



# Advance Care Planning

Cari Hoffmann, Project Implementation Coordinator,  
Advance Care Planning

[Cari.hoffmann@fraserhealth.ca](mailto:Cari.hoffmann@fraserhealth.ca)

604-587-4408

# Disclosure

I have no conflicts of interest to disclose in relation to the content of this presentation.





# 1. History

## Advance Care Planning in Fraser Health

# A Continuous and Evolving Journey

- What we felt was important:
  - Inclusive of public and professional
  - Development of public materials and resources
  - Focus on clinical education and communication skills
  - Systematic issues identified
- Next Steps
  - Medical orders across care settings





## 2. The Advance Care Planning Process

Potential Outcomes of the Process

# What is Advance Care Planning?

- *the process* of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

MOH, ACP and AD: Provincial Definitions and Planning, May 2011 slide 2.



# Following the Advance Care Planning process, there are now four options:

Create an Advance Care Plan that may include:

1. Documentation of wishes, beliefs, values; or
2. Appointment of a Representative; or
3. Creation of an Advance Directive **NEW**; or
4. Do all of the above **NEW**



# What is an Advance Care Plan?

- a *written summary* of the capable adult's advance care planning conversations and wishes to guide their temporary substitute decision-maker or representative, if called to make a health care decision in the event the adult is incapable of making decisions. May include advance directive &/or Rep Agreement

MOH, *ACP and AD: Provincial Definitions and Planning*, May 2011 slide 2.



# What is Representation Agreement?

- A document in which a capable adult names a Representative and sets out the type and scope of decisions the Rep may make on behalf of the adult if the adult becomes incapable

MOH, ACP and AD: *Provincial Definitions and Planning*, May 2011 slide 4.



**NEW**

## What is an Advance Directive?

- **Advance Directive (AD)**-a *written instruction* made by a capable adult that gives or refuses consent to health care *directly to the health care provider (HCP) if no named Representative.*

MOH, ACP and AD: *Provincial Definitions and Planning*, May 2011 slide 3.



# Impact of New Legislation

- BC Medical Association & Ministry of Health
  - Practice Support Program – Module including ACP
- Ministry of Health
  - Development of Provincial ACP Guide
- Attorney Generals Office
  - Development of Representation Agreement forms
- Health Authorities and other health care organizations





# Advance Care Planning Process

What it might look like?

# Who should HCP initiate these conversations with?

- **Ideally:**

Healthy capable adults, to create awareness, normalize ACP & begin the culture change!

- **More Imperative With:**

Capable adults with chronic diseases *before* they are become ill

- **Absolutely:**

Capable Adults with life expectancy less than 6/12 months (Surprise Question)



# Successful Conversations include:

1. Capable adult readiness to talk
2. Healthcare professional prepared to:
  - Initiate the conversation and follow up
  - Explore and clarify statements
  - Elicit beliefs, values, goals and quality of life
  - Assess understanding of medical condition



# Core Elements of ACP Conversation

1. S.P.E.A.K to adult about Advance Care Planning
2. Learn about & understand the adult & what is important to them. Involve substitute decision makers.
3. Clarify understanding & provide medical information about disease progression, prognosis, & treatment options.
4. Ensure interdisciplinary involvement and utilize available resources/options for care
5. Define goals of care, document and create plan (including potential complications).



# Core Element 1: SPEAK mnemonic

Determine if the adult has:

- Chosen a **Substitute Decision Maker** (Representative appointed or TSDM)
- Thought about **Preferences** for treatment options.
- Any previously **Expressed wishes** (e.g. Advance Care Plan, Living Will).
- Written an **Advance Directive**. (instructions)

*Then assess the adult and/or SDM's:*

- Level of **Knowledge** regarding diagnosis, treatment options, risks and benefits.



Core Element #2: Learn about & understand the adult & what is important to them. Involve Substitute Decision Maker(s).

- What does it mean to **live well**? What gives your life meaning? What does quality of life mean to you? Tell me your thoughts about quantity of life.
- What fears/concerns do you have? How has your changing health status impacted you and your family? What is acceptable risk? Who or what gives you support in times of difficulty?



## Core Element #3: Clarify understanding & provide medical information about disease progression, prognosis & treatment options.

