

Advanced Care Planning

A GUIDE FOR BEGINNERS

DEVELOPED BY PITT'S SCHOOL OF SOCIAL WORK HARTFORD FELLOWS



Image courtesy of Martha Rial

Advanced Care Planning (ACP) is the process of planning now for future medical care you may need, in case you become too sick to make your own decisions. This typically looks like having a conversation and putting your wishes into writing as part of an advance directive, that you can then share with your loved ones and medical team.

This guide will help you think about how to have conversations about ACP with your loved ones, and maybe even your own advanced care planning.

DEFINITIONS

Power of Attorney (POA) for Personal Care: A legal document naming someone to make personal and healthcare decisions on your behalf if you cannot

Goals of Care: The overall aims guiding medical treatment, based on a person's values such as prolonging life, maintaining comfort, or maximizing function



FIND MORE
DEFINITIONS HERE



WHAT TO CONSIDER

When starting this conversation, it is critical to keep in mind the Rapport, Explore, Listen, Adapt, Tailor, and Empower (RELATE) method. First, establish or maintain rapport with your loved one, allowing them to feel safe while you explore their circumstances*. It is recommended to start with current issues to address concerns in the near future**. Listen to their goals of care and adapt to their needs, values, and priorities.

Keep in mind that ACP is an individualized process, so you must tailor the next steps to their goals and wishes, and empower action moving forward*. Using a document or guide, such as the resources shared on the next page, can help move the conversation forward and alleviate the pressures of initiating it.

SUMMARY

- ACP helps reduce familial stress and helps loved ones feel confident that they know the best way to provide support during times of uncertainty.
- Conversations may feel difficult and may require multiple discussions, but using the talking points and resources on the next page can help you get started.



Image courtesy of Nate Smallwood

*(Candrian et al., 2019), **(Wichmann et al., 2018)

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TALKING POINTS

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WHAT MATTERS MOST TO YOU?

- What do you wish to prioritize as you age, both physically and mentally?
- Is staying independent most important?
- Does being comfortable take precedence?

WHO SHOULD SPEAK FOR YOU?

- If you are unable to advocate for yourself, who do you trust to do so?
- Does that person know what you want?
- Do you have a formal power of attorney?

IF YOU GOT REALLY SICK...

- Would you want doctors to do everything possible to keep you alive?
- Would you want to be resuscitated using CPR, even if it may cause physical strain?
- Would you want to be on a breathing machine?

WHERE DO YOU PREFER CARE?

- Would you rather be at home, in a hospital, in a Skilled Nursing Facility, or somewhere else?
- If you are towards the end of your lifespan, would you find comfort being somewhere familiar?
- What kind of supports do you have depending on location?

QUALITY VS LENGTH

- Is living longer most important?
- What would feel like a “good” day to you? What does that require?
- Is your quality of life different if you are unable to do things like eat, move, or speak?

HARD CONVOS W/ MEDICAL STAFF

- Do you want to be aware of all the medical details? Or would you rather not know everything?
- What are your hard boundaries?

RESOURCES

[Conversation Project: ACP Starter Guide](#)

[UPMC Template for PA Advanced Health Care Directive](#)

[Five Wishes](#)

[Stanford Letter Writing Project](#)

NEXT STEPS

- Familiarize yourself with ACP documents
- Consider when and where you'd like your conversation to take place
- Keep in mind our talking points when having the conversation, and accept that it may not happen in just one conversation
- Lead by example by thinking about your own Advanced Care wishes and consider completing your own Advance Care Directives alongside your loved ones.