Advance Care Planning in Canada

Resource Guide for Home and Community Care Providers

Canadian Home Care Association | Association canadienne de soins et services à domicile

Canadian Hospice Palliative Care Association
Association canadienne de soins palliatifs

Speak Up · Parlons-en

Advance Care Planning is a lifelong process of thinking and talking about the kind of health and/or personal care an individual would want if they could not speak for themselves.

The process should include the people they have chosen to speak for them—their Substitute Decision Maker(s)—and may also include healthcare providers, lawyers and/or other professionals helping them with their life and care planning. During the conversations that are part of Advance Care Planning, they share their values, beliefs and wishes, and make sure the people they've chosen to speak for them understand what matters most to them.

(Advance Care Planning in Canada: A Pan-Canadian Framework)

Contents

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The views expressed herein do not necessarily represent the views of Health Canada.

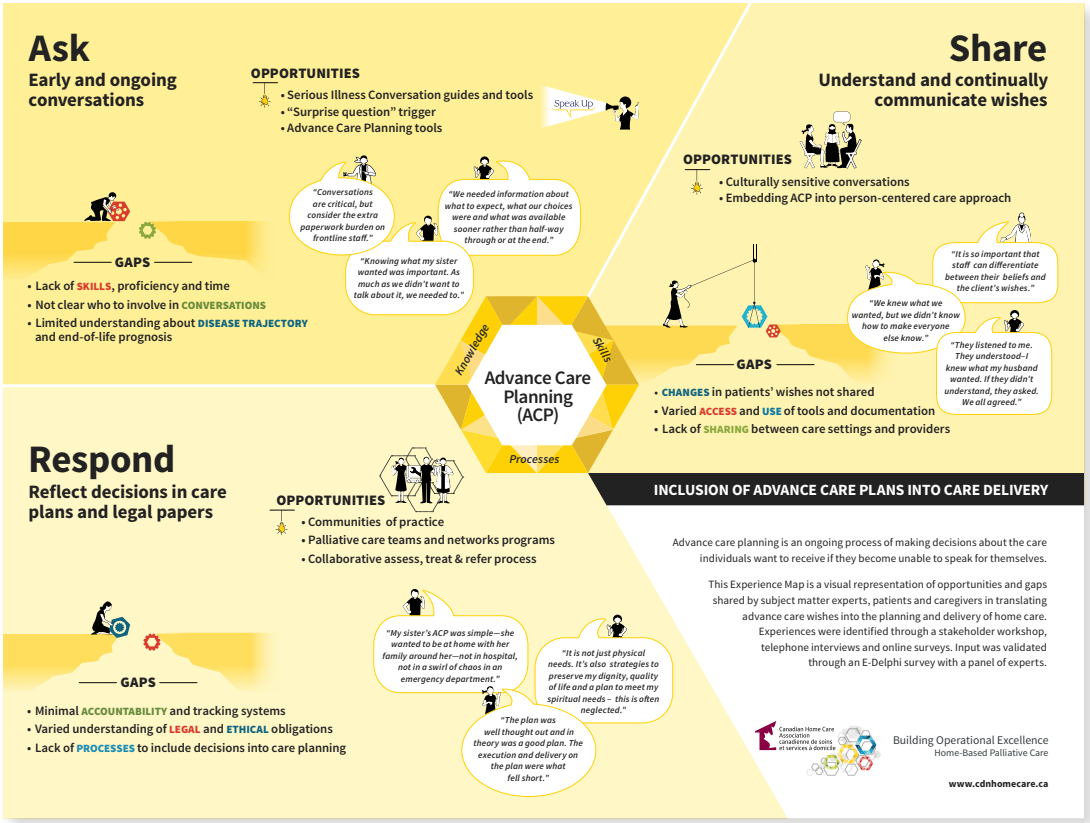
About the resource guide

What is this resource guide?

Advance care planning helps individuals prepare for situations where difficult decisions need to be made. Without having conversations or access to information about a person's values and wishes, it's unclear how to proceed in a way that is appropriate for that person. This resource guide provides a map of available resources to engage home and community care providers in three target behaviours for successful advance care planning:

1. **Facilitating early and ongoing advance care planning conversations**
2. **Understanding patients' care wishes**
3. **Reflecting wishes in the care plan and legal considerations**

Subject matter experts, patients and caregivers have identified these target behaviours through the two-year funded Health Canada project, "Building Operational Excellence in Home-Based Palliative Care," led by the Canadian Home Care Association. The palliative care experience map, on the right, highlights opportunities and gaps in integrating advance care wishes into the planning and delivery of home care.



Operational Excellence in Home-Based Palliative Care—Mapping the Palliative Care Experience

Who is this resource guide for?

This resource guide outlines current resources that can be used, customized and/or adapted to build the necessary knowledge, processes and motivation for your regulated and unregulated care providers to engage in Advance Care Planning. It is designed for a variety of stakeholders involved in home- and community-based palliative care, specifically:

- **policy planners**
- **program developers**
- **educators**
- **team leaders**

Advance Care Planning initiatives are more sustainable when jurisdictions share knowledge and resources. While the resources have been carefully curated, this guide is not intended to be an exhaustive listing of all Advance Care Planning resources and tools. The resources and tools have been drawn from interviews with subject matter experts and relevant web searches of open resources across Canada.

> The laws, structures and protocols around Advance Care Planning vary from jurisdiction to jurisdiction. As such, it is important to understand the laws and protocols in your province/territory, as well as policies and guidelines of the respective organizations and regulatory professional bodies.

How can you use this resource guide?