- Diagnosis and implications now and in the future. Expected prognosis: Months to years? Weeks to months? Days to weeks? Hours to days?
- How might this disease progress (include discussion regarding resuscitation (CPR) and other life prolonging treatments (dialysis, tube feeds, ventilation support, etc))
- What are the expected benefits and burdens of treatment?



## Core Element #4: Ensure interdisciplinary involvement and utilize available resources

- Ensure process is interdisciplinary. Utilize available resources and expertise including MD, NP, Social work, Palliative care; Community resources (Alzheimer's, Parkinson's or Hospice Society)
- If treatment is not available in current location, does the adult wish to be transferred from their current location? Options may include acute care, hospice residences, residential care, and home.



# Core Element #5: Define goals of care, document & create plan.

- Discuss specifics of plan to ensure understanding of possible complications and how to manage them.
- If goal may not be attainable, what are the alternatives?





## 2. Legal Framework

### Consent and Substitute Consent

# Important Facts about Advance Care Plans, Advance Directives and Representation Agreements

- Can only be made by capable adults for themselves
- As long as the adult is capable of understanding treatment choices and communicating wishes they (*and not their Substitute Decision Maker or Advance Care Plan*) will be asked to provide consent



# Formally Appointed Substitute Decision Makers (Long Term)

## Two types (listed in order of priority):

1. Personal Guardian appointed by the court under *Patients Property Act* (also called Committee of the Person)
2. Representative named by capable adult - bound by Representation Agreement and *Representation Agreement Act*, is **long-term**



# Temporary Substitute Decision Makers (Short Term)

- The following may be a TSDM (*in priority order*):
  - The adult's spouse (legally married or cohabitating; same gender)
  - The adult's child (ranked equally)
  - The adult's parent (ranked equally)
  - The adult's brother or sister (ranked equally)
  - The adult's grandparent – **New** (ranked equally)
  - The adult's grandchild – **New** (ranked equally)
  - Anyone else related by birth or adoption to the adult
  - A close friend of the adult – **New**
  - A person immediately related to the adult by marriage – **New**
  - Public Guardian & Trustee will appoint or act as TSDM if no TSDM available, qualified or there is a dispute





# Advance Care Planning: VCH Experience

Pat Porterfield, RN, MSN  
Regional Lead, Palliative Care

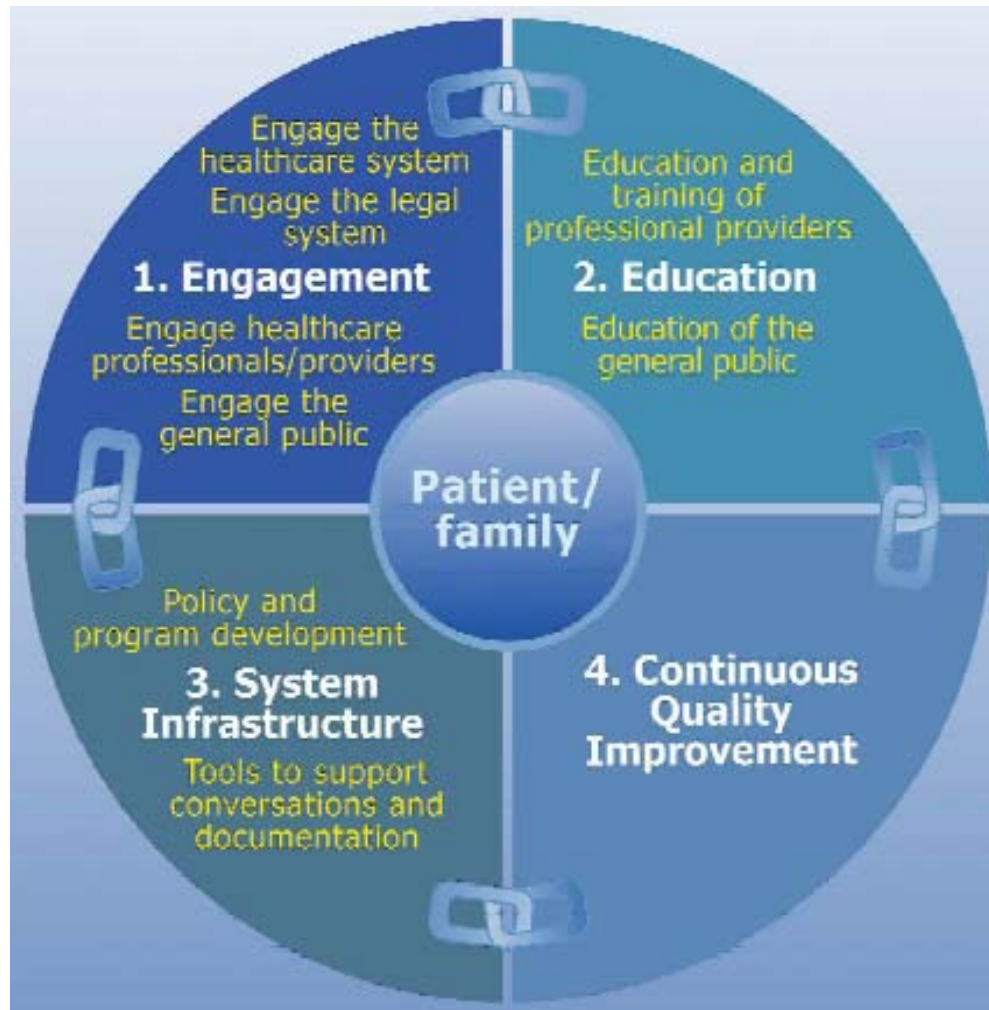
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# Advance Care Planning VCH Experience

