Advance Care Planning in the Elderly

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KEYWORDS

• Advance care planning • Advance directives • Surrogate decision maker
• Patient-doctor relationship • Communication

KEY POINTS

- Advance care planning (ACP) can help individuals and their loved ones receive medical care that is aligned with their values, and experience more satisfaction and peace of mind.
- ACP involves a process identifying personal values first, and then translating those values into medical care plans.
- ACP can be viewed as a health behavior that involves multiple steps and evolves as a process over time.
- Clinicians can assist older adults with ACP through assessing readiness, promoting identification and documentation of appropriate surrogate decision makers, engaging patients and surrogates in discussions, and helping patients document their medical wishes.
- Outpatient approaches to support ACP can be brief, multidisciplinary, and involve several visits over time.

INTRODUCTION

Advance care planning (ACP) allows individuals to specify in advance how they want to be treated should serious illness prevent them from being able to make decisions or communicate their choices. Just as tobacco cessation counseling could be considered a primary care provider's "procedure," engaging patients and their potential surrogate decision makers in ACP is a key skill in the care of the older adult. ACP involves multiple conversations that identify a surrogate decision maker, explore the individual's values about medical care, complete advance directive documents, and

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translate values into medical care plans. This article describes the need for ACP in the elderly and highlights several key concepts for clinicians to assist older adults with ACP. Practical approaches for integrating ACP into busy primary care practices are provided, while recognizing common barriers, and recently developed ACP tools for clinicians and the outpatient care team are highlighted.

WHAT IS ADVANCE CARE PLANNING?

ACP is the process of planning for future medical care with the goal of helping patients receive medical care that is aligned with their preferences, especially in the setting of serious illness or as the end of life approaches. **Table 1** provides common terms and definitions used in ACP. For example, one component of ACP is advance directives, which include medical power of attorney appointments or living wills; these written forms facilitate end-of-life decision making based on a patient's values. Fundamentally ACP involves more than completing an advance directive in isolation because ACP is based on an individual's evolving values regarding future medical care, not only their preference for particular medical procedures, such as cardiopulmonary

Table 1
Advance care planning terms and definitions

Advance Care Planning Terms	Description of Terms
Advance care planning (ACP)	Process of considering and communicating health care values and goals over time
Advance directive	Legal document describing preferences for future care and appointing a surrogate to make health care decisions in the event of incapacity
Medical durable power of attorney	Legal documents that appoints an "agent" to make future medical decisions. Becomes effective only when the patient becomes incapacitated
Surrogate decision maker or health care proxy	A decision maker that makes medical decisions when the patient becomes incapacitated and the individual did not previously identify a medical durable power of attorney. Most states use a hierarchy system to designate a health care proxy, whereas a few states appoint a proxy that is agreed on by all interested parties
Living will	Documents an individual's wishes prospectively regarding initiating, withholding, and withdrawing certain life-sustaining medical interventions. Effective when the patient becomes incapacitated and has certain medical conditions
Cardiopulmonary resuscitation (CPR) directive or do-not-resuscitate (DNR) order	Documents preferences to refuse unwanted resuscitation attempts
Orders for life-sustaining treatment (ie, Physicians Orders for Life-Sustaining Treatment [POLST] paradigm)	Order set that translates patient preferences for life-sustaining therapies into medical orders Primarily intended for seriously ill people with life-limiting or terminal illnesses and patients in long-term care facilities Portable and transferable between health care settings