Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Faculty/Presenter Disclosure Slide 1

- **Faculty:** Judy Gillies

- **Relationships with commercial interests:**
  - All work was completed by staff members of the Timmins Family Health Team and Nursing Summer Student

Disclosure of Commercial Support Slide 2

- **This program has received in-kind support from Timmins Family Health Team in the form of QIDDS Staff, IT Staff, Nursing staff and Nursing Student**

- **Potential for conflict(s) of interest:**
  - Judy Gilles has received no money from any organization for this program and pilot project. The Timmins Family Health Team fully supported this project and is now in the pilot testing phase.

IMPROVING OUR UNDERSTANDING OF ADVANCE CARE PLANNING (ACP)

Collaboration Group,

Dr. Judy Gillies, Lisa Russell, Kevin Peever, Charles Bruntz, Dr. Patrick Critchley, Dr. Rachelle Maisonneuve, Stacey White, Ashley Gillies, Brittany Bellavance BScN Student and The Timmins Family Health Team.

OBJECTIVES

- Assess need for end-of-life care planning
- Explore patient values that can guide decision making
- Understand the components of a ACP guide
- Improve appreciation for Inter-professional collaboration for ACP conversations

Speak Up

Start the conversation about end-of-life care

It's about conversations.
It's about decisions.
It's how we care for each other.



Most of us hope to die peacefully, able to communicate with loved ones until the very end. It doesn't always happen that way. Making your wishes known now helps those who care about you make the right decisions if you can't speak for yourself.

Speak up. Start the conversation about end of life care today.
Find out more at: **www.advancecareplanning.ca**

Did You Know?

100% of Canadians will die

8 out of 10 Canadians have never heard of Advance Care Planning

Advance Care Planning is a process of reflecting on and communicating your wishes for end of life care with your family, friends and health team

Only about half of Canadians have had a discussion with a family member or friend about what they would want or not want if they were ill and unable to communicate

That means 50% of their families

don't know their loved one's wishes — and may have some very difficult decisions to make

