Advance Care Planning

Disclosure

Relationship with Commercial Interest:

Pallium

- Not-for-profit
- Funded by Health Canada and Gillin Estate

Facilitator

[Facilitator to disclose]

Commercial Support:

Pallium

- No Industry funding

Facilitator

[Facilitator to disclose]

Mitigating Potential Biases:

Pallium

- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration fees

Facilitator

[Facilitator to disclose]

Learning objectives

Upon completing this module, you should be able to:

- Define Advance Care Planning (ACP);
- Promote Advance Care Planning (ACP);
- Undertake Advance Care Planning discussions;
- Differentiate between terms such as ACP, goals of care, Power of Attorney (POA), substitute decision-maker (SDM), advance directives, and “DNR” discussions;
- Identify resources to help with ACP;
- Be aware of the regulations related to ACP in the province you practice in.

Module Plan

1. Short Case
2. Overview
3. ACP Resources
4. Case continued

Part 1:
Short Case

Vignette A

Mrs. DV is a 73 year-old lady with kidney failure, peripheral vascular disease and diabetes mellitus. She is admitted to the ED with a massive stroke. She is accompanied by family members; her husband, three sons and two daughters. They say that until yesterday she was engaging and "doing okay". She has hemiplegia and is unable to communicate or swallow. You note that her husband seems confused. There is disagreement amongst the family; two sons and a daughter say that she needs a tube for hydration and feeding and that she should be started on dialysis and she should be hooked up to life support machines if her heart stops. The other children disagree; they say it will simply prolong her life and suffering. She has no advanced care plan. There is no Power of Attorney identified. One of the sons asks you to sign a paper to allow him to manage his mother's finances.

How do you manage this situation?

Part 2:
Overview

Which of the following best describes ACP in Canada?

A. A discussion to establish code status (DNR)
B. A discussion regarding values & wishes for end of life care and identifying a power of attorney
C. Preparing a “Living Will”
D. All of the above

What is ACP?

Two essential components:

1. A reflection on values and wishes for EOL care
2. Formally identifying a person(s) to make decisions on one's behalf if one is unable to do so

- Share these discussions
- Document them
- Only activated when capacity lost

Advance care planning is….

- NOT one single conversation
- NOT refusal of medical treatments
- NOT establishing “DNR”
- NOT a document or form
- NOT a goals of care discussion
- NOT a checklist of instructions or treatment preferences under different circumstances
- NOT consent to treatment

Definitions

- Advance Care Plan
- Advance Directive
- Living Will
- Power of attorney (POA)

Note: Different terms & laws in different provinces/territories

Hierarchy of Substitute Decision Makers (e.g. Ontario)

1. Guardian of Person
2. Attorney named in a POA for Personal care (POAPC)
3. Representative appointed by Consent and Capacity Board
4. Spouse or Partner
5. Child or Parent or CAS (Person with Right of Custody)
6. Parent with right of access
7. Brother or Sister
8. Any other relative
9. Office of the Public Guardian and Trustee

Ontario Health Care Consent Act 1996 (HCCA)

Documenting ACP

- It is important the decisions made by ACP
- The decisions should be shared with family and health care providers.
- Each province has it's own forms and terms for documenting ACP.
  - Find province-specific information at: www.advancecareplanning.ca

ACP in Canada

Province	Document arising from ACP	ACP-designated SDM	Advance Directives (constitute consent)	GOC Designations	Hierarchy of SDMs
British Columbia	Standard Representation Agreement (Sect 7) Enhanced Representation Agreement (Sect 9)	Representative	X		X
Alberta	Personal Directive	Agent		X	X
Saskatchewan	Health Care Directive	Proxy			X
Manitoba	Health Care Directive	Proxy		X (Winnipeg RHA)	X
Ontario	Power of Attorney for Personal Care	Attorney			X
Quebec	Protection Mandate	Mandatary	X		X (limited)
New Brunswick	Power of Attorney for Personal Care	Donee/Attorney			Not found
Prince Edward Island	Health Care Directive	Proxy		X	X
Nova Scotia	Personal Directive	SDM			X
Newfoundland & Labrador	Advance Health Care Directive	SDM			X
Yukon	Advance Directive	Proxy			X
NWT	Personal Directive	Agent			X
Nunavat	None	None			Court appointed

