Health Home Program
Washington

CARE COORDINATOR ADVANCE CARE PLANNING (ACP) GUIDE SHEET

OVERVIEW

Determining our preferences for health care, medical emergencies, disability, and end of life care poses a challenge not only for ourselves but also for our clients, parents, caregivers, and family members.

Advance Care Planning (ACP) is a process in which an individual explores their goals, values, and beliefs and considers what health care they would want in their future, including wishes and preferences for care at the end of life. It involves choosing a health care agent who can communicate their wishes if they can no longer speak for themselves, and having conversations with their loved ones about their choices.

An Advance Directive (AD) is a legal document that includes two parts: a health care directive for documenting client treatment wishes and a durable power of attorney for health care used to name their selected health care agent (HCA).

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) are required to provide is the opportunity for clients to consider and discuss ACP. While CCs do not draft ADs for their clients they should assist clients and their families in accessing legal assistance if they wish to complete an AD. A discussion about ACP must be offered within the first year of the client's agreement to participate in the Health Home program. CCs are expected to simply begin the conversation to determine the client's interest in ACP. This offer of assistance and any actions taken should be documented in the client's case record.

ITS ABOUT THE CONVERSATION

CCs might consider opening the conversation in the following ways:

First, ask for permission:

- Introduce ACP as a statewide initiative. We are talking with our clients about the importance of ACP and ADs to help them and their families learn how to plan for future health care decisions. Would you mind if we talked a bit about this?

Second, consider these questions to assist the client in thinking about ACP:

- You may have received information about ACP. Tell me what you understand about this type of planning? *[The CC should confirm knowledge or provide clarification about ACP and ADs.]*
- Do you have any concerns about this planning? What experiences have you had with family or friends who have become seriously ill or injured? *[The CC should be prepared to listen for experiences that will help the client think about their personal goals and values regarding decision making. Promote dialogue by asking "what did you learn from that experience?" "What else did you learn?"]*

- Do you have questions about the role of an HCA? *[The CC should be prepared to review the qualities of an HCA including – does the HCA accept their role; does the HCA accept the client's goals, values, and preferences; does the HCA agree to follow their wishes even if they do not agree with them; and can the HCA make decisions in difficult moments?]*

SUMMARY OF THE THREE DECISIONS FOR ACP

Summarize the three decisions that need to be made as part of ACP:

- Who your health care decision maker or HCA should be;
- What cultural, religions, spiritual, or personal beliefs you have that might impact your decisions, and discuss these with your HCA and loved ones; and
- What health care would you like to receive if you have a sudden illness or injury?

NEXT STEPS

- Offer assistance with getting more information about ACP or connecting them to someone who could help them complete an AD.
- If the client is interested in incorporating ACP or the development of an AD in to their Health Action Plan ask the following questions:
  - Would they like to set a short term goal of pursuing an AD?
  - What action steps are necessary?
  - Who will complete them and by when?
  - Who else should be involved?
  - Who should be informed that they are pursuing an AD?
  - Who should receive copies of any documents created?

RESOURCES

Health Home Care Coordinators Toolkit website located at:

https://www.dshs.wa.gov/altsa/stakeholders/chronic-disease-and-education-materials