NAVIGATING CARE – FROM HOSPITAL TO HOME

THE CHANGING HEALTH CARE MARKET

- Hospital system mergers
- The increased volume of patients
- Staffing shortages
- Pandemics – vulnerability – i.e. SARS, Covid, flu
- Outcome-based reimbursement
- Technology – AI, EHR, wearable devices, and robotics
- Personalized health care – concierge service
- Rising costs of care
- Financial challenges for providers
- Big data and cybersecurity concerns

TYPES OF ADVANCED DIRECTIVES

- **Do Not Resuscitate (DNR) -** A do-not-resuscitate/DNR order, is a medical order written by a health care provider. It instructs providers not to do CPR (cardiopulmonary resuscitation) if a patient's breathing stops or if the patient's heart stops beating.

- **Living Will:** Is a legal document that spells out medical treatments you want or would not want to be done to keep you alive, i.e. organ donation, mechanical ventilation, tube feeding. It takes effect when you can no longer make medical decisions independently.

TYPES OF ADVANCED DIRECTIVES CONTINUED

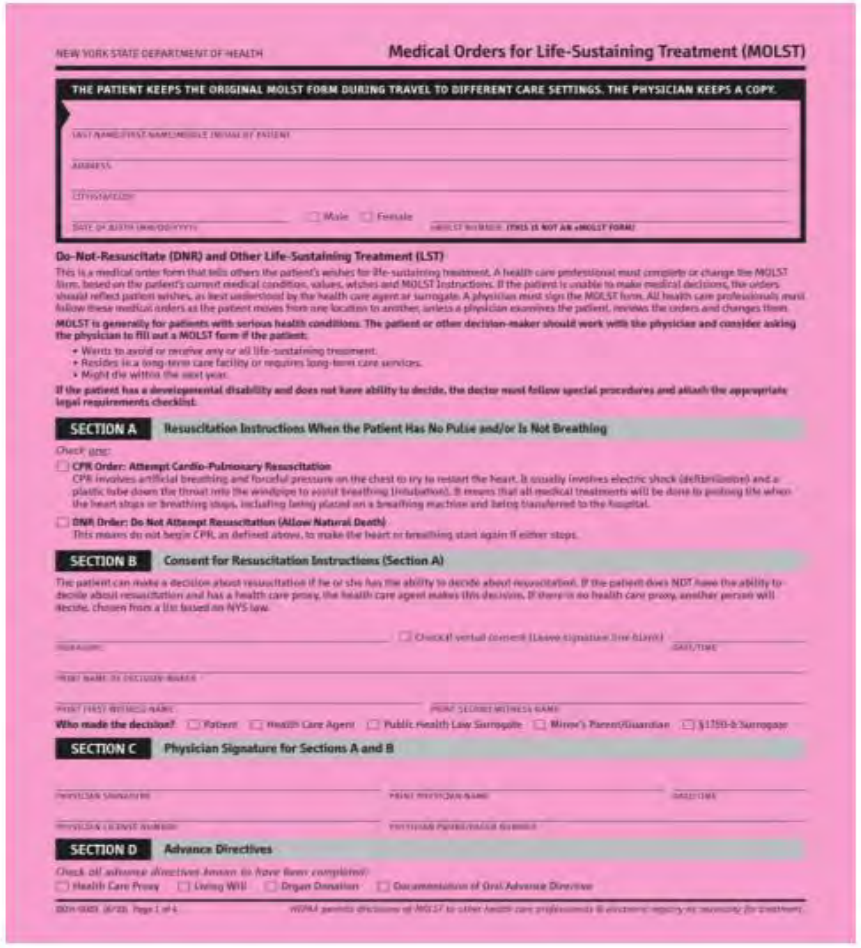
- **Power of Attorney (POA):** A power of attorney (POA) is a legal document that allows someone to act on behalf of another person

1. **Durable Power of Attorney:** Takes effect immediately and allows the agent to continue acting on behalf of the principal even if the principal becomes incapacitated. It only ends when the principal dies or the POA is revoked.

