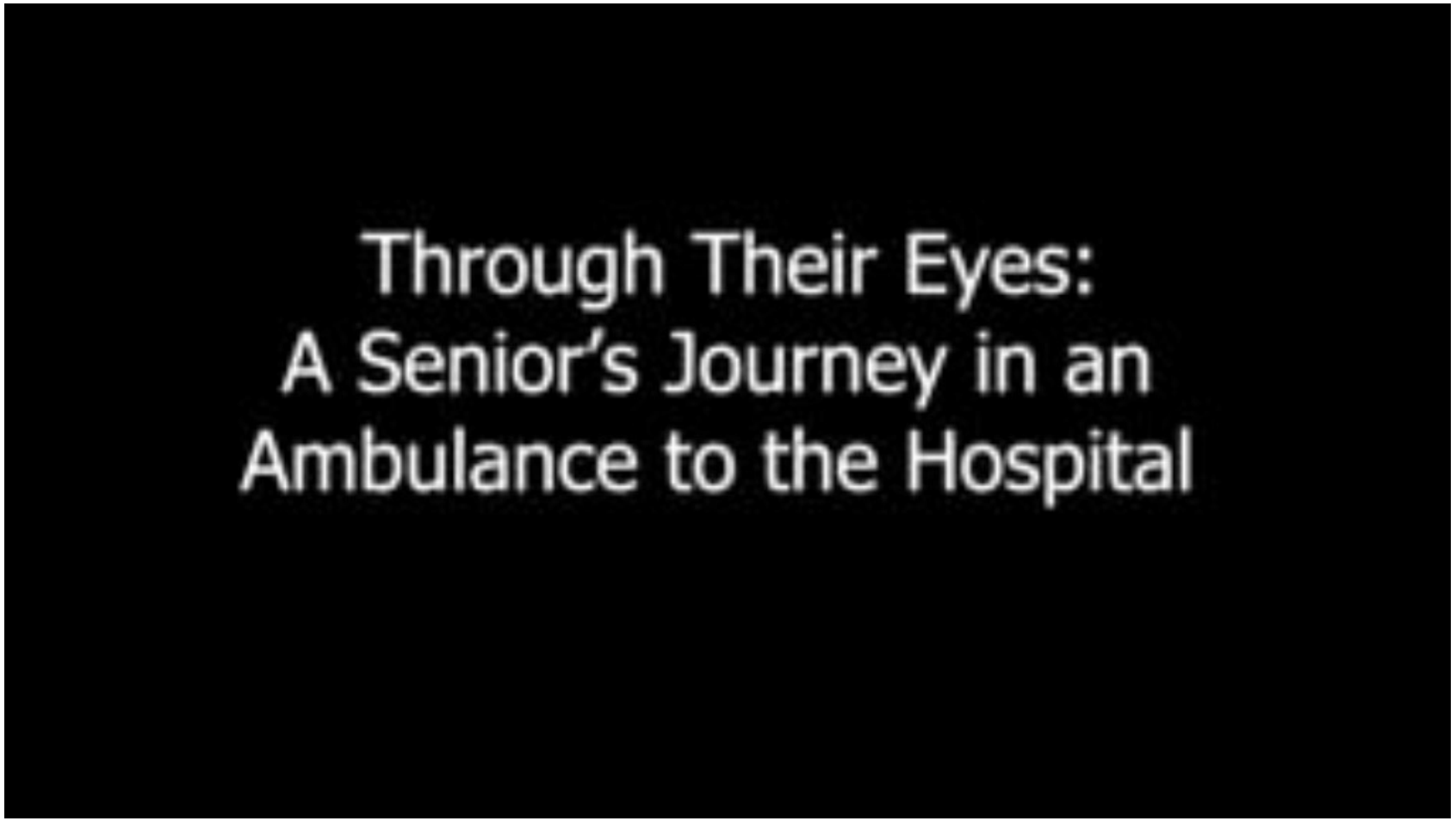
Why Transfers Happen

The Society for Post-Acute and Long-Term Care Medicine (PALTC, or AMDA) divides transfer causes into two categories[1].