We have identified and organized the resources and tools in this guide to support the three domains described in the Behaviour Change Model (COM-B Model) of Mitchie and colleagues. The three domains that must be met for any behaviours (B) to occur are Capability (C), Opportunity (O) and Motivation (M). Each domain of the COM-B model can be broken down into further components:

- **CAPABILITY** includes the knowledge, skills and abilities required to perform the target behaviour. In this domain, you will find resources to build frontline providers' psychological capacity (e.g., comprehension, reasoning) and physical abilities (e.g., skills) in fundamental areas of Advance Care Planning.
- **OPPORTUNITY** includes the processes, resources and culture that make the execution of the target behaviour possible. In this domain, you will find resources to build external factors that will enable your frontline team to incorporate Advance Care Planning into everyday clinical practices.
- **MOTIVATION** includes the role identification, confidence and reinforcement that make an individual want do the target behaviour. In this domain, you will find resources that address two types of motivation that promote frontline providers' engagement in Advance Care Planning: reflective processes (e.g., beliefs about the consequences and professional identity) and automatic processes (e.g., emotions and desires).

User-friendly icons denote various resources:

 **Workbooks/Forms**

 **Videos**

 **Guides**

 **Web content**

 **E-learning/Training**

How can you apply the COM-B Model of Behavioural Change?

The COM-B Model outlines how behaviour (B) results from an interaction among Capability (C) to perform the behaviour, as well as Opportunity (O) and Motivation (M) to carry out the behaviour. Interventions must target one or more of these domains in order to result in sustainable behaviour change. Consider these behavioural diagnoses: Which of capability, opportunity or motivation are most relevant for your healthcare providers to reach the target behaviour change? Which of these might present major obstacles?

Source: Michie, Atkins & West (2014). The Behaviour Change Wheel: A Guide to Designing Interventions

Domain 1: CAPABILITY

HEALTHCARE PROVIDERS

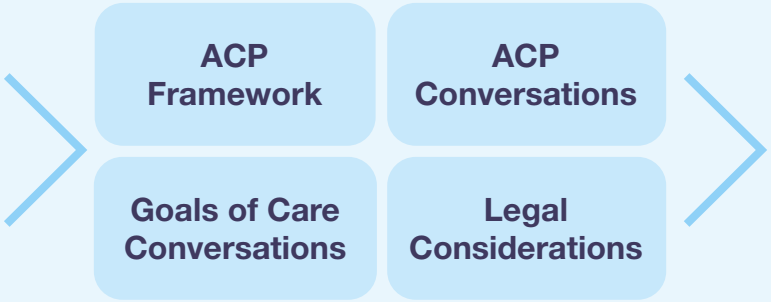
Knowledge · Skills · Abilities

In this domain, you will find resources to build frontline providers' psychological capacity (e.g., comprehension, reasoning) and physical abilities (e.g., skills) in fundamental areas of Advance Care Planning (ACP).

CAPABILITIES

- Do frontline providers understand ACP?
- Can providers facilitate conversations in ACP?
- Do providers understand the legal requirements?

RESOURCES



BEHAVIOUR CHANGES

1. Providers facilitate early and ongoing advance care planning conversations
2. Providers understand patients' care wishes
3. Providers ensure patients' wishes are reflected in the care plan and legal considerations

ACP Framework

Understanding core topics and foundational steps in ACP for healthy individuals and those with serious illness.

Speak up Advance Care Planning – Five Steps *(National)*

A short, light-hearted animated video defining advance care planning and the five steps for making a plan: Think, Learn, Decide, Talk, Learn, Record. The video is also available in a number of other languages on the ACP YouTube Channel: French, Chinese, Italian, French, German, Punjabi, Spanish, Portuguese, Tagalog and Korean.

Alberta Health Services E-learning module on Advance Care Planning Goals of Care Designations for Adults and Pediatrics *(Alberta)*

E-learning modules on the Advance Care Planning (ACP) and Goals of Care policy for AHS employees, contracted service providers and volunteers to standardize the process for determining Goals of Care Designations (GCD). Three modules feature case studies and pop quizzes. The models cover basic content (steps in ACP, GoC conversations), Goals of Care content (i.e., approaches, designations and applications) and Designation Process (i.e., writing a GCD Order, documenting ACP conversations on the health record, use of language and source for decision support).

Fraser Health Advance Care Planning Framework for Health Care Providers *(British Columbia)*

One-page overview of the overarching process of ACP, what to do and when. It outlines conversation topics and a progression for planning, starting with healthy adults (>19 years or older) to individuals in their final weeks.

Fraser Health Advance Care Planning *(British Columbia)*

A short video of Fraser Health's Advance Care Planning Team illustrating what Advance Care Planning is all about by sharing what gives their life meaning and/or what they do for fun.

> To build confidence and emotional comfort, engage in the Advance Care Planning process yourself.

Speak Up · Parlons-en

The Speak Up Campaign is part of a larger initiative – Advance Care Planning in Canada. Check out the Frequently Asked Questions page for an overview of ACP, such as:

What is ACP?

Who should I talk to about my wishes?

What if I change my mind?

When does this planning come into effect?

What is a substitute Decision Maker?

Fraser Health Advance Care Planning Online Module *(British Columbia)*

An independent, self-paced course for a basic introduction to Advance Care Planning: what it is; why it is important; when it should start; and who should be involved in the discussions. It is recommended for all healthcare professionals. The course consists of slides and interactive activities and take about 30 minutes to complete.

