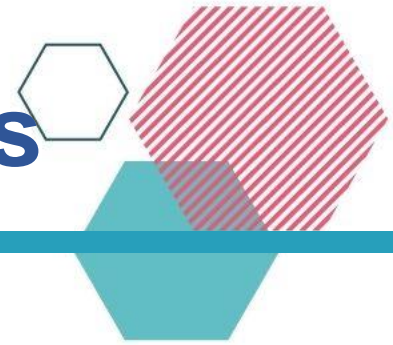


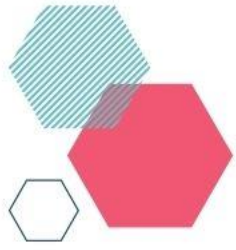
Advance Care Planning Update for Practitioners



Naushira Pandya MD, CMD, FACP
Professor and Chair, Department of Geriatrics
Director, NSU South Florida GWEP
Kiran C. Patel College of Osteopathic Medicine

Kathy L. Cerminara J.D., J.S.D., LL.M.
Professor of Law
Shepard Broad College of Law
NSU

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Speaker Disclosures

Dr. Pandya and Professor Cerminara have no relevant financial relationship(s) to report.



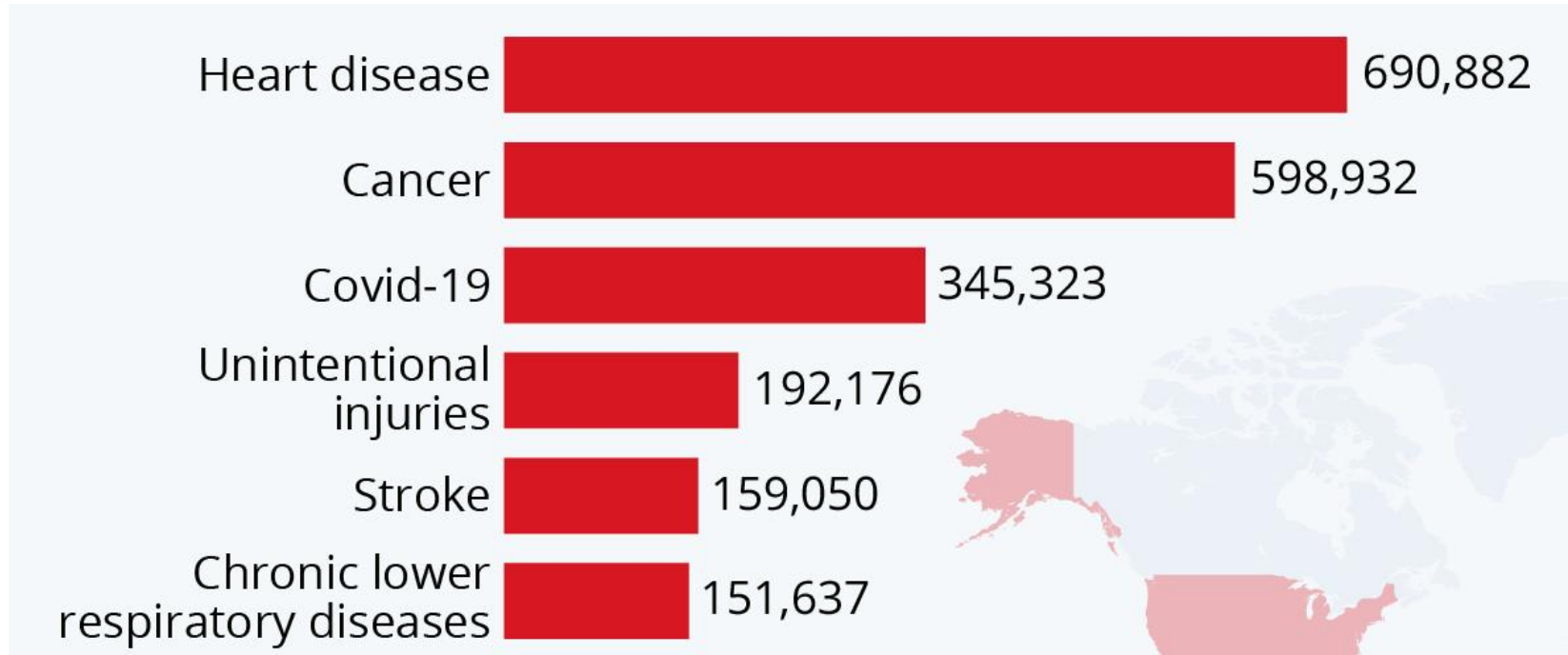
Objectives

