1 PATIENT INFORMATION

1 PATIENT & CONFERENCE DETAILS

PATIENT NAME
Alvaro J. Benedetti-Ruiz

DOB
04/18/1952

AGE / SEX
74 / Male

MRN / PATIENT ID
NSD-1174562

DATE OF CONFERENCE
07/30/2026 — 14:00–15:12

LOCATION / FORMAT
Neuro-stepdown family conference room; two participants by video, one by telephone

CONFERENCE TYPE
Interdisciplinary care conference with goals-of-care and discharge planning — third conference this admission

CURRENT LOCATION / LEVEL OF CARE
Neuroscience stepdown unit — hospital day 31

PRIMARY DIAGNOSIS / REASON FOR CARE
Large left middle cerebral artery ischemic stroke (06/30/2026) with hemorrhagic conversion and decompressive hemicraniectomy 07/02. Residual dense right hemiplegia and global aphasia. Tracheostomy 07/14, PEG 07/16. Course complicated by ventilator-associated pneumonia, hospital-acquired sacral pressure injury, and recurrent aspiration.

2 REASON FOR CONFERENCE

2 INDICATION

Convened for four converging reasons. (1) **Prolonged hospitalization** — day 31 with medical stability achieved but no disposition secured. (2) **Goals-of-care clarification** — the neurologic prognosis is now sufficiently defined that continued rehabilitation-directed care versus comfort-focused care is a real decision, not a premature one. (3) **Family conflict** — the patient's spouse (healthcare proxy) and his two adult children hold materially different views on tracheostomy and feeding-tube continuation, and this disagreement, not the medicine, is currently the rate-limiting step. (4) **Barriers to care** — the LTAC authorization was **denied on 07/28** and the two accepting SNFs require a documented plan for tracheostomy care that does not yet exist.

3 CONFERENCE PARTICIPANTS

3 PRESENT OR PARTICIPATING

PRIMARY PROVIDER
Dr. Hana Oyelaran, MD — Hospital Medicine (attending)

CONSULTING SPECIALISTS
Dr. P. Sandoval, MD — Neurology · Dr. R. Ntumba, MD — Palliative Medicine · Dr. E. Kwiatkowski, MD — Pulmonary/Critical Care (by video)

NURSING TEAM
M. Adeyemi, RN — primary nurse · T. Vasquez, RN, BSN

THERAPY TEAM
J. Okafor, PT, DPT · S. Lindqvist, OT · D. Marchetti, MS,

— stepdown charge nurse · L. Brennan, RN, CWOCN — wound care

CCC-SLP

CARE COORDINATOR / CASE MANAGER
K. Thibodeaux, RN, CCM

SOCIAL WORKER
A. Nwachukwu, LCSW

PATIENT
Present but unable to participate — global aphasia; alert, tracks, follows no reliable commands. Assessed by SLP as **lacking decisional capacity** (documented 07/22 and reconfirmed 07/29)

FAMILY MEMBER OR CAREGIVER
Marisol Benedetti-Ruiz — spouse of 46 years, **designated healthcare proxy** (present) · Diego Ruiz — son (present) · Camila Ruiz-Hartley — daughter (by telephone from out of state)

LEGAL REPRESENTATIVE / SURROGATE
No guardianship. **Valid durable power of attorney for healthcare** naming the spouse, executed 2019, verified in chart

INTERPRETER
E. Duarte — certified Spanish medical interpreter, present in person for the full 72 minutes

OTHER PARTICIPANTS
Chaplain R. Feldman (first 20 minutes, at family request) · Ostomy/tracheostomy educator not available — flagged as a gap

Note on process: All discussion was interpreted consecutively into Spanish. The spouse's primary language is Spanish; both adult children are English-dominant. **The interpreter confirmed comprehension checks at each decision point** rather than at the end, which changed the tenor of the meeting materially — the spouse's earlier apparent agreement at the 07/16 conference was found to have rested on an incomplete understanding of what 'permanent tracheostomy' entailed.

