Promoting Integrated Care for People with Serious Illness: Improving Access, Coordination and Psychosocial Outcomes
LEARNING OBJECTIVES

• Know what the unit of care is in a nursing home and on hospice and what this unit of care sees as important at the patient’s end of life.
• Learn why Advanced Directives are important in the prevention of burdensome transitions.
• Understand how hospice care in a facility is systemically beneficial at the end of life.
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

UNIT OF CARE

MEDICAL MODEL

- a sick patient
- medical interventions: physical, psychological
- often defined by: the disease/diagnosis
- cure

SOCIAL MODEL

- systemic, the patient and ‘family’
- holistic interventions: biospsychosocialspiritual
- in hospice this includes the staff of the facility and all the natural support caregivers
- care
MYTH: People want to die at home.

MYTH: The majority of people die at home.

REALITY: Preferences change over time; sometimes people are unaware of their own preferences; and sometimes consumers need to grapple with their own competing goals and the inevitable trade-offs posed.

REALITY: Dying in old age has become the majority dying of the developed world, yet older people are routinely denied palliative care, their dying characterized by failure to facilitate choice and recognize their needs.

REALITY: 1/4 of deaths in older adults occur in nursing homes.

REALITY: 2/3 of nursing home residents remain and die in the facility.

Kane, Robert L. and Kane, Rosalie A. (2011), What Older People Want From Long-Term Care, And How They Can Get It, Health Affairs, 20, no.6, pp 114-127.


PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

Health, Maximum Independence

Increasing Age

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95

Infancy: Child Autonomy vs. Shame, Play Initiative vs. Guilt, School Age Industry vs. Inferiority

Adolescence: Identity vs. Confusion, Early Adulthood Intimacy vs. Isolation

Adulthood: Generativity vs. Stagnation

Old Age: Integrity vs. Despair
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

Health, Maximum Independence

Increasing Age

1 2 3 4 5 6 7 8 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 60 61 62 63 64 65 66 67 70 71 72 81 82 83 91 92 95

Infancy

Child Autonomy vs. Shame
Play Initiative vs. Guilt
School Age Industry vs. Inferiority
Adolescence Identity vs. Confusion
Early Adulthood Intimacy vs. Isolation
Adulthood Generativity vs. Stagnation
Old Age Integrity vs. Despair
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

What facilities?

What causes a person to need a facility?

Who determines if a person needs a facility?

What are the determinants?

What is the person’s response to moving?
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

What facilities?
ALFs SNFs LTC

What causes a person to need a facility?
Level of care needs – ADLs – of patient / care receiver
Burden of care issues – of caregiver

Who determines if a person needs a facility?
Person vs. family members

What are the determinants?
Cost, pay source, level of care needs, caregiver availability (family and/or private pay), burden of care

What is the person’s response to moving?
• If the move is to an ALF
• If the move is to a SNF

All these need to be assessed—the answers create interventions.
BURDENSOME TRANSITIONS

- any transfer in the last 3 days of life
- multiple hospitalizations in the last 90 days of life
  - more than 2 hospitalizations for any reason
  - more than 1 hospitalization for pneumonia, UTI, dehydration or sepsis
- lack of continuity in nursing homes - this is generally a result of going from a nursing home to a hospital and then being discharged to a different nursing home after the acute care hospitalization
- THESE ARE POTENTIALLY MANAGEABLE OR PREVENTABLE WITH ADVANCE DIRECTIVES

PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

PATIENT TREATMENT PREFERENCE INTERVENTIONS

• Code Status
  • DNR – Do Not Resuscitate - the most commonly discussed
  • Full Code - CPR – Cardiopulmonary Resuscitation: poor success rate, automatic if no documentation of a DNR exists
  • Hospice /Comfort Care
• By planning ahead, a person can get the medical care they want, avoid unnecessary suffering and relieve caregivers of decision-making burdens during moments of crisis or grief. It also helps reduce confusion or disagreement about the choices the person would want people to make on their behalf
• Advance Directives and Living Wills
  • Each state regulates the use of advance directives differently.
  • A living will is one type of advance directive
  • Living wills and advance directives describe your preferences for end-of-life care (enactment or springing)
• Healthcare professionals can incorrectly interpret Living Wills. It is important to have both a DNR order and a Living Will

PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

INDIVIDUAL REALITIES

CLIENT

SOCIAL WORKER
IDT Professionals
Facility Staff

FAMILY
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

SHARED REALITY & THE UNIT OF CARE

- SOCIAL WORKER
- IDT Professionals
- Facility Staff

- CLIENT
- FAMILY
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

SHARED REALITY & THE UNIT OF CARE

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PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

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FAMILY
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

SHARED REALITY

SOCIAL WORKER
IDT Professionals

CLIENT

SPOUSE
FAMILY
YOUNGER GENERATION
SIBLINGS
# PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

Family Support of the Client in the Decision Making Process

<table>
<thead>
<tr>
<th>SPOUSE</th>
<th>PRIDE</th>
<th>SHAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representing</td>
<td>Mediate</td>
<td>Gone too far</td>
</tr>
<tr>
<td>Adapting</td>
<td>Self determination</td>
<td>Not in charge</td>
</tr>
<tr>
<td>Avoiding</td>
<td>Part of the family</td>
<td>Betrayed</td>
</tr>
</tbody>
</table>

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Soderberg, Maria, Stahl, Agnea, Emilsson, Ulla Melin (2012), Family member’s strategies when their elderly relatives consider relocation to a residential home – Adapting, Representing and Avoiding, *Journal of Aging Studies* 26, 495-503
Soderberg, Maria, Stahl, Agnea, Emilsson, Ulla Melin (2012), Family member’s strategies when their elderly relatives consider relocation to a residential home – Adapting, Representing and Avoiding, *Journal of Aging Studies* 26, 495-503.
HOSPICE IN FACILITIES

- Hospice use in facilities is highest for residents with reported pain and dyspnea
- Hospice use in facilities is lowest for persons with dementia
- Spiritual support and care is considered an important component provided by hospice to the patients and families.
- Hospice is associated with higher levels of family satisfaction.
- Ecological Systems: Micro-patient & family; Meso-facility and hospice, improved care and communication and shared goals; Macro-political advocacy for better funding, options for services for naturally occurring communities and aging in place.

Munn Jean C., Hanson, Laura C., Zimmerman, Sheryl, Sloane, Philip, Mitchell, Madeline (2006), Is Hospice Associated with Improved End-of-Life Care in Nursing Homes and Assisted Living Facilities?, Journal of the American Geriatric Society 54, pp 490-495
PSYCHOSOCIAL END OF LIFE CARE IN FACILITIES

CONTACT INFORMATION:

Skitch Ferguson LMSW

505-453-3018

fergusonskitch@aol.com