- 2008-VCH ACP Planning team “Respecting Client Wishes” -integration of ACP with Adult Guardianship; in preparation for changes in legislation (which did come in Sept 1, 2011)
- Joint Providence/VCH initiative
- Guided by experience of Fraser Health & other HAs
- Advance Care Planning in Canada, National Framework document, 2010, useful in describing the elements of ACP at system level

# Framework for Advance Care Planning in Canada



# Engagement: Health Care Providers, Legal system, & Public

- Initially, anticipated legislation changes & subsequent actual changes in legislation on Sept 1, 2011, have increased HA & Health Care Professional engagement
- Within VCH, creation of two VCH working groups: Encouragement & Development & Receipt & Management to begin staff engagement
- Accreditation standards support importance of ACP
- Public engagement through CEAN (Community Engagement Advisory Network)

# VCH Approach to Public Engagement

- Public consultation as we developed policy
  - Eg who in the organization should ask about future health care decisions/advance care planning
- Developed the “CEAN team”
  - Public education - major message is “importance of the conversation”
  - “For the public by the public”



# Education

- Framework to understand the public's information needs in regard to ACP:
  - Health Adult
  - Healthy Senior
  - Those living with life-limiting chronic illnesses
  - Those within the last year of life
- Framework to understand the knowledge & skills needed by health care professionals
  - Levels of education: basic, resource persons, advanced

# System Infrastructure

- Development of VCH policy & practices; policy consultation: met with councils & groups—Operational & Professional Practice
- Initially adopted FH My Voice, use of greensleeves, developed own brochure
- As of Sept 1, 2011, some system infrastructure such as tools for conversations will be developed by MoH & provincial in scope

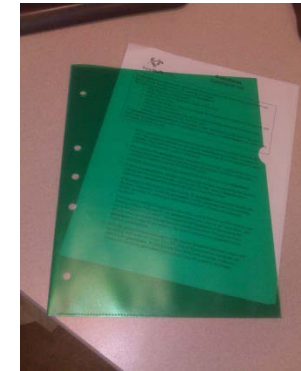
# VCH Advance Care Planning: Development, Receipt & Management



1. Discussion with Family is imperative; Hopefully HCP too

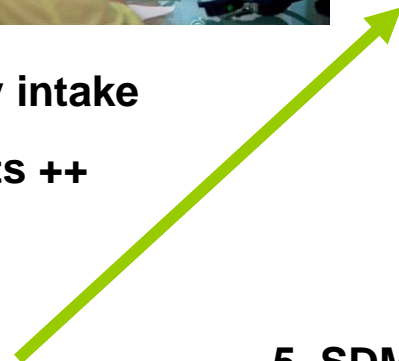
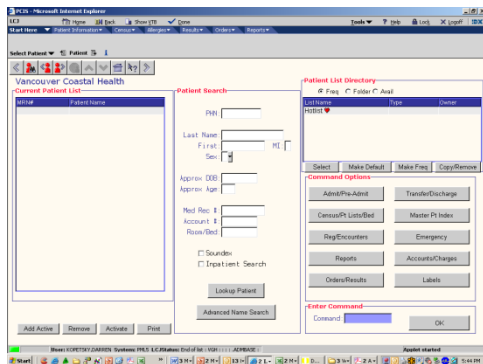