BC Centre for Palliative Care Serious Illness Conversation (SIC) Training Program for Clinicians *(British Columbia)*

Three-levels of training program on (1) using the SIC Guide in clinical practice, (2) becoming a certified facilitator for SIC workshops and (3) becoming a master trainer to train facilitators of SIC workshops. With each level of training completed, participants receive access to materials that will support them as a trained clinician, certified facilitator or master trainer.

BC Centre for Palliative Care Advance Care Planning Event *(British Columbia)*

Training and coaching to help community-based organizations host and facilitate group conversation events around ACP. My wishes, My Care Toolkits are available to community organizations upon completion of training by the BC Centre for Palliative Care.

The BC Government My Voice Expressing My Wishes for Future Health Care Treatment–Advance Care Planning Guide *(British Columbia)*

The BC government's advance care planning guide provides information to learn about advance care planning and how to make your own advance care plan that will serve as your voice in the future.

Speak Up Ontario Person-Centred Decision-Making E-Learning Modules (2020) *(Ontario)*

Five self-directed online modules intended for Clinician Competency Training on Health Care Consent, Advance Care Planning, and Goals of Care Conversations. Learners will develop clinical skills through interactive case scenarios, reflective questions and videos of both simulated and real clinical encounters.

> Approach education for healthcare providers as an interprofessional initiative. This can be a tool for enhancing team collaboration as all members of the care team may be involved in facilitating ACP conversations at different stages.

What's the difference between Advance Care Planning and Serious Illness Conversations?

Advance Care Planning

A lifelong process of thinking and talking about the kind of health and/or personal care an individual would want if they could not speak for themselves.

Serious Illness Care Conversation

Sharing prognosis and eliciting a person's priorities in the context of a serious illness, initiated and led by the healthcare provider.

ACP Conversations

Building a step-by-step approach and skills in facilitating conversations appropriate to the patient's context.

Speak Up **My Speak Up Plan** *(National)*

Online interactive workbook designed to guide individuals through the five steps of Advance Care Planning: "Think" about value and wishes, "Learn" about different medical procedures, "Choose" a substitute decision maker, "Talk" with your substitute decision maker about your wishes and values and "Record" to make sure your wishes are well documented.

Virtual Hospice **Coming Full Circle Planning for Your Care** *(First Nations)*

A booklet developed by Indigenous Peoples to ensure their choices for future healthcare are heard and respected. It helps First Nations, Inuit and Métis in planning for and having discussions about their care should they become seriously ill or unable to speak for themselves. The booklet includes questions to help people reflect on their values, beliefs and wishes for future healthcare, consideration for identifying a substitute decision maker, conversation starters and quotes from Elders and Knowledge Carriers.

Alberta Health **Serious Illness Conversation Guide** *(Alberta)*

A guide outlining conversation flow tips and patient-tested language to create a safe, therapeutic space for clinicians to engage in patient-centred serious illness conversations. It outlines the steps to elicit important information from patients about their goals and values: setting up the conversation, assessing the patient's illness understanding and information preferences, sharing prognosis, exploring key topics, and closing and documenting the conversation. The guide is a from Ariadne Labs: A Joint Center for Health Systems Innovation and supported by the Serious Illness Care Program: Reference Guide for Clinicians.

Alberta Health Services **Conversation Matters** *(Alberta)*

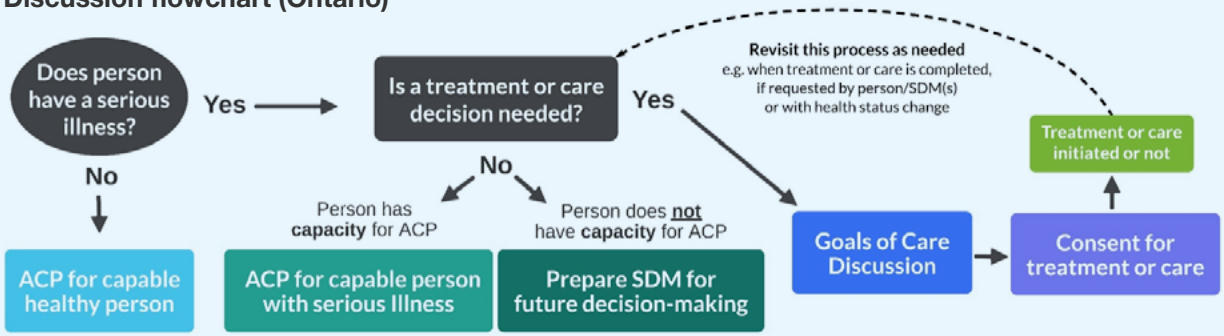
Interactive guidebook designed for the public to learn about Advance Care Planning in Alberta. Prompted questions are available throughout the workbook to foster conversations, in addition to ACP checklists and information about Alberta's Goals of Care Designation orders.

The "surprise question" helps clinicians identify patients who may benefit from palliative care services or serious illness conversations.

"Would I be surprised if my patient died in the next twelve months?"

A serious illness conversation can benefit patients for whom the response is, "No, I would not be surprised."

Discussion flowchart (Ontario)



BC Centre for Palliative Care **Serious Illness Care Program–Reference Guide for Interprofessional Clinicians** *(British Columbia)*

A structured guide helps support conversations with patients, triggers clinicians to have conversations, prepares patients and families using a standardized letter, and documents outcomes in a structured format in the electronic medical record (or green sleeve) for easy access across settings.

Fraser Health **My Advance Care Plan. My Voice in Action: A Supportive Workbook to My Voice** *(British Columbia)*

An interactive workbook that accompanies the My Voice Guide. It is a supportive, fill-in-the-blank booklet to guide adults through the reflective process of advance care planning. It acts as a record for initial ACP thoughts and encourages further education/conversation and regular revisions.

