

The Unrepresented Resident IDT: Working with the Office of the Long-Term-Care Patient Representative

CAHF Annual Meeting

November 15, 2022

Inland Empire CAHF Meeting

January 9, 2023

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The Unrepresented Resident IDT (sometimes called the Epple IDT)

The statutory requirements discussed in this presentation apply ONLY to IDTs convened for the following reasons:

- ▶ 1. “A medical intervention or treatment that requires informed consent” is proposed for a resident
- ▶ 2. The resident lacks the capacity to understand the risks and benefits of the proposed intervention or treatment
- ▶ 3. The resident does not have a legally authorized representative to act on his or her behalf in making the treatment decision
- ▶ 4. The facility is unable, after reasonable effort, to locate a family member or other individual to serve as a patient representative on the IDT*

*Even if a family member or other person is located to serve as a patient representative (but not as a decisionmaker), there are data reporting requirements effective as of January 27, 2023

The Origin of the Unrepresented Resident IDT

- ▶ Since 1992 a CA statute authorized the SNF interdisciplinary team (IDT) to “review” (in reality “approve”) “medical interventions that require informed consent” when a SNF resident lacks decision-making capacity and does not have a health care agent or other decisionmaker (Health & Safety Code §1418.8, “Epple”)
- ▶ The IDT consisted of the attending MD, an RN, other appropriate staff, and a patient representative “where practicable”
- ▶ Historically, in almost all cases, it was not practicable to find a patient representative for such a resident.

Constitutional Challenges

- ▶ The first challenge to the law's constitutionality: *Rains v. Belshe* 32 Cal.App.4th 157 (1995)
- ▶ The court held that the law was constitutional and was “an effective legislative solution that would allow timely medical treatment” without the delay of having to go to court.
- ▶ The next constitutional challenge: *CANHR v. Smith* 38 Cal.App.5th 838 (2019)
- ▶ The court found some aspects of the law to be unconstitutional – most notably that the patient representative was required only “where practicable.” The court held that having a patient representative is “crucial to the functioning and constitutionality of the statute.”
- ▶ The court also ruled that notices must be given to the resident both before and after the IDT takes place.
- ▶ The ruling also stipulated that the Patient Representative must be completely unaffiliated with the facility.

“Informed Consent” and “Capacity”

- ▶ Where there are significant risks, benefits and alternatives to a prescribed medical intervention, a physician must disclose these to the patient or, if the patient is unable to understand the nature and consequences, including risks and benefits, or is unable to express a preference, to his or her legally authorized decisionmaker.
- ▶ In a Skilled Nursing Facility, these procedures are typically the following:
 - ▶ A medical intervention to treat severe and sustained emotional distress
 - ▶ Psychotherapeutic medication
 - ▶ Physical restraints
 - ▶ Change or creation of a POLST
 - ▶ Do Not Resuscitate orders
 - ▶ Comfort care orders
 - ▶ Election of Hospice Care
- ▶ An individual's capacity to give informed consent is determined by the attending physician based upon interview of the resident, review of the medical records and consultation with facility staff and family members if any. **The physician must document the determination that is made along with the basis for it in the medical record.**

Examples of When Informed Consent is Not Required

- ▶ Routine nursing care
- ▶ Dietary recommendations and orders
- ▶ Commonly used medications, including those appropriate for pain management related to the patient's diagnosis
- ▶ Ordinary non-surgical wound treatment
- ▶ Physician requested medical consultation referrals
- ▶ Blood draw for laboratory testing
- ▶ Simple procedures where it is commonly understood that risk is minimal

Legally Recognized Decisionmakers

Health & Safety Code §1418.8

- ▶ A court appointed conservator, or a person appointed by the court to authorize specific treatment
- ▶ A person designated by a resident as an agent in an advance health care directive
- ▶ A person orally designated by a resident as a surrogate (note: such designation is only effective for the course of treatment or stay in the facility or 60 days whichever is shorter).
- ▶ A resident's spouse or registered domestic partner.
- ▶ A parent or guardian of a resident who is a minor.
- ▶ A resident's closest available relative or another person whom the resident's physician and surgeon, nurse practitioner, or physician's assistant reasonably believes has authority to make health decisions on behalf of the resident and that will make decisions in accordance with the resident's best interests and expressed wishes and values to the extent known.

If There Is No Patient Appointed Surrogate, Health Care Agent, or Conservator the Following May Apply.