2. **Non-Durable Power of Attorney:** Takes effect immediately, but the agent can't continue acting on behalf of the principal if the principal becomes incapacitated.

3. **Medical Power of Attorney:** This POA allows the principal to appoint a healthcare agent to make medical decisions on their behalf when they are unable to do so.

MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT (MOLST) FORM



NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

MOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decisions. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

PHYSICIAN ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

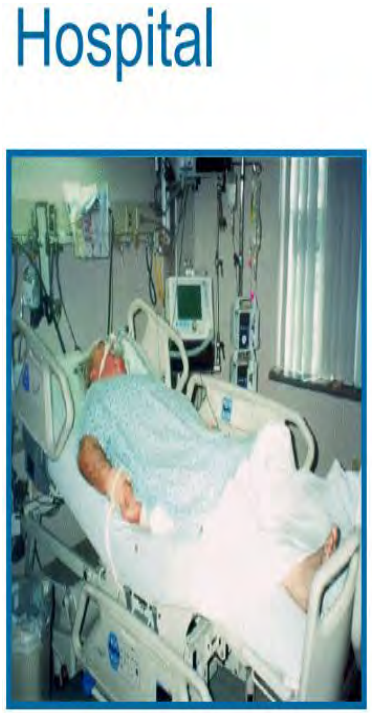
PHYSICIAN LICENSE NUMBER PHYSICIAN PAGER/PHONE NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

DOH-5003 (6/10) Page 1 of 4 HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.



CRITICAL HEALTH RISK FACTORS

- **Diabetes**
  - Eye damage
  - Kidney damage
  - Peripheral vascular disease
  - Nerve damage (neuropathy)
  - Heart attack/stroke
  - Non-healing wounds (dermal ulcers, venous stasis ulcers)
  - Skin infections
  - Bladder problems
- **Drug/Alcohol Use**
- **Smoking**
- **Obesity**
- **Inactivity**
- **Familial History**

HOSPITAL RISK FACTORS

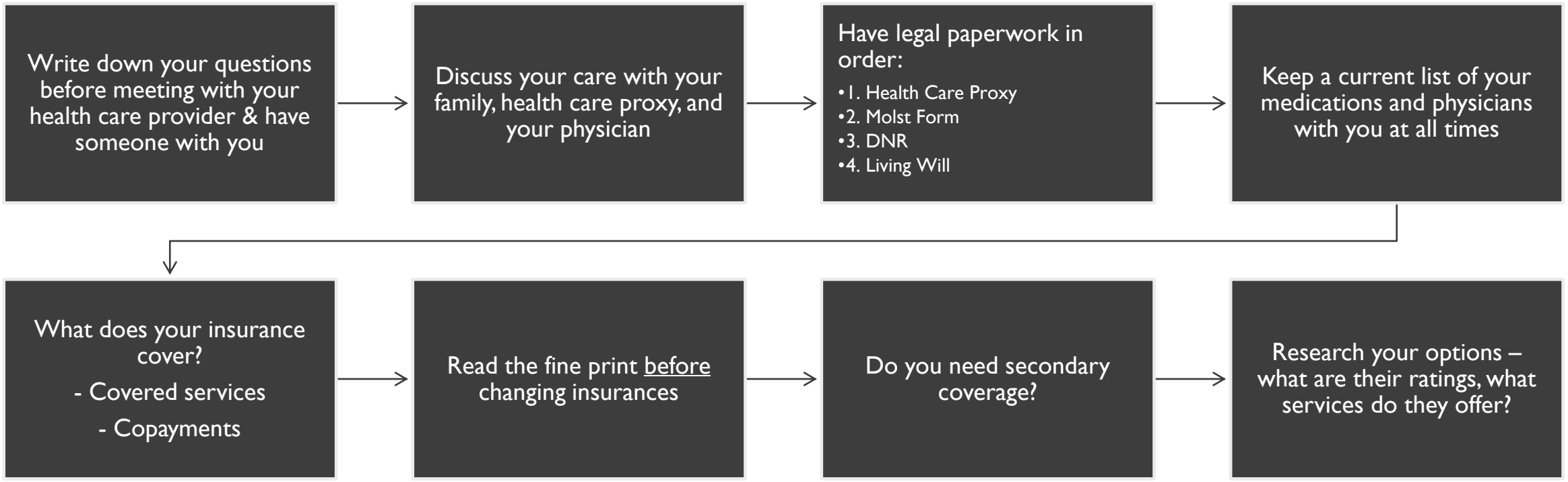
- Time is muscle:

