ADVANCE CARE PLANNING (ACP)

Discussion Guide and Visit Documentation Template

A valuable tool in assisting patients and their families in navigating the decisions required for advance care planning in the long-term care, assisted living, and other settings

This ACP Discussion Guide includes a series of questions and discussion topics, thereby assisting the professional as they encourage patients to consider the full range of issues informing these very personal decisions.

This tool also includes 25 copies of the individual ACP template on convenient tear-off pages that can be kept in the medical record as documentation an ACP discussion took place with the patient or the patient's health care agent. Clinicians will benefit from maintaining a copy among their standard forms set for easy access when addressing the needs of this population.

ADVANCE CARE PLANNINNG (ACP) DISCUSSION GUIDE

5-S CARE PLAN

5-S (Environment)

1. **S**cene – Select location for privacy and comfort sensitive to patient's needs.
2. **S**etting – Create friendly, engaging, quiet and confidential environment.
3. **S**eating – Make patient, family, staff at ease; seating that is congenial and conducive to interaction.
4. **S**cenario – Long-Term Care (LTC) and other settings.
5. **S**tart with open ended question – No interruption for the first two minutes and allow silence between responses.

C-A-R-E (Engagement)

1. **C**ONSIDER AND CLARIFY
   - **Cause:** What is the reason for the ACP discussion?
     ("It is important to know we are choosing medical treatments in keeping with your wishes; these discussions are routine and necessary for all patients in LTC.")
   - **Clarify:** Simplify medical language in patient's own words; "ask-tell-ask" to aid understanding.
   - **Condition:** What are the relevant medical diagnoses and treatments?
   - **Consider:** The extent to which today's statements are consistent with previous statements. Seek goals of care consistent with patient preference.

2. **A**SSESS AND ASSUME NOT
   - **Assess:** Patient's perspective with empathy and unbiased, active listening.
   - **Assess:** What is the patient's (or proxy's*) self-described perception of their illness, functional status, clinical trajectory, prognosis, and expectation of treatment options and results?
   - **Assess**: What are the cultural, social, family, religious, or other life values that shape the patient's response to their situation and their perspective on illness?
   - **Assess:** What are the trust issues, if any, that patient has toward medical care?
   - **Assess:** What is the patient's preference concerning:
     - the balance between longevity, functional status and quality of life?
     - the balance between relief of symptoms and maintaining lucidity and awareness?
   - **Assume Not:** Avoid imposing your own opinion on the preferences of the patient.

3. **R**EFLECT AND RESPOND
   - **Reflect:** On patient's preference for treatment in their own words.
   - **Restate:** The patient's ideas, comments, questions.
   - **Reflect:** Are there impending anniversaries "bucket list items", unfinished business, unspoken agendas or coercive factors which may be influencing patient preferences?
   - **Respond:** Affirm your desire to develop a medical treatment plan consistent with patient preferences, in the context of the issues identified immediately above, if any.
   - **Respond:** Provide education about prognosis and clinical benefits, or lack thereof, of any proposed medical treatments (e.g., CPR, intubation and tube feeding), unless patient does not wish to receive this information. Seek to be culturally sensitive to your individual patient[1,2,3].

C-A-R-E (Engagement) *(cont'd)*

- **Review:** Patient's perspective with affirmation and options for honoring their wishes. Allow them to respond. Engage in shared deliberation of how to best honor their wishes.
- **Review:** The applicability, if any, of their current Advance Directives and other medical treatment forms, to their current clinical situation. If the current forms do not reflect their goals and desires, recommend the creation of new forms.
- **Respond Back:** Educate patient on options that reflect their preferences. Review available Advance Directives, Living Will, DNR, and/or POLST Paradigm forms or documents in their particular State.
- **Reflect Back:** Ask whether the patient has additional questions or change of perspective. Restate their perspective after education and discussion of options.

4. **EVALUATE AND EXECUTE**
   - **Evaluate:** What are the next steps, in light of the above discussion?
   - **Enter**: Any appropriate order to represent those choices (e.g., DNR, Full Code).
   - **Execute:** If any Advance Directives or medical treatment order documents have been completed by the patient at the ACP meeting, document this in this note and make copies of all previous and new document(s) that are valid for the patient and the medical record.
   - **Execute:** Unless patient does not want it shared send copies to the community primary care physician and local hospital.

P-L-A-N (Execution)

1. **PREPARE AND PLAN**
   - **Prepare**: Document the Advance Care Plan discussion (see ACP Documentation Template).
   - **Plan:** Schedule another meeting if follow-up discussions are required and document in the note.
2. **LEAVE**
   - **Leave:** Appropriate contact information for the patient and family.
   - **Leave:** A few moments of silence towards the end of discussion for any other questions.
3. **ALWAYS AFFIRM**
   - **Always Affirm:** Be supportive even if they disagree with your recommendations.
4. **NOTE, NAVIGATE AND NEVER LOSE HOPE:**
   - **Note:** Significant clues to unaddressed needs that arose in the discussion.
   - **Navigate:** For unresolved or difficult situations, commit to further facilitation of ACP discussions.
   - **Never** lose hope throughout the process. More ACP visits may be needed.

