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Guide to Advance Care Planning Discussions

Developed by Residents for Residents

What is advance care planning?

Advance care planning (ACP) is a process in which a person reflects on and communicates their values, beliefs, goals, and preferences to best prepare for their future medical care. The designation of a substitute decision maker (SDM) is a key element of ACP.[1]

Why is ACP important?

Up to 76 per cent of patients will be unable to participate in some or all of the decisions affecting their own health care at the end of life,[2] and 47 per cent of Canadians have not had a discussion with a family member or friend about what they would want or not want if they were ill and unable to communicate.[3] Without the direction provided by ACP, families often feel burdened by directing medical care in crisis situations, and may feel ill-prepared to make decisions due to a lack of understanding of the patient's values and preferences. When no prior direction has been documented, physicians often resort to using full resuscitative and medical care. This can mean aggressive treatments that the patient might not have wanted, and may result in unnecessary suffering for both the patient and their family.

Previous research has highlighted numerous benefits of ACP, including:

- Improved quality of end-of-life care[4]
- Improved patient and family satisfaction with end-of-life care[5]
- Reduced stress and anxiety for families[5]
- Reduced hospital admissions and length of stay[6]
- Increased use of hospice care[6]
- Shorter intensive care unit stays[7]

How to perform ACP:

1. Triage the discussion according to the patient's health status (Table 1)
2. Check for and review previous ACP conversations
3. Plan for a serious discussion in an appropriate setting (for well patients, this discussion may take only a minute or two; for patients with more serious conditions, this conversation will take some time)
4. Encourage the patient's SDM to be present for ACP discussions
5. Have an ACP discussion using the Introduce, Discuss, Decide, Document (ID3) Framework (Table 2)
6. Revisit the ACP discussion over multiple visits/discussions as appropriate given the patient's health status

Table 1: When to have an ACP discussion with your patient

Health Status	Acuity	Actions
Well patient	Non-urgent	» Have a full ACP conversation during each periodic health exam and when triggered by important life events (e.g., marriage, pregnancy, new job) » Emphasize choosing an SDM
Patient with chronic disease	Semi-urgent	» Have a full ACP conversation during each periodic health exam and when triggered by medical events (e.g., new diagnosis, discharge from hospital) » In the patient with chronic disease, discuss the disease course and potential health outcomes as the disease progresses and at decision points that may arise in the future » Revisit at regular intervals as appropriate
Patient with acute deterioration in health	Urgent; decision needed now	» Revisit the ACP conversation with the patient/SDM, or initiate the discussion if this has not already been done » Code status and/or goals of care must be discussed with the patient or SDM at this stage » Physician may recommend best treatment based on the patient's goals, fears, values, and their specific illness context » Emphasize immediate or anticipated health care decisions

ID3 Framework for ACP discussions

The ID3 Framework (Table 2) provides an approach for clinicians to conduct ACP discussions. It may not be possible or appropriate to complete the full ID3 process during a single discussion. In between appointments, encourage the patient to review patient resources from Speak Up (available at **www.advancecareplanning.ca**), and to discuss their values with their family and SDM.

Table 2: ID3 for ACP discussions – Introduce, Discuss, Decide, Document

Introduce 	» Introduce: "Can we talk about where things are with your health, and where things might be going?"* » Seek permission: "Is this okay?"* » Inform: What is ACP and why is it important? Describe the process. Explain that the patient's decisions can be revised as their health/life situation changes. » After introducing the idea of ACP, it may be appropriate for the patient to return for a dedicated appointment to continue the rest of the process.			
Discuss 	**Understanding**	**Goals**	**Fears**	**Trade-offs**
	"How much do you (and/or your family) know about your illness?" "What information would you like from me?"*	"What are the most important things you want to do in life?" "What are some abilities in life you can't do without?"*	"What are your biggest fears and worries about your health? About life in general?"*	"If you get sicker, what kinds of health care services are you willing to endure to gain more time?"*
Decide 	» Decide on an SDM: "If you are unable to speak for yourself about medical decisions, who do you want to speak for you?"* » Decide on patient-centred principles of care that are based on, and comply with, the values that the patient has identified as being most important in their life. » This component of the ACP discussion may require multiple discussions, if there is no medical indication for an urgent decision.			
Document 	» Document the designation of the SDM. The patient should ensure that their SDM is aware of their role and informed of the patient's priorities and wishes. » Document any principles of care decisions that have been made. » Ensure that documentation complies with relevant provincial/territorial/regional regulations regarding the documentation of designated SDMs and decisions specifying principles of care.			

*Indicates text that has been adapted from the *Serious Illness Conversation Guide*,[8] licensed under the Creative Commons Attribution Non-Commercial-ShareAlike 4.0 International License, **http://creativecommons.org/licenses/by-nc-sa/4.0/**.

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