By the end of the session, participants will be familiar with:

- **Objective 1:** Causes and contributors for increased mortality in older adults
- **Objective 2:** Barriers in discussing and implementing advance care directives
- **Objective 3:** State of ACP discussions and execution of advance care planning
- **Objective 4:** Recent trends in advance care planning



COVID-19 was the Third Leading Cause of death in the US in 2020

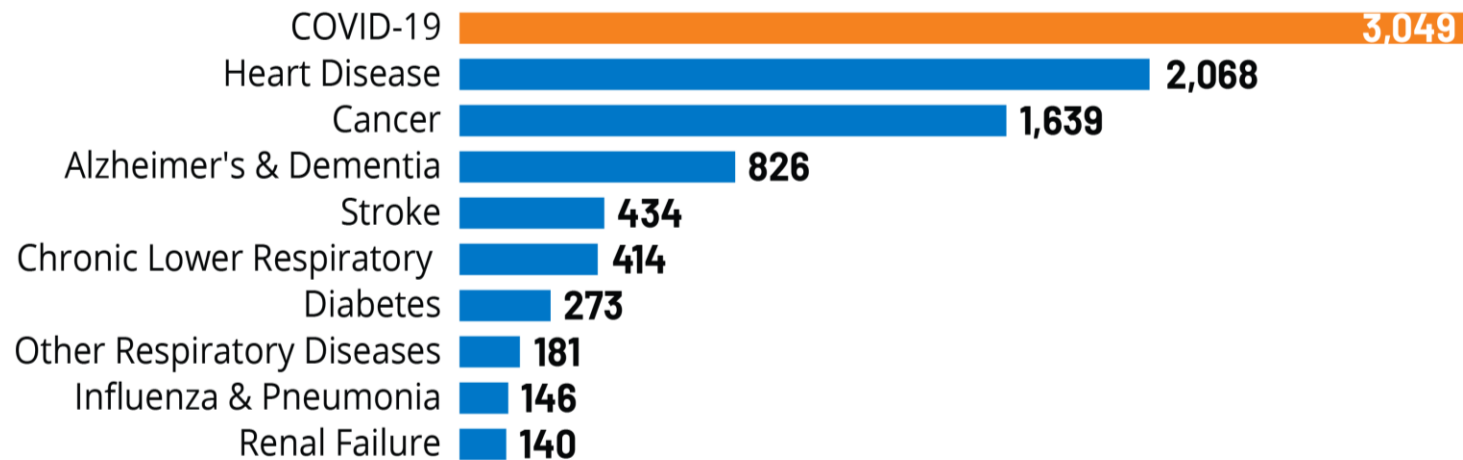


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COVID-19 was the Number One Cause of Death in the US in early 2021