Reasons Related Primarily to Patient's Current Condition or Status	Reasons Less Directly Related to Patient's Current Condition or Status
Availability of in-house diagnostic and support services (e.g., radiology, laboratory, pharmacy)	Inability of staff at long-term care facility to obtain medical supervision of the Acute Change of Condition (ACOC)
Level of care to which patient is assigned on admission to the long-term care facility	Inadequate practitioner-nurse communication
Patient's level of dependency in performing activities of daily living	Inadequate reimbursement for provision of acute care in the long-term care facility
Patient's underlying medical complexity or comorbidity	**Pressure from family, nursing staff, or physician to hospitalize the patient**
Premature discharge from acute-care facility to long-term care facility	Time of day or week when the ACOC occurs.
Presence or absence of advance care planning instructions about management of acute medical illness (e.g., a "Do Not Hospitalize" order)	
Severity of illness or degree of medical instability	

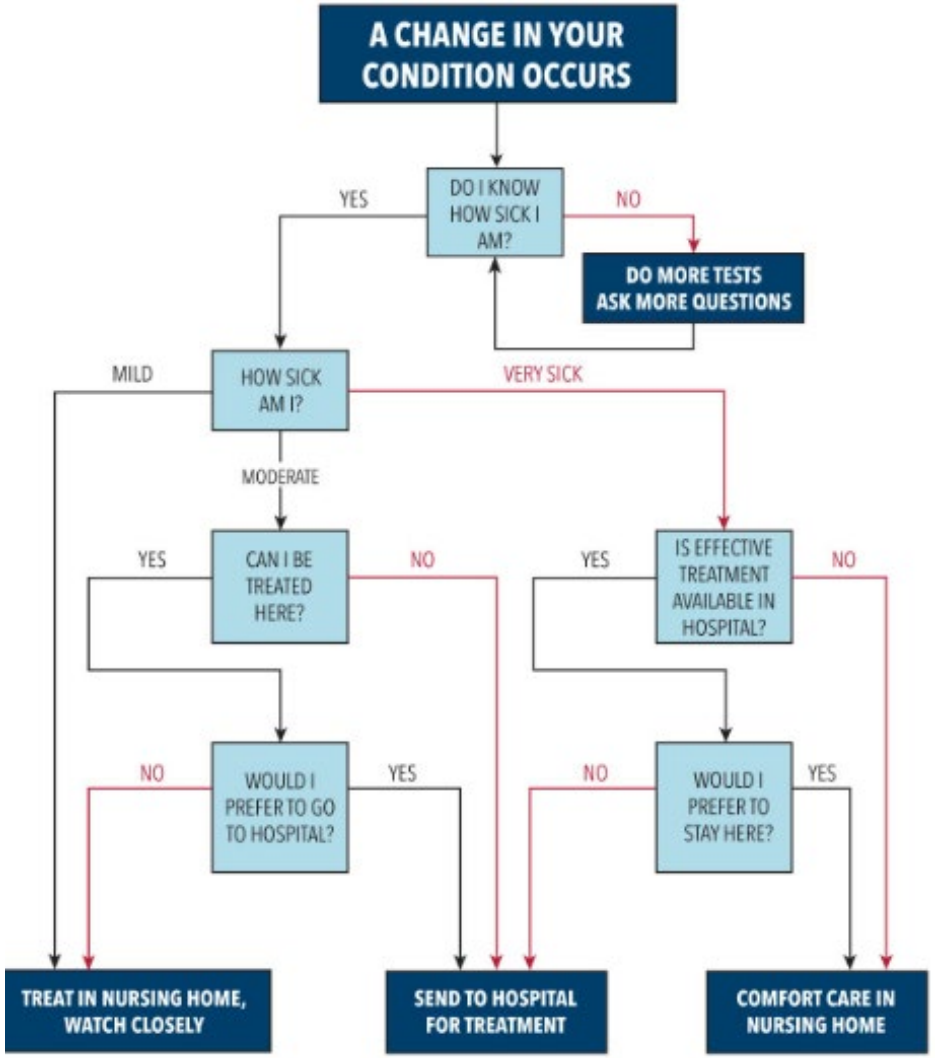
1. Acute Change of Condition in the Long-Term Care Setting Clinical Practice Guideline. Used with permission

