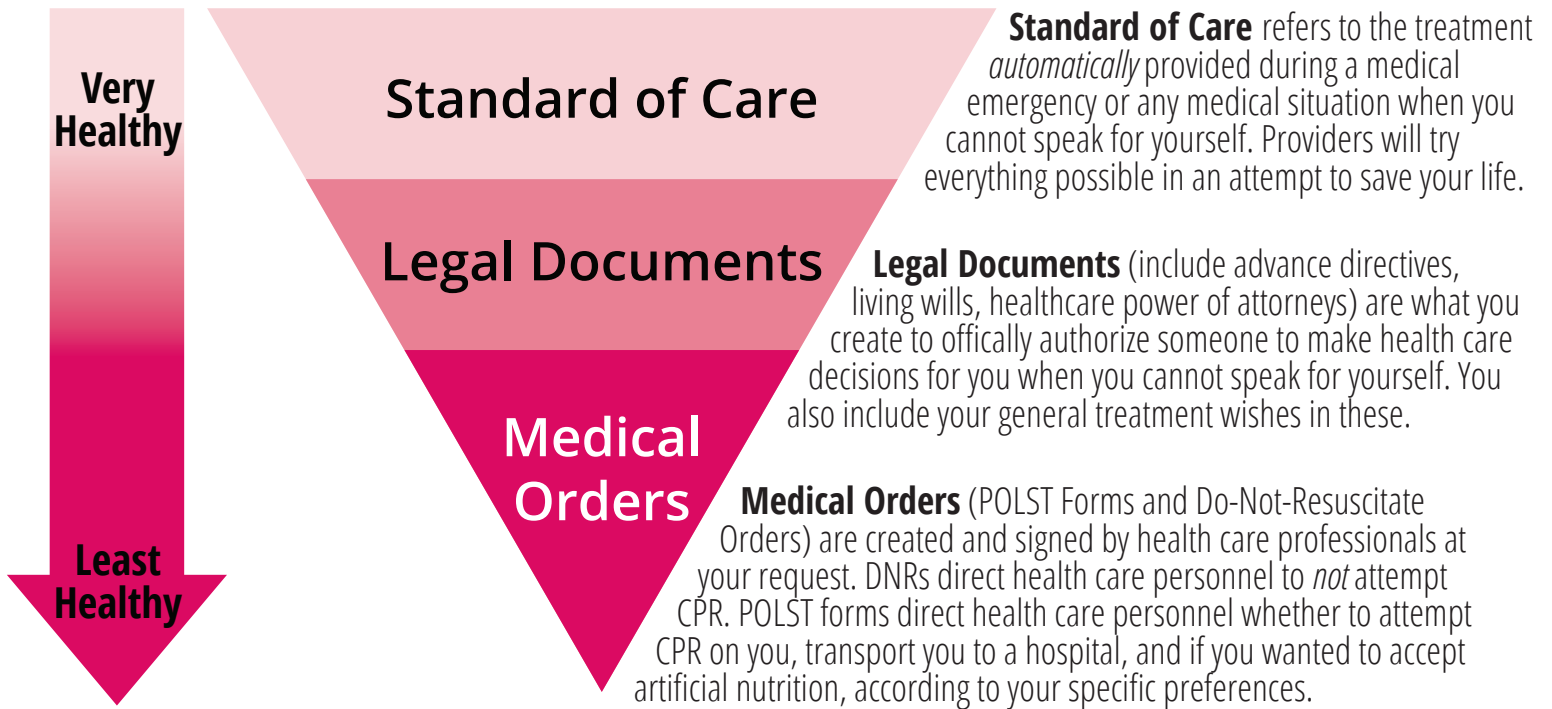


## Understanding Advance Care Planning

Advance care planning means taking steps to share your goals, values, beliefs and whatever most matters to you, so that if there is ever a time you cannot make health care decisions for yourself, others will know what you would have wanted.

