Advance Care Planning in Older Adults with Multiple Chronic Conditions undergoing Surgery

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Associate Professor of Surgery
Harvard Medical School

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Today’s Speakers

Victoria Tang, MD, MAS

Zara Cooper, MD, MSc
For questions about the AGING Initiative or today’s webinar, please contact:

Kathryn.Anzuoni@meyersprimary.org
Advance Care Planning Practices in Older Adults with Multiple Comorbid Conditions (MCC) undergoing High Risk Surgery

Victoria Tang, MD, MAS
The AGING Initiative
Advancing Geriatrics Infrastructure & Network Growth

- Ellis Dillon, PhD, Palo Alto Medical Foundation Research Institute
- Ming Tai-Seale, PhD, MPH, University of California, San Diego
- Yan Yang, PhD, Palo Alto Medical Foundation Research Institute
- John Boscardin, PhD, UC San Francisco and San Francisco VA
- Rebecca Sudore, MD, UC San Francisco and San Francisco VA
Background
19.2M Operations/Year in Age 65+

They make up 38% of the Surgical Population

Surgical Population by Age
>4 Million High Risk* Operations/Year

* >1% Risk of 30-day Post-Op Mortality

Expected to grow to 14 Million by 2030

Type of Operation (in Age 65+)

High Risk, 21%
High Rates of Morbidity and Mortality

- >1 in 5 will experience a life-altering complication
- Post-operative complications precipitate a loss of physical functioning and independence

Operative mortality, by procedure and age.

Light gray: 65 to 69 years
Dark gray: 70 to 79 years
Black bar: 80+ years
Advance Care Planning is Recommended

ACS NSQIP®/AGS
BEST PRACTICE GUIDELINES:
Optimal Preoperative Assessment of the Geriatric Surgical Patient

THE Coalition for Quality in Geriatric Surgery PROJECT
Mr. D is an 86 year old man with chronic kidney disease, mild dementia, and a bile duct tumor.
Goal: Improve Pre-operative Advance Care Planning (ACP) Rates and Documentation

Pilot Project Objectives

• To characterize the prevalence of ACP and the patient characteristics associated with ACP documentation

• To describe the content of the ACP discussion
Methods
Palo Alto Medical Foundation Data Analysis and Chart Review

**Design:**
- How many and who are more likely to have ACP?
  - Secondary data analysis
- What is the content in the ACP?
  - Mixed methods

**Data Source:**
- Palo Alto Medical Foundation (PAMF)
  - large, multispecialty ambulatory care system that serves Northern California
Cohort: Older Adults with MCC undergoing High Risk Surgery in the PAMF system

- Active in PAMF in 2013-2014 (1+ office visit) 
  \[ N = 111,851 \]
- Age 65 years and older 
  \[ N = 96,230 \]
- Charlson Comorbidity Score >1 
  \[ N = 17,217 \]
- CPT code associated with high risk surgery 
  \[ N = 393 \]
How Many and Who are More Likely to have an ACP?

**Measures:**

- Patient demographics:
  - Age, Sex, Race/Ethnicity, Language, Marital Status

- Clinical data:
  - Medical comorbidities, Severity of comorbidities
  - CPT codes associated with high risk surgery
    - Ex: esophagectomy, abdominal aortic aneurysm repair
How Many and Who are More Likely to have an ACP?

**Outcome:**
- ACP documentation in Electronic Health Record
  - Advanced Health Care Directives (AHCD)
  - Physician Order for Life Sustaining Treatment (POLST)

**Analysis:**
- Logistic regression
What is the ACP content?

**Identification of ACP content:**
- Chart review of a random sample of 25 decedents who died within 1 year of surgery
  - Progress notes
  - Scanned legal documents

**Qualitative Data and Analysis:**
- Topics in progress notes and scanned legal documents
  - Patient goals and values, surrogate decision maker
- Department of ACP note author and discussion location
Results
Elderly, White, and English Speaking