***New Law* Probate Code §§ 4711 & 4712 (AB 2338)**

- ▶ If there is no patient appointed surrogate, healthcare agent, or conservator, a health care provider or a designee of the health care facility caring for the patient may choose a surrogate to make health care decisions on the patient's behalf, as appropriate in the given situation. **The patient's surrogate shall be an adult who has demonstrated special care and concern for the patient, is familiar with the patient's personal values and beliefs to the extent known and is reasonably available and willing to serve.**
- ▶ A surrogate may be chosen from any of the following persons:
 - ▶ The spouse or domestic partner of the patient.
 - ▶ An adult child of the patient.
 - ▶ A parent of the patient.
 - ▶ An adult sibling of the patient.
 - ▶ An adult grandchild of the patient.
 - ▶ An adult relative or close personal friend.

NOTE: The basis for the choice among potential agents should be documented

The Resident Lacks Capacity and No Legally Recognized decisionmaker: Now What?

- ▶ The facility must use “due diligence” to search for a patient representative. Due diligence includes the following:
 - ▶ Interviewing the resident who may, in some cases, be able to appoint a patient representative to serve on the IDT
 - ▶ Reviewing the medical record,
 - ▶ Consulting with facility staff
 - ▶ Consulting with family or friends of the resident (if any)
 - ▶ If friends or family are identified, making a reasonable effort to contact them
- ▶ The patient representative must be “unaffiliated” with the facility EXCEPT an employee who is also a family member of the resident may serve as a patient representative. A former employee or volunteer may serve as a patient representative at a facility they were previously affiliated with, but only after two years of separation from the facility or related entities.
- ▶ Unaffiliated means that they are not the resident’s provider of health care, not an employee of the facility or any related company and not a facility service provider.
- ▶ **NOTE: Efforts to find a patient representative must be documented in the medical record**

It Helps to be Pro-Active

- ▶ Which of your residents can currently make their own healthcare decisions but do not have a legally recognized decisionmaker in case they are no longer able to do so?
 - ▶ While the facility cannot require a resident to have an advance healthcare directive (AHCD), they can explain this option and, if the resident wishes to have one, contact the Ombudsman to witness the document
- ▶ Which of your residents lack capacity and have a health care directive completed some time ago with contact information for people who have not been known to visit or interact with the patient or staff?
 - ▶ Start the process now to see if the agent(s) are still available and, if not, begin due diligence to see who might be able to act as a patient representative if one is needed
- ▶ Which of your residents lack capacity and do not have anyone in place to serve as a legally recognized decisionmaker or patient representative if a medical intervention requiring informed consent is proposed?
 - ▶ Start looking for possibilities now

NOTE: A current need to find a patient representative or notify the OPR within 72 hours that one cannot be found would, of course, be a higher priority.

Introducing the Office of the Long-Term-Care Patient Representative (OPR)

- ▶ The Office of the Long-Term-Care Patient Representative is a new agency created by statute for the purpose of providing a patient representative for the IDT conducted when a SNF resident is prescribed a medical intervention requiring informed consent, lacks capacity to make a healthcare decision, and has no legally recognized decisionmaker.
- ▶ The OPR is part of the Department of Aging. The staff is led by Susan Rodrigues who has extensive experience with the Department of Aging; prior to that she once worked as a SNF social worker.
- ▶ The Public Patient Representatives who will work with the facilities and serve on the IDT are direct employees of the OPR or of agencies under contract with the OPR. The OPR is scheduled to be fully operational by January 27, 2023
- ▶ The role of the PPR is limited to serving as a patient representative on the IDT

Who are the Public Patient Representatives?

- ▶ The PPRs will have a formal certification process which will include a background check as well as substantial training in the following areas (as well as other related topics):
 - ▶ PPR Role and Responsibilities
 - ▶ Making healthcare decisions using basic bioethics principles
 - ▶ The IDT process
 - ▶ Medical issues: Dementia / End of life care (including hospice and POLST)
 - ▶ The role of the PPR on the IDT
 - ▶ Reviewing Medical Records / Confidentiality
 - ▶ Legally required notices and other legal requirements
 - ▶ Resident rights / Mandated Reporting / Role of the Ombudsman
 - ▶ Communication / Providing Culturally Responsive Service

