Advance Care Planning (ACP) Guide to ACP Conversations

ACP conversations:
• Prepare patients for future health care decisions by exploring their values, beliefs, goals, and preferences
• Help patients decide on a surrogate decision maker (SDM) and engage the SDM in the ACP process
• Are for everyone, not just the seriously ill
• Do not require decisions be made after just one discussion
• Are not just about resuscitation orders

Triage ACP conversations according to life situation:

<table>
<thead>
<tr>
<th>Well patient</th>
<th>Full, focused ACP discussion triggered by life events (e.g., marriage, pregnancy, new job); emphasize choosing an SDM</th>
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</thead>
<tbody>
<tr>
<td>Patient with chronic disease</td>
<td>Full ACP discussion at regular intervals and following medical events (e.g., new diagnosis, discharge from hospital)</td>
</tr>
<tr>
<td>Patient with acute ↓ in health</td>
<td>Revisit the ACP discussion with the patient or SDM emphasizing immediate or anticipated health care decisions</td>
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Remember:
• Check for and review previous ACP conversations
• Follow up over time to better understand patient’s context and monitor changes in patient’s health status and decisions

Compiled and prepared by the CFPC Section of Residents (2017)
Key references and resources:
http://www.cfpc.ca/sectionofresidents_training_guides/
### The ID3 Framework for ACP Conversations: Introduce, Discuss, Decide, Document

#### 1. Introduce:
- Seek permission: “Can we talk about where things are with your health and where things might be going?”*
- Explain ACP’s rationale and that the patient’s decisions can be revised as their health/life situation changes.

#### 2. Discuss:

| Understanding: “How much do you (and/or your family) know about your illness? What information would you like from me?”* | Goals: “What are the most important things you want to do in life?”
| | “What are some abilities in life you can’t do without?”* |
| Fears: “What are your biggest fears and worries about your health? About life in general?”* | Trade-offs: “If you get sicker, what health care services are you willing to endure to gain more time?”* |

#### 3. Decide:
Decide on an SDM and on patient-centred principles of care. Reaching a decision may require multiple visits, depending on urgency.

#### 4. Document:
Document the discussion and encourage your patient to record their wishes (i.e., SDM, values) in a formal document. Complete province-specific ACP documents.

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