- inactivity (including resting at home) is associated with atrophy and a loss of muscle strength

    - Passive range of motion (ROM)
    - In-patient physical therapy

- Confusion – sundowning & risk of falls
- Fatigue – lack of sleep - ICU psychosis
- Nosocomial Infections
- Risk of dermal ulcers: important to off-load/reposition, follow a healthy diet, and elevation as ordered.

BE AN ACTIVE & INFORMED PARTICIPANT IN YOUR CARE



BE HONEST ABOUT YOUR DISCHARGE NEEDS

1. Do you need help at home?
2. Can your family/caregiver realistically provide the hours you need?
3. Can they realistically provide the care you need?
4. Are you safe going home?
5. What resources do you have? i.e. private duty aides
6. Can you manage independently?
7. Would you have a better outcome if you did short-term rehab?
8. Follow discharge instructions
9. Do you have someone to assist with your pets?

BARRIERS IN DISCHARGE CARE

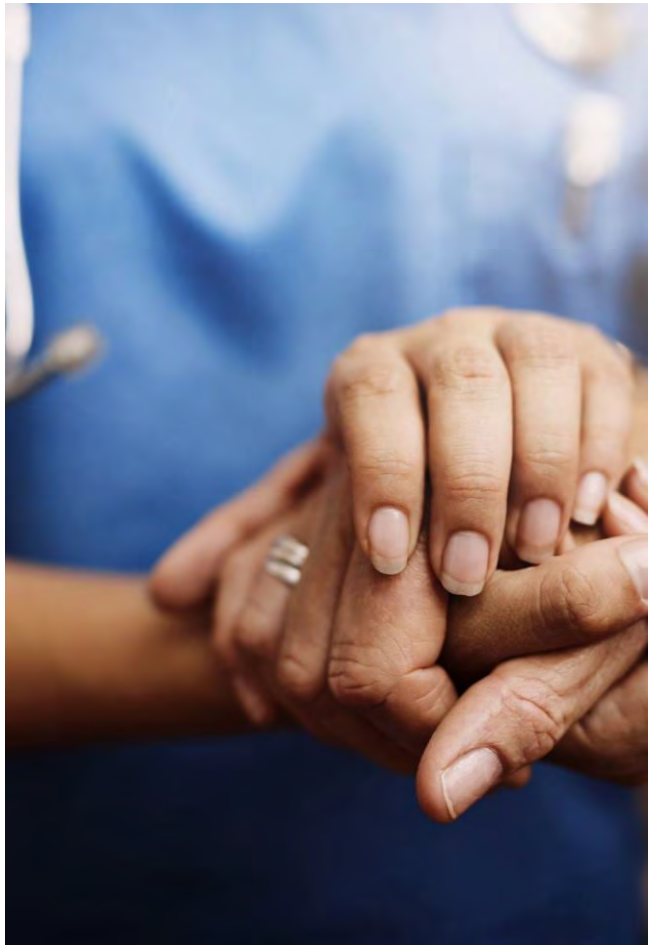
- Discharge planning should begin at the start of hospitalization
- Don't wait until the last minute to plan!
- Use the facility resources
- Challenges of Discharge – Social Determinants of Health:
  - Caregiver Availability
  - Patient Environmental Safety – Structural Conflict
  - Lack of discharge understanding/education
  - Lack of resources, i.e. medications or transportation
  - Unemployment and job insecurity
  - Food insecurity
  - Housing with basic amenities, i.e. heat, water, utilities
  - Access to affordable health services
  - Exposure to violence or coercion

