

# **Hospital Medicine – Ambulatory Care Case Conference: Advance Care Planning Across Care Settings**

Erin Egan, MD, JD and Jean Kutner, MD, MSPH  
University of Colorado Denver  
Division of General Internal Medicine

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.

2006: Brief hospice admission based on severe lung disease – revoked hospice at family request. Became 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 is 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 can not 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 incapacitated- 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 if 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







# **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

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

### Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First Name, Middle Initial	
Date of Birth	

**A** Check One  
Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.  
 Resuscitate/CPR     Do Not Attempt Resuscitation (DNR/no CPR)  
When not in cardiopulmonary arrest, follow orders in B, C and D.

**B** Check One  
Medical Interventions: Person has pulse and/or is breathing.  
 **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.  
 **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.  
 **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.  
Additional Orders: \_\_\_\_\_

**C** Check One  
Antibiotics:  
 No antibiotics. Use other measures to relieve symptoms.  
 Determine use or limitation of antibiotics when infection occurs.  
 Use antibiotics if life can be prolonged.  
Additional Orders: \_\_\_\_\_

**D** Check One  
Artificially Administered Nutrition: Always offer food by mouth if feasible.  
 No artificial nutrition by tube.  
 Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.  
Additional Orders: \_\_\_\_\_

**E** Summary of Medical Condition and Signatures

Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other:	Summary of Medical Condition:	
Print Physician / Nurse Practitioner Name	MD/DO/NP Phone No.	Office Use Only
Physician / NP Signature (mandatory)	Date	

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

© CENTER FOR ETHICS IN HEALTH CARE, Oregon Health & Sciences University, UHN-95, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239-3098 (503) 464-3955

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

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

Signature of Person, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.  
(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature (optional)	Name (print)	Relationship (write "self" if patient)
----------------------	--------------	--

**Contact Information**

Surrogate (optional)	Relationship	Phone Number	
Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared

**Directions for Health Care Professionals**

**Completing POLST**

Must be completed by a health care professional based on patient preferences and medical indications.  
POLST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.  
Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are legal and valid.

**Using POLST**

Any incomplete section of POLST implies full treatment for that section.  
No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."  
Oral fluids and nutrition must always be offered if medically feasible.  
When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only" should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).  
IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."  
Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."  
A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

**Reviewing POLST**

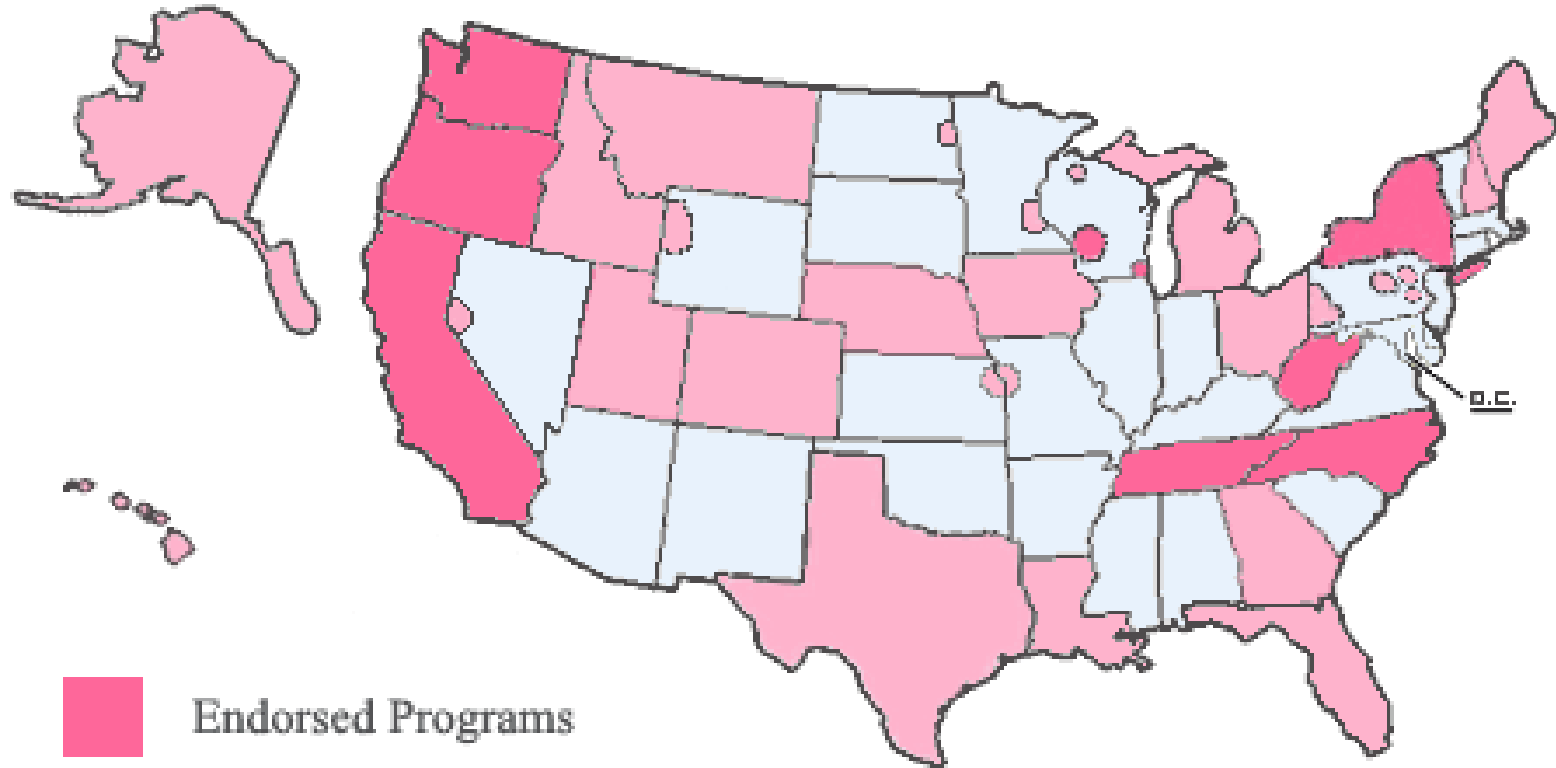
This POLST should be reviewed periodically and if:  
(1) The person is transferred from one care setting or care level to another, or  
(2) There is a substantial change in the person's health status, or  
(3) The person's treatment preferences change.  
Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.




**The Oregon POLST Task Force**

The POLST program was developed by the Oregon POLST Task Force. The POLST program is administratively housed at Oregon Health & Science University's Center for Ethics in Health Care. Research about the safety and effectiveness of the POLST program is available online at <[www.polst.org](http://www.polst.org)> or by contacting the Task Force at <[polst@ohsu.edu](mailto:polst@ohsu.edu)>.

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

# POLST Paradigm Programs



-  Endorsed Programs
-  Developing Programs
-  No Program (Contacts)

[www.polst.org](http://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