Title

Reply to: Comment on: Adaptive care planning: A paradigm shift

Authors

Moody, Sandra Y
Bell, Christina L
Lindenberger, Elizabeth C
et al.

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LETTER TO THE EDITOR

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Reply to: Comment on: Adaptive care planning: A paradigm shift

We appreciate Tan and colleagues' interest in our recently published *Special Article*.[1] As they correctly indicated, "The article described a novel approach [, Adaptive Care Planning (AdaptCP),] to iteratively develop advance care planning (ACP) conversations with patients and their families."[2] Tan and colleagues raise several interesting points worth addressing.

First, Tan and colleagues highlight patient/family/cultural as well as provider barriers to participating in serious illness discussions. These barriers are not unique to Adaptive Care Planning but to any discussion related to serious illness. The resources presented in Tables 1 and S1 of the original article[1] can help providers address these barriers when engaging in serious illness communications.

Secondly, we appreciate the important point that Tan and colleagues raise concerning who is best positioned to conduct these discussions during bouts of serious illness. Ideally, this individual should be a clinician who has an established relationship with the patient/family. In this era of telemedicine, we are routinely asked to participate in phone/video conference discussions related to serious illness taking place in the acute care setting. Tan and colleagues are correct that most of these conversations do happen with changing teams over time. It is important to document these discussions fully in the electronic medical record (EMR) so that as subsequent discussions occur, providers have a record of what was shared and decided in prior meetings. When possible, new teams may reach out to the previous team to gather data that may not have been recorded in the EMR to ensure they understand what information was conveyed, any challenges that occurred, and decisions made at the time of the last discussion.

Thirdly, Tan and colleagues raise a concern that having "multiple discussions with various healthcare professionals with evolving opinions and communication preferences"[2] could have unintended consequences that include confusing patients and their families. We acknowledge that this may be a risk, but if we do not undertake iterative discussions when clinical situations change and simply act on prior preferences, it is possible that those prior preferences are no longer valid. Thus, desired treatment in the current moment may be withheld or patients may receive treatment they no longer prefer. Relatedly, they question whether undertaking these discussions during acute clinical events is a suitable time to engage in serious illness discussions. Previous sudies[3–5] have shown that patient preferences change frequently over time (e.g., over 1 month, 6 months, and 1 year), and thus, "Regular reevaluation of advance care planning is necessary, particularly when patients experience a change in health status, mobility, symptoms of anxiety or depression, …."[4] This is important both in the acute care and outpatient settings. Additionally, to our knowledge, little or no literature exists indicating that serious illness conversations during acute hospitalization increase distress in patients/families. On the contrary, much of the literature indicates that these conversations improve coping, psycho-emotional preparation, quality of life, and facilitation of goal-concordant care.[6,7]

Fourthly, Tan and colleagues voice additional concerns "that premature ACP decisions made thinking they are flexible, transient, and adaptable as clinical conditions progress may be disadvantageous as patients may be too sick to change their ACP decisions later on."[2] We share the belief that conversations regarding goals, values, and care preferences before acute crisis are of great importance. These ongoing conversations outside of acute crisis are indeed critically important to promote coping and prognostic awareness.[8] AdaptCP complements these conversations by grounding them in a particular context, adapting to the changing landscape of the patient's situation to better tailor the decisions made with each discussion. When it comes to in-the-moment decision-making, our experience is that patients' preferences and goals do sometimes change with evolving clinical scenarios and that we need to respond by revisiting previously articulated goals and preferences when the clinical picture changes; these discussions could be had with family or a designated surrogate if the patient is unable to engage. We believe that the benefits of doing this far outweigh the risks.

Finally, Tan and colleagues raise concerns about providing interventions that are not medically appropriate.

This letter comments on the letter by Tan et al.

We agree that these situations should be avoided when possible. In the AdaptCP model, providers should provide information about the relative benefits and risks of possible treatments to patients with serious illness to include pointing out treatments that would be considered medically futile.

In closing, we fully support Tan and colleagues' calls for addressing established barriers to communication in the context of serious illness and redoubling our efforts to educate providers on how to conduct these important discussions.

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S.Y.M., C.L.B., E.C.L., and M.C.R. take full responsibility for the contents of the manuscript and satisfy the requirements for authorship.

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Sandra Y. Moody MD, BSN[1]
Christina L. Bell MD, PhD[2]
Elizabeth C. Lindenberger MD[3]
M. Carrington Reid MD, PhD[4]

[1]*Department of Medicine/Divisions of Hospital & Geriatrics Medicine, University of California, San Francisco, California, USA*
[2]*Hawaii Permanente Medical Group, Department of Geriatric Medicine, University of Hawaii John A. Burns School of Medicine, Honolulu, Hawaii, USA*
[3]*Division of Palliative Care and Geriatric Medicine, Massachusetts General Hospital, Boston, Massachusetts, USA*
[4]*Department of Medicine/Division of Geriatrics and Palliative Medicine, Weill Cornell Medical College, New York, New York, USA*

Correspondence
Sandra Y. Moody, Zuckerberg San Francisco General Hospital and Trauma Center, 1001 Potrero Avenue, Box 0862, San Francisco, CA 94110, USA.
Email: sandra.moody@ucsf.edu

ORCID

Sandra Y. Moody https://orcid.org/0000-0001-6672-9863

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