Dementia is a leading cause of death in the United States. This article outlines the current understanding of advanced dementia and identifies research priorities for the next decade. Research over the past 25 years has largely focused on describing the experience of patients with advanced dementia. This work has delineated abundant opportunities for improvement, including greater recognition of advanced dementia as a terminal illness, better treatment of distressing symptoms, increased access to hospice and palliative care services, and less use of costly and aggressive treatments that may be of limited clinical benefit. Addressing those opportunities must be the overarching objective for the field in the coming decade. Priority areas include designing and testing interventions that promote high-quality, goal-directed care; health policy research to identify strategies that incentivize cost-effective and evidence-based care; implementation studies of promising interventions and policies; and further development of disease-specific outcome measures. There is great need and opportunity to improve outcomes, contain expenditures, reduce disparities, and better coordinate care for the millions of persons in the United States who have advanced dementia.

For author affiliations, see end of text.

Current Understanding of Advanced Dementia

Clinical Course

The last year of life in persons with advanced dementia differs from that of persons with other common causes of death, in that it is characterized by a prolonged trajectory of severe disability (11). The Global Deterioration Scale (12) is a validated and reliable instrument that describes the clinical progression of dementia (Table 1). The scale ranges from stages 1 to 7, with higher scores indicating more severe dementia.

Stage 7 of the Global Deterioration Scale provides a useful description of the features of advanced dementia for clinical and research purposes: profound memory deficits (inability to recognize family members), speech limited to fewer than 5 words, total functional dependence, incontinence, and inability to ambulate. The CASCADE (Choices, Attitudes, and Strategies for Care of Advanced Dementia at the End-of-Life) study used this definition to describe the clinical course of 323 nursing home residents with advanced dementia (13). Over 18 months, 55% of the cohort died, 41% had pneumonia, 51% had a febrile episode, and 86% developed an eating problem. Other major acute illnesses (for example, hip fracture and myocardial infarction) were rare.

The CASCADE study thus confirmed that advanced dementia is characterized by a high mortality rate and the onset of infectious episodes and eating problems. Moreover, it demonstrated that most patients with advanced dementia die of this disease and its expected complications, not other acute illnesses.

Prognosis

Prognostication has important implications for clinical decision making and for accessing Medicare hospice benefits, which requires an estimated survival time of less than 6 months (13–15). The development of risk models for mortality that accurately estimate survival in advanced dementia has unfortunately proved elusive (16–21). In a prospective validation study (16), the 12-item Advanced Dementia Prognostic Tool predicted 6-month survival with only modest accuracy (area under the receiver-operating charac-
teristic curve, 0.67); however, these findings were better than those of current Medicare hospice eligibility guidelines (area under the receiver-operating characteristic curve, 0.55) (16). The difficulty of estimating 6-month survival in advanced dementia suggests that access to palliative care for these patients should be guided not by their prognosis but rather by their preference to focus care on maximizing comfort and quality of life.

Sources of Distress
Patients with advanced dementia commonly experience distressing symptoms that are amenable to treatment (6, 13, 22–29). In the CASCADE study, the proportion of nursing home residents with advanced dementia who experienced pain and dyspnea increased as death approached, in a pattern similar to that of patients with cancer who are dying (30). Assessing patients’ symptom distress is difficult because of their loss of language skills, but advanced dementia-specific instruments have been developed that quantify symptoms on the basis of the observations of caregivers. Several measures have gained greater endorsement because of their favorable psychometric properties and increasing collective experience among investigators (31–34).

Management of Common Complications
Treatment decisions in advanced dementia should be guided by patients’ care preferences as specified in advance directives or as perceived by their proxies. Goals of care must be used to guide initiation of new treatments, as well as the withdrawal of ongoing treatments. Most proxies state that comfort is the primary goal of care (13, 35), although patients with advanced dementia commonly receive treatments that are inconsistent with this goal (36–43). Possible reasons underlying this disconnect include such factors as inadequate advance care planning (40, 43, 44), the challenges of prognostication (16–21), providers giving misinformed and inconsistent counseling to proxies (13, 45), cultural influences (43, 46–48), limited access to high-quality palliative care that is tailored to the unique needs of patients with dementia (7, 39), and misaligned fiscal incentives in a fee-for-service health care system (49, 50).