*Where "patient" is referred to in this discussion guide, healthcare proxy may be substituted when patient lacks capacity for ACP discussion.

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Patient's Name: _____
DOB: ____/____/____
Date: ____/____/____

ADVANCE CARE PLANNING (ACP) VISIT DOCUMENTATION TEMPLATE

(This is a template only and not a medical order form.)

(99497/99498)

1. **BRIEF CLINICAL SUMMARY**

Provide brief overview of relevant medical history, recent hospitalizations and clinical prognosis trajectory:

_____
_____

What are the current and proposed treatments:

_____
_____

Summary of any previous ACP discussions and reason for this ACP discussion:

_____
_____

2.

AVAILABLE EXISTING ADVANCE DIRECTIVES AND MEDICAL ORDERS		
Are Advance Directives available?	☐Yes	☐No
If there are Advance Directives, please specify.		
Are Medical Orders for levels of care (e.g. POLST Paradigm form) available?	☐Yes	☐No
If there are Medical Order for levels of care, please specify.		
Health Care Proxy (HCP or POAHC)?	☐Yes	☐No
If no HCP or POAHC identified by Advance Directive is a healthcare surrogate identified?	☐Yes	☐No
How was this person identified to be the surrogate?		
Is there any controversy over who is to serve as proxy?	☐Yes	☐No

3.

CAPACITY DETERMINATION AND CONSENT		
In your professional judgment at this time, does the patient have capacity for medical treatment decision-making?	☐Yes	☐No
Does patient or proxy consent to this ACP visit?	☐Yes	☐No
Do they understand that the ACP visit is billed separately from other services, and that unless it is part of an annual wellness visit they may be responsible for the co-pay?	☐Yes	☐No

Describe the evidence on which your capacity determination is based (i.e., understanding of options, appreciation of consequences of options, reasoning to arrive at a choice, expression of a choice):

_____
_____
_____

4. **List all participants in the ACP Discussion and their role in relationship to the patient:**

_____
_____

Summary of today's ACP Discussion and PLAN including but not limited to, patient or proxy perceptions of Quality of Life (QOL), values, and preferences regarding levels of care and medical treatment. What was covered in the ACP discussion? What key statements did the patient or proxy make?

_____
_____
_____

What new decisions have been made, if any?

_____
_____

5.

This list may be useful as a prompt concerning specific therapeutic options. It may not be necessary to discuss each of these treatments in every ACP visit.		
Has a health care proxy (or POAHC) been selected?	☐Yes	☐No
Has a decision been made regarding CPR?	☐Yes	☐No
Has the option of intubation been discussed?	☐Yes	☐No
Have scope of treatment orders been discussed?	☐Yes	☐No
Has a scope of treatment order form (e.g., POLST) been completed?	☐Yes	☐No
Has a feeding tube been discussed?	☐Yes	☐No
Has a decision regarding use of a feeding tube been made?	☐Yes	☐No
Has dialysis been discussed?	☐Yes	☐No
Has a decision on use of dialysis been made?	☐Yes	☐No
Has use of IV hydration been discussed?	☐Yes	☐No
Has a decision whether or not to use IV hydration been made?	☐Yes	☐No
Has a limitation on hospital transfers been discussed?	☐Yes	☐No
Has a decision to limit hospital transfers been made?	☐Yes	☐No
Was there a discussion of implanting an ICD or Pacer?	☐Yes	☐No
Was there a discussion of turning off ICD or Pacer?	☐Yes	☐No

Document the number of face-to-face minutes spent discussing Advance Care Planning
(If 16-45 minutes, bill 99497. If 46-75 minutes, bill 99497 and 99498).

Minutes: _____ Billing code(s): _____

Practitioner's Name: _____

Signature: _____Date: ___/___/_____

Sources

AMDA - The Society for Post-Acute and Long-Term Care Medicine. 10500 Little Patuxent Parkway, Suite 210, Columbia, MD 21044. Advance Care Planning (ACP) Discussion Guide and Visit Documentation Template.

1. Brangman S, Periyakoil VJ, et al. Doorway Thoughts: 2014, 2nd Edition. New York: The American Geriatrics Society; 2014. Available at https://geriatricscareonline.org/toc/doorway-thoughts-cross-cultural-health-care-for-older-adults/B016.
2. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. 8th ed. New York, NY: McGraw-Hill;2015.
3. Kobylarz FA, Heath, JM, Like RC. The ETHNIC(S) Mnemonic: A Clinical Tool for Ethnogeriatric Education. JAGS 2002;50:1582-1580.

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