ACP in Relation to Goals of Care and Health Care Decision Making

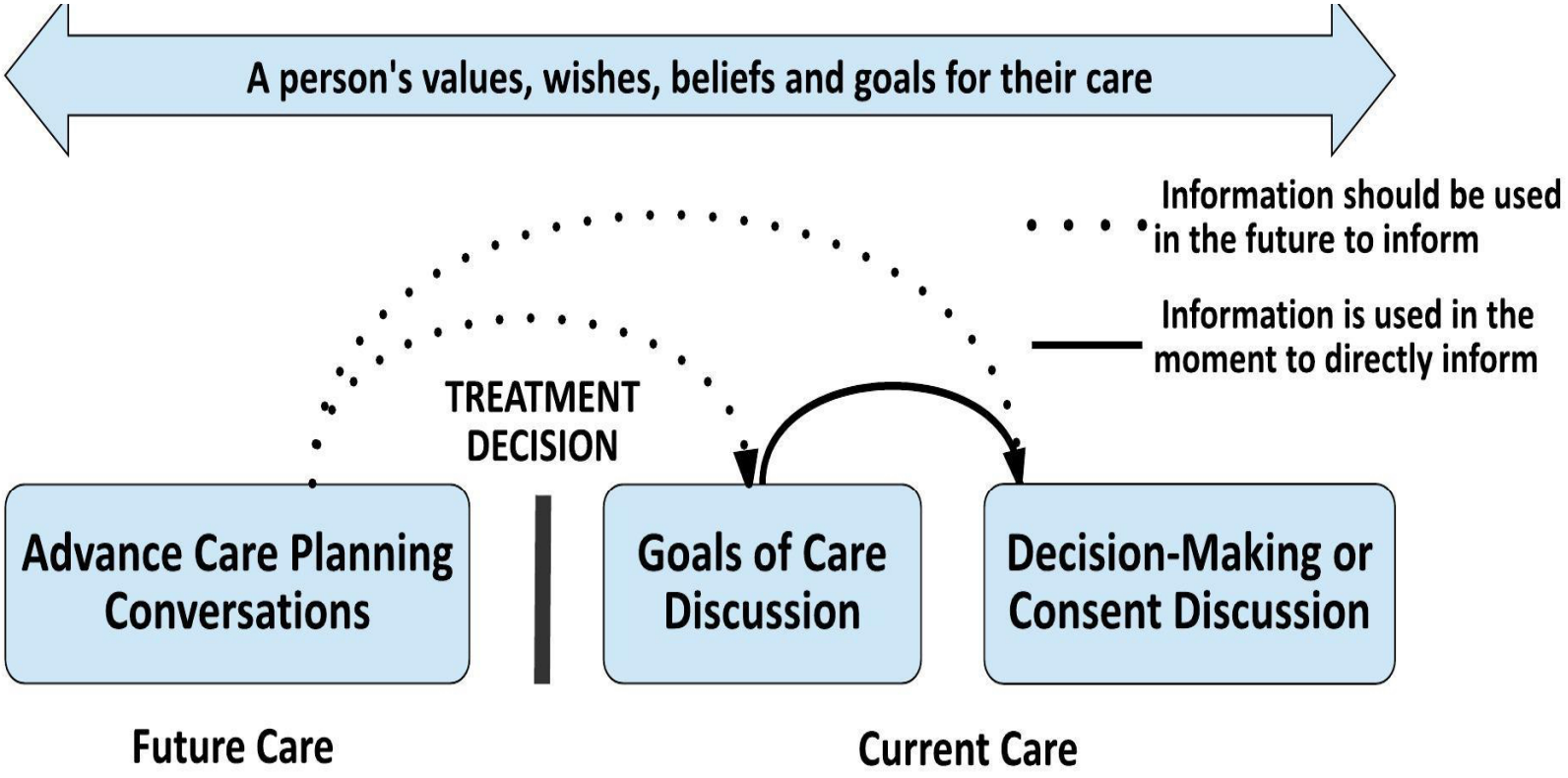


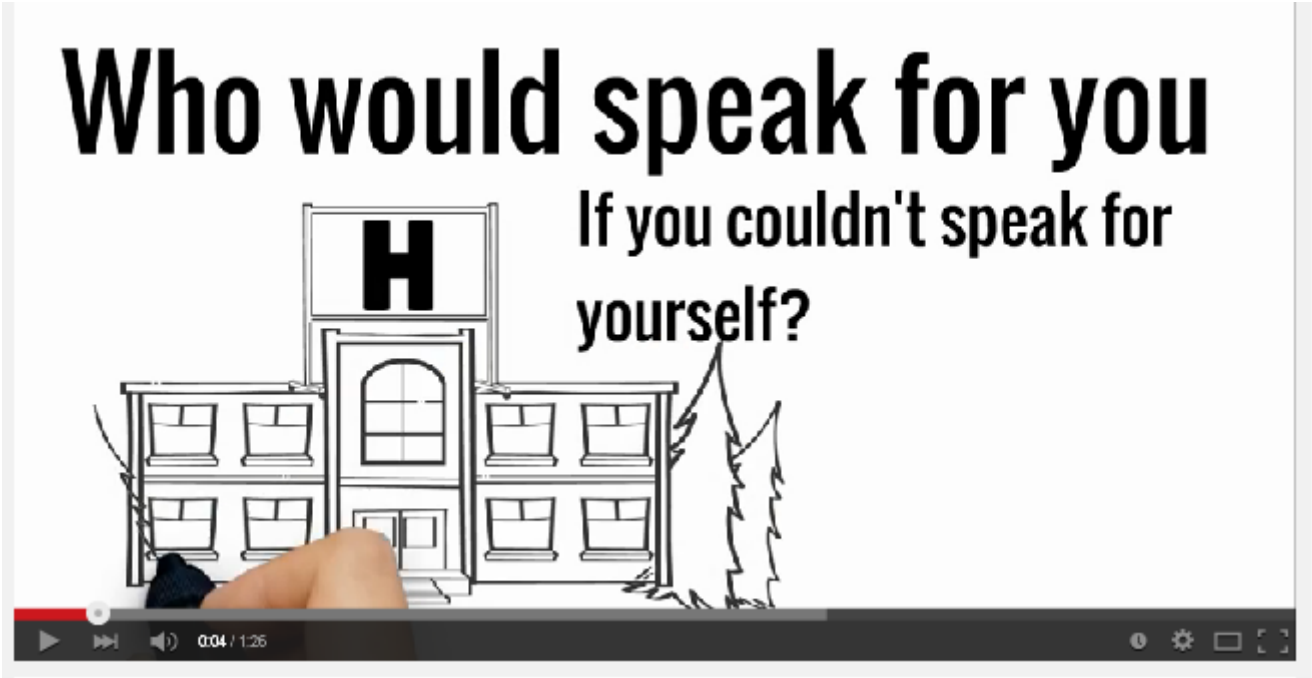
Figure: Relationship between three key discussions as components of informed consent

	Clinical Context	Outcome is …..
Advance Care Planning	Future	• Values and wishes related to EOL care discussed. • POA (or equivalent) is identified for future decision-making.
Goals of Care Discussion	Current	• Different every time. • Includes exploring patient's goals and understanding of illness and treatment/care options, providing information according to patient's information preferences and readiness.
Decision-making or Consent Discussion	Current	• Outcome relates to a specific intervention or treatment; e.g. code status, withholding or withdrawing treatment.

Adapted from Dr. Jeff Myers, Dr Lean Steinberg and Dr, Nadia Incardona.

Speak Up: Five steps of advance care planning

https://www.youtube.com/user/AdvanceCarePlanning



Why is advance care planning important?

What is the impact of avoiding ACP discussions?

Why is advance care planning important?

Multiple studies have shown that if patients engage in ACP:

- They are more likely to have their end-of-life wishes known and followed.
- Their family members will have less stress and anxiety
- Patients and families are more satisfied with care
- Patients have a better quality of life and death
- Patients are less likely to be hospitalized and/or admitted to ICU.

What is the impact of avoiding ACP discussions?

- High burden of suffering for patients
- Inappropriate utilization of resources
- Care that is inconsistent with patients' wishes
- Patients lose good time with their families
- Lose opportunities for reflection and preparing for their life's end
- Spend more time in the hospital and ICU
