Probability of 50-year-old Living to 90 Years

	Male	Female
1900	2.7%	3.8%
1950	5.0%	9.6%
2003	16.4%	28.2%
2014	21.6%	33.5%

Centenarians in USA

1950	2300
1970	4800
1990	28,000
2010	53,364

Caring for Very Old Patients

- Shift in focus from screening and health maintenance to maintaining function, quality of life, and assisting patients in the choice of medical interventions

What Is Important to Very Old Individuals

- Independence
- Continued roles in life
- Connections with family, friends, and community
- Leaving a legacy
- Staying in control of decisions and life

People who are satisfied and fulfilled in their last years

- They are realistic about the nature of these last years. They know that the end is near, and that their capabilities will lessen as they get to the end.
- They focus on others.
- They stay connected to those people and institutions who have been a major part of their lives.
- They have a strong sense of self, know who they are, what gives them satisfaction and pleasure, and what they need to do to maintain their personality and integrity.

- They make sure that they continue an effective role with their families, as well as with friends and institutions in which they have long been active.
- They see their value as being members of extended families, religious organizations, neighborhoods, and cultures.
- They trust their judgment
- They feel good about themselves.
- They keep control of their lives to the end.

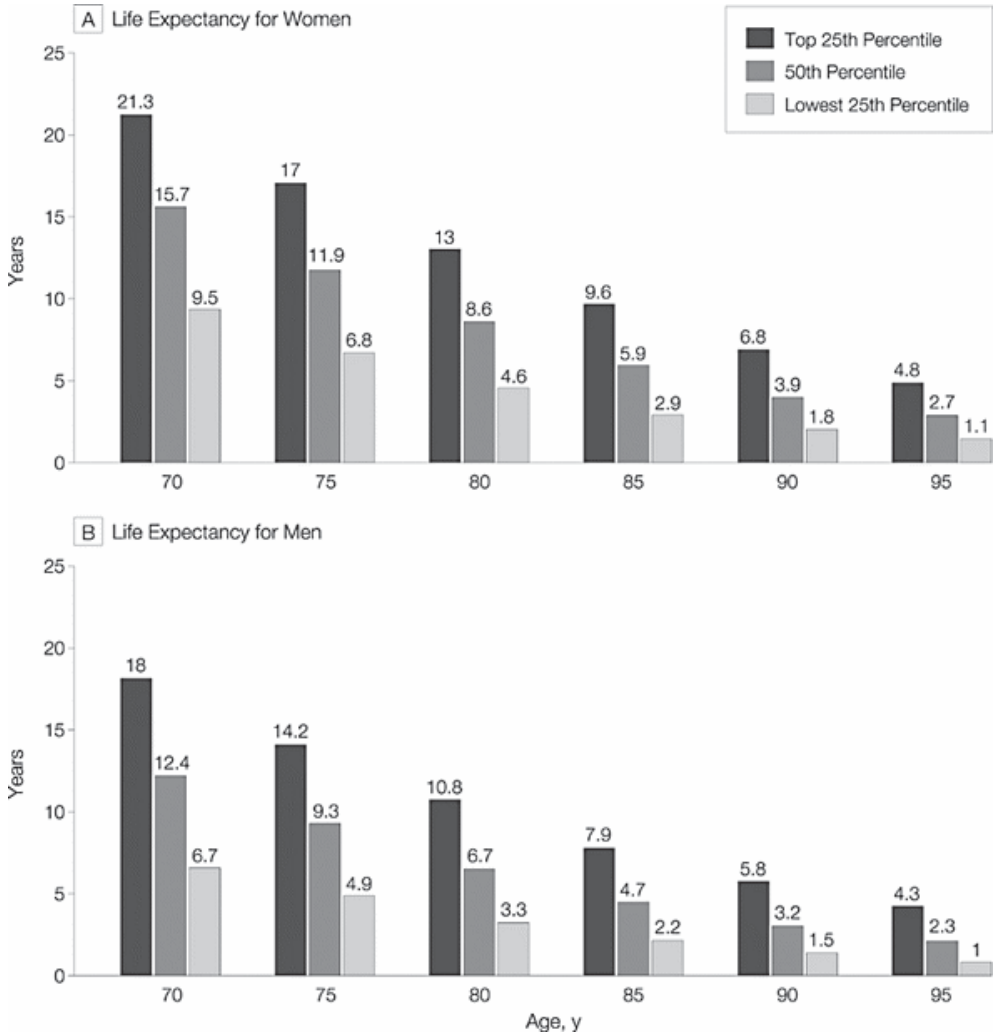
Caring for Very Old Patients

- When to shift focus
- Screening in older patients
- Maintaining independence
- Staying connected
- Maintaining roles
- Leaving a legacy
- Staying in control
- Choosing medical interventions