Fraser Health **Serious Illness Conversation Guide – A Conversation Tool for Clinicians** *(British Columbia)*

A one-page guide to support and facilitate conversations between clinicians, serious ill adults and their families. It includes conversation flow tips and patient-tested language.

Fraser Health **Serious Illness Care Program Reference Guide for Clinicians** *(British Columbia)*

Strategies for common conversation scenarios that can be challenging for clinicians. It offers key ideas, principles and practices for successful discussions about serious illness care in outpatient, non-emergent settings.

Cancer Care Manitoba **Serious Illness Conversation Guide** *(Manitoba)*

A practical tool outlining a clinical step-by-step approach and conversation guide to having successful serious illness conversations.

Dr. N. Incardona and Dr. J. Myers **Advance Care Planning Conversation Guide Clinician Primer (2018)** *(Ontario)*

A 16-page primer helps clinicians prepare for Advance Care Planning conversations with patients and Substitute Decision-Maker(s). It provides information on consent, capacity and decision-making, how to determine who the automatic SDM(s) are for a patient and how to prepare SDM(s) for decision-making about healthcare in the future. It also includes a chapter on assessing the patient's readiness for ACP conversations.

Speak Up Ontario **Which discussion do I have?** *(Ontario)*

A flowchart to direct clinicians to the right conversation that supports person-centred decision-making. It helps providers understand the conversations most appropriate to the patient's context.

Saskatchewan Health Authority **My Voice (2019)** *(Saskatchewan)*

A workbook for completing an Advance Care Plan that includes these sections: "Think" about what makes life meaningful to you, " Talk" about possible medical options, and "Act" by discussing your choices and wishes with those closest to you and choose an individual (proxy) to speak for you.

Goals of Care Conversations

Linking ACP to goals of care and decision-making in the context of clinical progressions/crisis/poor prognosis.

Goals of care conversations involve putting prior ACP conversations about wishes into the current clinical context, resulting in medical orders for the use or non-use of life-sustaining treatments.

Speak Up Just Ask: A Conversation Guide for Goals of Care Discussions *(National)*

This 16-page guide provides a framework with "scripts" to help providers engage patients and/or their Substitute Decision Makers (in the case of an incapacitated patient) in goals of care (GOC) conversations that lead to medical orders for the use or non-use of life-sustaining treatments.

Alberta Health Goal of Care Designation Order *(Alberta)*

Goal of Care Designation (GCD) is the medical order in Alberta that can only be completed by physicians and nurse practitioners; home care staff need to know how to act based on the GCD order. The second page includes a Goals of Care Designations Guide for Clinicians.

Alberta Health Serious Illness Care Program Reference Guide for Clinicians *(Alberta)*

A companion to the Serious Illness Conversation Guide that provides practical tips for clinicians in conducting successful serious illness conversations and is adapted to relate these to Alberta's Goals of Care Designations.

Alberta Health Services Provincial Clinical Knowledge Topic Advance Care Planning and Goals of Care Designations, All Ages All Locations *(Alberta)*

An extensive "clinical knowledge topic" document to help providers interpret the province's Goals of Care Designations.

Fraser Health Medical Orders for Scope of Treatment (MOST) Online Modules *(British Columbia)*

An e-learning course for physicians and clinicians working with adults with chronic and advanced medical illness. It is designed to help them become familiar with the MOST form, recognize changes to policy, identify correct completion steps for each section of the MOST form, distinguish between different MOST designations and identify ways in which the MOST form integrates with Advance Care Planning.

Fraser Health **Serious Illness and Goals of Care Conversations** *(British Columbia)*

A two-hour interactive virtual learning for healthcare providers working with and supporting patients with a life expectancy of one to two years. It provides a forum to practice having conversations and focuses on the importance of documenting in the ACP Record.

Ontario Palliative Care Network **Person-Centred Decision-Making Resource for Healthcare Providers** *(Ontario)*

A user-friendly overview for healthcare providers, this resource explores how treatment decisions should align with a patient's wishes, values and beliefs for their care. It includes information about the continuum of Advance Care Planning conversations, Goals of Care conversations, and Treatment Decisions and Informed Consent within a person-centred decision-making framework.

Sinai Health System **Improving your Goals of Care Conversations** *(Ontario)*

A self-paced e-learning module guiding learners through the steps of Goals of Care conversations. Learners work through three case scenarios to help them begin implementing the skills learned when carrying out goals of care conversations with patients.

Speak Up Ontario **Person-Centred Decision-Making Documenting Goals of Care Discussions** *(Ontario)*

A documentation form for Goals of Care discussions, this form has also been designed as a tool to help clinicians through each step of Goals of Care discussions. It includes information on: how to prepare yourself, explore your patients' illness of understanding, give information if necessary, ask about values and goals, and recommend a plan that meets those goals.

Dr. J. Myers and Dr. N. Incardona **Advance Care Planning Conversations and Goals of Care Discussions: Understanding the Difference (2017)** *(Ontario)*

A PowerPoint presentation featuring the components of person-centred decision-making, case studies on when ACP and GOC discussions occur, and an overview of most important encounters and practical realities.

Speak Up Ontario **Goals of Care and Code Status discussions in the Emergency Department** *(Ontario)*

A reference guide outlining the steps to having a Goals of Care discussion when cardiopulmonary resuscitation (CPR) is in progress poor outcome is anticipated, or patients are at risk of deteriorating within 24 to 48 hours or requiring admission to hospital.

