

Advance Care Planning

By the year 2030, approximately 20% of the population in the United States will be 65 or older.¹ Given this reality, more attention has been devoted on ways to provide quality care and control costs at end of life. Despite advances in care and changes in health care delivery, the percentage of Medicare expenditures in the last year of life have remained largely unchanged over the past two decades.² Significantly more than any other developed country, the U.S. spends roughly 30% of all Medicare costs (almost \$180 billion dollars in 2014) on Medicare beneficiaries in their last year of life.³

Given this finding and other data demonstrating poor end-of-life care in this country, the Center for Medicare and Medicaid services (CMS) proposed and passed a new Medicare reimbursement policy that includes separate payments to physicians for counseling patients on advance care planning. "For Medicare beneficiaries who choose to pursue it, advance care planning is a service that includes early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is right for them," according to CMS.⁴ Under the proposal, beginning in January 2016, the Medicare physician fee schedule would include two new Current Procedural Terminology (CPT) codes for advance care planning – one would cover the first 30 minutes; the other, any subsequent 30-minute blocks of time.

With the growth of specialized palliative care in hospitals and an increase in utilization of hospice among Medicare enrollees, especially those with cancer, this new focus is increasingly prompting clinicians to engage in care conversations earlier in the course of illness.

Advance care planning, defined as 'a process of communication between individuals and their healthcare agents to understand, reflect on, discuss and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions'⁵ is thought to increase patient and family satisfaction with care as well as prevent overtreatment at end of life. Previous studies have shown discussions at end of life are associated with lower rates of patient anxiety and depression as well as less aggressive care.⁶ Specifically, this multi-site, prospective, longitudinal cohort study included 638 patients with advanced cancer and their informal caregiver, with trained interviewers talking with patient and caregiver about care. They assessed whether patients had spoken about their goals of wishes, "Have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?" Overall only 37% of patients or caregivers reported having conversations about their goals for care; however, those that reported engaging in these conversations were significantly ($P \leq .001$) more likely to accept that their illness was terminal (52.9% vs 28.7%), prefer medical treatment focused on relieving pain and discomfort over life-extending therapies (85.4% vs 70.0%), and have completed a do-not-resuscitate order (63.0% vs 28.5%).

Much conflicting data exists on whether simply completing an advance directive alone actually changes care outcomes or if patient's wishes are followed in an urgent medical situation. Additionally, there may be nothing harder in medical care—cognitively, technically, or emotionally—than talking to patients, especially younger ones, about dying and thus advance care planning. Bringing up the topic, guiding

the conversation to stay focused on the issues and clinical options, and ultimately reaching decisions are not naturally occurring skills. Rather, they require training, cultivation, and practice.

If the major barrier to engaging patients about end-of-life care is physicians' self-defined lack of skill, knowledge and comfort to engage in these conversations, money is unlikely to be the right catalyst. However, removing any and all barriers, including financial, is potentially a step in the right direction. Further research is needed to establish how best to educate providers, remove barriers, and empower patients and family members to best engage in their care in order to improve end of life care in this country.

At Jefferson, the Palliative Care Team is engaged in both inpatient and outpatient activities to both increase patient and provider comfort and familiarity with advance care planning. In addition, the [5th Annual Palliative Care Symposium](#) will be held Friday, June 3, 2016. This interprofessional program is designed to improve the quality and delivery of primary palliative care to all patients and their families with serious, life-threatening illness by acquiring skills and strategies for inter-professional practitioners who care for these patients.

If this is a topic of interest, many on-line sites are designed to empower patients, families and providers to engage in these discussions. For more information visit:

[The Conversation Project](#)

[PREPARE](#)

[Engage with Grace](#)

[Death Over Dinner](#)

[Making Your Wishes Known](#)

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