

# Advance Care Planning Framework for Health Care Providers

**A**

Healthy adults  
> 19 years or older

## Begin ACP Conversations

Learn about **Substitute Decision Maker(s)**.

- Identify & understand **Temporary Substitute Decision Maker (TSDM)** list.
- Consider appointing a **Representative(s)**. Consider **Advance Directive(s)** for any enduring consent or refusal of particular treatment.

Consider **preferences for making medical decisions**.

Consider **organ donation**

**Document** any beliefs that impact healthcare treatments.

**Discuss** above with family, SDMs & health care providers.

**B**

Diagnosed with chronic or serious illnesses

## EVERYTHING IN A +

### Continue ACP Conversations

Review completed ACP documentation (values/wishes/beliefs, **Advance Directive, Representation Agreement**).

Review completed **Temporary Substitute Decisions Maker (TSDM)** list.

**Learn** about illnesses & possible future complications & treatment options with health care team.

**Review life & health care values, goals, wishes, priorities** in light of new health reality.

**C**

Identified as having 1-2 years prognosis

## EVERYTHING IN A & B +

### Initiate Serious Illness Conversation

Use **Serious Illness Conversation Guide**:

- Set up Conversation
- Assess illness understanding & preferences
- Share prognosis
- Explore key topics
- Close conversation
- Document on ACP Record
- Communicate with key clinicians

Incorporate complementary **Serious Illness Conversation Guide resources** for health care provider reference & to support conversation.

**D**

Ongoing decline or transfer of location of care

## EVERYTHING IN A, B & C +

### Continue ACP Conversations

**Review SICG** answers.

**Shared decision making** about future medical decisions.

**Goals of Care conversations** in context of current health issues.

**Medical Orders for Scope of Treatment (MOST)** form completed by physician or NP based on everything above.

**Document ALL** of the above on the ACP Record.

**Discuss** these choices with family and SDMs.

**E**

Final weeks/days

## EVERYTHING IN A, B, C & D +

### Continue ACP Conversations

**Ensure treatments are in alignment** with MOST & all previous ACP processes & documentation.

**F**

Review

Goal concordant care

Family satisfaction

Quality improvement



fraserhealth

Better health.  
Best in health care.