2. Many intake points ++



4. Encouragement for inclusion in planning

3. Many communication / archiving System(s)



5. SDM (or Advance Directive) decisions that reflect client's wishes



# Continuous Quality Improvement

- Need for the right metric to measure system performance???.is it documented conversations, wishes recorded, wishes fulfilled
- Feedback loops within our organizations—how are we doing asking, facilitating & using ACP
  - CQI with two care provider groups: chronic disease nurses & community health centre staff
- Plan for feedback provincially-connections between MoH & HAs
- Need for more evidence including research to inform best practice

# Scenario #1

- Advance Care Planning conversations held between patient, physician and/or family/friend;
- patient may choose to write advance care plan stating their beliefs, values, wishes for health decisions; (doesn't make advance directive or representation agreement).



# Who Decides?

## What are decisions based upon?



# Who Decides?

## What are decisions based upon?

- *Temporary substitute decision-maker makes health decisions with physician or health care provider and respects/honours previously 'expressed wishes'*



## Scenario #2

- ACP conversations held between patient, physician and/or family/friend;
- patient chooses to write advance care plan and decides to name a representative in a representation agreement to present their wishes.



# Who Decides?

## What are decisions based upon?



# Who Decides?

- *Representative makes health decisions with physician or health care provider and respects/honours previously 'expressed wishes'*



## Scenario #3

- ACP conversations held between capable adult and physician, and/or family/friend;
- patient chooses to write advance directive and a representation agreement;



# Who Decides?

## What are decisions based upon?

- If patient has both advance directive and representative:
  - Physician or other HCP must obtain health care decision from representative, unless adult has provided in the RA that the HCP may act on an AD without the consent of the Representative



## Scenario #4

- ACP conversations held between capable adult and physician, and/or family/friend;
- patient chooses to write advance directive but not a representation agreement



# Who Decides?

## What are decisions based upon?

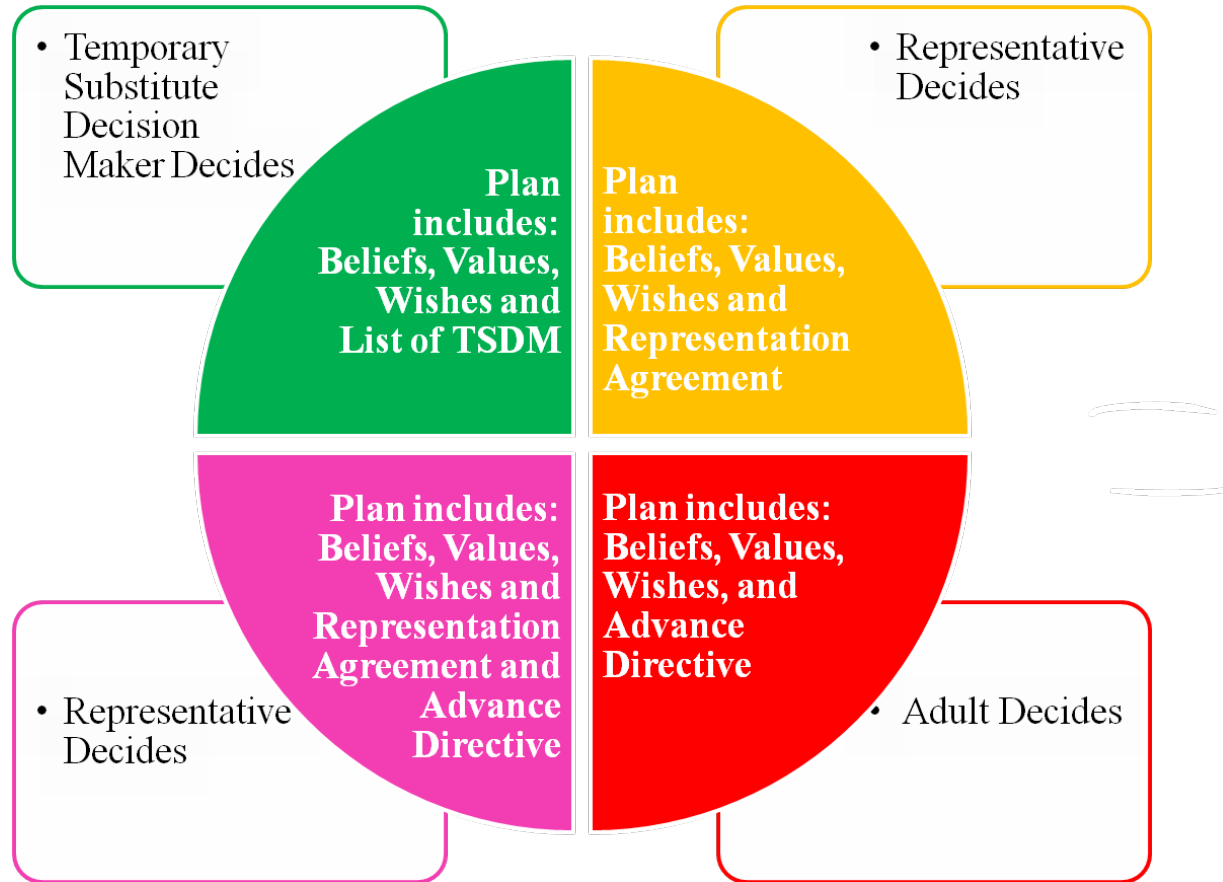
- **If patient has an advance directive but no representative:**
  - **Physician or other HCP follows advance directive as long as it addresses the care required;**
  - **TSDM needed if advance directive does not address the health issue**



