Advance Care Planning 2015

The purpose of this guideline is to assist the practitioner in engaging the patient in a discussion of goals, preferences, and priorities regarding the patient's care at different stages of life. The guideline recommends tools and interventions to address Advance Care Planning across the patient population.

Eligible Population	Key Components	Recommendation
1.Patients whose death in the next twelve months would not be surprising 2. Patients with a chronic, life-limiting illness who are experiencing more symptoms, hospitalizations, etc. 3.Patients aged 55 and over, in any stage of health	Advance Care Planning Process	**Relevant topics include:** ♦ The value of making one's goals preferences and choices for care and treatment known both verbally and in writing ♦ The importance of early conversations with family in a non-crisis situation ♦ The value of identification of a surrogate decision-maker, with consent ♦ The value of cultural sensitivity ♦ For appropriate patients, the value of having a Physician's Orders for Life-Sustaining Treatment (POLST) ♦ Discussion should include family members, the surrogate decision-maker, and others who are close to the patient ♦ Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.) ♦ These individuals are encouraged to seek training to improve their ability to handle the issues ♦At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (CHF, ESRD, cancer, etc.)
	Assist patient in Advance Care Planning	**Use an Advance Care Planning tool to:** ♦ Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity ♦ Incorporate the patient's goals preferences and choices into the advance care plan ♦ Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others ♦Encourage the patient to complete an Advance Directive
	Revision of Advance Care Plan	Review the patient's goals and preferences for end-of-life care and Advance Directives at least annually ♦ Work with the patient to update his/her Advance Directives, giving consideration to specific potential scenarios ♦ Discussions should occur with a significant change in prognosis (metastatic cancer, oxygen-dependent COPD, progressive heart failure) ♦ If patient has limited life expectancy, consider using the POLST tool to address the patient's specific requests for end-of-life care
	Documentation and Implementation	Place a copy of the Advance Directive and other documentation of the patient's goals and preferences for end-of-life care in the patient's record ♦Share the POLST throughout the health system as appropriate, and make accessible to emergency departments, EMS companies, nursing homes, etc.