- Higher health care costs

When should Advance Care Planning be done?

Situation	Yes	No
At time of an annual physical	☐	☐
In a general conversation with family members	☐	☐
When a life threatening illness is diagnosed	☐	☐
When an incurable illness is found to be progressing despite treatments	☐	☐
When a person's health status changes	☐	☐

PERSONAL CHALLENGE: HAVE YOU…..

- …discussed with your family your values, wishes related to EOL care?
- …got an advanced care directive?
- ..encouraged your own family members to undertake advanced care planning?

How would you initiate an ACP discussion?

Starting goals of care discussions

1. “What do you understand about what is happening to you [your loved one]?”
2. “Have you thought about what you would like in the last phase of your life or what would be the most important for you during that time?”
3. “There is a change we are seeing and we need to have these conversations so we are clear that we are all on the same page as to what treatment direction we will be taking.”
4. “We need to talk about the treatment direction and goals.”
5. “What is most important to you [your loved one] regarding your quality of life?”

Ramsbottom, K., & Kelley, M.L. International Journal of Palliative Care, 2014

Starting goals of care discussions

6. “We noticed that you [patient’s name] condition is changing so we think it is important to review the goals of care at this time.”
7. “There is a change we are seeing and we need to have these conversations so we are clear that we are all on the same page as to as to what treatment direction we will be taking.”
8. “Has [patient’s name] ever talked to you about his/her wishes when faced with these circumstances?”
9. “What is in the best interest of [patient’s name]. What do you think [patient’s name] would want under these conditions?”

