Cordt Kassner

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HOSPICE & PALLIATIVE CARE TODAY

August 31st, 2024

Saturday newsletters focus on headlines and research - enjoy!

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Research News

Modeling nursing home harms from COVID-19 staff furlough policies

JAMA Open Network; by Sarah M Bartsch, Colleen Weatherwax, Bruce Leff, Michael R Wasserman, Raveena D Singh, Kavya Velmurugan, Danielle C John, Kevin L Chin, Kelly J O'Shea, Gabrielle M Gussin, Marie F Martinez, Jessie L Heneghan, Sheryl A Scannell, Tej D Shah, Susan S Huang, Bruce Y Lee; 8/24

What is the tradeoff between COVID-19–related harms and non–COVID-19–related harms when allowing nursing home staff with mild COVID-19 to work while masked? The findings of this study suggest that allowing nursing home staff who were mildly ill with COVID-19 to work while masked was associated with less harm from alleviated missed tasks, outweighing increasin g harm from COVID-19 transmission.

Trends in post-acute care use in Medicare Advantage versus Traditional Medicare: A retrospective cohort analysis

Journal of the American Medical Directors Association; by Robert E Burke, Indrakshi Roy, Franya Hutchins, Song Zhong, Syama Patel, Liam Rose, Amit Kumar, Rachel M Werner; 8/24

We sought to describe national trends in hospitalization and post-acute care utilization rates in skilled nursing facilities (SNFs) and home health (HH) for both

Medicare Advantage (MA) and Traditional Medicare (TM) beneficiaries, reaching up to the COVID-19 pandemic (2015-2019). We found hospitalizations, SNF stays, and HH stays were all decreasing over time in both populations. Although similar proportions of MA and TM beneficiaries received SNF or HH care, MA beneficiaries received fewer days. The largest difference we found was in the number of post-acute care providers used in TM and MA, with MA using far fewer; however, quality ratings were similar among post-acute care providers used in each program.

Fairness in predicting cancer mortality across racial subgroups

JAMA Open Network; Teja Ganta, MD; Arash Kia, MD; Prathamesh Parchure, MSc; Min-heng Wang, MA; Melanie Besculides, DrPH; Madhu Mazumdar, PhD; Cardinale B. Smith, MD; 7/24

In this cohort study, a machine learning [ML] model to predict cancer mortality for patients aged 21 years or older diagnosed with cancer … was developed. … The lack of significant variation in performance or fairness metrics indicated an absence of racial bias, suggesting that the model fairly identified cancer mortality risk across racial groups. The findings suggest that assessment for racial bias is feasible and should be a routine part of predictive ML model d evelopment and continue through the implementation process.

Patient-Reported outcome measures help patients with cancer

Michael J. Hassett, MD, MPH; Christine Cronin, BS; 8/24

Outside of cancer medicine, there is ample evidence that care management interventions improve patient-related, therapy-related, and health care utilization outcomes, especially when PROMs [patient recorded outcome measures] are incorporated. Altogether, these findings led to the hypothesis that symptom-focused care management programs that rely on PROMs could have a

substantial positive impact for patients with cancer. Over the past 2 decades, dozens of clinical trials have explored this question. The analysis by Balitsky and colleagues adds further support to the argument that PROMs shoul d be used routinely in oncology practice.

Reducing central nervous system–active medications to prevent falls and injuries among older adults-A cluster randomized clinical trial

JAMA Open Network; Elizabeth A. Phelan, MD, MS; Brian D. Williamson, PhD; Benjamin H. Balderson, PhD; Andrea J. Cook, PhD; Annalisa V. Piccorelli, PhD; Monica M. Fujii, MPH; Kanichi G. Nakata, PhD; Vina F. Graham, BS; Mary Kay Theis, MA, MS; Justin P. Turner, PhD; Cara Tannenbaum, MD, MSc; Shelly L. Gray, PharmD, MS; 7/24

This cluster randomized clinical trial found that a health system–embedded deprescribing intervention was no more effective than usual care in reducing medically treated falls among community-dwelling older adults prescribed CNS-active medications. Patients were … adults aged 60 years or older, prescribed at least 1 medication from any of 5 targeted medication classes (opioids, sedative-hypnotics, skeletal muscle relaxants, tricyclic antidepressants, and first-generation antihistamines) for at least 3 consecutive months. [The interventions included] patient education and clinician decision support. For health systems that attend to deprescribing as part of routine clinical practice, additional interventions may confer modest benefits on prescribing without a measurable effect on clinical outcomes.

Feasibility of a serious illness communication program for pediatric advance care planning

JAMA Open Newtwork; Danielle D. DeCourcey, MD, MPH; Rachelle E. Bernacki, MD, MS; Brett Nava-Coulter, MPH; Sithya Lach, BS; Niya Xiong, MSPH; Joanne Wolfe, MD, MPH; 7/24

Children and adolescents and young adults (AYAs) with serious illness often have a variable clinical course with periods of stability alternating with life-threatening deteriorations; consequently, many children and AYAs experience health crises without opportunities to discuss preferences for medical care. Furthermore, bereaved parents report a lack of preparation to address their child's medical and emotional needs at end of life (EOL) . Advance care planning (ACP) is an iterative process to honor patient and family goals and values involving communication about prognosis and the formulation of care plans addressing

symptom management, quality of life, preferences for life-sustaining interventions, and anticipatory guidance about EOL. Pediatric advance care planning (ACP), which aims to ensure care is aligned with family goals and values, is associated with better end-of-life outcomes; however, ACP in pediatrics remains uncommon. This pilot cohort study found that the PediSICP [Pediatric Serious Illness Communication Program] was feasible, acceptable, and highly valued by clinicians and parents of children with serious illness.