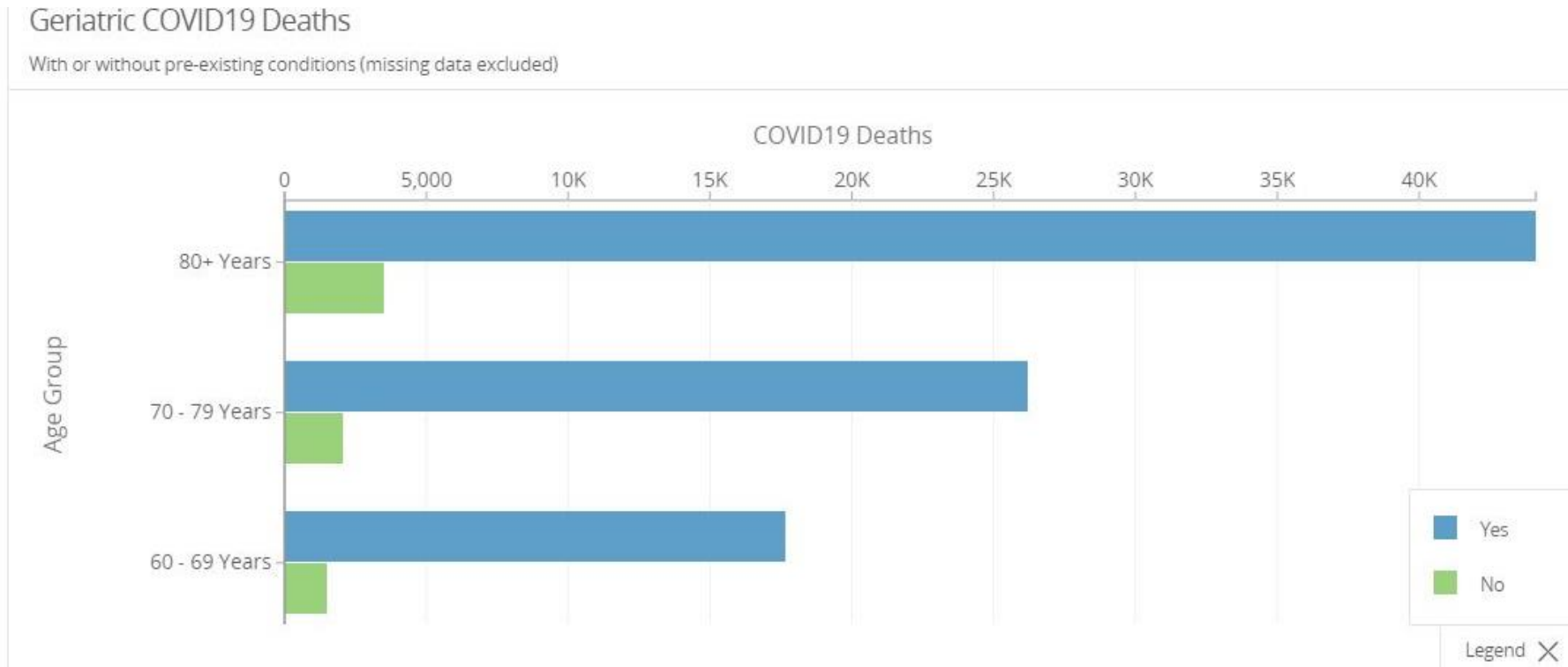
Average daily deaths in the U.S. from COVID-19 (Jan. 2021)
and other leading causes (2020)



NOTES: The COVID-19 mortality rate is the daily average for January 2021 through January 26, 2021 using the KFF COVID-19 Tracker data.



COVID-19 Deaths in Older Adults With or Without Pre-existing Conditions



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Impact of COVID-19 on Dying

- COVID-19 is quickly becoming the leading cause of death
- Articulating ones wishes for end-of-life health care is more important than ever
- Only 1 in 3 Americans has completed any type of advance directive (varies by race and ethnicity)
- COVID-19 disease can progress so rapidly to death before last minute expressions or discussions are possible
- Limited visitation regulations in hospitals and long-term care institutions, concerns about discriminatory treatment, and overwhelmed healthcare staff, make it difficult for clinicians to initiate conversations about care preferences



Personal constraints in post acute care setting- visitation restriction

Visitation restriction

Guilt of noninvolvement

Anxiety of not seeing loved one

Transferring of resident's anxieties

Diagnosis of COVID-19

Grief



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Poor Outcomes and Death More Likely