## Scenario #5

- *If the patient has not done, or does not want to do ACP:*
  - Physician or other care provider must choose a qualified temporary substitute makers from HCCA List
- \* ACP cannot be a requirement or condition to receive health care or be admitted to a facility





MOH, *Consent Matters: ACP Planning Options*, Sept 2011 slide 6.



# BC Provincial Ministry Resources

- Seniors BC website link:

<http://www.seniorsbc.ca/legal/healthdecisions/>

- Ministry of Health:

[www.health.gov.bc.ca/hcc/advance-care-planning.html](http://www.health.gov.bc.ca/hcc/advance-care-planning.html)

- [AdvanceCarePlanningBC@gov.bc.ca](mailto:AdvanceCarePlanningBC@gov.bc.ca)



# Additional Provincial Resources

- Health Care Providers Guide to Consent
  - <http://www.health.gov.bc.ca/library/publications/year/2011/health-care-providers'-guide-to-consent-to-health-care.pdf>
- BCMA
  - <https://www.bcma.org/news/advance-directives>



# Contacting BC Health Authorities

- Fraser Health
  - [advancecareplanning@fraserhealth.ca](mailto:advancecareplanning@fraserhealth.ca)
  - 1-877-825-5034
  - [www.fraserhealth.ca/your\\_care/advance\\_care\\_planning](http://www.fraserhealth.ca/your_care/advance_care_planning)
- Vancouver Coastal
  - [advancecareplanning@vch.ca](mailto:advancecareplanning@vch.ca)
  - <http://www.vch.ca/acp>



# Contacting BC Health Authorities

- Providence
  - [acp@providencehealth.bc.ca](mailto:acp@providencehealth.bc.ca)
  - Wallace Robinson WROBINSON@providencehealth.bc.ca
- Vancouver Island
  - [http://www.viha.ca/advance\\_directives/](http://www.viha.ca/advance_directives/)
- Northern Health
  - <http://www.northernhealth.ca/YourHealth/AdvanceCarePlanning.aspx>
- Interior Health
  - Judy Nicol Judy.Nicol@interiorhealth.ca



[www.advancecareplanning.ca](http://www.advancecareplanning.ca)

# Speak Up

Start the conversation  
about end-of-life care



# International Society of Advance Care Planning and End of Life Care

International Society of

**Advance Care Planning  
& End of Life Care**

[www.acpelsociety.com](http://www.acpelsociety.com)



# Suggestions:

- Education, education, education
- Set small achievable goals
- Include ACP question on assessments
- Provide materials and resources
- Follow up

