Advance Care Planning Toolkit

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For more information visit: www.prepareforyourcare.org

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What is Advance Care Planning?
It is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding current and future medical care. The goal is to help ensure that people receive medical care that is consistent with their values, goals, and preferences during serious and chronic illness.

Advance care planning is MORE than just an advance directive and more than just about the end of life!
Advance care planning can be done at ANY stage in life. It includes thinking about and identifying one’s goals for medical care, both right now as well as in the future. It also involves talking about these goals with family, friends and medical providers.

Why is Advance Care Planning Important?
Advance care planning is considered a standard good health practice and should ideally be done before a health crisis. Similar to having a safety back-up plan, advance care planning can help you get to know your clients better and ensure they are getting the medical care that is right for them at any stage in their health and at the end of life.

What Can I Do?
We will give you the words you can say to start the advance care planning process with your clients. But, please use whatever words you are most comfortable with. We will also give you some easy-to-use tools (see below).

Some people will never fill out an advance directive. That is OK. We just want to help people get started. This Toolkit should help.

Materials:

- Go to the [www.prepareforyourcare.org homepage](http://www.prepareforyourcare.org)
- Print the pamphlet & advance directive.
- Have these 2 videos ready on a phone or tablet
Here are some words you can say to start advance care planning. Anything in [brackets] can be changed based on the client’s situation.

Case Manager: “It is really important to [your organization/me] that you get the medical care that is right for you.

I have some materials that will help you [If they have close contacts: and your family/loved ones] prepare to make medical decisions. This type of preparation is called advance care planning.

The goal of advance care planning is to give you a voice in your medical care and help you talk to your doctors about your wishes [If applicable: and give your family and friends peace of mind]. This way they don’t have to guess about what is important to you.

These materials are optional. This means it is your choice to hear about them. Our program feels it is important to share these materials with you, and we hope you will look them over before we meet again on [date].”

Is it OK for me to tell you more about these materials?

If no stop and say “That is OK. I will leave these materials with you now, and I will ask you about them again in the future. If you want, we can put this on the list for a future goal.”

If yes: “Great!”
Part 3: Materials

Case Manager: “Let’s watch [this/these] short video[s] that will help explain why preparing for medical decisions is important”:

- Show the 1:30 min introduction video on the homepage of www.prepareforyourcare.org

- If they have family/friends: Scroll down and also show the “Thanks Mom and Dad” video

“There are many video stories like [this/these] on the PREPARE website that will help you walk through the process of advance care planning.”

1. **Show the PREPARE pamphlet**

   Link: https://prepareforyourcare.org/pamphlet

   “The PREPARE pamphlet has brief notes about the 5 steps of the PREPARE website. The steps help people answer questions about what is important to them. If you want to go to the website [If applicable: or have a family member or friend help you], the pamphlet also has the PREPARE website address.

   Show and circle the url: www.prepareforyourcare.org

   **IF YOU HAVE TIME:** Go over the pamphlet with them. Briefly read the 5 step topics to the client.

   “Some people prefer to just use the paper version of this PREPARE pamphlet and not the website. That is OK. I will leave this pamphlet with you.

   Please look over the pamphlet when you have time. Ask your doctor if you have any questions. Feel free to go to the website too.”

   [If applicable] “It can be helpful to watch PREPARE with someone else. Many people also get help from their family and friends to use a computer, phone, or tablet to watch PREPARE.”
2. **Show the Easy-to-read advance directive:**

   Link: https://prepareforyourcare.org/advance-directive-state/ca

   “I also wanted to give you this PREPARE advance directive. It is a legal form that lets you have a say about how you want to be cared for if you get very sick.”

   “The advance directive has 3 parts:

   **Part 1: Choose a medical decision maker**

   A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

   They are also called a health care agent, proxy, or surrogate.

   **Part 2: Make your own health care choices**

   This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

   **Part 3: Sign the form**

   The form must be signed before it can be used.

   It is OK if you do not want to choose a decision maker right now. Many people are not ready or do not have someone they trust. This is OK. I see this all the time. In that case, you could just focus on Part 2 and signing the form.”

   If they do not have a surrogate, you could show them this video on the PREPARE website:

   **Step 1: “If You Are Not Ready to Choose a Decision Maker”**

   Link: https://prepareforyourcare.org/prepare/1-3-2a?from=1-3-2
“To complete the form, you will need 2 witnesses to sign it (show them page 13). I can help you think through who that may be. Unfortunately, it cannot be me or anyone who provides you care. The witness cannot be your medical decision maker either. Witnesses are just people who are willing to sign the form saying you are who you say you are and you are the one who signed the form. They could be a friend or neighbor. Does anyone come to mind?

If not, we can still help you make this form legal when you are ready to sign it. Please look over this form and ask your doctor if you have any questions.”

IF YOU HAVE TIME: Please go over the directive with them

“If you fill out this form before I see you again, please share it with your medical providers [If applicable: and with your family, friends]. Your doctors can help make sure the information gets into your medical chart.

Your medical providers, such as doctors, nurses, and social workers need to know this information so they can take better care of you. It is also their job to talk to you about your wishes and these materials. So, don’t be shy and bring it up when you see your medical providers.”
**Part 4: Follow Up**

**Case Manager:** “Last time I saw you, I shared the PREPARE pamphlet and advance directive form with you.” Show another copy of each.

“What did you have time to look over the pamphlet and advance directive?”

- **If Yes:** “That is GREAT! Did you happen to visit the website? Do you want help reviewing the pamphlet or website videos?”
- **If No:** “[If applicable: Here is another copy of the pamphlet/advance directive]. What questions do you have?”

“Would you be interested in coming to a meeting to watch the PREPARE video stories in a group setting?” **Put their name on the list for upcoming events.**

**FOR QUESTIONS:** Consult the list of frequently asked questions (FAQ)s:

[https://prepareforyourcare.org/faq](https://prepareforyourcare.org/faq)

If you are not able to answer a question:

“I am sorry, I cannot answer that question. But that is a very important question to follow-up and ask your doctor about.”

**IF YOU HAVE TIME:** If your client has filled out the advance directive, please help make copies and send a copy to their primary care provider and/or to the clinic and hospital in which they receive their medical care.