Treatment choices regarding eating problems and infections are the most common decisions that proxies confront (51). A substantial body of research exists on managing feeding problems in advanced dementia (41, 44, 52–60). This topic has served as the paradigm for approaching dementia as a terminal illness with respect to examination of outcomes, decision making, and health care utilization.

Treatment options for feeding problems include continued assisted oral feeding (when possible) or tube feeding. In the United States, approximately one third of nursing home residents with advanced dementia who develop feeding problems are tube-fed (40). However, observational studies have consistently failed to demonstrate any clinical benefits of this intervention in this population (41, 44, 53). This evidence, together with an appreciation of eating problems as part of the natural history of advanced dementia, has led experts to advocate against the use of tube feeding in this condition (53, 55, 61).

Decision making for infections involves whether to administer antimicrobials or to use supportive measures only. Antimicrobial use is extensive in advanced dementia (62–66) and increases as death approaches (66). Up to 40% of patients with advanced dementia receive antimicrobials in the last 2 weeks of life (66). The extent to which antimicrobials meaningfully extend life or improve comfort in these patients, for whom infections are often a terminal event, remains unclear (38, 65, 67–69). Nursing home residents with advanced dementia are 3 times more likely than other residents to be colonized with antimicrobial-resistant bacteria (70). Altogether, the widespread use of antimicrobials in advanced dementia raises concerns not only from the perspective of individual benefits and burdens near the end of life but also from a public health standpoint with respect to the emergence of antimicrobial-resistant bacteria.

Health Care Utilization
Approximately 16% of persons in the United States who die of dementia do so in hospitals (5). Nursing home residents with advanced dementia experience an average of 1.6 hospital transfers in the last 90 days of life (42), and residents living in regions with higher transfer rates experience worse end-of-life outcomes (43). Hospitalizations can be traumatic for these frail patients (37), as they receive care from unfamiliar providers and undergo uncomfortable tests and interventions (36, 38, 42, 42).
In the CASCADE study, hospitalizations accounted for 30% of Medicare expenditures; care at skilled nursing facilities after hospitalization accounted for an additional 10% (50). Research suggests that most conditions precipitating hospitalization in advanced dementia (for example, pneumonia) can be treated with the same efficacy in the community or nursing home setting (64, 65, 71, 72). For most patients for whom comfort is the priority (13, 35), hospitalization is seldom consistent with this goal, albeit with rare exceptions (for example, a hip fracture).

Hospice care is a beneficial (26, 73–75) yet underutilized service in advanced dementia (7). Patients dying with dementia who received hospice care have better symptom management (26, 74), fewer terminal hospitalizations (76), and greater family satisfaction with care than those not receiving hospice care (28, 74). Trends indicate that hospice enrollment of patients with dementia is increasing; however, only 11% of hospice recipients in 2009 were reported to have a primary diagnosis of dementia, whereas 40% had cancer (77). Hospice professionals cite prognostication as the main hindrance to enrolling patients with dementia (78).

There are profound disparities in advanced dementia care. Nonwhite race is the most consistent risk factor associated with outcomes considered markers of poor-quality end-of-life care, including increased use of tube feeding (40), terminal hospitalizations (43), and lack of advance directives (46, 47). However, even after patient characteristics are controlled for, these outcomes vary dramatically across the United States in a strikingly consistent pattern, with a general propensity for worse quality of care in the southeast (42, 43, 48, 52, 54, 58, 79). The reasons for these disparities remain unclear, but they underscore that care of advanced dementia care is driven by a complex interplay of individual preferences, cultural influences, regional market factors, facility characteristics, local practice patterns, and health care policies.