Life Expectancy

Age	Male	Female
60	20.36	23.53
70	13.27	15.72
75	10.24	12.29
80	7.62	9.22
85	5.45	6.62
90	3.80	4.60

Figure. Upper, Middle, and Lower Quartiles of Life Expectancy for Women and Men at Selected Ages Data from the Life Tables of the United States.9.



Walter, L. C. et al. JAMA 2001;285:2750-2756

Estimating Life Expectancy

- Is patient at middle of cohort or at upper or lower limits?
- Useful variables
  - Number and severity of co-morbid conditions
    - Congestive heart failure
    - Renal disease
    - Chronic lung disease
  - Functional status
  - Cognitive status
  - Nutritional status

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Preventive Measures

- Primary Prevention, avert the development of disease
  - Immunization
  - Life-style adaptations
    - Smoking cessation
    - Exercise
  - Chemoprophylaxis
    - Aspirin to prevent heart disease and stroke

- Secondary prevention – early detection and treatment of asymptomatic disease – screening for:
  - Cancer
  - Hearing and vision impairment
  - Osteoporosis
  - Hypertension
  - Abdominal aortic aneurysm

- Tertiary prevention – identifying established conditions to prevent further morbidity or functional decline
  - Cognitive problems
  - Disorders of gait and balance
  - Malnutrition
  - Urinary incontinence

2008 Colorectal Guidelines – ACS and Multi-society Task Force

- Offer screening beginning at age 50 for average risk patient
- Discontinue screening when life expectancy < ten years
- No single test is of unequivocal superiority
- Screening should be supported by a program which assures proper follow-up of abnormal findings and ongoing testing of identified levels

Breast Screening Recommendation in Older Women

- Data limited on effectiveness of screening in those 75 and older
- Age, however, should not be the sole determining factor for determining the indication for screening
- Should take into account individual estimates of risk and benefit, and take into account patient preferences
- One suggestion – breast screening with mammography be continued as long as life expectancy is at least ten years.

Screening for Prostate Cancer -2008

- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than 75 years
- The USPSTF recommends against screening for prostate cancer in men age 75 or older
- Given the uncertainties and controversies surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment

Conclusion - USPSTF

- The vast majority of men who are treated for PSA-screened prostate cancer do not have prostate cancer death prevented or lives extended from that treatment, but are exposed to significant harms
- The USPSTF concludes that there is moderate certainty that the harms of PSA screening for prostate cancer outweigh the benefits

Oct 10, 2011 USPTSF Draft Recommendation

- The US Preventive Services Task Force recommended against Prostate Specific Antigen (PSA) based screening for prostate cancer

Screening for Cervical Cancer

- The USPSTF recommends against routine screening women older than 65 yrs for cervical cancer if they have had adequate recent screening with normal PAP smears and are not otherwise at high risk for cervical cancer
- American Cancer Society recommendation suggests stopping cervical cancer screening at age 70 yrs
- Screening is recommended in older women who have not been previously screened, when information about previous screening is unavailable, or when screening is unlikely to have occurred in the past

Screening for Abdominal Aortic Aneurysm

- The USPSTF recommends one time screening for abdominal aortic aneurysm by ultrasonography in men 65 to 75 who have ever smoked.
- The USPSTF makes no recommendation for or against screening for abdominal aortic aneurysm in men age 65 to 75 who have never smoked
- The USPSTF recommends against routine screening for abdominal aortic aneurysm in women
- The major risk factors for abdominal aortic aneurysm include age (being 65 or older), male sex, and a history of ever smoking (at least 100 cigarettes in a person’s lifetime)

- For most men, 75 years may be considered an upper age limit for screening. The increased presence of co-morbidities for people age 75 and older decreases the likelihood that they will benefit from screening.
- One time screening to detect an abdominal aortic aneurysm using ultrasonography is sufficient. There is negligible health benefit in rescreening those who have a normal aortic diameter on initial screening.