The Ambulance Experience



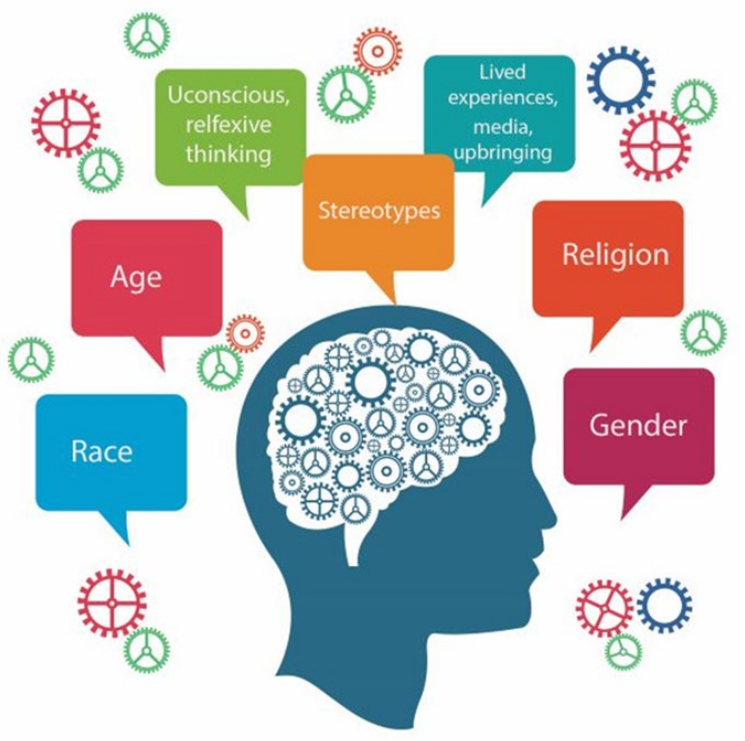
https://bit.ly/ThroughTheirEyes_AHS

Go To the Hospital or Stay Here: Decision Tree



The Role of Bias in Communication

- Authority Bias
- Anchoring Bias
- Framing/loss aversion
- Confirmation Bias
- Implicit Bias



https://bit.ly/JointCommission_QuickSafety

Can I Be Treated Here?

"It depends on what is going on, the severity of the illness. Give me a run down on what the hospital can do for me and what they can do for me here." (Patient)

"I don't want to push the panic button and send her to a hospital if it can be kept under control here." (Son)

REASONS TO PREFER BEING TREATED HERE

Many tests and treatments can be provided in the nursing home:

- Medications
- X-rays
- Blood tests
- Oxygen
- Wound care
- Checking on you and reporting to your doctor or other medical provider
- Comfort care (pain relief, fluids, bed rest)
- IV (intravenous) fluids in some facilities
- Physical or Occupational Therapy
- Speech Therapy

You can ask your nurse, doctor or other medical provider what else can be done for you here.

REASONS TO PREFER BEING TREATED IN THE HOSPITAL

Hospitals can provide more complex tests and treatments including:

- Heart monitoring
- Body scans
- Intensive care
- Blood transfusion
- Surgery

THERE ARE ALSO RISKS TO GOING TO THE HOSPITAL

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Person-Centered Shared Decision Making

"It depends on what is going on, the severity of the illness. Give me a rundown on what the hospital can do for me and what they can do for me here."

"I don't want to push the panic button and send her to the hospital if it can be kept under control here"

Setting the Stage for A Meaningful Conversation

- Review what is known about the individual's goals and values.
- Find uninterrupted time for the discussion.
- Provide information in small amounts within your scope of practice.
- Give time for response, questions and clarifications.
- Respond with empathy

BlueShield, E. B. (2023). Thoughtful MOLST Discussions. MOLST. https://molst.org/how-to-complete-a-molst/thoughtful-molst-discussion/

Goals-of-Care Conversation in 8 Steps

1. Review previous discussions and documented wishes for care.

2. Assess willingness to receive information and their preferred role in decision making.

3. Discuss prognosis and anticipated outcomes for current treatment. Assess for understanding.

4. Ask patient about their values, goals and fears for the future.

Goals-of-Care Conversation in 8 Steps

5. Discuss health states the patient would find unacceptable.

6. Discuss specific preferences for life sustaining treatments and interventions being considered.

7. Summarize and make a plan.

8. Complete/update advanced directives and document conversation in medical record.

ACP. (2021, January 15). IMPLEMENTATION | January 15, 2021 The Goals-of-Care Conversation: A Best-Practice, Step-By-Step Approach. Implementation. October 24, 2023, https://www.acpdecisions.org/goals-of-care-conversations-a-best-practice-step-by-step-approach/

Physician and Patient Discussion

https://bit.ly/PhysicianandPatientDiscussion_AHS

Knowledge Check

What key points did Dr. Adams discuss with Mrs. H. about going to the hospital?

