Hospital Medicine – Amulatory Care Case Conference: Advance Care Planning Across Care Settings

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September 22, 2009
Case: Mrs. M

81 yo woman

PMHx:
- oxygen-dependent COPD with trach; recurrent hypercarbic respiratory failure
- pancreatic cancer (cystadenocarcinoma) dx 3/2008 (prior abnormal CT 2005) treated with stent and gemcitabine, stable per CT and PET scans

Additional medical hx: htn, diastolic dysfunction, CHF, GERD, hyperlipidemia, osteoporosis with multiple fractures requiring surgical tx, DM, OA, depression, anxiety, anemia, Bell’s palsy, recurrent pneumonia, cystocele and rectocele, peripheral neuropathy

FHx: mother died ovarian cancer (far outliving initial prognosis)
Social Hx: married x > 50 years, husband a Holocaust survivor. Lives in S Denver. Adult son in home. 2 adult dtrs in Denver. 1 adult dtr (an MD) in Washington, DC. Jewish Family Services homemaker in home ~ 3 times/week. Decline additional assistance.
Outpatient physicians involved:
   PCP, oncologist, pulmonologist, neurologist

Established care with new PCP April, 2008
   - Mentally alert and engaging
   - Poor functional status
   - Multiple falls
   - Weight loss
   - Pain (severe)
   - SOB
   - Constipation
   - “I want to die”

Between Spring 2008 and Summer 2009
   - Multiple hospitalizations and LTAC, SNF, rehab stays at multiple facilities in the Denver metro area
Code status / Advance Care Planning

2005: multiple hospitalizations for COPD exacerbations and fractures. Documented as full tube/full resuscitation.


2008:
- DNR during UCH hospitalization 6/4/08, Rose hospitalization 7/13/08
- Dtr in DC insists pt be full code, refuses hospice
- DPAHC signed 11/21/08 naming dtr and son in Denver as agents
- CPR Directive signed 11/21/08

2009:
- Hospice referral April 17, 2009 – declined to enroll
- 5/1/2009 – pt confirms DNR/DNI, clarifies that doesn’t want CPAP
- 5/29/09: pt states preference to die at home
- DNR during UCH hospitalization 6/16/09
Ethical and Legal Issues
Advance Directives

- Durable power of attorney for healthcare (DPA-HC)
- Living will
- Surrogate decision making

- Pitfall- not having a DPA-HC
- Pitfall- not talking to your DPA-HC
- Pitfall- not talking to others about who is your DPA-HC, why, and what your wishes are
Decision making standards

Substituted judgment- what would the person had wanted if they were able to make this decision themselves

Best interest- only applicable when substituted judgment in not available- either person never spoke of circumstances like these, or the patient has never had capacity to make their own decisions
A few Caveats

- A surrogate cannot reverse a patient’s express wishes
- Cannot wait for a patient to become incapacitated to make a “best interest” judgment
- Cannot wait for a patient to become incapacitated to invoke the emergency consent doctrine
DPA-HC

- Only effective when the patient becomes in capacitated - cannot be used to get consent when the patient has capacity
- VERY broad latitude in the scope of decisions that can be made - the DPA “stands in the shoes of the patient”
- Substituted judgment standard, but the DPA can make more assumptions or extrapolations
Default Surrogate Decision Making

- No DPA-HC, no living will
- Consensus of “all interested parties”
- Reasonable effort must be made to identify all interested parties
- CANNOT make a decision to withhold or withdraw life sustaining treatment without documentation by two physicians that further treatment is not medically indicated, unlikely to succeed.
- Should follow substituted judgment standard, only deferring to best interest standard is there is no information on what the patient would want
Living Wills

- Can assert any range or treatments to be consented to, withheld or withdrawn

- 3 blanket clauses
  - Do everything possible to sustain life at all costs
  - Determine when care is unlikely to succeed, and burdens of continuation outweighs burdens
  - Do not resuscitate
DNR

- Meaning unclear
- Efficacy of custom codes
- Typical consent process
  - Risks
  - Benefits
  - Alternatives
  - Expression of a desire/decision (ideally demonstrable consistent with beliefs and values)
  - What will the post-code will look like
Barriers to Advance Care Planning

