# FIVE WISHES®

## ADVANCE CARE PLANNING CHECK-UP FOR HEALTHCARE SYSTEMS

A solid advance care planning (ACP) program can help your system or practice improve clinical and organizational outcomes, and enhance the patient experience. *Five Wishes* resources include a unique, easy-to-follow advance directive document and conversation framework, training guidance, and several complementary resources that support compassionate, effective advance care planning programs that work for patients and providers.

As you work to develop or improve your ACP program or initiative, consider the following best practice ideas that can bring your organization or system up-to-speed.

### Program Support

- ☐ Designate a department or unit as the champion/owner of ACP programs, processes and procedures, and name an executive as sponsor of ACP initiatives
- ☐ Institute ACP Quality Improvement initiatives as per system processes
- ☐ Identify clinical/patient outcomes related to ACP conversations (pain scores, family meetings, advance directive completion rates, treatment alignment with documented preferences, etc.)
- ☐ Develop a system for tracking and reviewing ACP clinical/patient outcomes data
- ☐ Identify organizational/system outcomes related to ACP conversations (length of stay, readmissions, code frequency, ethics consults, patient experience scores, patient engagement, etc.)
- ☐ Establish a system for tracking and reviewing ACP organizational/system outcomes data

### Education and Training

- ☐ Implement system-wide educational initiatives for all employees on ACP (wellness initiatives, annual education updates)
- ☐ Provide formal conversation training for all professionals who engage in ACP conversations with patients and families
- ☐ Provide regular education updates for all professionals who engage in ACP conversations with patients and families
- ☐ Institute support mechanisms for all professionals who engage in ACP conversations with patients and families, including time for case discussions, best practice review, and resource identification

### Conversations and Documentation

- ☐ Ensure ACP conversations and advance directive decisions are documented in patient chart
- ☐ Initiate and revisit ACP conversations at key touchpoints in patient care such as:
  - annual wellness visits, pre-surgery intake, admission to hospital, hospice, palliative care, home health, or other programs
  - changes in care setting or level of care
  - whenever there are major changes in a patient's social support network, medical condition, or life expectancy

## Advance Directives in the Patient Record

- ☐ Name a decision-maker capable of executing the duties of a health care agent
- ☐ Indicate clear, non-contradictory, unambiguous end-of-life treatment choices and preferences covering different end-of-life situations
- ☐ Reflect decisions based on the patient's values and experiences, desires, fears and concerns
- ☐ Are informed by accurate information about the patient's current condition and likely complications
- ☐ Are shared with the patient's healthcare providers and family
- ☐ Meet current care-setting needs and are readily available
- ☐ Are up-to-date and appropriate for current health condition, social support situation, and circumstances

**For more information about how your health organization can use *Five Wishes* resources and services to improve your advance care planning program, contact Aging with Dignity.**

## Forms and Materials

- ☐ Provide advance directive forms that are clear, understandable, and easy to complete for patients and families
- ☐ Ensure advance directive forms support and guide advance care planning conversations
- ☐ Provide advance care planning resources and materials for patients that encourage discussions about values, dignity, and goals as well as treatment choices
- ☐ Make available informational materials about advance care planning for patients at various touchpoints in their care
- ☐ Provide advance directive forms and supporting materials for patients and families that are available in a variety of languages