A. Risks and benefits of hospitalization

B. Current change in condition

C. Signs and symptoms to report to nursing

D. All of the above

Knowledge Check

The correct answer is:

D. All of the above

Dr. Adams explained to Mrs. H. that she had a urinary tract infection that requires intravenous antibiotics and that she could go to the hospital to receive treatment there and that they could monitor her heart and other vital signs for worsening infection while there. Dr. Adams explained that being in the hospital would potentially expose her to virus' such as COVID and that she would likely be less mobile while in the hospital

Best Practices

On Admission

- Give the Guide to patient and care partner on admission
- Include in Baseline Care Plan

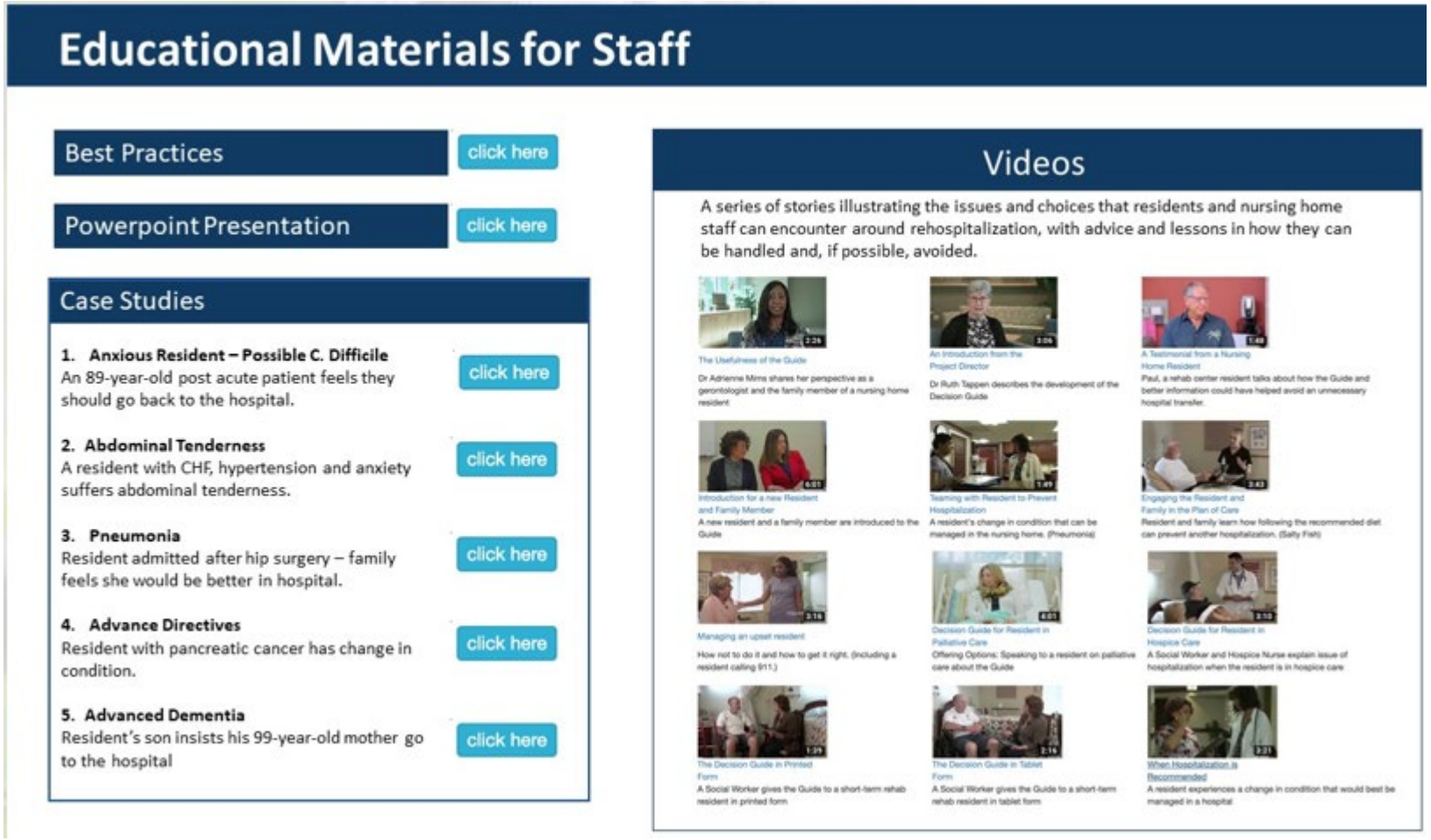
Care Conferences

- Refer to the Guide during subsequent care conferences
- Share the Guide with Resident and Family councils

Advanced Care Planning/Change of Condition

- Use the Guide to start difficult conversations
- Discuss when change of condition occurs
- Discuss when Patient or care partner are considering hospice or palliative care

Building Conversation Skills



- decisionguide.org/training.aspx

Next Steps

Thank you for joining us today.