- 393 patients were identified with a high-risk operation
  - 42% were 75-84 years of age; Mean of 79 years old
  - 55% Male
  - 74% White
  - 92% English-speaking
  - 59% Married/Partnered
Sick and Have High Health Care Needs

- 63% had 8+ office visits within the year prior to surgery
- 3% had a diagnosis of Dementia or Mild Cognitive Impairment by the time of surgery
- 31% had at least one serious illness*
- 65% had Charlson comorbidity score of 3+

*(ex: cancer [brain, esophageal, pancreatic], heart failure, Parkinson’s, stroke)
(National Committee for Quality Assurance/The Physician Consortium for Performance Improvement, 2008)
68% underwent a surgery associated with ≥5% risk of dying within 30-days of the surgery or during hospitalization.

**Type of Surgery**

- Cardiothoracic: 54%
- Gastrointestinal: 23%
- Vascular: 16%
- Other (i.e. Brain, Urological): 7%
26% had ACP documented prior to surgery
More likely to have ACP: Older, White

<table>
<thead>
<tr>
<th>Age at date of surgery</th>
<th>N = 101 (%)</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74 years</td>
<td>24 (24%)</td>
<td>1.0 (Ref.)</td>
</tr>
<tr>
<td>75-84 years</td>
<td>44 (44%)</td>
<td>1.5 (1.1-24.4)</td>
</tr>
<tr>
<td>85+ years</td>
<td>33 (33%)</td>
<td>2.0 (1.0-4.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>N = 101 (%)</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-White</td>
<td>19 (19%)</td>
<td>1.0 (Ref.)</td>
</tr>
<tr>
<td>White</td>
<td>82 (82%)</td>
<td>1.9 (1.0-3.6)</td>
</tr>
</tbody>
</table>
Greater # office visits 1 year prior to surgery, Cognitive impairment

<table>
<thead>
<tr>
<th># Office Visits 1 Year Prior</th>
<th>N (%)</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3</td>
<td>4 (4%)</td>
<td>1.0 (Ref.)</td>
</tr>
<tr>
<td>4 - 7</td>
<td>7 (7%)</td>
<td>5.3 (1.1-24.4)</td>
</tr>
<tr>
<td>8+</td>
<td>90 (89%)</td>
<td>18.5 (5-67.8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cognitive impairment</th>
<th>N (%)</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>94 (93%)</td>
<td>1.00 (Ref.)</td>
</tr>
<tr>
<td>Yes</td>
<td>7 (7%)</td>
<td>6.9 (1.6-29.8)</td>
</tr>
</tbody>
</table>

No association found with sex, language, marital status, insurance type or serious illness at time of surgery.
Chart review

Among the 25 charts we reviewed, 12 patients had ACP in progress notes or legal document within 1 year prior to surgery (N=23 notes)

• 5 patients with legal documentation
  – 2 POLSTs (Physician Order for Life Sustaining Treatment)
  – 2 DPOA (Durable Power of Attorney)
  – 1 AHCD (Advanced Health Care Directives)
# Who Authored Them and Where?

## Department of provider who wrote the ACP note

<table>
<thead>
<tr>
<th>Department</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>7</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>6</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Hospital Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>1</td>
</tr>
</tbody>
</table>

## Location of ACP discussion

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>14</td>
</tr>
<tr>
<td>Home</td>
<td>3</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
</tr>
<tr>
<td>Telephone encounter</td>
<td>1</td>
</tr>
</tbody>
</table>
Most frequently mentioned ACP topics

• Legal document or form (N = 16)
  “Has a durable power of attorney for health care at home and asked to provide me with a copy. I have given a copy of POLST form”

• Code status (N = 11)
  “The patient is FULL CODE.”

• Goals of care (N = 10)
  “To avoid hospitalizations, stay at home. Comfort. She expresses the wish to go home to Columbia to die but understands this probably will not happen.”

