A Guide to Advance Care Planning (ACP)

This guide gives: 1) a simple 3- step framework, 2) sample phrases to facilitate effective conversations about goals of care and 3) key steps for documenting this work in BIDMC OMR.

1: Identify a PROXY	
If no proxy:	*"If you become too ill to speak for yourself, who should make medical decisions on your behalf?"*
If proxy in chart:	*"Is NAME still your proxy? Have you and your proxy discussed your thoughts and wishes, so s/he knows how approach medical choices?"*
Document:	**In OMR, enter name and phone # under** Advance Care Planning **>>Health Care Proxy** Edit
2: Elicit patient PREFERENCES. These are examples of samples phrases to stimulate a conversation. Choose 1 or 2.	
Starting line	*"If you are too sick to speak for yourself, what kind of medical care you would want?"*
Defining "quality of life"	*"Everyone has different things that bring joy. What matters most to you? This is what 'defines' quality of life for you."*
Explore attitude toward risk	*"If doctors were unsure if a medical procedure would help you, would you consider trying it? . . . What if the odds were low that it would help? . . . What would make you want to try/not try it (e.g., COVID infection)?"*
Normalize choices	*"Many patients tell me they do not want to be a vegetable/ be kept alive on a machine? Have you ever thought about that?"*
Explore end of life thoughts	*"If you knew that time were short, what would you want the end of your life to look like? Would you want to be at home? In a hospital?"*
Responding to challenging comments from patients	
"I want to live as long as possible."	*" I fully support doing what we can to extend your time. When you think about the future, is there anything that worries you?"*
"Right now, I feel well and I want you to do everything. But if I get really sick, I don't want to be kept alive."	*"Tell me more about that."* *"Help me understand what 'really sick' means to you."*
"Doc, why are you asking me these questions? Are you giving up on me?"	*"It's so hard to think about this. Right now you are doing well. We hope you will continue to do well. At the same time, it is important to prepare for a time in the future, when you won't be doing well."*
3: Recommend a PLAN Patients want and expect our guidance. Be honest about uncertainty. Give a recommendation that takes into account the individual patient's prognosis (specifically around survival of CPR/intubation.) Sadly, most patients with advanced CA will NOT survive/recover from the prolonged intubation that is anticipated with COVID.	
Pt 1: clear about wishes	*"You seem clear in your desire to avoid being put on a machine. If you are certain, then we should complete some paperwork to document that."*
Pt 2: Everything now, but not later	*"It's important to you that you have as much time as you can. You want comfort at the end of your life. To honor that, we should continue current Rx. I would also recommend, in the event you get critically ill, we do not hook up to machines. When the time comes, we can focus on quality of life and time with family."*
Pt 3: ambivalent	*"Anything in particular you are worried about?"* *"We have a team skilled at these discussions. Shall I have them reach out to you?"* - **Consider referral to Pall Care**
Document:	**Enter note in OMR. Check** ☐ Advance Care Planning **on list of problems under note.** **Consider using MACRO: ACP Pall Care Template.** **Complete MOLST, if DNR/I is clear.**