

ETHICAL CHALLENGES OF “REVOLVING DOOR SYNDROME” BETWEEN LONG TERM CARE & HOSPITALS



MINDY SKELTON, ANP-BC
OCTOBER 27, 2011



PARTICIPANTS AFFILIATION?

1. HOSPITAL
2. ASSISTED LIVING FACILITY
3. LONG TERM CARE
4. OTHERS

Questions for Consideration:

- WHAT ARE THE LEADING CAUSES OF REVOLVING DOOR SYNDROME (RDS) IN LONG TERM CARE?
 - PATIENT NON-COMPLIANCE
 - ADVANCE DIRECTIVE ISSUES
 - SURROGATE DECISION MAKER/S CONFLICT
 - LACK IN CONTINUITY OF CARE PRE AND POST ACUTE HOSPITALIZATION
- WHAT ARE THE ETHICAL IMPLICATIONS OF STATED CAUSES OF RDS?
 - PATIENT AUTONOMY VS PROFESSIONAL OBLIGATIONS
 - APPROPRIATE VS INAPPROPRIATE MEDICAL CARE
 - APPROPRIATE DECISION MAKERS
 - DISTRIBUTIVE JUSTICE
- WHAT ARE WE DOING TO PREVENT POTENTIAL ETHICAL CRISIS WITH RDS?
 - AGGRESSIVE ADVANCE CARE PLANNING
 - PALLIATIVE CARE PROGRAM
 - CLINICAL ETHICS CONSULTATION
 - INTERDISCIPLINARY COMPLEX CASE REVIEW

<http://www.healthbeatblog.com/2011/06/keep-the-bar-raised-on-reducing-hospital-readmissions.html>

- *One in five elderly patients is readmitted to the hospital 30 days after leaving. That is 2.3 million re-hospitalizations a year that rack up more than \$17 billion in annual Medicare costs, according to an April 2, 2009, study in The New England Journal of Medicine.*
- *About 40% -- nearly 1 million re-hospitalizations annually -- are avoidable, said Stephen F. Jencks, MD, MPH, lead author of the NEJM study and former director of the Centers for Medicare & Medicaid Services' Quality Improvement Organization Program.*

CASE REVIEW #1

MR. NON-COMPLIANCE (NC)

- 65 y/o morbidly obese male with Past Medical History of COPD, OSA on chronic BiPAP, CAD, OLD MI, AFIB, HTN, CHF, DM2, hyperlipidemia, PVD, MRSA osteomyelitis, s/p L AKA, PE, Depression, GERD, hypothyroidism, multiple acute admits with recurrent hypercapneic respiratory failure, recurrent pleural effusion, s/p pleurodesis and subsequently +hemothorax, s/p chest tube placement, Distal LAD disease mild, s/p thoracotomy, pericardial fluid drain, pericardial window

CASE #1 ETHICAL CHALLENGES

- 10 acute hospitalization within period of 4 months secondary to fluid overload and hypercapnic respiratory failure
 - NON-COMPLIANCE
 - MULTIPLE CO-MORBIDITIES
 - OVERALL POOR PROGNOSIS
- Advance Directives FULL CODE, MPOA – friend
- PATIENT IS FULLY DECISIONAL

CASE REVIEW #2

MS. LET ME GO (LMG)

- 78 y/o female with past medical history of Persistent Vegetative State (PVS), anoxic brain injury after cardiac arrest approximately 6 months ago, Ventilator Dependent Respiratory Failure – s/p tracheostomy, + PEG tube, Recurrent pneumonia w/ MRSA, +staph and pseudomonas bacteremia; h/o recurrent HD line sepsis; h/o VRE UTI, h/o C-Diff colitis, DM, Hyperlipidemia, ESRD – chronic HD, GERD, h/o upper GIB, COPD, IVC filter placement; total dependent care; recurrent hospitalizations

CASE #2 ETHICAL CHALLENGES

- EEG – abnormal diffuse suppression and severe slowing
 - could be consistent with severe cerebral dysfunction
 - OVERALL POOR PROGNOSIS
- NO Advance Directives, no MPOA, no spouse, 9 children – conflict in goal of care
 - FAMILY CONFLICT
 - UNKNOWN PATIENT PREFERENCES
- Despite multiple ethics consultation inpatient, patient remained FULL CODE – aggressive care – multiple acute hospitalizations
 - MEDICAL FUTILITY

CASE REVIEW #3

MS. DO EVERYTHING (DE)

- 40 year old African American female with past medical history of transverse myelitis with quadriplegia and ventilator dependent respiratory failure (VDRF) - s/p tracheostomy; Cardiopulmonary arrest X2 left her in persistent vegetative state (PVS); Severe bradycardia - not pacemaker candidate per cardiologist second to overall poor prognosis; Pseudomonas Pneumonia, Mucus plugging with lung collapse-prior bronchoscopies, Seizure disorder, chronic anemia, R sided Pulmonary Embolism (PE), Neurogenic Bladder - s/p suprapubic catheter; Anoxic Encephalopathy per EEG, Sepsis, DM2.

