

ADVANCE CARE PLANNING

FOR SERIOUS ILLNESS



Making plans for the health care you want during a serious illness is 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 about care choices, choosing someone to make choices if you cannot. “Family” can be people related to us or those we choose to call family.

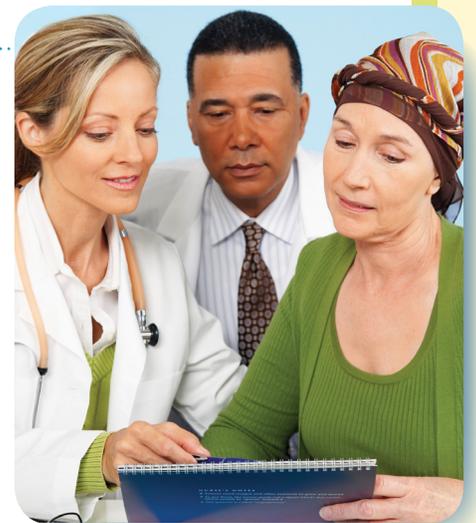
Communicate Your Wishes: Talk about health care decisions with your family and health care providers. Be clear about the type of care you want. Think about what you feel would make you comfortable during the last stages of your life.

Medicare covers voluntary planning discussions with your health care professional during the *Welcome to Medicare* preventive visit, your *Annual Wellness Visit*, and at other times when you need to have this discussion as part of your medical care. You may want to discuss planning documents, like a durable power of attorney for health care, or medical care decisions and their impact on your life.

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 **Physician Orders for Life-Sustaining Treatment** or POLST form (name may vary by state). This is an option for people with a serious illness that is likely to get worse over time or people with frailty—such as advanced heart or lung disease—whose health care professionals would not be surprised if they died within a year.

- 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 or 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 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

Shows which states have POLST and how to get more information about their forms
<http://www.polst.org/programs-in-your-state>