4 CLINICAL BACKGROUND

4 RELEVANT HISTORY & COURSE

- **Primary diagnosis:** Large left MCA territory ischemic stroke, cardioembolic, presenting 06/30/2026 outside the thrombolytic window with NIHSS 22. Mechanical thrombectomy achieved TICI 2a recanalization. **Hemorrhagic conversion on 07/01** with malignant cerebral edema; **decompressive left hemicraniectomy 07/02.**
- **Secondary diagnoses:** Atrial fibrillation (previously undiagnosed — the presumed embolic source), type 2 diabetes (A1c 9.1% on admission), hypertension, stage 3a chronic kidney disease, obesity (BMI 34), obstructive sleep apnea untreated, and a 30-pack-year remote smoking history.
- **Relevant past history:** Independent and working part-time as a machinist until the stroke. Drove, managed his own finances, walked without aid. **No prior hospitalizations in 12 years.** No prior advance directive beyond the healthcare proxy designation; **no documented conversation about life-sustaining treatment preferences.**
- **Hospital course:** Ventilated 07/01–07/14. Two failed extubations (07/09, 07/12) with immediate stridor and aspiration. **Tracheostomy 07/14** and **PEG 07/16** after two failed swallow evaluations. Ventilator-associated pneumonia 07/11 treated with a 7-day course. **Hospital-acquired stage 3 sacral pressure injury** identified 07/19. Recurrent aspiration events 07/21 and 07/26 despite PEG feeding, both attributed to secretion management rather than reflux. Transferred from ICU to neuro-stepdown 07/20.
- **Current treatment plan:** Tracheostomy collar trials 12 h/day, PEG feeding at goal, apixaban restarted 07/22 for AF, insulin, sacral wound care with negative-pressure therapy, and daily PT/OT/SLP.

- **Events precipitating this conference:** Neurology's 07/29 prognostic reassessment; the 07/28 LTAC denial; and a documented **disagreement at the bedside on 07/27** between the son and the spouse regarding whether to pursue further intervention, which nursing escalated appropriately.

5 CURRENT CLINICAL STATUS

5 CONDITION AT TIME OF CONFERENCE

- **Neurologic / mental status:** Alert, eyes open, tracks faces and follows people across the room. **Global aphasia** — no expressive output beyond occasional undifferentiated vocalization; no reliable command following, no consistent yes/no. Dense right hemiplegia with right facial involvement. Left side moves purposefully and he will reach toward his spouse. **Lacks decisional capacity** (reassessed 07/29). Hemicraniectomy defect unrepaired, helmet in place when out of bed.
- **Hemodynamic status:** Stable. Sinus rhythm at 78 with occasional paroxysmal AF on telemetry, rate-controlled. BP 128/74 on amlodipine and losartan. **No vasoactive support since 07/08.**
- **Respiratory status: Tracheostomy, size 8 cuffed, off the ventilator since 07/23.** Tolerating trach collar 12 hours daily on 28% humidified oxygen; nocturnal pressure support for OSA and fatigue. **Suctioning required q3–4h** for moderate secretions — this is the single finding that determines placement options.
- **Nutrition status:** PEG feeding at goal, 1,650 kcal / 95 g protein. Albumin 2.4, prealbumin 12. **Weight down 14 kg since admission.** SLP: **nil by mouth, no safe oral intake** — third instrumental assessment 07/28 showed silent aspiration on all consistencies.
- **Functional status:** Total dependence for all activities of daily living. Sits in a chair with a full-body lift and two-person assist for 90 minutes daily. **No sitting balance, no bed mobility, no transfer capability.** FIM equivalent at the floor of the scale.
- **Pain control:** Adequate. Scheduled acetaminophen with PRN low-dose oxycodone; nonverbal pain scale 0–2 at rest, 4 with wound dressing changes. **Grimacing consistently observed during turns** — pre-medication protocol now in place.
- **Infection status:** No active infection. Afebrile 9 days, WBC 8.4, no antibiotics since 07/18. **Tracheal colonization with Pseudomonas** — not treated, correctly.
- **Wound / line / drain concerns: Stage 3 sacral pressure injury, 6 × 4 × 1.2 cm** with negative-pressure wound therapy; granulating, 30% smaller than at identification. Tracheostomy site clean. PEG site healed. **No central line, no urinary catheter** since 07/24 — both successfully removed.
- **Current medications / treatments:** Apixaban, amlodipine, losartan, insulin glargine plus correction, atorvastatin, pantoprazole, bowel regimen, acetaminophen scheduled, oxycodone PRN, nocturnal pressure support, NPWT dressing changes three times weekly.
- **Current limitations / risks:** Recurrent aspiration despite NPO status · pressure injury progression · contracture formation in the right upper and lower extremity · **bleeding risk on apixaban with an unrepaired cranial defect** · deconditioning · caregiver capacity far exceeded by the level of need.