CASE #3 ETHICAL CHALLENGES

- Advance Directive marked next to keep me alive to the "greatest extent possible"
- Health Care Provider ethically challenged to continue FULL resuscitations, going on #4 within period of 2 months
 - MEDICAL FUTILITY
- Grandmother insist on keeping her granddaughter alive as stated on her living will
 - MPOA/PATIENT AUTONOMY VS PROFESSIONAL OBLIGATION (NON-MALIFICIENCE)/STANDARD OF CARE

AUDIENCE RESPONSE

- IN THE CASE #1 OF MR. NC, WHO IS THE DRIVER (DECISION MAKER) OF MEDICAL CARE?
 1. PATIENT
 2. SURROGATE DECISION MAKER
 3. HEALTH CARE PROVIDER/S
 4. HEALTH CARE INSURANCE PLANS

30 DAY INCENTIVE

- The Affordable Care Act includes a hospital readmission reduction program (HRRP) that uses incentives and starting in October 2012, penalties to encourage hospitals to enact better follow-up and other procedures that reduce preventable readmissions among Medicare patients.

AUDIENCE RESPONSE

- IN THE CASE #1 OF MR. NC, WHO DO YOU THINK WILL BE THE DRIVER (DECISION MAKER) OF MEDICAL CARE AFTER (HRRP) IS IN EFFECT?
 1. PATIENT
 2. SURROGATE DECISION MAKER
 3. HEALTH CARE PROVIDER/S
 4. HEALTH CARE INSURANCE PLANS

CASE #2 CONFLICTS

- BETWEEN FAMILY MEMBERS
- HEALTH CARE PROVIDERS
- LTC FACILITY ADMINISTRATORS AND CLINICAL STAFFS

CASE #2 OPEN DISCUSSION

WHAT MIGHT BE THE REASON/S FOR THE FACILITY TO RESIST VENTILATOR SUPPORT/AHN WITH DRAW AND PERMIT DISCONTINUATION OF HEMODIALYSIS?

CASE #3

- ADVANCE DIRECTIVE PITFALLS
 - DO NOT HAVE ONE
 - TOO VAGUE
 - NOT HONORED

CASE #3 AUDIENCE RESPONSE

- IS IT MEDICALLY APPROPRIATE TO CONTINUE REPEATED FULL RESUSCITATIONS DESPITE IT'S BURDEN OUTWEIGHING IT'S BENEFIT?
 1. YES
 2. NO

HEALTH CARE PROVIDER OBLIGATION AND RESPONSIBILITY AMA CODE OF ETHICS, 2004-2005

- PHYSICIANS ARE NOT ETHICALLY OBLIGATED TO DELIVER CARE THAT, IN THEIR BEST PROFESSIONAL JUDGEMENT WILL NOT HAVE A REASONABLE CHANCE OF BENEFITTING THEIR PATIENTS
- PATIENTS SHOULD NOT BE GIVEN TREATMENTS SIMPLY BECAUSE THEY DEMAND THEM.
- WHEN FURTHER INTERVENTION TO PROLONG THE LIFE OF THE PATIENT BECOMES FUTILE, PHYSICIANS HAVE AN OLBIGATION TO SHIFT THE INTENT OF CARE TOWARD COMFORT AND CLOSURE

<http://www.nejm.org/doi/full/10.1056/NEJMsa1100347>

- **BURDENSOME TRANSITION**
 - ANY TRANSFER TO ACUTE IN LAST 3 DAYS OF LIFE
 - LACK OF CONTINUITY OF CARE PRE AND POST HOSPITALIZATION
 - MULTIPLE HOSPITALIZATIONS (> 2 ACUTE ADMIT WITH ANY DX OR > 1 ACUTE ADMIT WITH UTI, DEHYDRATION, PNEUMONIA, OR SEPSIS IN LAST 90 DAYS OF LIFE)

CASE #3 ETHICS CONSULTATION

- ETHICS RECOMMENDATIONS:
 - UNILATERAL DNR VS TRANSFER OF CARE
 - GRANDMOTHER ELECTED TO TRANSFER CARE TO ANOTHER PHYSICIAN WHO HAD ACCEPTED THIS PATIENT'S CARE

- OUTCOME:
 - PT DIED DURING 9TH CPR

PREVENTIONS

- ADVANCE CARE PLANNING
 - ORIENTATION
 - ADVANCE CARE PLANNING UPDATES
 - ONGOING STAFF, FAMILY, AND COMMUNITY EDUCATION
 - COLLABORATE WITH LOCAL HOSPICE AND PALLIATIVE CARE NURSES ASSOCIATION IN MOLST INITIATIVE
- PALLIATIVE CARE PROGRAM
 - BRIDGE THE GAP BETWEEN AGGRESSIVE CARE MANAGEMENT WITH HOSPICE CARE
- ETHICS CONSULTATION
 - COLLABORATION WITH ABN
- COMPLEX CASE REVIEW - INTERDISCIPLINARY

REFERENCES

- <http://www.healthbeatblog.com/2011/06/keep-the-bar-raised-on-reducing-hospital-readmissions.html>
- (Council on Ethical and Judicial Affairs) Code of Medical Ethics: Current Opinions with Annotations. American Medical Association, 2000, p.55-71, 82-85.
- <https://www.cms.gov/manuals/downloads/bp102c08.pdf>
- <http://www.nejm.org/doi/full/10.1056/NEJMsa1100347>