> "My sister's advance care plan was simple—she wanted to be at home with her family around her. That was it. Not in hospital, not in a swirl of chaos in an emergency department. What was equally important to her was living comfortably and leaving a legacy of memories, so we worked with her team to make it happen that way."
>
> —SISTER/CAREGIVER

Legal Considerations

Understanding the legal perspectives and requirements in ACP processes.

Speak Up Canada **Resources and Tools** *(National)*

An interactive website outlining legal requirements regarding the appointment of a Substitute Decision Maker, which vary across the country. The Speak Up Canada's directory provides resources and tools to access legal resources for every province and territory.

Speak Up Canada **How to Decide on a Substitute Decision Maker** *(National)*

A short animated video (1:27) exploring what a substitute decision maker is and how to decide on a substitute decision maker.

Speak Up Canada **Living Well, Planning Well: An Advance Care Planning Resource for Accessing Your Rights** *(National)*

A resource document providing information about the legal norms and requirements for advance care planning and designating SDMs. It also has information about the legislation in each of the provinces and territories, including where to get more information within each jurisdiction.

Government of Alberta **Understanding Personal Directives** *(Alberta)*

A 24-page booklet providing in-depth information about what a personal directive is, how to write a personal directive, areas of decision-making authority and how to choose an agent/representative.

> When individuals have to rely on others to speak for them, they must be confident that their Substitute Decision Makers have a good understanding of their role and are well prepared to make decisions that reflect their values and wishes.

Every province and territory in Canada has laws to help protect the processes of healthcare consent, capacity and substitute decision-making.

Office of the Public Guardian **Guide to Capacity Assessment under the Personal Directives Act** *(Alberta)*

In-depth information on the process and documents required to activate a Personal Directive and give legal decision-making authority to the agent listed. This guide helps clinicians understand the process and their role in enacting a Personal Directive.

Fraser Health **Identification of Substitute Decision Maker** *(British Columbia)*

Interdisciplinary, pre-planning tool for consenting for healthcare. This form is used for healthcare providers to document a client's formally appointed or temporary substitute decision maker(s).

British Columbia Law Institute **Health Care Decision-Making Legal Rights of People Living with Dementia** *(British Columbia)*

A series of three short animated videos addressing matters of healthcare decision-making for people living with dementia: (1) Who Makes your Health Care Decisions?, (2) Getting Support with Health Care Decisions, and (3) Protecting Your Decision-Making Rights.

BC Centre for Palliative Care **Substitute Decision Makers** *(British Columbia)*

An interactive webpage that provides information and a step-by-step guide for understanding how healthcare decisions are made for clients if they cannot speak for themselves.

People's Law School **Work it Out** *(British Columbia)*

Interactive webpages offering in-depth, step-by-step guidance on Advance Care Planning and the associated legal documents. It includes A Planning Primer to understand what it means to be mentally capable, legal decision-making and what legal documents to prepare.

Speak Up Ontario **Substitute Decision Maker Hierarchy** *(Ontario)*

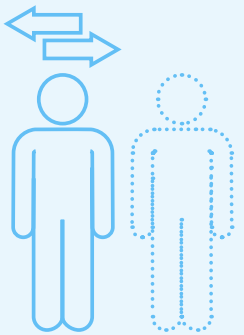
Information on the Substitute Decision Maker hierarchy based on the Ontario Health Care Consent Act.

Speak Up Ontario **Resource Guide to Health Care Consent and Advance Care Planning in Ontario** *(Ontario)*

A resource to help answer questions about healthcare consent, substitute decision makers and advance care planning. It includes information that everyone needs to know to understand the healthcare decision-making system in Ontario. It also provides answers to questions about a wide variety of topics.

Speak Up Ontario **Health Care Consent and Advance Care Planning Webinars** *(Ontario)*

A variety of webinars around healthcare consent and advance care planning for primary care, acute care, long-term care, regional networks and community partners.



A substitute Decision Maker is the person (or persons) who will make medical decisions for the patient if they are unable to do so. Depending on the jurisdiction, this person might also be known as a Proxy, a Mandatary, a Health Representative, an Agent, or a Power of Attorney for Personal Care.

Domain 2: OPPORTUNITY

ORGANIZATIONAL

Systems · Resources · Culture

In this domain, you will find resources to build external factors that will enable your frontline team to incorporate Advance Care Planning into everyday clinical practices.

OPPORTUNITIES

- What processes facilitate ACP conversations and documentation?
- What resources support clinicians?
- Does leadership support ACP?

RESOURCES

Policies and Practices

Communication

Continuous Quality Improvement

BEHAVIOUR CHANGES

1. Providers facilitate early and ongoing advance care planning conversations
2. Providers understand patient's care wishes
3. Providers ensure patients' wishes are reflected in the care plan and legal considerations

Policies and Practices

Having clinical mechanisms to integrate ACP conversations and documentation into routine patient care.

Alberta Health Services **Procedure for Advance Care Planning and Goals of Care Designation** *(Alberta)*

A detailed procedure outlining the objectives, application, element, and term definitions for ACP and GOC designations. It also includes supporting appendices: Alternate Decision-maker Quick Reference Guide, Degree of Clinical Benefit, Decision Support and Dispute Resolution Resources.

Alberta Health Services **Advance Care Planning/Goals of Care Designation Tracking Record** *(Alberta)*

A documentation form that can be used by any healthcare providers to sequentially record the outcomes of conversations related to Advance Care Planning and Goals of Care Designations. It helps providers be aware of previous conversations and understand the reasons underlying the current GCD order. The form includes question prompts for healthcare providers to encourage advance care planning and elicit patients' personal goals.