6 ACTIVE PROBLEMS / ISSUES DISCUSSED

6 ISSUES REVIEWED

- **Medical:** Stroke with severe irreversible deficit; AF with anticoagulation and cranial-defect bleeding
- **Surgical:** Unrepaired hemicraniectomy defect — cranioplasty timing undecided and prognosis-

risk; diabetes; CKD 3a

- **Functional:** Total ADL dependence; no rehabilitation gains in 3 weeks of daily therapy
- **Behavioral:** No behavioral disturbance; sleep-wake cycle disorganized
- **Medication:** Anticoagulation risk-benefit; insulin management with PEG feeding schedule
- **Disposition:** LTAC denied; two SNFs conditionally accepting; home is not currently feasible
- **Insurance:** 07/28 LTAC denial — appeal window closes 08/07

dependent

- **Psychosocial:** Family conflict between spouse and son; daughter geographically distant and receiving second-hand information
- **Nursing:** Suctioning q3–4h · NPWT · two-person turns · total care burden
- **Safety:** Aspiration despite NPO · pressure injury · contracture · fall risk in chair
- **Financial:** Medicare A exhausting; secondary coverage limits SNF days; spouse works part-time
- **Caregiver:** Spouse is 71 with her own osteoarthritis; son works nights; no other local support

7 RECORDS / DATA REVIEWED

7 CLINICAL DATA REVIEWED DURING THE CONFERENCE

- **Progress notes:** Hospital medicine daily notes 07/20–07/30; neurology serial examinations 07/01–07/29; critical care notes 07/01–07/20.
- **Consultant recommendations:** Neurology prognostic note 07/29 (reviewed aloud, verbatim, with interpretation); palliative medicine 07/23 and 07/29; pulmonary/critical care tracheostomy decannulation assessment 07/27; nephrology 07/11.
- **Laboratory results:** CBC, CMP, albumin, prealbumin, A1c 8.0 (improved from 9.1), INR/anti-Xa not indicated on apixaban.
- **Imaging:** MRI brain 07/25 — **completed left MCA territory infarction with encephalomalacia**, no salvageable penumbra, no hydrocephalus. CT head 07/29 — stable, no new hemorrhage. Chest radiograph 07/26 — right lower lobe atelectasis versus early aspiration change.
- **Procedure reports:** Thrombectomy 06/30; hemicraniectomy 07/02; tracheostomy 07/14; PEG 07/16.
- **Therapy notes:** PT/OT/SLP notes 07/16–07/29 reviewed in aggregate — **no measurable functional gain across 3 weeks of daily therapy.** FEES 07/28.
- **Medication list:** Full reconciliation reviewed with pharmacy input; five medications identified as candidates for discontinuation under either care pathway.
- **Nursing updates:** 24-hour care-burden documentation, turn logs, suctioning frequency logs, and the 07/27 conflict escalation note.
- **Prior care plans:** Conference notes 07/08 and 07/16 reviewed. **The 07/16 note documented family agreement to tracheostomy and PEG 'as a bridge to rehabilitation'** — this framing was revisited explicitly today.
- **Advance care planning documents:** Durable power of attorney for healthcare (2019) — verified. **No living will, no POLST, no prior code-status discussion documented before this admission.**