How to Effectively Partner with the OPR

- ▶ The Office of the Long-Term-Care Patient Representative has a very useful web site! It includes the following:
 - ▶ Frequently Asked Questions
 - ▶ Forms for Notices to the Resident (and some for other uses)
 - ▶ Policies of the OPR
- ▶ The OPR is also preparing to have electronic portals for communication between the OPR and facilities

Here is the site:

https://aging.ca.gov/Providers_and_Partners/Office_of_the_Long_Term_Care_Patient_Representative/

After Diligent Search, No Representative Is Found

- ▶ If the facility cannot find a patient representative within 72 hours from the time the physician orders the medical intervention that requires informed consent for a resident who lacks capacity, then the Office of the Long-Term-Care Patient Representative (OPR) must be contacted to provide a Public Patient Representative (PPR) to serve on the IDT.
- ▶ Even after notice is given to the OPR, if the facility finds someone to act as a patient representative, then the OPR should be notified that a PPR will not be required.

IMPORTANT NOTE: The facility must also provide quarterly data to the OPR regarding all unrepresented patient IDTs that took place whether or not there was a PPR participant.

Required Notices: The Non-Emergency IDT

- ▶ These Include
 - ▶ Detailed written and oral notice to the resident five days before convening the IDT (must be in primary language or translated)
 - ▶ Hearing and/or vision impairment must be accommodated
 - ▶ Follow up notice of IDT decision to resident and OPR including right to judicial review
 - ▶ IDT decisions must be reviewed at least quarterly (even if no changes in orders), upon a significant change of condition, or upon request of the resident or the patient representative. Notice requirements before and after the quarterly (or sooner) meeting must be given as above.

Notices must be kept as part of the medical record

Content of Notice to the Resident

- ▶ The resident is determined to lack capacity to provide informed consent
- ▶ A legal decisionmaker is not available
- ▶ A description of the proposed medical intervention
- ▶ Name and phone number of MD ordering intervention and of the Medical Director
- ▶ That a decision will be made by the IDT
- ▶ Explanation of the IDT process and right to a patient representative; name of representative or, if none, that the OPR will provide one
- ▶ Contact info for: local contact for OPR, Ombudsman and protection and advocacy organization
- ▶ The right to judicial review.

Preparation of Notices Before and After the IDT: Your Form or the OPR's

- ▶ The OPR has created useful forms with input from stakeholders including CAHF. Facilities are NOT required to use them and can create their own forms if desired so long as they contain the required information.
- ▶ The link is below. Here are the forms that you can find on the OPR site (see below):
 - ▶ Initial IDT Notice (non-emergency)
 - ▶ Notice of IDT outcome
 - ▶ Emergency Medical Intervention Notice
 - ▶ Emotional Distress or Use of Restraints Notice
 - ▶ Notice of Failure to Conduct Timely IDT Review

https://aging.ca.gov/Providers_and_Partners/Office_of_the_Long_Term_Care_Patient_Representative/Forms/

Facility preparation for the IDT review with a PPR (non-emergency)

- ▶ Provide required notice to the resident with a copy to the PPR at least five days before the IDT
- ▶ Provide access to the medical record and any other information required by the PPR in order to prepare for and participate in the IDT (including facility policies and procedures relevant to the IDT process if requested).
- ▶ Arrange for an in-person or virtual meeting with the resident prior to the IDT review
- ▶ Facilitate availability of the attending physician or medical director to discuss risks, benefits, and alternatives with the PPR at least 48 hours prior to the scheduled IDT

Emergency Exception

“Emergency” A situation when medical treatment is immediately necessary for the **preservation of life, the prevention of serious bodily harm, or the alleviation of severe physical pain or severe and sustained emotional distress.**

In an emergency, a medical intervention may be given upon 24 hours notice to the individual and the patient representative (individual or OPR). The emergency must be documented in the medical record and the IDT must take place within one week.

Exception: If the emergency results in the application of an intervention to treat severe and sustained emotional distress or the application of physical or chemical restraints, the OPR must be notified within 24 hours and the facility shall attempt to conduct the IDT within three days but no later than within one week. This type of intervention requires notice to the OPR even if a non-OPR patient representative is available.

The facility must notify the OPR of any delay in convening the IDT and the reason for the delay. There is also a form for this on the OPR website.