Screening for Carotid Artery Stenosis

- USPSTF recommends against screening for asymptomatic carotid artery stenosis in the general adult population
- This recommendation applies to adults without neurologic signs or symptoms, including a history of transient ischemic attacks or strokes. An individual who has a carotid-area transient ischemic attack should be evaluated promptly for consideration of carotid endarterectomy

Screening In Older Patients

- Cervical cancer – no screening after age 65 if Pap smears have been negative
- Breast cancer – stop screening when life expectancy, adjusted for co-morbidity, less than 10 years.
- Colon cancer – stop screening when life expectancy, adjusted for co-morbidity, less than 10 years.
- Prostate cancer – no evidence for screening at any age
- Abdominal aortic aneurysm – one time screening test for men who are current or past smokers, age 65 to 74

Caring for Very Old Patients

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Functional Assessment

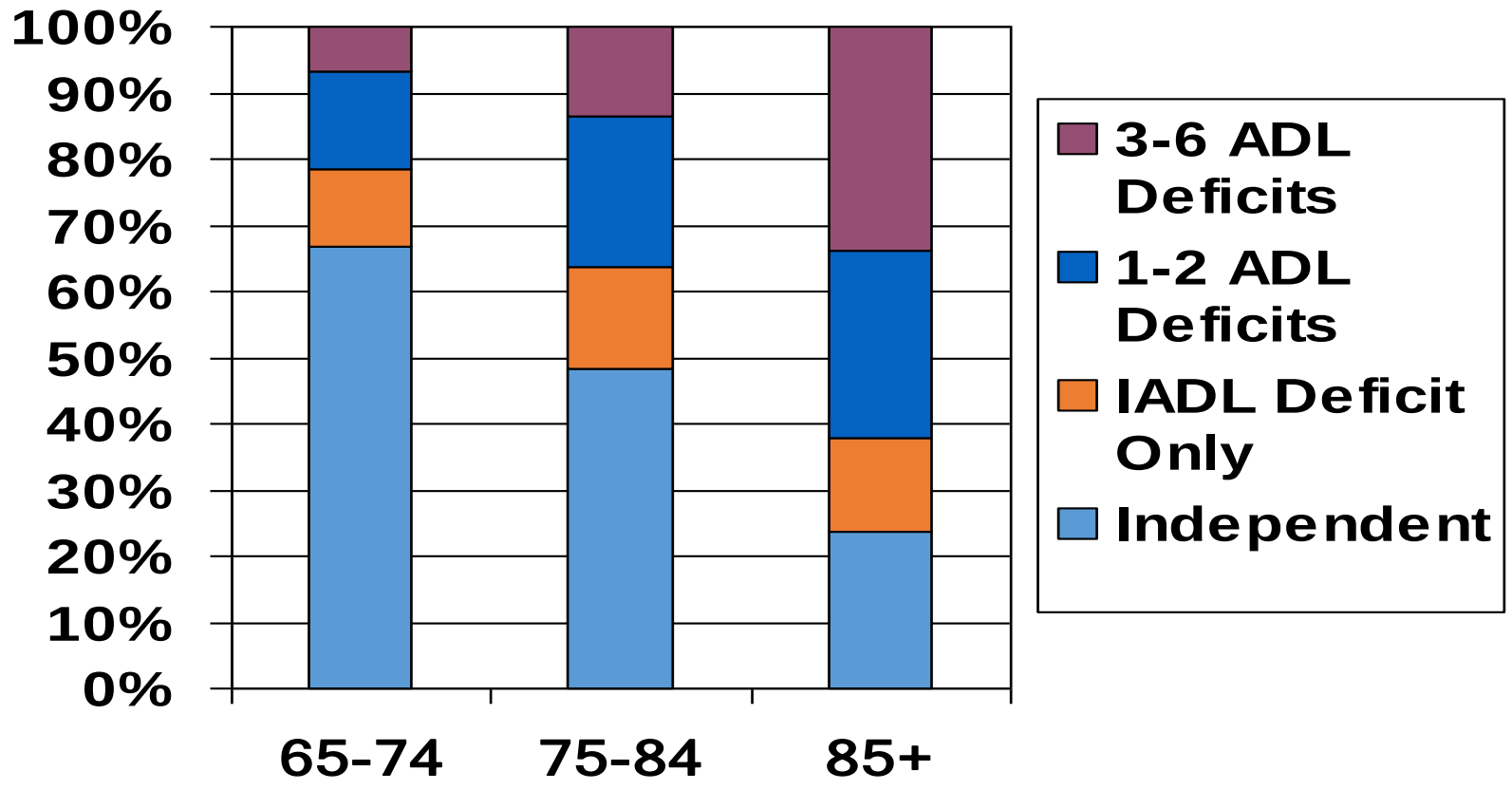
Activities of Daily Living

- Bathing
- Dressing
- Personal grooming
- Toileting
- Transferring
- Walking
- Eating

Instrumental Activities of Daily Living

- Telephone use
- Transportation
- Meal preparation
- Shopping
- Housework
- Medication management
- Manage Finances

Functional Status of US Elderly, 2002



Medicare Current Beneficiary Survey
www.cms.hhs.gov/mcbs

Ability to Transfer

- Go from sit to standing or sit to sitting
  - e.g. wheelchair to toilet
- Essential for independent toileting
- Can be independent in a wheelchair if you can transfer by yourself

Cause of Dependence

- What is “rate limiting factor” to independence?
- What is limiting you in that function?
- e.g. ability to transfer
  - Hip disease
  - Knee disease
  - Upper extremity pain or weakness
  - Lower extremity weakness
  - Neurologic disease
- What can improve your ability to transfer?
  - Physical therapy
  - Steroid injection into knee
  - Anti-Parkinsonian medications
  - Joint replacement

Maintaining ADLs

- Exercise
- Fall prevention
- Limit risk for
  - Diabetes
  - Stroke
  - Hip Fracture
- Use of assistive devices
- Safe environment

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Life Satisfaction

- 90 year old Swedes
  - Frequency of visiting church
  - Relationship with children
  - Contact with family