Alberta Health Services **ACP/GCD – Proven Working Solutions Integration in your Documentation System** *(Alberta)*

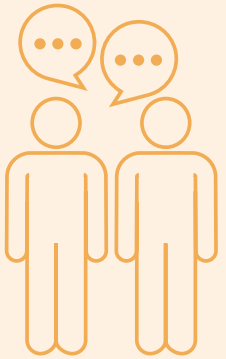
Evidence-informed suggestions on ways to integrate the process of ACP/GCD into organizations' and providers' documentation systems.

Fraser Health **Advance Care Planning (ACP) Record** *(British Columbia)*

A communication tool to document brief important details from Advance Care Planning, Serious Illness, and Goals of Care conversations. All members of the healthcare team in all program areas (acute and community) can use this form to chart conversations and previously expressed wishes; although many patients may not have completed advance Care Planning documents, they may have had a conversation with different providers about their wishes.

Interior Health **Serious Illness Conversation Documentation** *(British Columbia)*

An all-in-one document on serious illness conversation, including the steps to take, questions to ask, and responses and actions to document when having Serious Illness conversations.



Support for process implementation, such as modifying workflow processes, is crucial to create the time and space for healthcare providers to intentionally engage in high-quality Advance Care Planning conversations.

Fraser Health Medical Orders for Scope of Treatment *(British Columbia)*

Medical Orders for Scope of Treatment (MOST) are physicians' or nurse practitioners' medical orders as a result of Advance Care Planning, Goals of Care and/or Serious Illness conversations. This form is used to facilitate information sharing between healthcare team members to ensure individuals' values and goals are honoured regarding resuscitation, as well as the bucket of care a person currently fits under: medical or critical care treatments.

C. Sloan, Acclaim Health Improving Conversations and Documentation of ACP, GOC and Consent *(Ontario)*

A PowerPoint presentation outlining operational process considerations to improve the conversations and documentation of Advance Care Planning (ACP), Goals of Care, and consent to a plan of treatment. It includes core concepts and definitions, healthcare provider roles, ideas for process mapping and clinical pathways, communication and education suggestions, and a list of resources.

Speak Up Ontario Advance Care Planning Conversation Guide *(Ontario)*

A two-page guide serving as a conversation template and documentation form for clinicians to use in clarifying the Substitute Decision Maker, determining capacity to participate in ACP conversations and recording the conversation with the patient and their SDM(s).

> Recognize that culture plays a strong role in how people view decision-making, future planning, care at the end of their lives, and death. Ensure approaches to ACP respect cultural diversity and foster equitable participation.

> "They listened to me. They understood—I knew what my husband wanted. If they didn't understand, they asked. We all agreed."
>
> —PARTNER/CAREGIVER

Communication

Using prompts in physical environments to stimulate communication and normalize ACP activities.

Alberta Health Services ACP & GOC–Proven Working Solutions Visual Cues Use *(Alberta)*

Examples of visual cues that can be used to prompt healthcare providers, patients and their families to have ACP and GOC discussions.

Alberta Health Services Advance Care Planning & Goals of Care Designation Supplies List *(Alberta)*

Public posters, pocket cards and tools available free of charge to community clinics and physicians.

Multiple Provinces–Green Sleeve *(Alberta) (British Columbia) (Nova Scotia)*

A Green Sleeve is a plastic pocket that holds important Advance Care Planning documents and other forms that outline a patient's goals for healthcare. The Green Sleeve is kept at the front of the medical chart. At home, a Community Green Sleeve (green magnetized wallet) is placed on or near the fridge. Information contained in these sleeves helps clinicians in all settings know what planning has been done and provides a more accurate starting point for ongoing conversations. Patients should bring the Green Sleeve to all health appointments. A video is provided where a paramedic talks about the Green Sleeve and what the Green Sleeve looks like in Alberta.

BC Centre for Palliative Care Advance Care Planning Community Resources *(British Columbia)*

Easy-to-read brochures are available for community organizations to start meaningful conversations and promote advance care planning in their communities. The tools include What is Advance Care Planning?, Conversation Starter, Who Needs to Know your Future Health-Care Wishes?, HELLO Conversation Game Event Package, and Serious Illness Conversations Health Care Professional Brochure.

People's Law School Postcards on Planning *(British Columbia)*

A series of public information postcards highlighting why it's important for everyone to plan for their future, outlines three legal documents that can help people plan for a time when they aren't able to make their own decisions, and provides a planning toolbox. On the reverse side of each postcard, it explains where to learn more about planning for the future.

Education resources for patients are most helpful when they are used to prepare them for ACP conversations, or when they are integrated into intentional, comprehensive conversations.

Canadians value conversations about their future or personal healthcare.

80% think it's important to discuss this with a healthcare provider, but only **8%** did.

People need help to make it easier to have conversations:

More support **45%**
More resources **29%**
More personal time **9%**

ACP in Canada, National Poll 2019: ACP Attitudes and Behaviours

Fraser Health **Talking About the Future Advance Care Planning** *(British Columbia)*

A pre-visit letter for outpatient or primary care use to let patients/clients know ahead of time that the subject will be brought up at subsequent appointments and to be prepared by thinking ahead. It is available in Punjabi and Chinese.

Speak Up and Cancer Care Manitoba **Bookmark and Wallet Card** *(Manitoba)*

Individuals can use this bookmark or wallet card to let others know they have an ACP/Health Directive and where it is located.

Speak Up Ontario **Advance Care Planning Promotional and Educational Resources** *(Ontario)*

Posters, bookmarks, wallet cards, workbooks and postcards can be purchased for distribution and display in offices, clinics or libraries to increase awareness and spark conversations around advance care planning. Topics include "Who would speak for you?" and "Are you a Substitute Decision Maker?"