- Mortality from COVID-19 increases dramatically with age
- Death can occur more rapidly than from acute exacerbations or events related to chronic conditions
- Nursing homes affected by COVID-19 have witnessed high mortality rates in their sick residents
- Early experience showed a case fatality rate for residents was 34%
- Resuscitation outcomes for older adults affected by COVID-19 are poor
- **Contributing factors**: CV disease, HTN, DM, frailty, communal living, insufficient PPE, chronic understaffing

Arentz M et al. JAMA March 2020

McMichael TM et al. NEJM 2020



The Effect of Age on Mortality in Patients With COVID-19: A Meta-Analysis With 611,583 Subjects

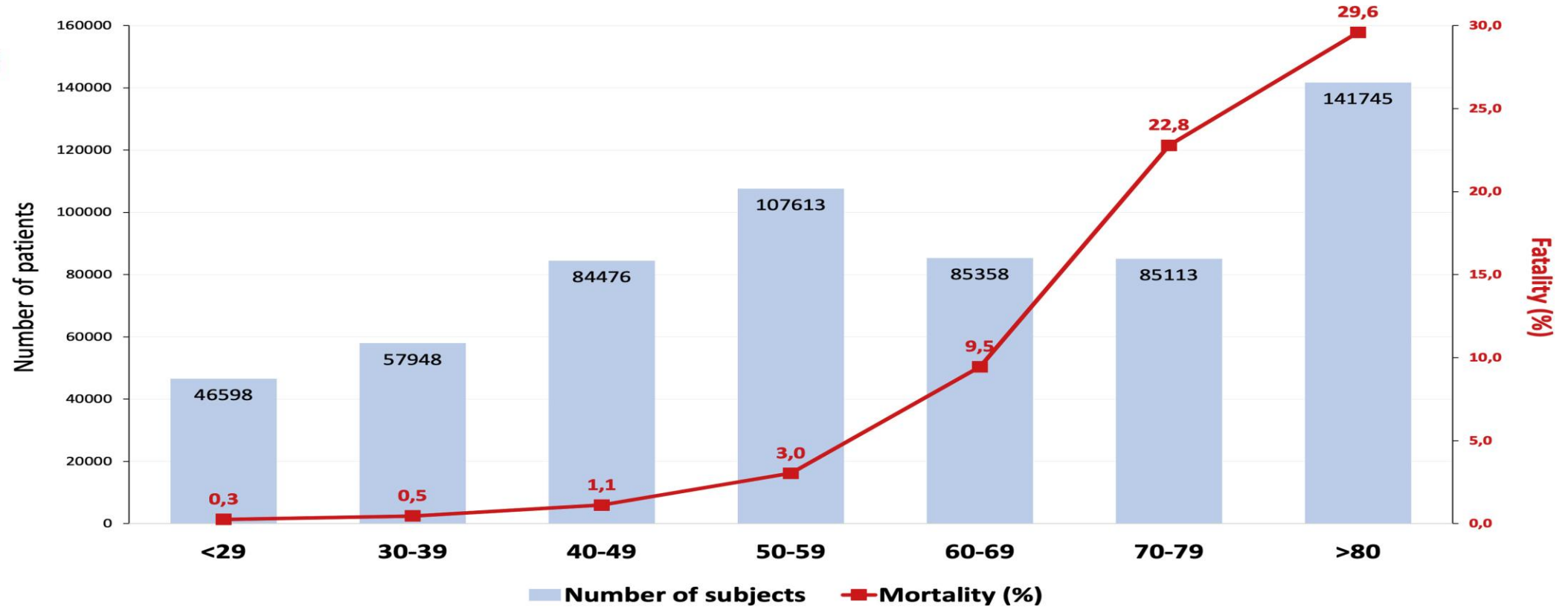
- *Clara Bonanad, MD, PhD, Sergio García-Blas, MD, PhD, Francisco Tarazona-Santabalbina, MD, PhD, Juan Sanchis, MD, PhD, FESC, Vicente Bertomeu-González, MD, PhD, FESC, Lorenzo Fácila, MD, PhD, Albert Ariza, MD, PhD, Julio Núñez, MD, PhD, FESC, Alberto Cordero, MD, PhD, FESC*

Journal of the American Medical Directors Association

Volume 21 Issue 7 Pages 915-918 (July 2020)

- A meta-analysis with available national reports on May 7, 2020 from China, Italy, Spain, United Kingdom, and New York State.