Ramsbottom, K., & Kelley, M.L. International Journal of Palliative Care, 2014

Part 3:
ACP resources

Speak Up Website

For:

- Public
- Patients and families
- Professionals
- Community organizations / agencies / programs
- Researchers

www.advancecareplanning.ca

PROVINCE specific information available on website

http://www.speakupontario.ca/what-is-advance-care-planning/

Province-specific toolkits

- For example:
- Cancer Care Ontario ACP Quality Improvement toolkit https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=353148

Cancer Care Ontario

Advance Care Planning in Ontario – A Quality Improvement Toolkit

Introduction

What is the Advance Care Planning (ACP) Quality Improvement Toolkit?

In January 2013, the Ministry of Health and Long Term Care (MOHLTC) introduced Quality Improvement Plans (QIP) to the primary care sector, including Aboriginal Health Access Centres (AHACs), Community Health Centres (CHCs), Family Health Teams (FHTs) and Nurse Practitioner Led Clinics (NPLCs). Beginning in 2014, QIPs were introduced to Community Care Access Centres (CCACs). Cancer Care Ontario (CCO), has partnered with various experts and leaders to develop an Advance Care Planning (ACP) Quality Improvement Toolkit[1] for those practices that decide to include ACP as part of their QIP.

"The QIP is about improving patient/client and provider experience, care effectiveness and value, through system improvement, continuously over time."[2] All of the above mentioned practices in Ontario are required to develop and submit a QIP to Health Quality Ontario (HQO) by April 1 of each year, outlining their planned quality improvement efforts for the upcoming fiscal year. This toolkit is for primary care practices that choose to include ACP as part of their annual QIPs.

Guidance and materials about QIPs are available on the Ontario Ministry of Health and Long-Term Care website at: http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/qi_primary.aspx

Part 4:
Case continued

Vignette A

Mrs. DV is a 73 year-old lady with kidney failure, peripheral vascular disease and diabetes mellitus. She is admitted to the ED with a massive stroke. She is accompanied by family members; her husband, three sons and two daughters. They say that until yesterday she was engaging and "doing okay". She has hemiplegia and is unable to communicate or swallow. You note that her husband seems confused. There is disagreement amongst the family; two sons and a daughter say that she needs a tube for hydration and feeding and that she should be started on dialysis and she should be hooked up to life support machines if her heart stops. The other children disagree; they say it will simply prolong her life and suffering. She has no advanced care plan. There is no Power of Attorney identified. One of the sons asks you to sign a paper to allow him to manage his mother's finances.

How do you manage this situation?

Palliative Care in New-Brunswick

Over the last 30 years, governance evolved and so did palliative care. A number of palliative care initiatives were developed by hospitals, including the NB Extra-Mural Program and nursing homes

Residential Hospice – 10-beds ea., 2010, 2016,
- community integrated approach, 2018

Medicare - Enhanced EMP home-visit rates 2015/16

Advanced Health Care Directive Act - 2016

Palliative Care in New Brunswick: A person-centred care and Integrated services framework has been released - 2018.

An advisory committee was formed:

- Develop an action plan
- Recommend strategies for the implementation and evaluation
- Advise on a standardized and coordinated approach to palliative care in the province

http://laws.gnb.ca/en/showdoc/cs/2016-c.46
http://laws.gnb.ca/fr/ShowTdm/cs/2016-c.46

CHAPTER 46

CHAPITRE 46

Advance Health Care Directives Act

Loi sur les directives préalables en matière de soins de santé

Assented to December 16, 2016

Sanctionnée le 16 décembre 2016

Table of Contents

https://www2.gnb.ca/content/gnb/en/departments/health/patientinformation/content/advance_health_care_directives.html

Health

Health Patients

Advance health care directives

An advance health care directive is a document in which a person sets out his or her wishes regarding future health care decisions. These might include consent, refusal to consent, or withdrawal of consent for any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health.

For more information

- Frequently Asked Questions
- Form

Related Acts

- Advance Health Care Directives Act
- Infirm Persons Act
- Mental Health Act

Legal Resources

http://www.legal-info-legale.nb.ca/en

Conclusions

- Advance Care Planning is an essential part of good end of life care
- Promote advance care planning for your patients, your family and friends and yourself
- Several factors need to be considered when making care plans and treatment decisions

References

- www.advancecareplanning.ca
- Ramsbottom, K., & Kelley, M.L. Developing Strategies to Improve Advance Care Planning in Long Term Care Homes: Giving Voice to Residents and Their Family Members. *International Journal of Palliative Care,* 2014, Article ID 358457, 8 pages