8 INTERDISCIPLINARY DISCUSSION

8 INPUT BY DISCIPLINE

- **Neurology (Dr. Sandoval):** Stated the prognosis plainly. **The infarction is complete and the deficit is irreversible.** At 30 days post-onset with dense hemiplegia, global aphasia, and no command following, **meaningful recovery of speech, ambulation, or independent function is not expected.** Some improvement in alertness and possibly limited left-sided function may occur over 6–12 months, but **he will not regain the ability to communicate, walk, or self-care.** Cranioplasty would be cosmetic and protective, not functional.
- **Hospital medicine (Dr. Oyelaran):** He is **medically stable and no longer requires acute hospital care.** Every additional hospital day now carries net risk — infection, delirium, further pressure injury, deconditioning. The medical question has moved from 'what else can we treat' to **'where is he cared for and with what goals.'**
- **Pulmonary/critical care (Dr. Kwiatkowski): Decannulation is not achievable** — secretion clearance depends on suctioning, and cough is absent. The tracheostomy is **permanent for practical purposes.** This was, by the spouse's own account, not what she understood on 07/16.
- **Palliative medicine (Dr. Ntumba):** Reframed the discussion around **what the patient would have wanted** rather than what the family wants for him. Elicited substantive substituted-judgment history for the first time this admission — see Section 9. Emphasized that **comfort-focused care is not withdrawal of care** and that both pathways under discussion are legitimate and supported.
- **Nursing (RN Adeyemi, RN Vasquez):** Documented the true care burden: **suctioning q3–4h including overnight**, two-person turns q2h, NPWT changes, total ADL care, PEG management, insulin. Observed that he **reaches for his wife and settles when she is present** — offered as a genuine clinical observation, not sentiment.
- **Wound care (RN Brennan):** Sacral injury is improving but **requires q2h repositioning to continue improving** — a standard that many facilities meet inconsistently and that a home setting will not meet. Wound trajectory is a concrete facility-selection criterion.
- **Therapy (PT Okafor, OT Lindqvist, SLP Marchetti): No functional gain in 3 weeks.** PT: not a candidate for acute inpatient rehabilitation — cannot tolerate or benefit from 3 hours daily. OT: focus should shift to **contracture prevention, positioning, and comfort** rather than restorative goals. SLP: **no safe oral intake now or foreseeably**; recommended a **pleasure-tasting protocol** with the family fully informed of the aspiration risk, which was received with visible relief by the spouse.
- **Case management (RN Thibodeaux): LTAC denied 07/28** on medical-necessity grounds; **appeal must be filed by 08/07.** Two SNFs will accept conditionally **subject to a documented tracheostomy care plan and a trained caregiver visit.** A third requires cranioplasty first. **Home with home health is not viable** at a q3–4h suctioning requirement. Medicare Part A days deplete 08/19.
- **Social work (LCSW Nwachukwu):** Identified the **root of the family conflict** — the son believes stopping any intervention equals abandonment, framed partly in the family's cultural and religious terms; the daughter is receiving fragmentary information by phone and has felt excluded. The spouse **feels responsible for a decision she did not understand she was making on 07/16.** Recommended chaplaincy involvement and a separate follow-up with the son. **Caregiver capacity is objectively insufficient for home care.**
- **Areas of agreement:** All disciplines and all three family members agreed that (a) the neurologic prognosis as stated is understood, (b) the patient should not return to the ICU or be re-intubated, (c) **aggressive discomfort is not acceptable** in pursuit of function that will not return, and (d) he should not remain in an acute hospital bed.
- **Areas of disagreement: Unresolved.** The spouse favours **comfort-focused care with tracheostomy retained for comfort and PEG feeding continued**, with no further hospital transfers. The son favours **continued full rehabilitation-directed care** including cranioplasty and a further rehabilitation trial. The daughter is undecided and asked for time and for the neurology note in writing. **No consensus was reached on code status** — this is documented deliberately rather than papered over.

9 PATIENT / FAMILY GOALS AND PREFERENCES

9 STATED GOALS, EXPECTATIONS & UNDERSTANDING

Substituted judgment — the substantive new information from this conference. The spouse recounted, and the son confirmed, that after his brother's prolonged ICU death in 2018 the patient said repeatedly that he **would not want to be kept alive by machines or fed by a tube if he could not talk to his family or work with his hands.** He specifically named **being unable to speak** as the outcome he feared most. **This was never documented in an advance directive.** The palliative team elicited it in detail with the interpreter present; the family agreed it is an accurate account.

