Preparation Matters: What We Can Learn From an Olympic Swimmer About the Value of Advance Care Planning Interventions

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In 2008, Olympic swimmer Michael Phelps broke a world record under unthinkably challenging circumstances—his goggles filled with water early in the race, and he was unable to see. When asked how he did it, he shared that he had grown bored with his coach's advice to mentally practice the perfect race and had instead begun to imagine what he would do if something went awry. When "swimming blind" unexpectedly became his reality, he already had a well-rehearsed strategy in his head for what he needed to do, enabling him to win his 10th gold medal (1).

Michael Phelps' success shows the value of "mental contrasting," a well-established behavior change strategy that involves identifying goals, imagining potential obstacles, and planning for how to overcome these obstacles (1). If the obstacles are too great, then persons are compelled to reevaluate their goals and effectively adjust their reality (2). Similarly, in advance care planning, patients are asked to imagine obstacles to their life and health goals and prepare for future decision making, such as identifying a health care agent in case they lose the ability to make their own decisions or discussing their values about quality versus quantity of life in case their health forces a choice. In palliative care, we use this strategy when we ask patients to "hope for the best, prepare for the worst." However, mental contrasting runs counter to our "think positive" culture (1), and there are persistent challenges in how to engage patients in advance care planning.

The STAMP (Sharing and Talking About My Preferences) cluster randomized controlled trial shows that providing computer-tailored information on advance care planning over time to patients in the

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outpatient setting helps prepare them for future decision making (3). Participants in the STAMP trial completed an initial assessment of their stage of change by telephone or online and were then provided with personalized brochures and feedback reports to support engagement in advance care planning behaviors. Six months later, a small but greater number of patients in the intervention group compared with those in the usual care group had engaged in all 4 targeted, self-reported advance care planning behaviors.

The STAMP team focused on a range of advance care planning activities, including identifying a trusted person and communicating with this person about views on quality versus quantity of life, formal assignment of a health care agent, completion of a living will, and ensuring that written documents are in the medical record. These behaviors all require a reflection on their goals and planning for potential obstacles (mental contrasting). In support of the important and pragmatic outcomes of advance care planning documentation and choosing a decision maker, the predicted probability of completing a living will was 28.5% for participants at intervention clinics versus 20.4% for participants at usual care clinics (adjusted risk difference, 6.5 percentage points); similarly, the probability of choosing a health care agent was 32.8% at intervention clinics versus 19.5% at usual care clinics (adjusted risk difference, 12.2 percentage points). The decision to focus on promoting conversations about quality versus quantity of life as opposed to specific treatment decisions is also appropriate given that this study was done in the ambulatory setting among community-dwelling older adults. Interestingly, communication about quality versus quantity of life was among the most commonly engaged in behavior by intervention (61.6%) and usual care (54.4%) participants, although the difference was not statistically significant. Specific data were not provided about the rates of ensuring advance care planning documentation was shared with the health care system or entered into the electronic health record. The STAMP outcomes reflect person-centered process and action advance care planning outcomes but do not address other key categories of advance care planning outcomes, including quality of care, health status, and health care

utilization, as well as surrogate decision-maker preparation (4, 5). The STAMP team's selection of person-centered outcomes reflects increased attention to the issue of measurement and broader range of outcomes in advance care planning, rather than being exclusively focused on goal-concordant care, which is a difficult outcome to measure and may not be realistic given the intervention focus (6, 7).

Without a doubt, community-based, primary and specialty care clinics are increasingly seeking evidence-based interventions that can help their patients prepare for what they may view as unimaginable but is actually quite common—the need for involvement of a surrogate decision maker or advance knowledge of a person's values and preferences during serious illness. The strengths of the STAMP intervention and the ability to affect outcomes in multisite, primary and specialty care practices are important. The STAMP intervention reflects the complex, multifaceted, and longitudinal nature of the advance care planning process that involves behavior change. By showing successful engagement of patients before a medical crisis, the STAMP trial joins other evidence-based advance care planning interventions that show positive advance care planning outcomes in ambulatory care (4, 8).

Moving forward, there are real challenges to overcome to implement STAMP. The authors propose that the work could be done by an existing member of the care team, such as a case manager, using STAMP assessment and feedback software. However, advance care planning is a complex intervention with several components and known challenges to implementation (5, 9). Using existing staff requires salary support and the potential need to shift a busy workforce's attention away from another activity. Implementation also requires access to the computerized tool, a standardized training manual, assessment and monitoring of any risks, on-going fidelity assessments, and outcomes tracking in a sustainable way under real-world practice settings.

Perhaps the most important implementation element is an alignment with practice and provider team goals. To maintain the intervention, there will need to be a positive effect on patient outcomes that can

be tracked in the clinical environment and that are meaningful to clinicians and clinical leaders. The STAMP trial's overall effect was modest and did not address pragmatic electronic health record health system outcomes, such as the Advance Care Plan measure defined by the National Quality Forum (10). This suggests a need for further study or adaptation to ensure that documentation is available and accessible to clinicians.

Most participants were White (76%). There were no differences based on race, but it is unclear how culturally relevant the intervention is to more diverse populations. Future research should focus on diverse participants, including persons receiving Medicaid and persons with limited English proficiency. Certainly the use of both telephone- and web-based approaches in the STAMP intervention increases accessibility to a broader range of participants, including those without access to technology (3).

Michael Phelps' intuitive use of mental contrasting to imagine and plan for potential obstacles highlights the value of this behavior change strategy and reinforces the importance of preparing for future medical decision making. Although there is no gold medal for advance care planning, evidence-based interventions like STAMP can play an important role in supporting patients and their families in identifying goals for care, imagining and planning for obstacles, and adjusting goals when obstacles are insurmountable to help prepare for future decision making during serious illness and at the end of life.

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