ADVANCED CARE PLANNING

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Kaye and James were in their early 80's with multiple chronic illnesses and decided it was time to renew their wishes and preferences for health care. They each reviewed their detailed preferences with their primary physician and communicated this to the appropriate family members. Soon thereafter, Kaye was unexpectedly diagnosed with end stage cancer. Advanced care planning assisted both Kaye and her family to openly discuss her preferences and revisit this daily as she continued to decline after being admitted to hospice. After she died, Kaye's family reviewed the plan several times in order to process and cope with her rapid decline in physical functioning, then cognitive and psychological functioning. The family was comforted knowing that Kaye's wishes were honored as she died peacefully.

Advanced Care Planning (ACP) is defined by the Center for Medicare and Medicaid (CMS) as planning for care that an individual would get if they become unable to discuss their health care preferences for themselves and is covered by Medicare Part B for those with this coverage. These discussions can occur during a Medicare Annual Wellness Visit where providers develop or update a client's Personal Prevention Plan and complete a Health Risk Assessment (Medicare.gov, 2021).

Discussions may include the explanation and discussion of advanced directives and outlining the health care wishes and preferences throughout their life such as using cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, and comfort care. In addition, this discussion includes an advanced directive or living will to put the preferences in writing to guide in decision making and designate a healthcare proxy to make decisions if an individual loses the capacity for deciding for themselves (U.S. Department of Health and Human Services and National Institute on Aging, 2018). While preferences may change over time, it is important to remind individuals that they have choices throughout their chronic illness trajectory. Key times to revisit an individual's preferences include declining physical, cognitive, or psychological functioning and during end-of-life care.

CMS covers up to 60 minutes per year of advanced care planning discussions with physicians or advanced care providers such as nurse practitioners. These discussions often cover strategic, patient-centered goal setting based on patient preferences and collaborating with patients on an appropriate plan for their health care trajectory (CDC Fact Sheet for Advanced Care Planning, 2018).

While the specific content of an advance care planning discussion may change depending on the circumstance, the key elements can be similar. These conversations are important opportunities to understand patients' goals, values, and preferences to help guide healthcare decision making.

Key elements may include:

- Review previous discussions and documented wishes for care (if any)
- Assess the patient's willingness to receive information and their preferred role in decision making
- Discuss prognosis and anticipated outcomes for any current treatments; assess for patient understanding
- Ask the patient about their goals, values, and fears for the future
- Discuss health states the patient would find unacceptable
- Discuss specific preferences for life-sustaining treatments
- Summarize and make a plan
- Complete/update advance directives and document conversation in medical record (Dunlay & Strand, 2016)

There are multiple resources for healthcare providers and patients to help facilitate an advance care planning conversation. Resources, such as VitalTalk (n.d.) and the Center to Advance Palliative Care (n.d.), can help providers develop their skills in advance care planning conversations and discussions of prognosis. For patients, The Conversation Project (n.d.) is a public engagement initiative to help everyone talk about their wishes for care through the end of life. Using these resources can guide providers and patients through these important conversations.

Although advance care planning conversations can be difficult for patients and providers, they provide an opportunity to identify, respect, and implement a patient's wishes for medical care. Unfortunately, despite these benefits, many older adults with chronic illness die after extended periods of disability, without prior advance care planning conversations with their primary care provider (Lum et al., 2015). Gerontological nurses, given their holistic and patient-centered approach, are well-poised to incorporate advance care planning concepts into their patient interactions.

RESOURCES

CDC Fact Sheet for Advanced Care Planning (2018). https://www.cdc.gov/training/ACP/Resources.pdf

Center for Medicare and Medicaid Services – Medical Learning Network. (2020). Advance Care Planning. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanningText-Only.PDF

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