COMMUNITY SERVICES ARE AVAILABLE

Food/Nutritional Insecurity	Utilities/Housing Instability	Transportation Barriers
• Supplemental Nutrition Assistance Program (SNAP) • Medically tailored meals • General meal services • Food vouchers / food cards • Home-delivered meals • Congregate meal settings	• Subsidies for utilities • Subsidies for rent or assisted living communities • Structural home modifications • Family & martial counseling • Access to companion care • Events to address isolation	• Parking / bus passes • Non-emergency / non-medical transportation • Local discount transportation services • Reimburse for transportation • Transportation vouchers: taxi, Uber, Lyft

DISCHARGE OPTIONS

- **Short Term Rehabilitation:** must be able to tolerate 3 hours of therapy per day
- **Assisted Living**
- **Skilled Nursing Facility**: for long term placement
- **Home Care**
- **Private Care**
- **Hospice**



REHOSPITALIZATION RISKS

- Medication Errors/non-compliance
- Non-compliance
- Complications: pneumonia, infections, lack of support in the home, unsafe environment
- Inadequate transitions of care
- Unable to get prescriptions filled
- Poor understanding of discharge
- Falls
- No medical follow-up or untimely follow up
- Lack of transportation to appointments
- Too early a discharge
- Lack of caregiving assistance at home
- Inadequate discussion of palliative care or hospice
- Not being open about actual patient needs

PREPARATION FOR A SUCCESSFUL HOME TRANSITION

- Get equipment in the home – i.e. mechanical bed, shower chair
- Make plans to get new medications
- Obtain durable medical equipment (DME)
- Food
- Pet care
- Follow up appointments scheduled with transportation

HOME CARE

Requirements for home care eligibility depend on your insurance.

- homebound status
- skilled need
- service area availability

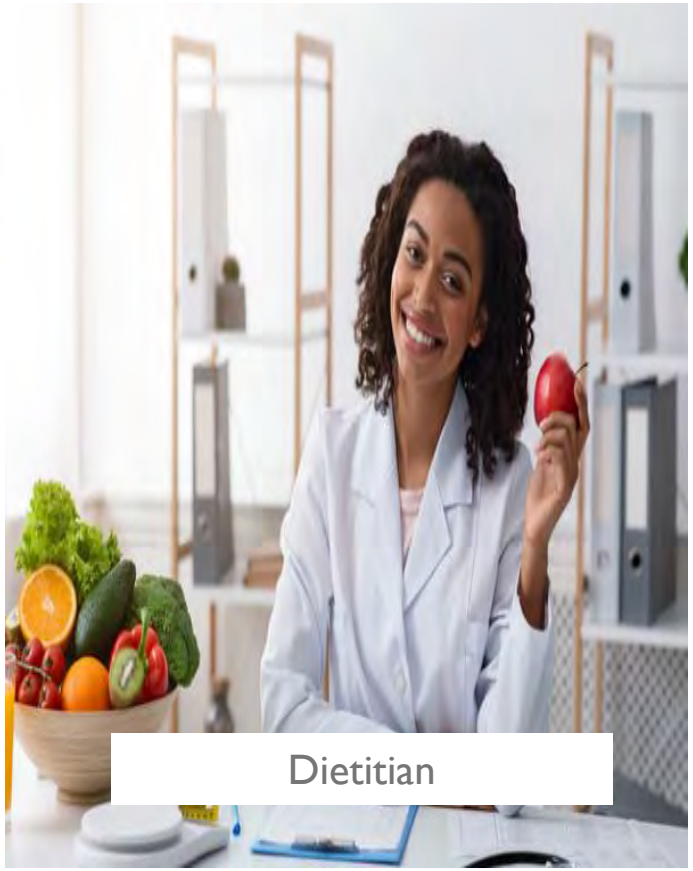
Home Care is short-term

HOME CARE SERVICES

Skilled Nursing

Physical Therapy

Occupational Therapy



Dietitian

Speech Therapy

Home Health Aide

Medical Social Worker

GOALS OF CARE

- Prevent rehospitalizations
- Resolution of social or safety risk factors
- Get patient back to their maximum potential
- To teach the patient and their caregiver/family to care for the patient in their home
- Encouraging patients to follow their plan of care

THANK YOU

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