# 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.

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<th>Eligible Population</th>
<th>Key Components</th>
<th>Recommendation</th>
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| 1. Patients whose death in the next twelve months would not be surprising          | 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.) |
| 2. Patients with a chronic, life-limiting illness who are experiencing more symptoms, hospitalizations, 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 |
| 3. Patients aged 55 and over, in any stage of health | 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. |