> *Spouse: 'He told me — if I cannot talk to you, do not keep me here. I agreed to the tube in July because they said it was a bridge. Nobody told me the bridge does not end.'*

> *Son: 'I hear what he said. But he is looking at us. He knows her. I am not ready to say we stop trying, and I do not want to be the family that gave up.'*

> *Daughter (by phone): 'I have been getting this in pieces. I need to read what the neurologist wrote, and I want to see him. Give me until the weekend.'*

- **Quality-of-life priorities (family consensus):** Freedom from pain and from suctioning distress · presence of family · dignity · not dying alone or in an ICU.
- **Treatment preferences: Unanimous — no return to the ICU, no re-intubation.** Divided on PEG continuation, cranioplasty, and code status.
- **Discharge preferences:** Spouse prefers a facility close to home over a distant LTAC even at the cost of a lower level of care. Son prefers the highest available level of care regardless of distance.
- **Caregiver capacity:** Spouse is 71 with osteoarthritis, works part-time, and cannot perform q3–4h suctioning or two-person turns. Son works night shifts. **Home care is not achievable with the present support structure** — stated plainly, and accepted without dispute.
- **Cultural / religious considerations:** Practicing Catholic family. Chaplain clarified that Catholic teaching **does not require disproportionate or burdensome treatment** — a point the family had not previously heard and which visibly reduced the son's sense of moral obligation to continue everything. Family requested anointing of the sick, arranged for 08/01.
- **Decision-maker involvement:** Spouse is the legal proxy and has authority to decide alone. She has **explicitly declined to exercise it against her children's wishes** and asked for time to reach agreement. **This preference is being honoured, with a defined deadline.**

10 MEDICAL DECISION-MAKING SUMMARY

10 MAJOR DECISIONS DISCUSSED

- **Options reviewed:** (A) **Continued rehabilitation-directed care** — LTAC appeal, cranioplasty, SNF with a trach program, full code. (B) **Continued life-sustaining treatment with a comfort-forward ceiling** — PEG and tracheostomy retained, DNR/DNI, no hospital readmission, SNF close to home. (C) **Comfort-focused care** — hospice-eligible, tracheostomy retained for secretion comfort, PEG discontinuation discussed as a separate decision, inpatient hospice or home hospice.

- **Risks and benefits discussed:** For (A) — **no realistic functional benefit** per neurology; risks of surgical complication, further pressure injury, prolonged institutional stay, and repeated aspiration. For (B) — avoids the burden of surgery and transfers while continuing nutrition and airway support; **does not restore function** and may extend a state the patient said he would not want. For (C) — prioritizes comfort and his stated values; **the family must accept a shortened life expectancy** and, if PEG is discontinued, must be prepared for that specific process, which was described honestly and without euphemism.
- **Alternatives considered: A time-limited trial** was raised by palliative medicine and is the option that gained the most traction — continue current care with defined functional endpoints reassessed at a fixed date, converting to comfort-focused care if those endpoints are not met. Cranioplasty was **deferred, not refused** — it is not required for comfort and would foreclose nothing.
- **Clinical rationale:** The medical facts are settled and are not in dispute among clinicians. **The remaining question is one of values, not evidence** — and the values evidence now available (the 2018 conversation) points more clearly than anything in the chart before today.
- **Unresolved questions:** Code status · PEG continuation · hospice eligibility election · whether to file the LTAC appeal at all · cranioplasty timing.
- **Consensus reached: Partial.** Agreed and documented today: (i) **no ICU transfer, no re-intubation**; (ii) **not a candidate for acute inpatient rehabilitation**; (iii) proceed with the **pleasure-tasting protocol** with informed acceptance of aspiration risk; (iv) **cranioplasty deferred**; (v) **a 14-day time-limited trial with defined endpoints and a reconvened conference on 08/13**; (vi) **protective LTAC appeal filed by 08/07** to preserve the option without committing to it; (vii) **palliative medicine to follow daily** regardless of pathway. **Code status remains full code pending the 08/13 conference** — at the spouse's request and with her authority acknowledged.

A ASSESSMENT

11 CLINICAL ASSESSMENT BASED ON THE DISCUSSION

Overall status: 74-year-old man on hospital day 31 after a completed large left MCA infarction with hemorrhagic conversion and hemicraniectomy, now **medically stable, tracheostomy- and PEG-dependent, with an irreversible severe neurologic deficit** — dense right hemiplegia, global aphasia, total ADL dependence, and no functional gain across three weeks of daily therapy. He is no longer receiving anything that requires an acute hospital bed.

