Talking To Members About Advance Care Planning

It is important to know members' wants and wishes when it comes to end of life and life-sustaining treatment. As a provider, you want to address advance care planning proactively, rather than wait until the member is in crisis, or declines in clinical status to introduce this topic. It is beneficial to the member and family to have the conversation as part of routine care.

Sometimes, members are unable to inform their doctors about treatment for themselves because of an illness or injury. As a provider, you want to approach the conversation in advance to ensure that members' wishes about treatment are followed, if they become incapacitated. The ultimate goal is to avoid any confusion and discord regarding the members' care.

The following is generally recommended:

1. Introduce advance care planning as part of your initial assessment with members.
2. Provide education to members regarding the significance of advance directives; include family members or social supports.
3. Review the various forms of the advance directives, i.e., health care proxy, living will, DNR and DNI. In some instances, members may have the MOLST or Five Wishes as their form of advance directives.
4. Spend time explaining the various treatments within the HCP and what they mean
5. Review what CPR is in connection to DNR; draw the member a picture
6. Revisit advance directives annually, as the member's wishes may change
7. Normalize the approach to advance care planning by making it part of your dialogue with members. Your level of comfort with the subject matter will be a reflection on how the member responds and follows through.

Below is a quick review of some forms of advance directives:

a. Health Care Proxy: A document delegating to another adult, known as a health care agent, the authority to make health care decisions on behalf of the individual in the future, if he/she becomes incapable of making his or her own health care decisions.

b. Living Will: A document which contains specific instructions concerning an individual's wishes about the type of health care choices and treatments that he or she does or does not want to receive, but which does not designate an agent to make health care decisions.

c. DNR: Consent to or request for the issuance of an order not to resuscitate (a "DNR order"); a living will that consents to or requests a doctor's order not to resuscitate. Under such an order, health care providers are not to attempt cardiopulmonary resuscitation (CPR) in the event the patient suffers cardiac or respiratory arrest. A request for such an order can be expressed in a health care proxy or living will.

By having the conversation about advance care planning, you can help members and families understand its importance and avoid any confusion and distress in the future.