- The patient’s view
- Health care professional’s view
- System communication
POLST Paradigm Development (POST, MOLST, MOST)
The POLST Paradigm
(Physician Orders for Life-Sustaining Treatment)

• Oregon POLST Task Force, 1991
• Bright medical order form for seriously ill (surprise question)
• Signed by physician, NP, (PA)
• Turns patient preferences and Advance Directives into orders
• Ensures wishes for treatment are honored
Core Requirements

✓ Medical orders
✓ Target population, patient-surrogate signature
✓ Full or limited treatment
✓ CPR and EMS orders
✓ Other orders (antibiotics, artificial nutrition, transfer)
✓ Identifiable, stays with patient
✓ Training and evaluation
HIPAA Compliant

Cardiopulmonary was added to clarify the type of resuscitation. Do Not Attempt Resuscitation was added to assist clinicians in communicating odds about success.

New options give people the choice to decide later since issue of when to use antibiotics is complex.

Instructions Simplified

Transfer to hospital and use of intensive care has been clarified.

IV fluids have been moved up to the Limited Additional Interventions section.

Determined that IV fluids more typically used for comfort. Grouping with nutrition often complicated decision here.
Back of form completely re-vamped
POLST Paradigm Programs

www.polst.org
Colorado: MOST (Medical Orders for Scope of Treatment)

Why? (from draft legislation)

- Current instruments…often underutilized, hampered by institutional barriers, and inconsistently interpreted and implemented
- …frail elderly, chronically or terminally ill, and nursing home resident…in particular need of a consistent method for identifying and communicating critical treatment preferences that each sector of the health care community will recognize and follow
Colorado MOST

What? (from draft legislation)

...will provide a process for timely discussion...about choices to accept, withdraw, or refuse life-sustaining treatment and, through the use of a single, standardized form, will ensure those preferences are clearly and unequivocally documented.
Colorado MOST: Current Status

- Pilot testing began 2005 (LTC facilities, hospitals, health systems)
- House Bill 09-1232: introduced then withdrawn to garner additional support
- 2010 legislative session – plan to reintroduce, addressing:
  1) Portability across healthcare settings
  2) Reciprocity with other state's POLST documents
  3) Signature issues - APN's and PA's
  4) Faxes, electronic forms and photocopies
  5) Immunity for following the patient's preferences as documented on the MOST
Care Transitions

1) Challenges
2) Interventions
Transitions

- Within hospital
- Transfers between units/hospitals
- Inpatient to outpatient
- Inpatient to SNF-> home-> inpt-> home-> SNF
- Typically decreased quality due to misuse, but some component of over-utilization and under-utilization
Patient Satisfaction

- Generally poor
- Identified
  - Lack of preparation, what to expect on leaving, how to facilitate coordination of care if they are moved or readmitted
  - Inadequate information to allow self care of chronic illnesses
  - Failure of discharge planning- where to get meds, anticipate problems, maximize resources
  - Identifying early and effective transitional care- interim visits, conversations with SNF/LTAC provider
  - Transfer of information across settings
Medication Errors

- Interactions- major and minor
  - More than 16 million *known* serious drug interactions yearly

- Inaccuracies in admitting and discharging medication reconciliation
  - At least one error in medication for every admission
  - Unlikely that inpatient and outpatient reconciliation is effective
What do PCP’s want to know

- Rarely vitals and detailed labs
- Early notification of admission
- New diagnoses
- Tests pending
- Follow up tests needed
- Medications discontinued
- Medications added
Interventions

- Summary of high impact info in discharge summary
- Fixed plan/habit for following up abnormal results
- Follow up patient phone calls
- Follow up communication strategies with PCP
- Effective discharge planning
Mrs. M

Her last days....

- Hospitalized x ~ 2 weeks after prolonged LTAC stay
  - Pneumonia, sepsis, respiratory failure
- Intubated for last ~ 1 week
- Died in ICU after ventilator withdrawal (8/15/09)

I found out about her death (and her hospitalization) when her DC dtr called me on 8/18/09
Discussion