ADVANCE CARE PLANNING
FOR SERIOUS ILLNESS

Administration for Community Living

Making plans for the health care you want during a serious illness is often called "advance care planning." Planning involves learning about your illness, understanding choices for treatment and care, talking with family and health care providers, and completing written documentation of these choices. "Family" can be people related to us or those we choose to call family.

Communicate Your Wishes: Talk about health care decisions with your family and health care providers. Be clear about the type of care you want. Think about what you feel would make you comfortable during the last stages of your life.

Legal documents make your wishes clear to family members and health care providers. Your choices include written directions in legal documents and Physician Orders for Life-Sustaining Treatment (POLST), among others.

Written directions: There are two types of written legal documents, also called advance directives:

- *A living will* spells out your decisions for treatments and life-sustaining measures such as mechanical breathing (respiration and ventilation), tube feeding, or resuscitation.
- *A durable power of attorney* for health care names a health care proxy, who is the person who makes choices for you when you cannot. If you do not name a health care proxy, states generally have rules about how families can make care decisions for you.

Health care providers and insurance companies need your permission to share personal information with the health care proxy.

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POLST: You may ask your health care providers to discuss and complete a ***P**hysician **O**rders for **L**ife-**S**ustaining **T**reatment* or POLST form. This is an option for people with a serious illness that is likely to get worse over time or who are very frail and dependent on others.

- A POLST makes sure that decisions about care at the end of life are written as medical orders that health care providers must follow.
- The POLST should list the medical care people do or do not want, given their current health condition. It should include decisions for cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing.

Without a POLST, emergency care providers generally must provide such medical treatment to keep people alive. Not every state has POLST, and some states have similar forms that go by different names.

Remember: You may change your mind about care as you get older or if you become ill, so it is important to review your advance directives and POLST regularly. States' rules and regulations differ, so it is important to make sure your documents work in your home state and others where you spend a lot of time.

Resources

Advance Care Planning
National Institute on Aging at the National Institutes of Health
Basic information on this topic and helpful links
http://www.nia.nih.gov/health/publication/advance-care-planning

Give Peace of Mind: Advance Care Planning
Centers for Disease Control and Prevention
Provides basic information on this topic and helpful links
http://www.cdc.gov/aging/advancecareplanning

Caring Conversations, Making your Health Care Wishes Known
Center for Practical Bioethics
Designed to help young people, older people, Spanish speakers, and Veterans start conversations and document their choices
http://www.practicalbioethics.org/download-caring-conversations

Caring Connections
National Hospice and Palliative Care Organization
Links to every state's advance care directive forms
http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289

The National POLST Paradigm Task Force
Oregon Health & Science University
Shows which states have POLST and how to get more information about their forms
http://www.polst.org/programs-in-your-state