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CLINICAL VIGNETTE

Re-Visiting Goals of Care for Long Term Residents at Skilled Nursing Facilities

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Introduction

Goals of care (GOC) conversations are of significant importance in caring for the primarily elderly populations that reside at skilled nursing facilities. These conversations ideally begin during the hospitalization or office visit proceeding the transition to the skilled nursing site; however, often patients arrive with no advanced directive or previous goals of care conversations. While it is standard practice for a POLST (Physician Orders for Life Sustaining Treatment) to be filled out on transfer to the facility, in this case, we present the importance of re-visiting GOC regularly for patients admitted to Skilled Nursing Facilities.

Case

A 70-year-old male with severe COPD with chronic supplemental oxygen dependence was admitted to a skilled nursing facility after a hospitalization for failure to thrive. Prior to his hospitalization, he had been residing alone with increasing support from relatives given his declining health. He was taken to the Emergency Room after being found down on the ground by a family member. He was admitted for adult failure to thrive. During the hospitalization, the etiology of his decline was evaluated and deemed related to end-stage COPD. Given his frailty, he was discharged to the skilled nursing facility with a goal of physical rehabilitation.

On arrival to the facility, a GOC conversation was held and POLST form was filled indicating that he would wish to be *Do Not Resuscitate* and *Do Not Intubate*, but he was open to repeat hospitalizations and other forms of medical interventions. He made it clear during the initial conversation that he had understanding of the severity of his overall lung condition and poor long-term prognosis. However, he had hopes that with aggressive skilled physical therapy at the facility, he would be able to regain his functionality to return to his previous living condition.

Unfortunately, at the facility, he had two repeat hospitalizations secondary to COPD exacerbations with further decline in his conditioning. A family meeting was held after his second return to the facility with the therapy team, social work staff, physician, and primary relatives in charge of his caretaking. During this conversation, the therapy staff had informed the other meeting participants that the patient had reached a plateau and would unlikely make further major improvements in his physical state. The physician reviewed recent Pulmonology recommendations noting that his COPD condition was end-stage with no additional therapies were available at this time. With the information provided during the meeting, the patient and family had a firm understanding that the initial goals of returning home under the previous conditions were not realistic. Goals of care were re-addressed and the patient and family agreed that Hospice would be the most appropriate next step. The patient passed away comfortably on Hospice two weeks later.

Discussion

Skilled nursing facility (SNF) care represents a significant portion of US healthcare costs. In 2010, $143 billion were spent on SNF care and one-quarter of all U.S. deaths take place at a SNF.[1]

SNF residents fall into two-groups: short-term residents who focus on rehabilitation and medical stability and return to the community; and, long-term or ‘custodial’ residents who stay beyond 90 days. Long-term SNF residents are typically older, frail, with life-limiting conditions.

In the long-term resident population, advanced directives have been shown to reduce health system utilization, and costs, without negatively impacting patient satisfaction and mortality.[2] Re-hospitalizations are costly, both monetarily and clinically. They expose older adults to additional risks, including hospital-acquired delirium, iatrogenic infections, falls, added anxiety and interruptions to care plans. On the other hand, readmissions also negatively impact a SNF’s financial stability. Readmissions may impact SNF reputation, which can affect its occupancy and can result in financial penalties from Centers of Medicare and Medicaid (CMS). CMS has further incentivized SNFs to reduce readmissions through programs like the SNF value-based purchasing program, which provides payment adjustments to SNFs that proactively reduce readmissions.[3] Nearly 70% of SNF to hospital readmissions are potentially avoidable.[4]

Advanced directives are important to optimize health outcomes in SNF populations. Do not resuscitate (DNR) is the most common advanced directive at SNFs and has been selected by 56% of long-term SNF residents in the US.[5] Without a DNR, SNFs are obligated to provide basic life support measures under CMS rules. One study found only 1% of residents who had

cardiac arrest at a SNF survived and were dischargeable after acute care hospitalization.[6] Advanced directives should be included as part of larger goals of care discussions. Ideally, these discussions should start prior to SNF admission. One study found only one in three US adults completes any type of advanced directive for end-of-life care.[7] At the SNF, goals of care should be addressed at intake and periodically thereafter. Discussions should review symptoms, medication lists, anticipated clinical course, updates to advanced care documentation, and, importantly, discussion of rehospitalization. For some frail elderly residents, the harms of rehospitalization may outweigh its benefits. Periodic assessments are also good opportunities for introducing hospice, for those with progressive, deteriorating disease. Hospice is available at most SNFs and is generally covered by Medicare.

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