Health PEI **Advance Care Planning Wallet Card** *(PEI)*

A simple-to-use card allows individuals to show they have a Health Directive and its location.

Saskatchewan Health Authority **My Life Capsule** *(Saskatchewan)*

The website outlines an innovative way to make medical information and Advance Care Plans available to medical personnel when an emergency occurs in the home. It includes a client information form and instructions to complete and store "My Life Capsule."

Saskatchewan Health Authority **My Voice Poster** *(Saskatchewan)*

Using poster as a communication tool to reenforce the "Think, Talk, Act" process of Advance Care Planning.

Continuous Quality Improvement

Supporting implementation of quality ACP practices within local environments.

Alberta Health Services Quality Improvement Project Advance Care Planning/Goals of Care *(Alberta)*

Website featuring a four step process to evaluate and improve ACP/GCD practices to help patients and families receive more, better and earlier ACP/GCD conversations. Resources include suggestions for indicators along with sample audit tools and questionnaires and a list of potential stakeholders to involve in the improvement work. The questionnaire evaluates:

- Number of patients with a completed and documented ACP/GCD
- Percentage of healthcare providers who understand provider roles and responsibilities related to ACP/GCD (can also measure the level of understanding)
- Number of patients who have heard about ACP/have a documented ACP/have been involved in a GCD discussion

Advance Care Planning Collaborative Research & Innovation Opportunities Program Research Impact Report 2013-2019 *(Alberta)*

A comprehensive report examines six years of research and quality improvement in Alberta about how to optimally implement widespread uptake of a formalized advance care planning framework, across a large population and throughout a complex, multi-sector healthcare system. The research addressed (1) barriers, facilitators and readiness to participate in ACP from public and HCP perspectives, (2) assessment of tools for education and engagement and evaluation of how to best adapt to the local environment, (3) performance indicators (Infographic/Standard Manual) to monitor ACP uptake and guide continuous quality improvement, and (4) economic costs and consequences of ACP implementations.

Implementation Guide to Advance Care Planning in Canada: A Case Study of Two Health Authorities (2008) *(Alberta, British Columbia))*

A 58-page comprehensive guide is intended to support health administration and provider organizations in the development of advance care planning initiatives. Supported by Health Canada, the guide includes practical steps (i.e., engagement, education, system infrastructure, continuous quality improvement) supported by lived experiences from Alberta Health Services – Calgary Zone and Fraser Health Authority.

ACP activities need to be tracked, evaluated and modified to ensure programs are accessible, beneficial and effective.

Domain 3: MOTIVATION

HEALTHCARE PROVIDERS

Role · Confidence · Reinforcement

In this domain, you will find resources that address two types of motivation to promote frontline providers' engagement in Advance Care Planning: reflective processes (e.g., beliefs about the consequences and professional identity) and automatic processes (e.g., emotions and desires).

MOTIVATION

- Do all members of the healthcare team understand their role in ACP?
- Do they know the benefits of ACP?
- Do they have confidence in having ACP conversations?

RESOURCES

Benefits of ACP

Role Clarity and Team Building

BEHAVIOUR CHANGES

1. Providers facilitate early and ongoing advance care planning conversations
2. Providers understand patients' care wishes
3. Providers ensure patients' wishes are reflected in the care plan and legal considerations

Benefits of ACP

Promoting beliefs in the benefits of having Advance Care Planning conversations at any stage of life.

Advance Care Planning **Talking to #mycommunity** *(National)*

A short video, Lori, Stacey, Yessica, Elspeth and Don talk about why advance care planning and sharing wishes with their loved ones are so important.

Healthy Debate **Planning for Care at the End of Life: Our Collective Responsibility** *(National)*

An article highlight how comprehensive advance care planning can improve patient and caregiver satisfaction and reduce unwanted admission to hospital and aggressive intervention at the end of life.

Alberta Health Services **The Benefits of Having an Advance Care Plan in Place** *(Alberta)*

A short (3:11) video of a caregiver talking about her mother's dementia diagnosis and the importance of knowing your loved one's end-of-life wishes.

Alberta Health Services **Having an Advance Care Plan Brings Peace of Mind** *(Alberta)*

A short (3:13) video of a cancer patient sharing the benefits of having a Personal Directive and Goals of Care Designation in place in case of an unforeseen health crisis.

Alberta Health Services **Chronic Illness and Advance Care Planning** *(Alberta)*

A short (2:55) video of a client sharing how having an advance care plan helped him and his family know about his end-of-life wishes when he developed a chronic illness.

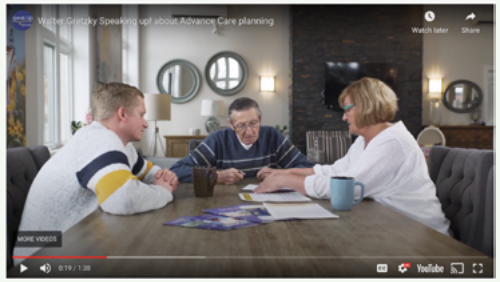
Responding to Policy Issues: How a Provincial ACP/GCD Community of Practice Promotes Excellence *(Alberta)*

A PowerPoint presentation sharing the approach and experience of creating and sustaining a Community of Practice (COP) to support the Alberta Health Services' five zones in operationalizing an ACP policy. The COP is a place for stakeholders to collectively identify, share and problem-solve clinical ACP and GCD issues, and build confidence through mentorship and collaboration.