  - Visiting clubs and societies
  - Extraversion – good
  - Neuroticism - bad

Relationships

- Relationships with others are an essential component of existence
- These connections become even more important in the last years
- Bonds with others are at the core of human experience
- Building strong relationships is a life-long process
- Efforts of building relationships will be in vain if patients don’t stay closely connected to individuals important to them

Medical Interventions

- Disrupt patient's lives
- Removes them from home, family, and friends
- May cause pain and disability
- May result in delirium and agitation during hospitalizations, robbing them of their dignity.

Saying Connected Throughout Life

- Attend family gatherings
- Help out with child care, family responsibilities, etc.
- Provide mentoring and help for younger members of family
- Phone calls, e-mails, hand-written notes
- Make sure that telephone calls are focused on the recipient; avoid a litany of complaints

Staying Connected

- Which persons and institutions are most important in patients' life?
- Geography is important – make sure that moves do not separate them from friends and family
- Do they make the effort to be an active part of family and community?
  - Need frequent and close contact with family and friends
- Do they truly connect with others?
- Need network of family and friends more and more as they age.

Staying Connected

- Work with patient and family to help provide resources to keep patient in home environment
- Geriatric consultation might be helpful in this effort
- Focus on physical independence and keeping close connections with community and families
- Knowledge of community resources can be helpful

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Feeling needed

- Older people all want to feel needed
- They fear the thought of:
  - Feeling superfluous
  - Of little value to others
  - Becoming a burden to those around them
- Need to adapt roles to new levels of function

Resourcefulness in Adapting

- Older people must adapt to new levels of capacities and revise their family and community roles
- They must adjust their goals and expectations to their new level of capacity
- They must find new roles to fit their new level of abilities
- They need to learn how to use their skills best for their family and community.