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- The largest increase in mortality risk was observed in patients aged 60 to 69 years compared with those aged 50 to 59 years (odds ratio 3.13, 95% confidence interval 2.61-3.76).



Survival Following CPR in COVID-19 Patients

- Among patients hospitalized for severe COVID-19 pneumonia, the 30-day survival following CPR for in-hospital cardiac arrest was only 2.9% in Wuhan, China
- In most resuscitation (89%) was initiated <1 min
- ***This has direct implications for individuals living in LTC settings***

Shao F, Xu S, Ma X, et al. Resuscitation. April 2020.doi:10.1016/j.resuscitation.2020.04.005



Outcomes of CPR in Older Adults

- Recent cohort of 2215 adults with COVID-19 admitted to ICU at 65 sites: 784 (35.4%) died within 28 days
- Factors associated with death included older age, male sex, morbid obesity, coronary artery disease, cancer, acute organ dysfunction, and admission to a hospital with fewer ICU beds
- In general: frail patients are unlikely to survive discharge following in-hospital cardiac arrest (independent of age, comorbidity or cardiac arrest rhythm)
- Survival for CPR recipients with chronic illness is much shorter than those without (3-5 mth. VS 26.7 mth.)

Arentz M, Yim E, Klaff L, et al. *JAMA*. March 2020. doi:10.1001/jama.2020.4326

Gupta S, Hayek SS, Wang W, et al.. *JAMA Intern Med*. 2020;180(11):1436–1446

Ibitoye S. Et al. *Age and Ageing*, Volume 50, Issue 1, 2021

Stapleton et al. *Chest* 2014; 146(5)



The practitioner

The patient

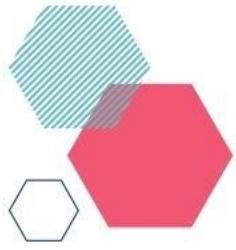
The system

Barriers to
Completion
and Use of
Advance
Directives



Reluctance of Practitioners to Discuss Advance Care Planning

- Lack of time
- Lack of training
- Lack of comfort with the discussion
- Lack of belief in the necessity of the discussion



Patients

- Access issues
- Trust
- Language barriers
- Cultural beliefs and traditions
- Unpredictability/newness of illness
- Ambivalent messaging in the typical channels of information for family and residents
- Limited insight into outcome of the severe disease



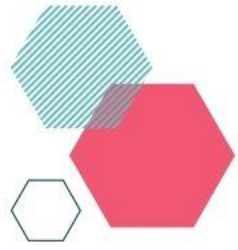
The System

- Issues of portability
- Litigation
- States may have own laws



Advance Care Planning in the Ambulatory Setting-New Opportunities

- ACP discussions are often not addressed despite ability to bill for them, due to chronic disease management and other care coordination priorities
- Patients appear more willing to discuss care goals and wishes in the context of severe COVID-19 infections (e.g., pneumonia, ventilator requirement)
- More nuanced conversations are required; patients are informed about potential consequences due to media coverage of the pandemic
- Anticipatory planning affords more control than in acute or NH settings



A Structured Tool for Communication and Care Planning in the Era of the COVID-19 Pandemic

- *Swati Gaur, MD, MBA, Naushira Pandya, MD, Ghinwa Dumyati, MD, David A. Nace, MD, MPH, Kaylesh Pandya, DO, Robin L.P. Jump, MD, PhD*

Journal of the American Medical Directors Association

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Moral Distress

- Occurs when health care professionals are unable to do what they think is morally right because of obstacles
 - For example, providing aggressive care that you may believe is futile to a critically ill patient
- Different aspects of a patient's care may cause moral distress for different clinicians
- Has been noted in nearly all health care professions