Primary clinical concerns: Permanent tracheostomy dependence with a q3–4h suctioning requirement that constrains every placement option · recurrent aspiration despite NPO status · a hospital-acquired stage 3 sacral injury that is improving but repositioning-dependent · anticoagulation for AF against an unrepaired cranial defect · progressive contracture and deconditioning · ongoing weight loss on adequate enteral nutrition.

Major barriers to progress: The barriers are **not medical.** They are (1) **an unresolved goals-of-care question** in which the substituted-judgment evidence now points toward a comfort-forward approach that one family member is not yet able to accept; (2) **family disagreement** rooted in the son's understandable fear of abandonment and in a 07/16 consent that the spouse did not fully understand; (3) **an insurance denial** with a closing appeal window; and (4) **caregiver capacity that is objectively insufficient** for any home-based pathway.

Risks requiring monitoring: Aspiration · pressure injury progression · bleeding on apixaban · hospital-acquired infection and delirium with continued length of stay · **Medicare Part A depletion on 08/19**, which will narrow options if disposition is not settled. **Clinical reasoning for the agreed approach:** A **14-day time-limited trial with explicit, measurable endpoints** respects the son's need not to have given up prematurely, honours the spouse's authority without forcing her to exercise it against her family, gives the daughter time to see her father and read the prognosis herself, and **costs the patient little because the endpoints are ones his own trajectory will answer honestly.** It converts an intractable values dispute into a question with a date on it.

P PLAN

12 AGREED CARE PLAN

- **Medical treatment plan:** Continue current medical management for 14 days under the time-limited trial. **No ICU transfer, no re-intubation** — order written today. **No new diagnostic workup** unless it changes comfort or the trial endpoints. Manage AF, diabetes, and blood pressure as at present.
- **Diagnostic plan: Deliberately minimal.** No repeat neuroimaging unless there is a clinical change. No routine daily labs — basic metabolic panel and CBC twice weekly. **No repeat swallow study before 08/13** — three have been done and the answer has not changed.
- **Medication plan:** Pharmacy-led deprescribing — **discontinue atorvastatin and pantoprazole** (no ongoing indication). **Continue apixaban for now**, to be revisited at the 08/13 conference as a comfort-versus-stroke-risk decision. Optimize scheduled analgesia; **pre-medicate before every turn and dressing change.** Simplify the insulin regimen to reduce finger-sticks to q8h.
- **Nursing plan:** q2h repositioning (non-negotiable for wound trajectory) · suctioning PRN with a defined comfort-directed threshold rather than a fixed schedule · nonverbal pain assessment q4h and before all care · **family presence facilitated without visiting-hour restriction** · sleep protection 23:00–05:00 with no non-urgent care.
- **Therapy plan: Shift from restorative to maintenance and comfort goals** — PT/OT for contracture prevention, positioning, and splinting; frequency reduced to three times weekly. SLP to **implement the pleasure-tasting protocol** and train the spouse in it. No acute inpatient rehabilitation referral.
- **Behavioral health plan:** No patient-directed intervention required. **LCSW to meet with the son separately** within 48 hours — his moral distress is the specific target. Chaplaincy to continue; **anointing of the sick arranged for 08/01.** Bereavement support offered to the spouse pre-emptively.
- **Nutrition plan:** Continue PEG feeding at goal through the trial period. **PEG discontinuation is explicitly not on the table before 08/13** — the family was told this directly so that no one fears a unilateral change. Dietitian to review the ongoing weight loss.
- **Wound / line / drain plan:** Continue NPWT three times weekly with weekly measurement and photography. **Wound trajectory is one of the four trial endpoints.** No new lines; no urinary catheter.
- **Safety plan:** Aspiration precautions with HOB 30° and cuff-pressure checks · helmet whenever out of bed · two-person lift transfers only · bleeding precautions on apixaban · **escalation for comfort, not for resuscitation.**
- **Discharge / transition plan: File the LTAC appeal by 08/07** as a protective measure. Continue SNF applications; **build the required tracheostomy care plan document this week** — it is currently the concrete blocker at both accepting facilities. **Refer to hospice for eligibility assessment and information only**, with the family's explicit consent and understanding that assessment is not enrolment. Case management to model the 08/19 Medicare Part A depletion against each pathway and present it in writing.
- **Goals-of-care plan: 14-day time-limited trial, 07/30 to 08/13, with four pre-specified endpoints:** (1) any reliable, reproducible command following or yes/no communication; (2) any measurable improvement in sitting balance or bed mobility on PT assessment; (3) reduction of the suctioning requirement toward a q6h interval; (4) continued sacral wound improvement. **If none of the four are met, the family has agreed in advance that the conversation converts to comfort-focused care** — this agreement is the substance of today's conference and is documented as such.
- **Family / caregiver communication plan: Daily brief update to the spouse** by the primary nurse; **twice-weekly physician calls to the daughter** (Tuesday and Friday) so she is no longer receiving information second-hand; **the neurology prognostic note to be provided in writing, in Spanish and English, by**