New Roles

- What are patients capable of doing?
- What activities give them satisfaction and enjoyment?
- What can they do to meet the needs of:
  - Family
  - Community
  - Religious groups

Adapting Roles in Late Life

- If life satisfaction is tied to professional and social roles, may have difficulty adapting to new roles
- If self esteem depended on public recognition of achievements, life gets tough when the cheering stops
  - Fragile ego
  - Difficult time adjusting to role as grandparent, mentor and care giver

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Legacy

- How do older people want to be remembered?
- What do they want to leave behind?
- Unlikely to be great works of art, monuments, or edifices
- How they lived their life – example they set for others
- How can they pass on their values and beliefs?
- How can they preserve theirselves in the memories of those who follow them?

Pass On Family Values

- Older people are all products of those who came before them
- Value systems, traditions, beliefs, approaches to life
- Cultural heritage, methods of dealing with the problems of life
- They hone these concepts and values in the context of their own life and times

Passing the Torch

- Serving as a link between generations is an important role in late life
- Brings meaning to patients' last years
- To live on in the lives of others, they must stay connected with who they are and continue to face life's challenges in their last years

Importance of Last Years

- Final years will leave lasting impressions on those closest to older people
- Final legacy to those who follow
  - How to live a life
  - How to depart from it with dignity and grace

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Staying in Control

- Being able to choose life style, place of residence, diet, patterns of the day, and companions is very important to older people
- Performing tasks by oneself (meal preparation, cleaning, financial management) is closely tied to life satisfaction for many
- Institutional living greatly limits a resident's sense of control
  - When to rise and return to bed
  - When and what to eat
  - Who your associates are
  - When you bathe and dress

Maintaining a Sense of Control

- Assist an older person with a task, try not to take over
  - Meal preparation
  - Choice of clothes
  - Financial management
- Worry less about risk and more about live satisfaction
- There are, however, risks that should be avoided if they affect the safety of others
  - Driving
  - Fires

Retaining Your Identity

- Ensure that older people remain who they are to the end
- Their identity will be battered by illnesses, disabilities, and personal losses
- Trust their judgment as they make choices in their last years
- Continue to make the most of every day
- Maintain their integrity to the end to leave a legacy of how to lead a life of substance and value

High Life Satisfaction

- Frequent contacts with family and friends
- Continue to plan for future
- Role as a link between generations

Poor Quality of Life

- Poor self-esteem
- Worn out from losses or problems
- Lost interest in life
- Little sense of control over life

Life Satisfaction

- Not an objective measure of your capabilities, achievements, or resources
- Relative concept – depends on:
  - Personality traits
  - Peers with whom you compare yourself
  - Your past experiences
  - Your expectations of future

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Goals of Care

- A new role in late life, that of a patient
- What do they want from health care
  - Extend their life at all cost?
  - Maintenance of flow of their life, connection with those most important to them, able to do as much for their selves as possible?
- Do medications that might extend their lives preclude them from many daily activities?
- Would a major medical intervention lessen their contact with those most important to them?

Goals of care

- At what point do patients want to focus on the quality, not the duration, of their life?
  - Unable to recognize family members
  - Physical, cognitive, and nutritional problems indicate a very limited short term prognosis
- Do they want
  - Hospitalization
  - Surgery
  - Pacemaker
  - Dialysis

Goals of Care

- May want to be very aggressive with efforts to improve function and quality of life:
  - Joint arthroplasty
  - Treatment of
    - Arthritis
    - Parkinson’s Disease
    - Other neuromuscular conditions

Choices for Older Individuals

- Will a medical intervention improve our function, decrease pain, or improve our quality of life?
- What is our prognosis with and without this intervention?

Information Needed for Choices

- What factors predict short term (6-12 month) mortality in older persons?
- Can these factors be combined to estimate short term mortality risk?
- Can this information predict recovery from common conditions that affect the elderly, such as pneumonia or hip fractures?

Consistent Predictors of Poor Prognosis

- Dependence in ADL's
- Dementia
- Poor nutritional status
  - Weight loss
  - Low BMI
  - Low albumin
- High co-morbidity

Short-term Mortality

- Impaired physical function is a more important predictor of mortality than disease processes.
- Patients with severe cognitive difficulties have a very poor prognosis, especially when they have intercurrent problems such as hip fractures and pneumonia

Identifying High Mortality Risk

- The domains of cognitive function, physical function, nutrition, and medical conditions have an additive effect on mortality, and can be used together to identify patients with high short-term mortality.