Walter Gretzky Speaking Up! About Advance Care Planning

In this short video, we see a conversation with Walter Gretzky, his daughter Kim, and grandson Nathan. Walter talks about his experience with Advance Care Planning and how it helped his family members know about his wishes and values.

Learn more



Watch Video

Role Clarity and Team Building

Understanding the role and influence everyone has within a broader Advance Care Planning perspective.

Canadian Home Care Association – **SPRINT-WCPR Implementation Collaborative** *(National)*

Through the SPRINT-WCPR Implementation Collaborative™, the CHCA helped local practice teams adapt and implement Whole Community Palliative Rounds (WCPR). Profiled as a High Impact Practice, WCPR is a strategy used to engage inter-professional palliative care teams in purposeful and timely communication, shared decision-making and collaborative care planning.

Healthy Debate – **How do you want to live your life at the end?** *(National)*

An opinion piece from the College of Physicians and Surgeons of Ontario sharing the role doctors can play in breaking down communication barriers, engaging with patients and encouraging them to think about and discuss these issues so that doctors can act appropriately.

Canadian Association of Social Workers and Fraser Health – **Advance Care Planning** *(National)*

Fraser Health, in partnership with the Canadian Association of Social Workers, hosted a series of interactive webinars to talk about the importance of planning in advance for future healthcare—for themselves and for their clients. Through this interactive series, over 300 social workers joined in across Canada and were supported to create action plans for social work leadership.

> Advance care planning is best introduced as an interprofessional practice involving all members of the care team.

Canadians are engaging in and promoting advance care planning in many ways. Learn about the various innovative and creative advance care planning activities across Canada at the Speak Up initiative website.

The Speak Up Podcast

Features guest speakers talking about life planning, Advance Care Planning and other topics relevant to their experiences. Listen to powerful stories or add your voice to the growing collection of experiences and conversation starters. The podcast is broadcast on Spotify, iTunes and the national Speak Up Canada website.

C. Anderson, Alberta Health Services – **Building Operational Excellence in Home-Based Palliative Care Access to Advice & Advance Care Planning An Edmonton Perspective** *(Alberta)*

A PowerPoint presentation featuring the Advance Care Planning strategies and work in Alberta Health Services, Edmonton Zone. The presentation shares the elements of teamwork, cultural changes and resource creation, and the values of an ACP program, including: enhanced goal-concordant care; improved quality of life; reduced suffering; better client and family coping; higher patient satisfaction; and less non-beneficial care and costs.

Alberta Health Services – **Advance Care Planning – The Health Care Provider Perspective** *(Alberta)*

A short (3:16) video of a healthcare worker providing his perspective on the importance of an Advance Care Plan.

Nova Scotia Hospice Palliative Care Association **Why should you talk to your patients about Advance Care Planning** (*Nova Scotia)*

A two page profile reinforcing the ACP process and the values of ACP conversations for the patient, the healthcare provider and the system, including improved quality of life and quality of end-of-life care, reduced stress and anxiety, better communication and a more effective healthcare system.

Speak Up Ontario – **Person-Centred Decision-Making Quick Reference Guide** *(Ontario)*

A quick reference guide for busy clinicians to help them understand their role in different types of person-centred decision-making conversations.

> ACP involving a facilitated conversation with a health or care professional is more effective than document completion alone.

Acknowledgments

This resource guide was developed by the Canadian Home Care Association with input and review from the National Advance Care Planning Advisory Committee.

Advance Care Planning in Canada Project

The Advance Care Planning (ACP) in Canada initiative is led by the Canadian Hospice Palliative Care Association (CHPCA) with a financial contribution from Health Canada. The project aims to help people living in Canada prepare for their future and personal health care if they are unable to speak for themselves. The project involves a series of public awareness campaigns, supports community-based ACP programs, and promotes ACP resources and guides.

For more information, visit www.advancecareplanning.ca

Advisory Committee Members

Alyson Hillier
Retired Teachers Organization, Nova Scotia

Cari Borenko Hoffmann
Fraser Health Authority

Chad Hammond
Canadian Hospice Palliative Care Association

Colleen Cash
Nova Scotia Hospice Palliative Care Association

Doris Barwich
British Columbia Centre for Palliative Care (2018–2019)

Eman Hassan
British Columbia Centre for Palliative Care

Jessica Simon
ACP CRIO Program/ University of Calgary

Julie Darnay
Hospice Palliative Care Ontario

Kathie Paddock
Health Canada, End-of-Life Care Unit

Kim Jakeman & Lisa Corrente
Canadian Bar Association, Health Law Section

Laurel Gillespie
Canadian Hospice Palliative Care Association

Maryse Bouvette
l'Association québécoise de soins palliatifs (AQSP)

Nadine Henningsen
Canadian Home Care Association

Sharon Baxter
Canadian Hospice Palliative Care Association

Sharon Kaasalainen
McMaster University

Canadian Home Care Association

The Canadian Home Care Association (CHCA) is a national non-profit membership association dedicated to strengthening integrated community-based care. We represent public and private organizations that fund, manage and provide services and products in the home and community. The CHCA informs policy, influences practice and advocates for better home and community care for all Canadians. www.cdnhomecare.ca @CdnHomeCare

Speak Up · Parlons-en

Canadian Hospice Palliative Care Association
Association canadienne de soins palliatifs

Annex D, Saint-Vincent Hospital
60 Cambridge Street North
Ottawa, ON K1R 7A5

Tel: 613-241-3663
Toll Free: 1-800-668-2785
Fax: 613-241-3986
Email: info@advancecareplanning.ca
www. advancecareplanning.ca