• Surrogate (N = 5)
  “Advance directive on file. No code. Daughter is DPAHC, POLST done/filed”
In-depth ACP discussion documentation is lacking

- However, many (N=7 of 12) mentioned a discussion without any indication of topics discussed, patient preferences, or decisions

"End of Life issues discussed. I am willing to follow patient’s wishes as stated in the advance directive if available"
Conclusions
In Older Adults with MCC and had a High-Risk Surgery…

- **Only 26%** had accessible ACP documentation
- **Non-white patients** were least likely to have ACP documentation
- **Older patients**, patients with **greater number of office visits in the year prior to surgery**, and those with **cognitive impairment** were more likely to have ACP documentation
Diving Deeper into the Chart…

▪ ACP documentation in the year prior to a major surgery frequently discussed topics of code status and legal documentation.

▪ For those with a goals of care discussion, few documented the details.

▪ ACP documentation were from Internal Medicine and Palliative Care Providers; most discussions took place in the clinic.
What to do about this?

- Incorporate ACP into the pre-operative workflow
- Include documentation of patient’s goals of care and values
- Can look different at each institution:
  - UCSF Surgery Wellness Program
  - SFVA Veterans Integrated Peri-Operative (VIP) Clinic
- Engaging all stakeholders (e.g., Patients, PCPs, Surgeons)
- Surgeon’s Role
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My Contact Information

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“We can fix it”: Pitfalls In Communication Between Surgeons And Seriously Ill Patients.

ZARA COOPER, MD, MSC, FACS
ASSOCIATE PROFESSOR OF SURGERY
HARVARD MEDICAL SCHOOL
BRIGHAM AND WOMEN’S HOSPITAL
Objectives

1. What is it with you surgeons?
2. Challenges in communication
3. Potential solutions
The Surgeon
The Surgical Covenant

“I will not abandon you; I will battle death for you ... it is a deeper and stronger commitment than money can buy; such a commitment is part of my identity as a surgeon.”

McKneally, MF World J Surg, 2009;33:1341-1347
Buchman, TG, JACS 2002;194:665-673
Mosenthal AC, CCM 2006;34:S399-S403
The Surgical Contract
Surgical Buy-in

Establishing buy-in
- “...This is a package deal, this is what this operation entails...”

Contributors to buy-in
- “...you don’t want to be the agent that you know...kills someone in the operating room...”

Consequences of buy-in
- “...I cannot, even if you wish it, I cannot turn off the machinery if I think you are survivable.”
Challenges
And I think we can fix it
<table>
<thead>
<tr>
<th>Types of Buy-in</th>
<th>Surgeon</th>
<th>Representative Quotes</th>
<th>Patient</th>
<th>Representative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgeon states the performance of surgery is contingent on a preoperatively determined agreement between surgeon and patient about participation in postoperative treatments.</td>
<td>MD: “If we decide we’re going to be there, then you and I have sort of a verbal contract that we are going to do everything that we can to have that outcome that we want. So if we’re going to go forward with that, then we have an understanding that everybody is going to do their utmost.”</td>
<td>Patient states that the surgeon can do whatever is necessary around the time of surgery.</td>
<td>PT: “You do what you have to do.” MD: “...It’s understandable to be nervous because it’s a big surgery.” PT: “But I have complete faith in you.” MD: “Okay, I know you’re anxious about this but we have to take it a step at a time.” PT: “I understand. You’re the boss!”</td>
</tr>
<tr>
<td></td>
<td>Surgeon emphasizes that the patient will participate in prolonged or unexpected treatments if necessary.</td>
<td>MD: “We are going to do the operation that Friday and then you’re here in the hospital as long as you need to be, and that’s the bottom line, right? If you need to be here longer, you’re here longer...” MD: “Sometimes it turns into a war and you have to fight battles to win the war, so you have to be prepared for that on some level.”</td>
<td>Patient notes a general recognition that death and other complications will be accepted or tolerated.</td>
<td>PT: “That’s God’s will, I’ve led a good life.” PT: “Yeah, okay. So that’s it. The lifestyle changes, you adjust to it, you know.”</td>
</tr>
<tr>
<td></td>
<td>Surgeon assumes that the patient agrees to postoperative care by acknowledging surgical risk.</td>
<td>MD: “And this is a form that basically says that we’ve gone over the risks... And that you agree to go forward. It’s not a contract, by any means. You can always just not show up.”</td>
<td>Patient states a willingness to proceed with surgery and acknowledgment that risks exist.</td>
<td>MD: “Yeah, and I think... I mean there are risks to it of course...” PT: “Yeah. There’s a risk to everything.” PT: “I think I’d like to have you do the surgery.”</td>
</tr>
</tbody>
</table>
It can go like this...