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Risk Factors for Moral Distress

- **Clinical Factors**

- Continuing life-prolonging care in cases of perceived futility, inadequately managing pain, providing false hopes, working with incompetent colleagues, and unclear goals of care

- **Institutional Factors**

- Poor administrative support, poor staffing ratios, policies that impact patient care, poor communication between disciplines

- **Individual Factors**

- Sense of powerlessness, lack of assertiveness, lack of understanding of the pertinent ethical issues, lack of understanding of all aspects of a given case

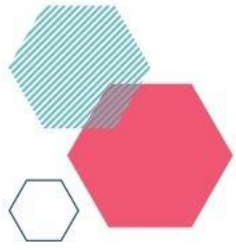
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Impact of Moral Distress

- Unaddressed moral distress can have devastating impacts on patient care, individual clinicians, and institutions
- Recognizing moral distress is an important first step toward mitigating its damaging effects
- Interventions have been developed to help clinicians understand their sources of moral distress and the relevant ethical tenets

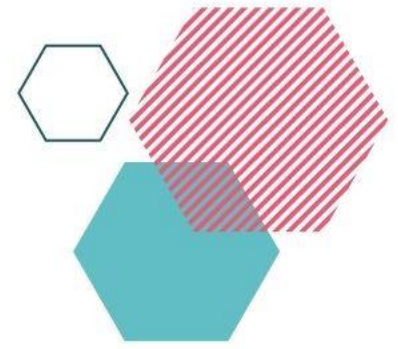
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Management of Moral Distress

Cultivating moral resilience can help in the management of moral distress, examples include:

- practicing mindfulness
- interrupting negative thought patterns and behaviors
- developing the ability to take positive action



What Matters?

- Remaining Involved
- Planning for the End of Life
- Ending Life As Envisioned





Remaining Involved

Guardianship

- Preference for Least Restrictive Alternative

Eldercaring Coordination

- Additional Tool to Include the Voice of Elders

Eldercaring Coordination

- Florida Statute 44.407 (2021) (first statutory authorization in nation)
- Officially recognized but not statutory in at least 10 other states
- Within guardianship, court-ordered dispute resolution process assisting in care management & decisions
- Outside guardianship, same benefits
- Conflict as a health issue





Planning For the End of Life

Traditional Tools

- Advance Directives
- POLST (jurisdiction-dependent)
- DNRs (outside of POLST setting)

Innovations

- Video Supplements to Advance Directives
- Remote Possibilities

Video Supplements to Advance Directives

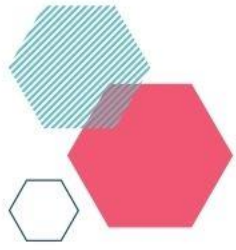
- Head off or settle a dispute about capacity
- Head off or settle a dispute about voluntariness (lack of coercion)
- Head off or settle a dispute about wishes
 - Defining language
 - Expressing values



Remote Execution Possibilities

- Useful during COVID
- Remote witnessing
 - Not *really* possible in Florida
- Remote signature of principal
 - Not *really* possible in Florida
- Remote notarization (when required)
 - Notarization not required for advance directives in Florida if principal and witnesses are all present





Ending Life as Envisioned

Traditional Tools

- Withholding/withdrawal of treatment
- Medical Aid in Dying (jurisdiction-dependent)

Innovations

- Medical Aid in Dying (jurisdiction-dependent amendments)
- Voluntarily Stopping Eating & Drinking



Medical Aid in Dying Amendments

- Expansion of “physician aid” to “medical aid”
- Expansion of professionals qualified to determine capacity
- Reduced amount of time between request(s) and receipt of medication
- Not in Florida

Voluntarily Stopping Eating & Drinking

- Increasingly used, especially among dementia patients
- Requiring requests for assistance with eating & drinking? (JAMDA)



Sources



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