If you were asked to participate in this training by your facility, follow the instructions on this slide to take the post-test.

Acknowledgements

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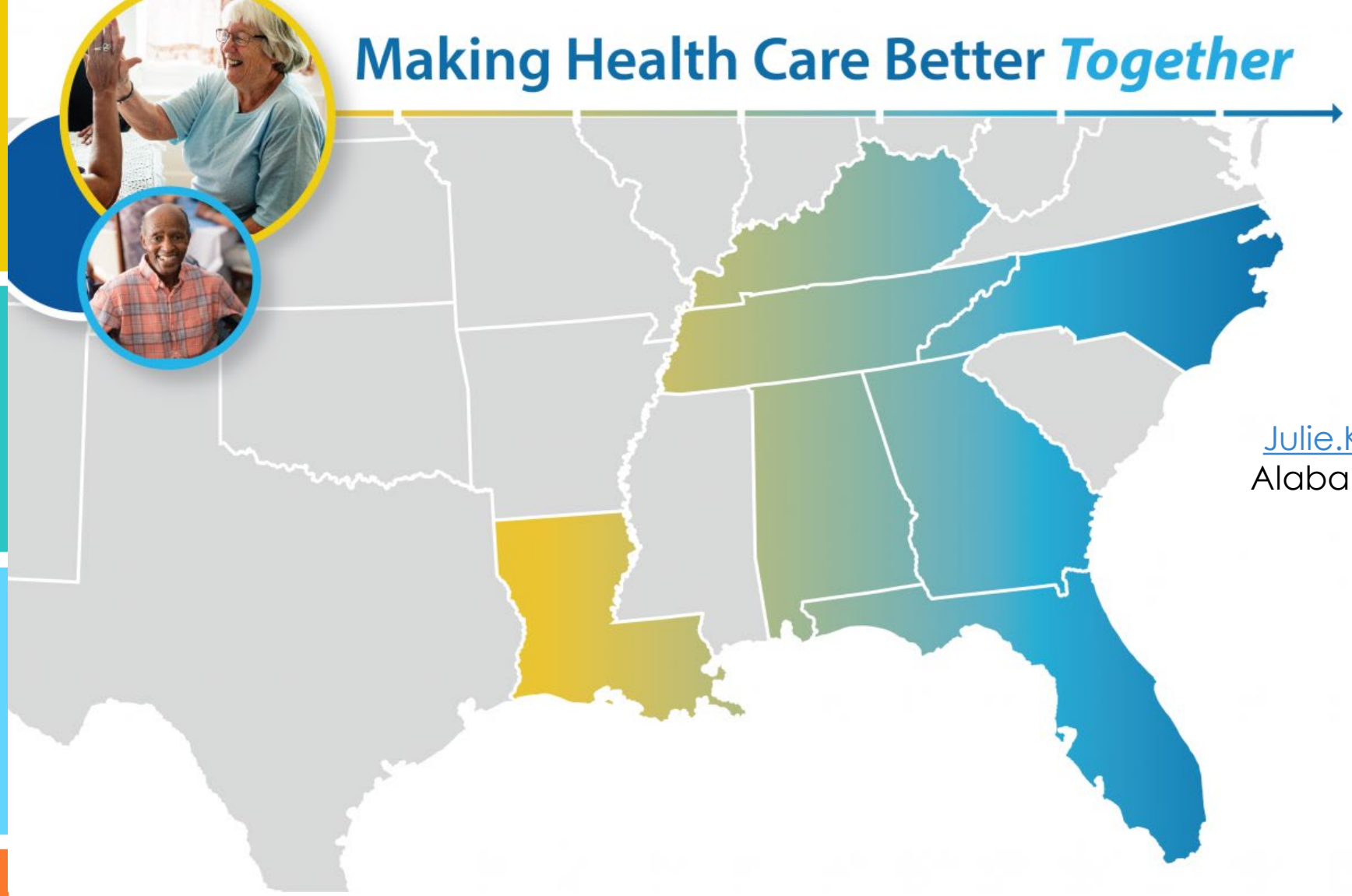

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