The Emergency IDT

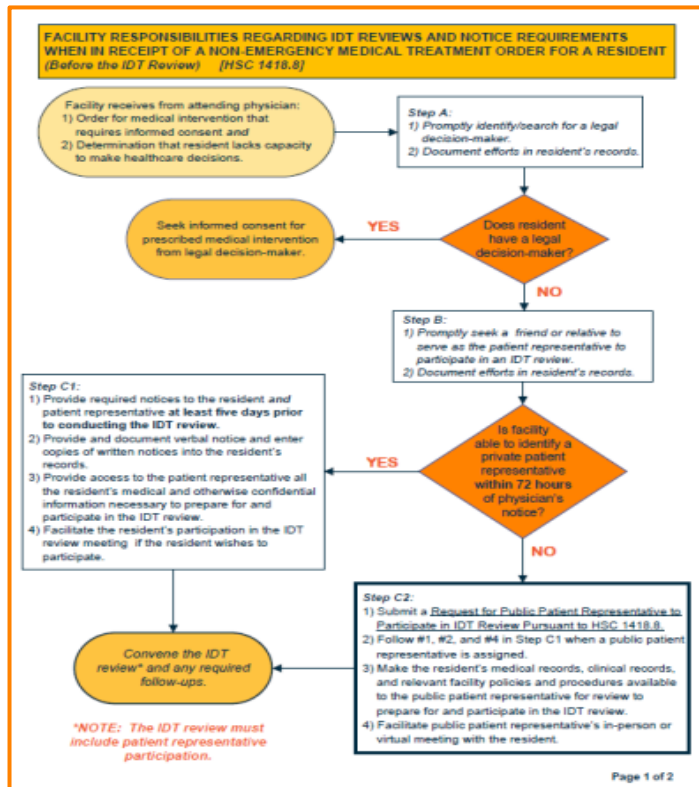
- ▶ If the MD determines that the resident will suffer harm or severe and sustained emotional distress if the medical intervention is delayed at least five days, the IDT may occur sooner
- ▶ In such cases, the facility must provide notice to the resident and to the PPR (or other patient representative if found) at least 24 hours prior to the IDT review
- ▶ If the medical intervention is necessary to preserve life, prevent serious bodily harm, or alleviate severe physical pain or severe and sustained emotional distress the facility may administer the medical intervention prior to issuing the notice and convening the IDT review
- ▶ Within 24 hours of the emergency intervention the facility must provide the resident and the PPR of notice of the intervention and the resident's right to judicial review
- ▶ The facility should make a prompt effort to convene the IDT within three days of administering the intervention, but not later than one week.

All of the above must be documented in the medical record

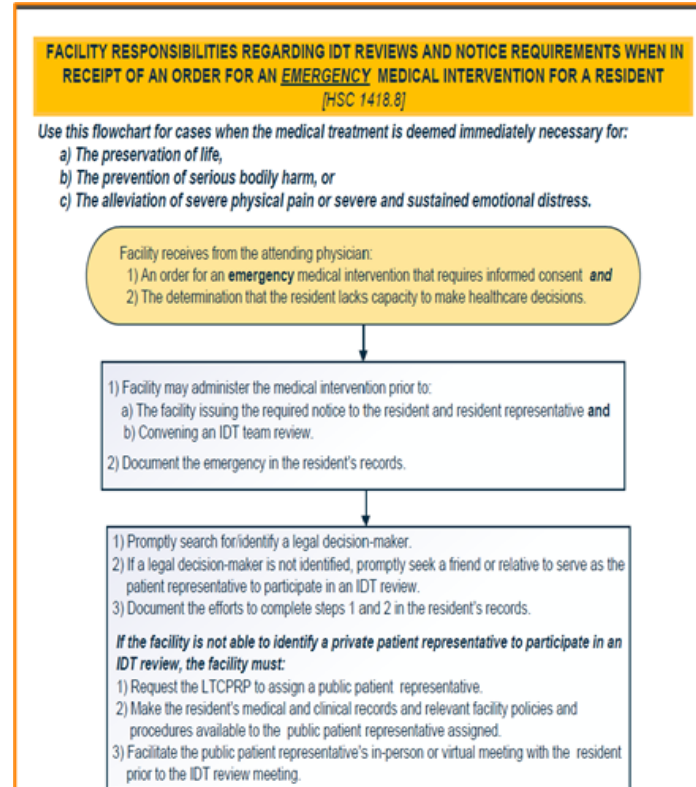
Facility Responsibility Flowcharts

(from the OPR)