08/01. Interpreter present for every substantive conversation — not optional and not family-mediated. **Reconvene the full conference 08/13 at 14:00**, with the daughter present in person if she can travel.

- **Escalation / contingency plan: If he deteriorates before 08/13** — sepsis, major aspiration, intracranial bleed, or airway emergency — **treat for comfort, do not transfer to the ICU, do not re-intubate**, and convene the conference immediately rather than waiting for the scheduled date. If the spouse chooses to exercise her proxy authority at any point, **her decision governs** and will be supported without delay or further deliberation.

AI ACTION ITEMS

13 ASSIGNED NEXT STEPS

ACTION ITEM	RESPONSIBLE	TARGET	FOLLOW-UP
Write DNI / no-ICU-transfer and no-re-intubation orders	Dr. Oyelaran	07/30	Verify in chart before shift end
Neurology prognostic note translated to Spanish, provided in writing to family	Dr. Sandoval + Interpreter Services	08/01	Confirm receipt with spouse and daughter
Separate meeting with the son regarding moral distress	LCSW Nwachukwu	08/01	Document; report at 08/13 conference
File protective LTAC appeal	RN Thibodeaux, CCM	**08/07 — hard deadline**	Appeal window closes; no extension
Draft tracheostomy care plan document required by both SNFs	RN Vasquez + Dr. Kwiatkowski	08/04	Submit to both facilities; confirm acceptance
Hospice eligibility assessment (information only, family consented)	RN Thibodeaux + Dr. Ntumba	08/05	Present findings at 08/13, no enrolment
Pleasure-tasting protocol implemented and spouse trained	SLP Marchetti	08/02	Document tolerance and family competence
Deprescribe atorvastatin and pantoprazole; simplify insulin	Pharmacy + Dr. Oyelaran	07/31	Medication list reconciled
Model Medicare Part A depletion (08/19) against each pathway, in writing	RN Thibodeaux	08/06	Provide to family before 08/13
Anointing of the sick	Chaplain Feldman	08/01	Family notified of time
Weekly wound measurement and photography for endpoint tracking	RN Brennan, CWOCN	08/06 and 08/12	Data required for 08/13 endpoint review
Reconvene full interdisciplinary conference	Dr. Oyelaran	**08/13, 14:00**	All disciplines + all three family members

Pending authorization, referral, test, placement, or family decision: LTAC appeal outcome (filed by 08/07, decision expected 10–14 days) · SNF acceptance contingent on the tracheostomy care plan document · hospice eligibility determination · **the daughter's in-person visit and stated position · code status and PEG continuation — both deferred to 08/13 by agreement.** No further diagnostic testing pending.