<table>
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<tr>
<th>Table 1. Stages of Dementia Described by the Global Deterioration Scale*</th>
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<td>Global Deterioration Scale Stage</td>
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* Information is from reference 12.
Table 2. Priorities for Advanced Dementia Research Over the Next Decade

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<th>Discipline</th>
<th>Broad Research Objectives</th>
<th>Specific Examples</th>
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| Intervention        | Design and conduct RCTs of interventions to promote high-quality, goal-directed care across health care settings  
Design and conduct RCTs of interventions to reduce disparities in end-of-life care | RCT of an intervention to reduce hospital transfers for nursing home residents with advanced dementia whose goal of care is comfort  
RCT of a clinical pathway to reduce feeding tube insertions in hospitalized patients with advanced dementia  
RCT of culturally sensitive video decision aids that use visual images (vs. verbal explanations) to illustrate treatment options |
| Health policy/services | Identify policies that incentivize high-quality, cost-effective end-of-life care  
Test strategies to increase access to hospice care and palliative care programs  
Conduct comparative effectiveness research of treatment strategies | Develop and evaluate nursing home quality indicators for end-of-life care  
Examine effect of introducing payment for hospice during receipt of skilled nursing facility care  
Determine the incremental cost-effectiveness ratio of not hospitalizing nursing home residents with advanced dementia for suspected pneumonia (e.g., incremental changes in quality-adjusted outcomes relative to costs) |
| Implementation       | Conduct projects to implement proven interventions and policies                         | Demonstration project of evidence-based advanced dementia care intervention into nursing home practice |
| Measurement          | Develop new advanced dementia-specific instruments for outcomes currently lacking valid measures  
Better establish psychometric properties of existing instruments | Measure of stress among family members of nursing home residents with advanced dementia  
Develop utility-based measures of health-related quality of life in order to conduct comparative effective research  
Determine minimally clinically important difference for Symptom Management at the End-of-Life in Dementia Scale (30) |

RCT = randomized, controlled trial.

The anticipated complexity of clinical interventions and policies to improve advanced dementia care necessitate the inclusion of implementation science as a key priority to ensure that they can be effectively translated into practice. The Patient Protection and Affordable Care Act presents a timely opportunity for demonstration projects that evaluate alternative financial structures to reduce unwarranted and unwanted hospitalizations for nursing home residents with advanced dementia, such as bundled payments or capitated programs, similar to the Program of All Inclusive Care for the Elderly (which integrates Medicare and Medicaid financing for frail elderly patients) (49).

Although progress has been made in outcomes measurement, many gaps remain. For example, there is no measure to quantify the stress that families of nursing home residents with advanced dementia experience. A disease-specific utility-based measure that takes into account health-related quality of life must be developed to conduct comparative and cost effectiveness research. Finally, greater delineation of meaningful effect sizes of existing measures is necessary to plan trials that will use these instruments as outcomes (31–34).

The research priorities set forth in this report align with those of the National Alzheimer's Project Act, which was signed into law in January 2011. This projects calls for the expansion and coordination of research and health services delivery across federal agencies for Alzheimer disease and related dementias in order to achieve 2 top priorities: improve the health outcomes of patients with dementia and reduce the financial burden of the disease at an individual and societal level. The act further prioritizes the need to reduce disparities and improve the coordination of dementia care, and it stresses the need for initiatives aimed at prevention and early detection of dementia. However, if
the top priorities of the act are to be met, significant focus must be placed on the millions of persons in the United States in the advanced stage of the disease, for whom there is great need and opportunity to improve patient outcomes, contain health care expenditures, reduce disparities, and better coordinate care.

Accomplishing these priorities will depend on several factors, including research funding. To date, roughly 63% of advanced dementia research has been supported by grants from the National Institutes of Health. However, with the National Institutes of Health budget at unprecedented lows, greater support from other federal agencies and philanthropic sources will be critical. In addition, the number of senior researchers dedicated to this field is small. Ongoing work will require close collaboration and intellectual and financial investment into the training of young investigators. Dissemination of key research findings through the education of policymakers, health care providers, and the public will be an essential step in translating this work into better advanced dementia care. Finally, the millions of Americans with dementia and their families are perhaps the most important stakeholders in this research. Ultimately, their advocacy and engagement may play the greatest role in driving advanced dementia research forward through the next decade.

