<table>
<thead>
<tr>
<th>Characteristics of Stage</th>
<th>Pre-Contemplation</th>
<th>Contemplation</th>
<th>Preparation &amp; Values Clarification</th>
<th>Action</th>
<th>Maintenance &amp; Reflection</th>
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<tbody>
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<td>Individual lacks awareness of or has no desire to engage in advance care planning</td>
<td>Individual understands the relevance of ACP to own life and begins to form intentions to engage in advance care planning</td>
<td>Transitory stage that links contemplation to the action stages but can also link many of the action phases to one another</td>
<td>Individual overtly engages in behaviors that makes own ACP wishes known</td>
<td>Individual has made end-of-life choices and is in a position to reflect on these choices given changes in life circumstances</td>
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### Common themes, phrases

- may be uninformed or misinformed about the issues
- may have painful personal experiences that cause them to avoid the discussion
- may have cultural, religious, or spiritual values and beliefs that preclude discussion
- may be ambivalent about engaging in advance care planning
- may be aware of both the pros and cons of advance care planning but may have barriers to action that need to be explored
- has not taken concrete steps toward advance care planning but is willing to do so
- "I have not participated in any sessions to plan for future medical care but I would like to do so"
- has considered values, knows what he/she wants (or has a good idea), may have talked with others, but needs to document wishes or communicate wishes with others
- has completed an ACP, may or may not remember what was documented
- may have concerns about permanence of document

### Goals for stage

<p>| Goal: The person will begin to think about participating in ACP to the extent his/her culture allows, begin to ask questions, and/or identify a surrogate decision maker. | Goal: The person will begin to examine the various aspects of and receive assistance with advance care planning. | Goal: The person will engage in ACP discussions with a facilitator, loved ones, chosen surrogate, physician or other healthcare provider, and others as appropriate. | Goal: The person will complete a plan that meets individual goals for documentation, values, beliefs. | Goal: The person will feel comfortable with the advance care plan. The person's advance care plan will be clear, communicated with all appropriate parties, and reviewed/updated as needed. |</p>
<table>
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<th>Phrases to encourage progress</th>
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|                               | • "Have you or anyone you know been involved with making healthcare decisions for another? If so, what happened and what did you learn?" | • Explore concerns and fears to help resolve ambivalence  
• Clarify misconceptions that may arise (e.g. role of a surrogate/DPOA)  
• Explain that patients can and do change their minds about their wishes as their health status changes  
• Start to clarify GOC to the degree pt will discuss | • "What do you know about advance care planning?"  
• "How can I best help you participate in advance care planning?"  
• "What information do you need before you participate in advance care planning?"  
• "If, at some point, you are unable to speak for yourself, who should speak for you about healthcare decisions? Does this person understand this responsibility and know what you would want done?"  
• "What assistance do you need to complete ACP documentation or talking to your loved ones (or physician)?"  
• "I'd like you to know more about the potential choices you may be asked to make, and what the benefits and burdens of those choices might be for you."
• "We may need to write down some ideas of the kinds of things to say to your loved ones."
|                               | • "Would you like to review your plan to see if it reflects your current wishes clearly?"  
• If your health condition changes, it may be important for you to learn more about the different healthcare options."  
• "Do you remember who you listed as your surrogate decision maker (DPOA)? Is this still the best person to speak for you?"
| Potential support tools       | • pamphlets on ACP (definition, rationale)  
• websites  
• DPOA paperwork (if ready to complete) | • pamphlets on ACP (definition, rationale)  
• websites  
• support/peer groups, other providers | • specific planning tools (5 Wishes, Advance Directive Form)  
• follow-up meeting to encourage action | • specific planning tools (5 Wishes, Advance Directive Form)  
• tips for discussions with surrogates  
• follow-up meeting to review & document | • specific planning tools (5 Wishes, Advance Directive Form)  
• tips for discussions with surrogates |