Die

Fight

Big

Fix

What outcomes are most important to you?
Pitfalls in communication

- Patient
- Surrogate
- Surgeon
- System
High 1-year Mortality Among Older Emergency Laparotomy Patients

Cooper Z. et al. JAGS 2015
Survival Estimates are Highly Variable

Vignette 1: Probability of Death within 72 hours
Without an Operation

Cauley CE, et al. JPM 2016
Even with surgery, expected survival is limited

Vignette 1: Length of Survival if an Operation is Performed
Potential Solutions
“I think if you don’t have some framework about how aggressive the family and/or the patient would want to be, and don’t have that conversation on the front end, it becomes very... it becomes a bit of a slippery slope that continues on, and sometimes can prolong the dying process.”

Cauley CE, et al. JPM 2016
Recommendations for Best Communication Practices to Facilitate Goal-concordant Care for Seriously Ill Older Patients With Emergency Surgical Conditions

Zara Cooper, MD, MSc,* †† Luca A. Koritsanszky, MPH,* Christy E. Cauley, MD,* § Julia L. Friedman, BA,*
Rachelle E. Bernacki, MD, MS,* || Anne C. Mosenthal, MD,* † Aatul A. Gawande, MD, MPH,* †
and Susan D. Block, MD* || || ||

Allow for silence/pause points
Verbal acknowledgment of emotions
Sit
Eye contact
Physical contact
Ask patient and family to summarize
Ask permission to move to next part of the conversation
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Connect</td>
<td>Introduce yourself, gather data, and make a personal connection</td>
</tr>
<tr>
<td>Explore Understanding</td>
<td>Establish shared understanding of the patient’s current condition</td>
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<tr>
<td>Inform</td>
<td>Disclose information about the acute problem</td>
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<tr>
<td>Goals</td>
<td>Understand the patient’s goals and priorities, and discuss tradeoffs</td>
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<tr>
<td>Options</td>
<td>Describe the benefits, burdens and likely outcomes of surgical and non-surgical options, including palliative treatments</td>
</tr>
<tr>
<td>Recommend</td>
<td>Recommend a course of treatment in the context of the patient’s goals</td>
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<tr>
<td>Support</td>
<td>Affirm the relationship and support the patient’s decision</td>
</tr>
<tr>
<td>Communicate</td>
<td>Document the conversation and discuss with the clinical team</td>
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A Conversation with Ramon

- What have these past few months been like?
- We’ve hit a bad problem...
- What I’m hearing is...
- I’m sorry, I imagine this is so hard
- Here’s what I think is likely to happen
- If you get sicker, what do you want to avoid?
- I would recommend x; we can revisit this at y
- We are with you
Two conversations...

**Communication Framework for Surgeons Caring for Seriously Ill Older Patients with Acute Surgical Emergencies**

<table>
<thead>
<tr>
<th>What surgeons do:</th>
<th>What patients value:</th>
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Surgery is the only option
Patients unprepared for surgery
Recovery was difficult
Advance Directives?

“There is a disconnect between what patients want and who is the right person to tell.”
Question Prompt List
For Patients
By Patients
Summary
THANK YOU