THE AMERICAN JOURNAL of MEDICINE®

# Increasing Rates of Advance Care Planning Through Interdisciplinary Collaboration

In 2014, 24% of the US population is aged 50 years and over, and 17 million are between 75 and 85 years. By 2044, the 17 million US older adults just between 75 and 85 years is estimated to grow to 30 million.[1,2] These unprecedented numbers of aging adults in the US present major challenges for the health care system as well as the economy. For example, 18% of the US gross national product is spent on health care.[3] Of that total, Medicare accounts for 21%, or $554 billion.[3] Most alarmingly, of the $554 billion spent on Medicare, 28%, or about $170 billion, is spent on health care during the last 6 months of life.[3] Physicians and nurses occupy a unique position to address one of the major consequences of a "Graying America." Their collaboration can ensure meaningful increases in the historically low rates of Advance Care Planning, which currently are at 33%.[4,5]

Despite federal and other mandates, at present, most older adults do not establish in writing their wishes for how they desire to be cared for at the end of life. Although 90% of adults over the age of 65 years live with one or more chronic illness, many do not believe that conversations about Advance Care Planning are necessary.[6] Nonetheless, when decisions about health care at the end of life are not made in advance, errors of omission or commission often occur. A laudable goal of prolonging life should not be confused with a goal of prolonging death. Unfortunately, at present, data are sparse about modifiable determinants of Advance Care Planning and, as a consequence, reliable evidence about effective strategies to increase the rates is also limited.[5,7]

Self-determination, ethics, and autonomy preservation are among the principles that should guide Advance Care Planning. Advance Care Planning ensures greater patient and family contribution to treatment plans when such plans can be made in advance of any decline in health status. Nonetheless, Advance Care Planning is far more extensive and complex than Advanced Directives, which have been in effect since the enactment of the Patient Self Determination Act in 1990.[8] The Patient Self Determination Act requires all health care organizations that receive Medicare or Medicaid reimbursement to provide written information to patients explaining specific state laws about Advance Directives, document in the chart the existence of completed Advance Directives, and educate their constituents and health care providers about Advance Directives. Most health care providers, including physicians and nurses, are more likely involved with Advance Directives (ie, a Living Will, Five Wishes, or Physicians Orders of Life Sustaining Treatment) but less likely to be involved with Advance Care Planning.

In fact, physicians and nurses can play crucial roles to achieve Advance Care Planning by facilitating individualized discussions and collaborations in all outpatient, hospital, and extended care settings. While discussions of all plausible future health care scenarios are neither possible nor necessary, physicians and nurses can initiate Advance Care Planning discussions with all their apparently healthy aging patients. In contrast, reasonable prognoses for existing health conditions can be made so sensitive issues of quality and quantity of life with patients and their families can be initiated at all stages of care. Such proactive Advance Care Planning discussions that occur in advance of any terminal illness are far more likely to enhance the abilities of patients and families to make "in-the-moment" decisions when later faced with any health crisis.[7] The Advance Care Planning discussions are likely to markedly reduce both the quantity and costs of medical care at the end of life; more importantly, patient goals, values, and preferences for treatments are identified and respected.[4-7] Because most patients are willing to discuss Advance Care Planning if the subject is broached,[9-11] frank discussions could be initiated for all apparently healthy older adults, not just those with chronic

**Funding:** None.

**Conflicts of Interest:** SMD and RT reported no conflicts of interest. CHH reported that he is funded by the Charles E. Schmidt College of Medicine of Florida Atlantic University; serves as an independent scientist in an advisory role to investigators and sponsors as Chair or Member of Data and Safety Monitoring Boards for Amgen, Bayer, British Heart Foundation, Cadila, Canadian Institutes of Health Research, Genzyme, Lilly, Sanofi, Sunovion, and the Wellcome Foundation; to Pfizer, the U.S. Food and Drug Administration, and UpToDate; and receives royalties for authorship or editorship of 3 textbooks and as co-inventor on patents for inflammatory markers and cardiovascular disease that are held by Brigham and Women's Hospital; and has an investment management relationship with the West-Bacon Group within SunTrust Investment Services, which has discretionary investment authority and does not own any common or preferred stock in any pharmaceutical or medical device company.

**Authorship:** All authors contributed to the writing of the manuscript.

Requests for reprints should be addressed to Charles H. Hennekens MD, DrPH, Charles E. Schmidt College of Medicine, Florida Atlantic University, 777 Glades Road, Building 71, Suite 337, Boca Raton, FL 33431.

E-mail address: chenneke@fau.edu

0002-9343/$ -see front matter 
http://dx.doi.org/10.1016/j.amjmed.2014.07.035

progressive illnesses, complications, frequent hospitalizations, or readmissions.

Communications that consider the logical consequences of health care situations may dispel many misconceptions about Advance Care Planning. Such dialogues may explore basic values for patients and families, meaning of life, opinions related to quality of life, as well as cultural and ethnic considerations.

Certain busy and high-stress practice settings, such as intensive care units or emergency departments, are suboptimal to engage in Advance Care Planning conversations. Family members or patients may misinterpret the initiation of Advance Care Planning dialogue as an indication of a worsening prognosis. Even in such settings, however, satisfaction of patients and families is generally improved when Advance Care Planning communication is initiated.

Based on patient preferences, the Advance Care Planning should specify the steps to be taken if an exacerbation of illness occurs. The Advance Care Planning may even specify expressed wishes about selected music to be played or poetry to be read at the end of life. Ideally, the discussions should begin in a primary care office, an outpatient setting, or a family-centered environment well in advance of any health care crisis. At present, however, Advance Care Planning discussions are generally initiated when the patient is very near the end of life and, as a consequence, patient preferences can neither be identified nor respected.

The process of Advance Care Planning is ongoing, should begin during healthy aging, and later be revised in response to illness. At present, there are successful regional and community-based Advance Care Planning strategies, but comprehensive or one-size-fits-all interventions do not exist.[5]

Optimally, as a useful prerequisite to initiation of discussions with patients and their families about Advance Care Planning, physicians and nurses should examine their own attitudes and values. Formal education is not a prerequisite to either initiate dialogue or achieve Advance Care Planning, but general guidelines are addressed in numerous professional continuing education courses. Effective communication, intentional presence, and compassion are essential complements to competence.

Thus, Advance Care Planning offers a unique and important opportunity for physicians and nurses to enhance their interdisciplinary collaboration. Both patience with the patient and timing of the initiation of discussions are crucial.[9-11] Few would disagree that patients who discuss their preferences for end-of-life care with their physicians and nurses in advance are more likely to receive the care consistent with their preferences. Such educated patients are also far more likely to choose palliative or limited life-sustaining procedures over aggressive measures in their end-of-life health care.[4,5,8,12]

As the US is experiencing unprecedented numbers of aging adults, there is an increasingly urgent need to increase rates of Advance Care Planning. Physicians and nurses can assume crucial and necessary roles in the initiation, facilitation, and communications related to determining future health care options for all their patients and their families. At the same time, to further improve the current low rate of Advance Care Planning in the US, further research is necessary to identify major modifiable determinants. Research on modifiable determinants of Advance Care Planning should encompass conventional and holistic approaches and should include physiological, psychological, religious, and spiritual factors.

Susan Mac Leod Dyess, RN, PhD, AHN-BC[a]
Ruth Tappen, EdD, RN, FAAN[a]
Charles H. Hennekens, MD, DrPH[b]
[a]*Christine E. Lynn College of Nursing*
*Florida Atlantic University*
*Boca Raton*
[b]*Charles E. Schmidt College of Medicine*
*Florida Atlantic University*
*Boca Raton*

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