From Hebrew SeniorLife, Institute for Aging Research, Boston, Massachusetts; Johns Hopkins University School of Medicine and Berman Institute of Bioethics, Baltimore, Maryland; School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania; Center for Aging and Health, University of North Carolina, Chapel Hill, North Carolina; Brown University Program in Public Health and Alpert Medical School at Brown University, Providence, Rhode Island; Indiana University School of Medicine and Indiana University for Aging Research, Regenstrief Institute, Indianapolis, Indiana; and Mount Sinai School of Medicine, New York, New York.

Note: The information presented in this article is based on Research in Advanced Dementia: State of the Science and Future Directions, a conference held in Boston on 20 June 2011. This conference was funded by the National Palliative Care Research Center. Participants included the authors of this report: a group of multidisciplinary senior investigators from across the United States who are focused on advanced dementia research. Each senior investigator was assigned to review, summarize, and present the existing literature on advanced dementia in a specific area (for example, cohort definitions, clinical course, outcomes, study design, health care utilization, strategies to improve care, and funding). Each presentation was followed by group discussion with the explicit purpose of reaching consensus about key findings that were well-established by the literature. After individual topic presentations, a broader group discussion was dedicated to reaching agreement about the remaining critical knowledge gaps and the overriding top research priorities for the field.

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Requests for Single Reprints: Susan L. Mitchell, MD, MPH, Hebrew SeniorLife, Institute for Aging Research, 1200 Centre Street, Boston, MA 02131.

Current author addresses and author contributions are available at www.annals.org.

References


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64. van der Steen JT, Kruse RL, Ooms ME, Ribbe MW, van der Wal G,


Current Author Addresses: Dr. Mitchell: Hebrew SeniorLife, Institute for Aging Research, 1200 Centre Street, Boston, MA 02131.
Dr. Black: Johns Hopkins University School of Medicine and Berman Institute of Bioethics, 1809 Ashland Avenue, Baltimore, MD 21205.
Dr. Ersek: School of Nursing, University of Pennsylvania, Room 329, Fagin Hall, 418 Curie Boulevard, Philadelphia, PA 19104-4217.
Dr. Hanson: Division of Geriatric Medicine and Center for Aging and Health, University of North Carolina, 5003 Old Clinic, CB 7550, Chapel Hill, NC 27599-7550.
Dr. Miller and Teno: Brown University Program in Public Health, Department of Health Services, Policy, and Practices, Alpert Medical School at Brown University, 121 South Main Street, Providence, RI 02912.
Dr. Sachs: Division of General Internal Medicine and Geriatrics, Indiana University School of Medicine and Indiana University for Aging Research, Regenstrief Institute, Inc., 1001 West 10th Street, OPW-M200, Indianapolis, IN 46202-2879.
Dr. Morrison: Department of Geriatrics, Box 1070, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, NY 10029.

Author Contributions: Conception and design: S.L. Mitchell, B.S. Black, L.C. Hanson, A. Sachs, R.S. Morrison.
Analysis and interpretation of the data: M. Ersek, S.C. Miller.
Drafting of the article: S.L. Mitchell, L.C. Hanson, A. Sachs, J.M. Teno, R.S. Morrison.
Critical revision of the article for important intellectual content: S.L. Mitchell, B.S. Black, M. Ersek, L.C. Hanson, S.C. Miller, A. Sachs, J.M. Teno, R.S. Morrison.
Final approval of the article: S.L. Mitchell, B.S. Black, M. Ersek, L.C. Hanson, S.C. Miller, A. Sachs, J.M. Teno, R.S. Morrison.
Obtaining of funding: S.L. Mitchell.
Administrative, technical, or logistic support: S.L. Mitchell, R.S. Morrison.
Collection and assembly of data: S.L. Mitchell, M. Ersek, S.C. Miller.