Advance Directives

- Patients usually have a long and rich relationship with their primary care physicians
- That physician usually knows the patient well – their goals and priorities, their approaches to life's problems
- Primary care physicians now rarely care for patients during hospitalizations
- Patients and families have to discuss treatment preferences and "code status" with clinicians they have just met, with whom they do not have a long or trusting relationship
- "Living wills" documents are often quite vague and diffuse, and leave the clinician with little clear direction

Goals of Care

- Live as long as possible
- Be spiritually and emotionally at peace
- Provide support for the family
- Be physically comfortable
- Be at home
- Not be a burden
- Be independent
- Achieve particular life goal
- Be mentally aware
- Have medical decisions respected

Future Health Situations

- When you think about your health situations you may experience in the future, how do you feel?
  - Life is always worth living no matter what type of serious illness, disability, or pain I may be experiencing.
  - There may be some health situations that would make my life not worth living.
  - I am not sure.

Function

- What abilities are so critical to your life that you can't imagine living without them? For example: ability to eat, recognize or interact with others, be aware or care for yourself
  - Being conscious
  - Being able to interact with others
  - Being without pain or great discomfort
  - Being able to talk
  - Being able to care for myself, such as toileting and feeding
  - Being able to be myself

In the Event of Serious Illness

- How do you balance quality of life with medical care? If you had serious illness, what would be important to you?
  - I want medical treatments to try to live as long as possible. I would not want to stop treatment even if I were in pain, could not feed or care for myself, or needed machines to live.
  - I want to try treatments for a period of time, but I don't want to suffer. If after a period of time the treatments do not help or I am suffering, I want to stop.
  - I want to focus on my quality of live and being comfortable, even if it means having a shorter life.
  - I am not sure.

Preferences

- If I were able to recognize my loved ones,
  - I would not want to receive treatment to keep me alive.
  - I would want to receive treatment to keep me alive.
  - I’m not sure about my answer to this question.
- If I were bedbound and unable to care for myself, requiring help from others for bathing, dressing, and feeding myself,
  - I would not want to receive treatment to keep me alive.
  - I would want to receive treatment to keep me alive.
  - I’ not sure about my answer to this question.

Preferences

- If I were dependent on breathing machines to continue living,
  - I would not want to receive treatment designed to keep me alive.
  - I would want to receive treatment designed to keep me alive.
  - I'm not sure about my answer to this question.
- If I were in severe daily pain, and this pain could only be controlled by medications which cause confusion and the inability to recognize loved one,
  - I would not want to receive treatment to keep me alive.
  - I would want to receive treatment to keep me alive.
  - I'm not sure about my answer to this question.

Advance Directives

- Patients and families would benefit from the opportunity to discuss their values, goals of care, and treatment preferences with their long standing clinicians
- Patients should always appoint a healthcare representative to speak for them if they are unable to voice their treatment preferences themselves
- Patients should document their treatment preferences in as clear a manner as possible to their physicians, healthcare representatives, and family
- These preferences should be available to clinicians in Emergency Departments, acute care hospitals, and intensive care units to help guide the care of patients

Recommendations for Advance Directives

- All Health System patients 50 and older should engage in advance care planning discussions with their clinicians. Younger patients with serious illness and advance chronic disease should also be engaged in advance care planning.
- These patients should identify a health care representative of his or her role, and discuss their goals of care with that individual.
- A health care representative form should be filled out, signed, witnessed, and scanned into the patient's Epic record.
- An advance care discussion should be held yearly with patients 50 and older at the time of their annual wellness visit, or at a visit specifically devoted to advance care planning.

Recommendations for Advance Directives

- For patients with advanced chronic or serious illness, an advance care discussion should be done at least annually but may require multiple discussions over the course of several visits. An advance care discussion should also occur with any change in condition.
- Following this discussion, the patient's advance car plans, and goals of care, should be documented and scanned into the patient's Epic medical record.
- An advance care planning discussion can be initiated by the patient, family member, nurse, social worker, trained facilitator, physician, or others.
- Clinicians who initiate this discussion should have training or experience in carrying out advance care planning conversations.