Non-Emergency Medical Intervention Order Received



Emergency Medical Intervention Order Received



Outline of IDT Discussion

- ▶ Review of the physician's assessment of the resident's condition
- ▶ The reason for the proposed medical intervention
- ▶ Discussion of the resident's desires, if known (research this before the meeting by asking resident if possible, reviewing records, and contacting family and friends if any)*.
- ▶ The type of medical intervention proposed including frequency and duration
- ▶ The probable impact on the resident's condition with and without treatment
- ▶ Reasonable alternative interventions considered or utilized and why they are not appropriate
- ▶ * NOTE: *There can be exceptions if the resident's wishes are inconsistent with the resident's best interests, require medically ineffective health care, or are contrary to generally accepted health care standards.*

Data Collection and Quarterly Reports to the OPR

Facilities must collect data as follows and provide a quarterly report to the OPR:

- ▶ The total number of interdisciplinary reviews conducted.
- ▶ The number of unique residents who have had an interdisciplinary team review conducted.
- ▶ The total number of emergency medical interventions authorized pursuant to HSC section 1418.8(h).
- ▶ The number of unique residents who have had an emergency medical intervention authorized.
- ▶ A tabulation of the following:
 - ▶ Medical interventions authorized by type.
 - ▶ The outcomes of the interdisciplinary team reviews.
 - ▶ Instances when judicial review was sought.
 - ▶ Emergency medical interventions where the interdisciplinary team failed to meet within the time required by HSC section 1418.8(h), including the causes of the delay and the number of days after the intervention that the interdisciplinary team finally met.
- ▶ Any other demographic or statistical data as may be required by the program.

Data collection begins on January 27, 2023. The quarter ends on March 31 and data is due on April 30. The following quarter end dates are: June 30, September 30 and December 31 with reporting due at the end of the next month.

The OPR will provide reporting guidance on its website prior to the first quarterly reporting deadline in 2023.

Basic Bioethics Principles when Making a Decision for Someone Else

- ▶ Autonomy: Protecting individual rights, self-determination and choice
- ▶ Beneficence: The course of action that will give the greatest benefit
- ▶ Non-Maleficence: The course of action that will cause the least harm
- ▶ Justice: Fairness to the patient with consideration of the needs and rights of others

Incorporating Bioethics Principles into the IDT

- ▶ Review of the physician's assessment of the resident's condition
- ▶ The reason for the proposed medical intervention
BENEFICENCE
- ▶ Discussion of the resident's desires, if known (research this before the meeting by asking resident if possible, reviewing records, and contacting family and friends if any).
AUTONOMY
- ▶ The type of medical intervention proposed including frequency and duration
- ▶ The probable impact on the resident's condition with and without treatment **BENEFICENCE/NON-MALEFICENCE**
- ▶ Reasonable alternative interventions considered or utilized and why they are now inappropriate **BENEFICENCE/NON-MALEFICENCE**

Autonomy:

Substituted Judgment

Members of the IDT should consider the following:

- ▶ Any healthcare wishes that have been expressed by the patient to others when the patient had capacity
- ▶ Any written documents created by the patient that pertain to his or her healthcare wishes (for example, an advance directive where the agent is no longer available)
- ▶ The patient's social history and background prior to admission
- ▶ Known religious or cultural beliefs of the patient

NOTE: The patient's previously expressed wishes should be afforded "particular consideration" **unless the wishes are inconsistent with the best interests of the patient, require medically ineffective health care, or are contrary to generally accepted health care standards.**
Health and Safety Code §1418.8 (e)(2)(C)

Beneficence/Non-Maleficence: Best Interest

- ▶ In many (if not most) cases, there is insufficient information to guide the IDT in order to determine what the patient would wish to do in the current circumstance, if they had capacity.
- ▶ In the event that the IDT cannot make a determination as to the patient's wishes based upon substituted judgment, the decision should be made based upon the patient's best interest.
- ▶ Best interest discussion considers the risks, benefits, and alternatives, as well as the individual's expected prognosis with and without the proposed medical intervention.
- ▶ The individual patient's best interest is the IDT's focus; the decision will not necessarily be the same as it would be in a similar situation involving a different patient.