Clinician-and patient-directed communication strategies for patients with cancer at high mortality risk-A cluster randomized trial

JAMA Open Network; Samuel U. Takvorian, MD; Peter Gabriel, MD, MS; E. Paul Wileyto, PhD; Daniel Blumenthal, BA; Sharon Tejada, MS; Alicia B. W. Clifton, MDP; David A. Asch, MD, MBA; Alison M. Buttenheim, PhD, MBA; Katharine A. Rendle, PhD, MSW, MPH; Rachel C. Shelton, ScD, MPH; Krisda H. Chaiyachati, MD, MPH, MSHP; Oluwadamilola M. Fayanju, MD, MA, MPHS; Susan Ware, BS; Lynn M. Schuchter, MD; Pallavi Kumar, MD, MPH; Tasnim Salam, MBE, MPH; Adina Lieberman, MPH; Daniel Ragusano, MPH; Anna-Marika Bauer, MRA; Callie A. Scott, MSc; Lawrence N. Shulman, MD; Robert Schnoll, PhD; Rinad S. Beidas, PhD; Justin E. Bekelman, MD; Ravi B. Parikh, MD, MPP; 7/24

Serious illness conversations (SICs) that elicit patients' values, goals, and care preferences reduce anxiety and depression and improve quality of life, but occur infrequently for patients with cancer. Behavioral economic implementation strategies (nudges) directed at clinicians and/or patients may increase SIC completion. In this cluster randomized trial, nudges combining clinician peer

comparisons with patient priming questionnaires were associated with a marginal increase in documented SICs compared with an active control. Combining clinician- and patient-directed nudges may help to promote SICs in routine cancer care.

Reviewing ethical guidelines for the care of patients with Do-Not-Resuscitate orders after 30 years: rethinking our approach at a time of transition

Anesthesiology; Matthew B. Allen, M.D.; Shahla Siddiqui, M.D., D.A.B.A., M.Sc.; Omonele Nwokolo, M.D.; Catherine M. Kuza, M.D.; Nicholas Sadovnikoff, M.D., H.E.C.-C.; David G. Mann, M.D., D.Be.; Michael J. Souter, M.B., Ch.B., D.A.; 9/24

The American Society of Anesthesiologists (ASA) opposes automatic reversal of do-not-resuscitate orders during the perioperative period, instead advocating for a goal-directed approach that aligns decision-making with patients' priorities and clin ical circumstances. Implementation of ASA guidelines continues to face significant barriers including time constraints, lack of longitudinal relationships with patients, and difficulty translating goal-focused discussion into concrete clinical plans. These challenges mirror those of advance care planning more generally, suggesting a need for novel frameworks for serious illness communication and patient-centered decision-making.

Pediatric complex chronic condition system

JAMA Open Network; Lisa C. Lindley, PhD, RN; 7/24

The pediatric complex chronic condition (CCC) system is the gold standard in classifying patients younger than 18 years who are seriously ill in pediatric research. Feinstein et al report on the development and comparison of the most recent revision (V3) of the CCC system [which includes] modifications to new, missing, and retired ICD-10-CM and procedure codes. The authors recommend using the newest V3 of the CCC system for research because it incorporates the evolving ICD-10 system. ICD-10 codes are continually being added, deleted, and modified, and the CCC system, which is based on the ICD and procedure c odes, needs to keep pace. Feinstein et al are to be commended for their significant effort to update codes, especially ahead of the imminent US transition to the International Classification of Diseases, 11th Revision (ICD-11).

Site-of-Care shifts and payments—A viable strategy to control health care costs?

JAMA Open Network; Lee A. Fleisher, MD, ML; Sheila P. Burke, RN, MPA; 8/24

The authors sought to determine what proportion of care was currently being performed in hospital-based settings and investigated how much could be shifted to nonhospital settings today and 7 to 10 years in the future with technological advances. They found that the major barriers to site-of-care shifts were economic arrangements, ownership models, and perceived loss of continuity of care at alternative sites. These results affirm their view that to reduce health care spending and protect Medicare trust funds, it will be critical to develop fina ncial incentives and, just as importantly, eliminate financial disincentives to drive care to the safest and lowest-cost site of service.

Clinical reasoning and artificial intelligence: Can AI really think?

Transactions of the American Clinical and Climatological Association; Richard M. Schwartzstein, MD; 2024

Artificial intelligence (AI) in the form of ChatGPT … holds great promise for more routine medical tasks, may broaden one's differential diagnosis, and may be able to assist in the evaluation of images, such as radiographs and electrocardiograms, the technology is largely based on advanced algorithms akin to pattern recognition. One of the key questions raised in concert with these advances is: What does the growth of artificial intelligence mean for medical education, particularly the development of critical thinking and clinical reasoni ng? AI will clearly affect medicine in the years to come and will change the ways in which doctors work. It will also make the ability to reason, to think, to analyze problems, and to know how best to apply principles of human biology at the bedside more important.

International News

[Australia] Maybe for unbearable suffering: Diverse racial, ethnic and cultural perspectives of assisted dying. A scoping review

Palliative Medicine; Melissa J Bloomer, Laurie Saffer, Jayne Hewitt, Lise Johns, Donna McAuliffe, Ann Bonner; 8/24

Perspectives on assisted dying are dynamic and evolving. Even where assisted dying is legalised, individual's cultural attributes contribute to unique perspectives of assisted dying as an end-of-life option. Thus, understanding a person's culture, beliefs, expectations and choices in illness, treatment goals and care is fundamental, extending beyond what may be already considered as part of clinician-patient care relationships and routine advance care planning.

Today's Encouragement

Success is walking from failure to failure with no loss of enthusiasm. ~ Winston Churchill

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