BC BARRIERS TO CARE / DISPOSITION

14 IDENTIFIED BARRIERS

- **Insurance authorization:** LTAC **denied 07/28**; appeal deadline 08/07. Medicare Part A depletes **08/19**
- **Home support:** Two-storey home, bedroom and bathroom upstairs, no first-floor bathroom
- **Transportation:** Family has one vehicle; distant LTAC placement would effectively end daily visiting
- **Equipment needs:** Suction unit, hospital bed, full-body lift, alternating-pressure mattress, humidified oxygen — none authorized
- **Medical instability:** None currently — **medically stable and this is not a barrier**
- **Pending results:** None pending that would change the plan
- **Placement availability:** Two SNFs conditionally accepting; a third requires cranioplasty first
- **Caregiver limitations:** Spouse 71 with osteoarthritis and part-time work; son works nights; no other local support
- **Medication access:** Apixaban copay is a stated financial concern; assistance program application pending
- **Therapy tolerance:** Cannot tolerate or benefit from 3 h/day — **ineligible for acute inpatient rehabilitation**
- **Safety concerns:** q3–4h suctioning requirement is the single hardest constraint on every option
- **The governing barrier: Unresolved family agreement on goals of care** — the 08/13 conference exists to resolve it

F FOLLOW-UP PLAN

15 POST-CONFERENCE FOLLOW-UP

- **Next provider evaluation:** Daily rounds by hospital medicine; **palliative medicine daily**; neurology to reassess on 08/12 specifically to score the four trial endpoints.
- **Next family update:** Spouse — **daily** by the primary nurse, plus physician contact any day something changes. Daughter — **Tuesday and Friday physician calls** beginning 08/04. Son — LCSW meeting by 08/01, then integrated into routine updates.
- **Repeat conference: 08/13/2026 at 14:00** — full interdisciplinary reconvening with interpreter, at which the four endpoints are reviewed against documented data and **code status and PEG continuation are decided.** Earlier if the patient deteriorates.
- **Pending results to review:** LTAC appeal determination · hospice eligibility assessment · SNF responses to the tracheostomy care plan · weekly wound measurements · PT endpoint assessments.
- **Referral follow-through:** Case management to **actively track** the appeal and both SNF applications with documented contact at least every 48 hours; failure to respond triggers escalation to the medical director.
- **Discharge planning milestones:** Tracheostomy care plan complete 08/04 · Part A analysis to family 08/06 · appeal filed 08/07 · goals-of-care decision 08/13 · **disposition secured by 08/16** to precede Part A depletion on 08/19.
- **Timeline for reassessment: 14 days, ending 08/13** — with the explicit understanding, agreed by all three family members today, that **the trial has an end date and the decision will be made at it**, not deferred again.

T TIME DOCUMENTATION

16 TIME SPENT

TOTAL TIME SPENT
104 minutes

CONFERENCE START TIME
14:00

CONFERENCE END TIME
15:12

CARE COORDINATION TIME
18 minutes (post-conference, case management and orders)

COUNSELING / FAMILY DISCUSSION TIME
72 minutes — of which greater than 50% was counseling and coordination of care

DOCUMENTATION TIME
14 minutes

B BILLING CONSIDERATIONS

17 BILLING ELEMENTS

E/M LEVEL
99233 — subsequent hospital care, high complexity

CARE CONFERENCE CODE(S)
99366 not applicable (physician present; use E/M with prolonged service)

CARE COORDINATION CODE(S)
Included in prolonged service time; not separately billable

PROLONGED SERVICE CODE(S)
G0316 × 1 — prolonged inpatient service beyond the 99233 threshold (104 min total)

BASIS FOR BILLING
Time-based with high-complexity medical decision making — greater than 50% of the encounter was counseling and coordination of care; interpreter-mediated goals-of-care discussion with surrogate decision-maker documented

PRIMARY ICD-10
I69.320 Aphasia following cerebral infarction · I69.351 Hemiplegia affecting right dominant side following cerebral infarction

SECONDARY ICD-10
Z93.0 Tracheostomy status · Z93.1 Gastrostomy status · L89.153 Pressure ulcer of sacral region, stage 3 · I48.20 Chronic atrial fibrillation · E11.22 Type 2 diabetes with diabetic CKD · N18.30 CKD stage 3a · R13.10 Dysphagia, unspecified · Z51.5 Encounter for palliative care · Z66 Do not resuscitate status (pending) · E43 Unspecified severe protein-calorie malnutrition

SO SIGNATURE

PROVIDER NAME	CREDENTIALS	SIGNATURE	DATE	TIME
Hana Oyelaran	MD, FACP	Hana Oyelaran	07/30/2026	16:05