Various options for advance care plans are designed to affirm your choices for medical treatments, prior to receiving those treatments, as part of patient-centered care:



## What happens under each Advance Care Planning option?

### Standard of Care (no advance care plans)

Patient-centered care includes honoring a person's choice not to do any advance care planning. However, choosing not to complete a legal document or medical order is still a choice about what treatment you may receive. A lack of advance care plans will result in your receiving the "standard of care," which is what is automatically provided to anyone in a similar situation. During a medical emergency, it means doing everything medically appropriate and possible to attempt to save your life. This can mean providing cardiopulmonary resuscitation (CPR) to attempt to bring you back to life, transporting you to the hospital, and possibly putting you in the intensive care unit (ICU) on a breathing machine.

If you can't communicate and the health care team needs to make decisions for you about medical treatments, they will look at the relevant state law (or, in states where there is no applicable law, facility policy) to determine who can help make those decisions for you.

### Legal Documents (also known as Advance Directives)

Legal documents are called different things in different states (e.g., living will, health care power of attorney) but, regardless of the term, these describe the legal document(s) you would use to:

1. Share what types of treatments you would want to receive or not receive in the case of a future, unknown medical emergency. Provide information about values, goals, etc.
2. Say who should make medical decisions for you if and when you are unable to speak for yourself.

Picking who speaks for you is the most important part of advance care planning: if nothing else, take time to think about who would best speak on your behalf if you couldn't communicate at all. Complete an advance directive to make sure everyone knows who this person is, called a "surrogate," "health care proxy" or "health care power of attorney" (it is called different things in different states). A legal document is the only way for you to officially designate a surrogate.

With an advance directive, during a medical emergency, the standard of care will be provided. Once you are at the hospital and stabilized, the health care team will look at the advance directive to see who your surrogate is and what guidance you have provided about your treatment wishes and values.

## Medical Orders (POLST Forms and DNR orders)

**A do-not-resuscitate, or DNR,** only orders emergency personnel to not attempt CPR if your heart has stopped beating and you are no longer breathing. Even with a DNR, if you were found to be breathing or with a pulse, you will be taken to the hospital for treatment. There, you will receive the standard of care—or your advance directive will be reviewed to guide further treatments.

**POLST forms** are more specific medical orders that state whether you want:

1. CPR attempted or not (unlike a DNR, a POLST can be used to confirm a person wants CPR);
2. Full, Selective, or only Comfort-Focused Treatments;
3. To go to the hospital or stay where you are during a medical emergency; and
4. Artificial nutrition (optional).

A POLST form is for you if you are seriously ill or frail and your health care provider wouldn't be surprised if you died within a year or two. (If you are healthy, there is no need to complete a POLST form to receive the standard of care.) If you are not yet appropriate for a POLST you can add the following to your advance directive: "In the event I am serious illness or advanced frailty, I request that my provider engage my surrogate and family in a conversation about POLST."

With a POLST form, the health care team should follow the POLST form orders, but, if there are questions and you cannot speak for yourself, they will look at your advance directive to see who your surrogate is and follow the guidance in the advance directive to make treatment decisions—so it is important to have an advance directive, as well as a POLST.

## More Information

| During an emergency...                      | Standard of Care | Legal Documents | POLST Forms  |
|---|------------------|-----------------|--|
| Will I receive CPR?                         | If needed, yes   | If needed, yes  | Only if your POLST says "Yes CPR"  |
| Will I be transferred to the hospital?      | Yes              | Yes             | If POLST orders Full or Selective Treatments, yes.<br>If POLST orders Comfort-Focused Treatments, you will only be transferred if you can't be made comfortable where you are. |
| Will I go to the Intensive Care Unit (ICU)? | If needed, yes   | If needed, yes  | If POLST orders Full Treatments, yes.<br>If POLST orders Selective or Comfort-Focused Treatments, no.  |

## Frequently Asked Questions / Other Resources

FAQs about POLST & Advance Directives at: <https://polst.org/advance-directives>

FAQs about POLST at: <https://polst.org/frequently-asked-questions-for-patients>

What Your POLST Form Means: <https://polst.org/patient-guide-after-pdf>