Recommendations for Advance Directives

- For patients with a limited life expectancy (approximately less than one year) a conversation should include the patient's prognosis, and goals of care focused on various potential outcomes. Health care representatives and living will forms should be completed and placed in the patient's Epic chart.
  - If applicable, a "Verification of DNR" form should be completed and an orange bracelet places on the patient's wrist or ankle in compliance with sated law (in Hartford or Windham counties may use green state pilot MOLST form instead)

Treatment Preferences and Living Will

- Patient/Individual's Name:_____ Date of birth_____
- I am providing the information below to help my physicians and care team understand my care choices, particularly to help them understand my wishes relating to end-of-live care.
  - □ I already have a Living Will or Advance Directive that I wish to be read in conjunction with this document
  - □ I do <u>not</u> have a Living Will or other Advance Directive, and would like Part 2 of this document to serve as my Living Will, and be read in conjunction with this document.

Part 1 – Information Abut My Treatment Preferences

- If I am no longer able to make my own health decisions, the information I have provided below outlines my goals and preferences for care at the end of life.

Future health situations:

- When you think about your health and health situations you may experience in the future, how do you feel?
  - □ Life is always worth living no matter what type of serious illness, disability, or pain I may be experiencing.
  - □ There may be some health situations that would make my life not worth living.

Part 1 – Information Abut My Treatment Preferences - continued

- How do you balance quality of life with medical care? If you had serious illness, what would be important to you?
  - □ I want medical treatments to try to live as long as possible. I would not want to stop treatment even if I were in pain, could not feed or care for myself, or needed machines to live.
  - □ I want to try treatments for a period of time, but I don't want to suffer. If after a period of time the treatments do not help or I am suffering, I want to stop.
  - □ I want to focus on my quality of live and being comfortable, even if it means having a shorter life.

Part 1 – Information Abut My Treatment Preferences - continued

In the event of serious illness:

- If I am terminally ill or so ill that I am unlikely to get better
  - □ I would not want to receive treatment to try to keep me alive
  - □ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death:
  - □ I would not want to receive treatment to try to keep me alive
  - □ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am in a coma from which I am not expected to wake up or recover, and life support treatment will only delay the moment of my death:
  - □ I would not want to receive treatment to try to keep me alive
  - □ I would want to receive treatment to try to keep me alive
- If my doctors decide that I have permanent and severe brain damage, and I am not expected to get better, and life support treatment would only delay the moment of my death
  - □ I would not want to receive treatment to try to keep me alive
  - □ I would want to receive treatment to try to keep me alive

Part 2 – Living will

If the time comes when I am incapacitated to the point when I can long longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

As the author of this document, I request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through live support systems. By terminal condition, I meant that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Treatment Options at the End of Life

- If I have a terminal illness and am close to death or am unconscious and not likely to wake up, I want the following care:
- If my heart stops:
  - □ I do want cardio pulmonary resuscitation done to try to restart my heart
  - □ I do not want cardio pulmonary resuscitation done to try to restart my heart; if I have an implanted automatic defibrillator in place, I want to have the defibrillator turned off.
- If I'm unable to breath on my own:
  - □ I do want a breathing machine
  - □ I do not want a breathing machine for any length of time
- If I am terminally ill or so ill that I am unlikely to get better, and I am unable to swallow enough food and water to stay alive:
  - □ I would want a feeding tube
  - □ I would not want a feeding tube

Billing Medicare for Advance Care Planning Services

- CPT code 99497 – advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- CPT code 99494 – each additional 30 minutes (list separately in addition to code for primary procedure)
- The services described by CPT code 99497 and 99498 can be provided by physicians, non-physician practitioners, and other staff under the order and medical management of the beneficiaries treating physician

Billing Medicare for Advance Care Planning Services - continued

- Medicare expects the billing physician or non-physician provider to manage, participate, and meaningful contribute to the provision of the services in addition to providing a minimum of direct supervision.
- Appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of these forms, when performed); who was present; and the time spent in the face-to-face encounter.

Billing Medicare for Advance Care Planning Services - continued

- Codes 99497 and 99498 may be billed on the same day as other E/M services.
- No specific diagnosis is required for the ACP codes to be billed.

Role of Physician

- Doctor = Teacher
- Know your patients
- Know what affects their prognosis
- Inform them about what the future might bring
- Avoid interventions which might impair their quality of life
- Help them stay in control
- Focus on the dignity and quality of their last years.