IDT Documentation Outline

- ▶ Meeting Attendees (name and title)
- ▶ Reason for meeting: Resident [name]'s attending physician, proposes [intervention that requires informed consent]. Dr. [name] has determined that [resident] lacks decision making capacity and has no legal representative.
- ▶ Attending physician: Dr. [name]'s assessment of the resident's condition, type of medical intervention proposed (including frequency and duration), reasons for the recommendation, probable impact on the resident's condition with and without treatment and reasonable alternatives considered or utilized. Dr. [name] also provides information about resident's expressed wishes if known.
- ▶ Facility Staff Member: Describe efforts made to locate a family member, other legal representative, or an appropriate individual to serve as a patient representative. Also include any available information as to the resident's expressed desires regarding health care should be made.
- ▶ Discussion, opportunity to ask questions, IDT consensus
- ▶ **NOTE: Documentation must be placed in the resident's medical record. Also, if there is no consensus, the medical intervention may not be initiated; the facility may seek a court order but is not required to do so.**

A Note about Life Sustaining Treatment (from California Law)

Legislative Findings:

- ▶ (a) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.
- ▶ (b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.
- ▶ (c) In the absence of controversy, ***a court is normally not the proper forum*** in which to make health care decisions, including decisions regarding life-sustaining treatment.

Probate Code §4650

End of Life Decisions

- ▶ A physician is not required to provide “medically ineffective health care” (Probate Code §4735)
- ▶ In many acute care hospitals, a bioethics committee will be involved in such cases and the hospital will have their own specific policies.
- ▶ A decision to withdraw life-sustaining treatment that is currently in place is NOT within the scope of the SNF IDT
- ▶ Court orders are sometimes obtained for withdrawal of life-sustaining treatment
- ▶ In any event, the IDT may NOT make decisions “that will directly and inexorably result in death”.
- ▶ However, the SNF IDT can authorize transition to comfort care, cessation of curative care (aka palliative care), change or initiate a POLST, approve a DNR order, and/or authorize Hospice election because, in the words of the court, “these are “decisions made in anticipation of the end of life, since they all have to do with ensuring comfort and quality of life as a patient’s end draws near” CANHR v. Smith 38 Cal. App. 5th 838, 900-901 (2019)

Special Considerations for End-of-Life Care and Hospice Election

- ▶ Terminology is important. Certain buzzwords and phrases such as “withdrawing care” are inaccurate and can be misunderstood. Care is never withdrawn, although medical treatments can be. If certain interventions would not provide a benefit and/or could cause harm then a decision may be made to transition to comfort care, palliative care and/or hospice care.
- ▶ Even if this change in care seems obvious, the attending physician must still present the medical rationale including risks and benefits (if any) and answer questions from other IDT members.
- ▶ Although not required by statute, it may be a good idea in some cases to have a second physician participate in the meeting (if available).
- ▶ A hospice election and/or POLST should be signed by one member of the IDT on behalf of the IDT. This individual should NOT be one of the physicians nor the appointed patient representative.
- ▶ A single IDT representative *on behalf of the facility* signs a POLST as the “legally recognized decisionmaker” and indicates their relationship as “IDT representative.” The physician signs in the area designated for the physician who is giving the order.

How Should the SNF IDT Handle a POLST change or Hospice Election?

- ▶ A “best practices” IDT will cover all that is required by the statute and consider patient’s known wishes and best interests
- ▶ One non-physician member of the IDT should sign the required document(s) on behalf of the IDT.

Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.		
Print Name:	MARIA ESTRADA FOR SUNNY VIEW SNF	Relationship: (write self if patient) SUNNY VIEW IDT
Signature: (required)	Maria Estrada	Date: 5/5/2022
Mailing Address (street/city/state/zip):	123 SUNNY LANE CA 90002	Phone Number: 855-123-4567
FOR REGISTRY USE ONLY		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

Working with Incapacitated and Unrepresented SNF Residents

- ▶ Recognize that the new IDT process will potentially invite additional scrutiny by CDPH (see AFL 20-83.2)
- ▶ The SNF IDT process will continue to be needed for additional orders that require informed consent where the individual lacks capacity to make his or her own healthcare decisions. Quarterly (or more often if condition changes) IDT review of decisions will be required. This means that the same series of notices will also be required.
- ▶ It is a good idea to have one facility staff member (and a backup if possible) to act as the primary liaison with the OPR.
- ▶ Subscribe to the CAHF listserv and stay tuned for even more new developments as the OPR is rolled out!

Questions? Comments?

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