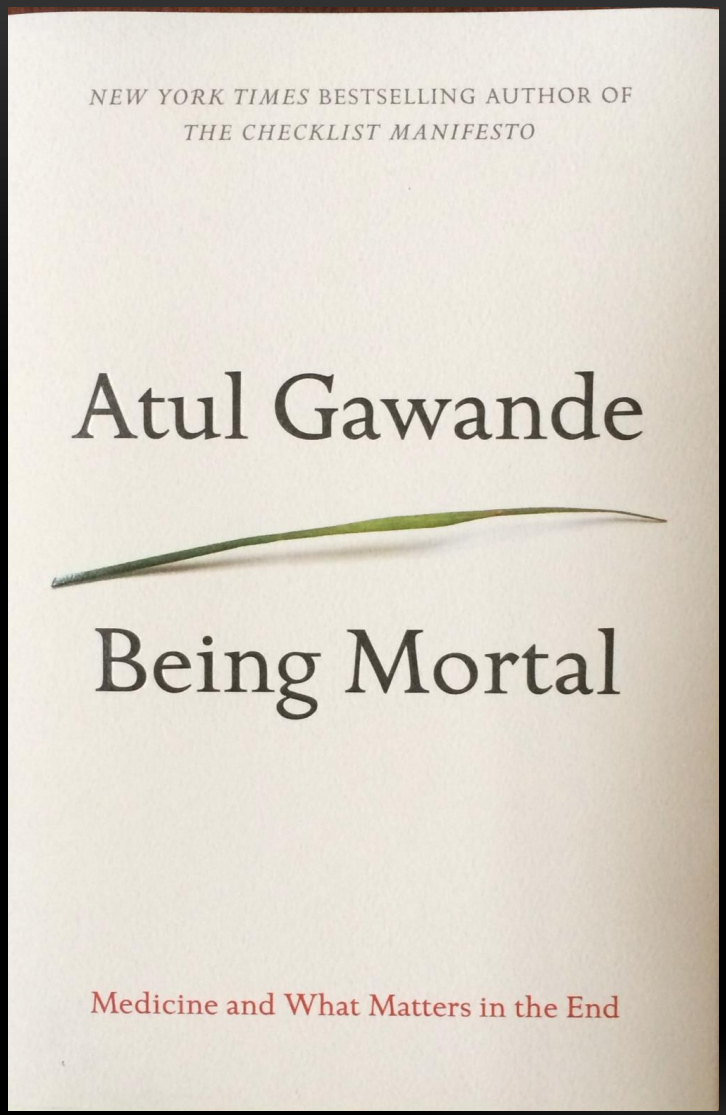
Make your wishes known today

Speak Up

www.advancecareplanning.ca

Thank you to our project funders:

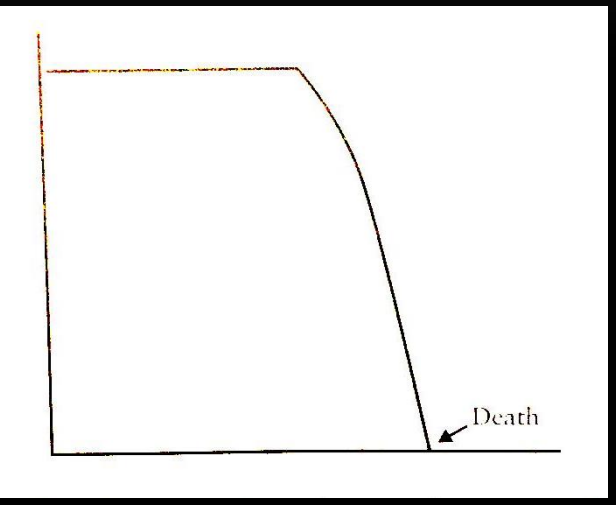
Foundation

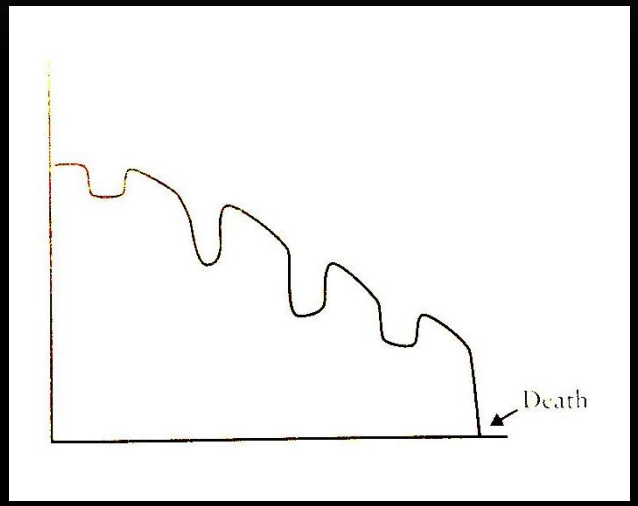


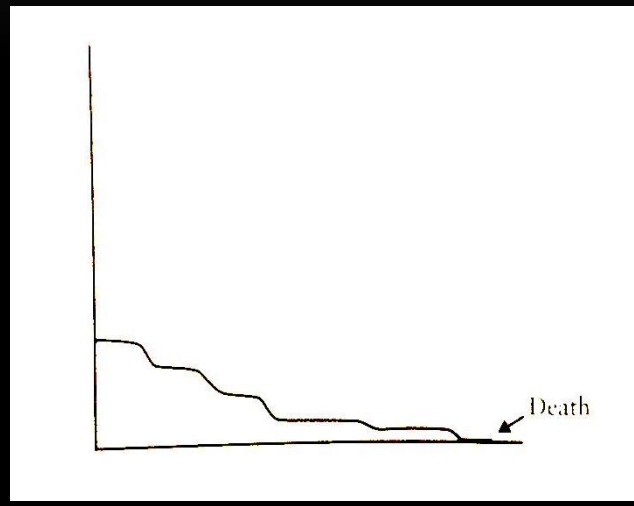
''Our reluctance to honesty examine the experience of aging and dying has increase the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view to their very end, we have allowed our fates to be controlled by the imperatives of medicine, technology, and strangers.''

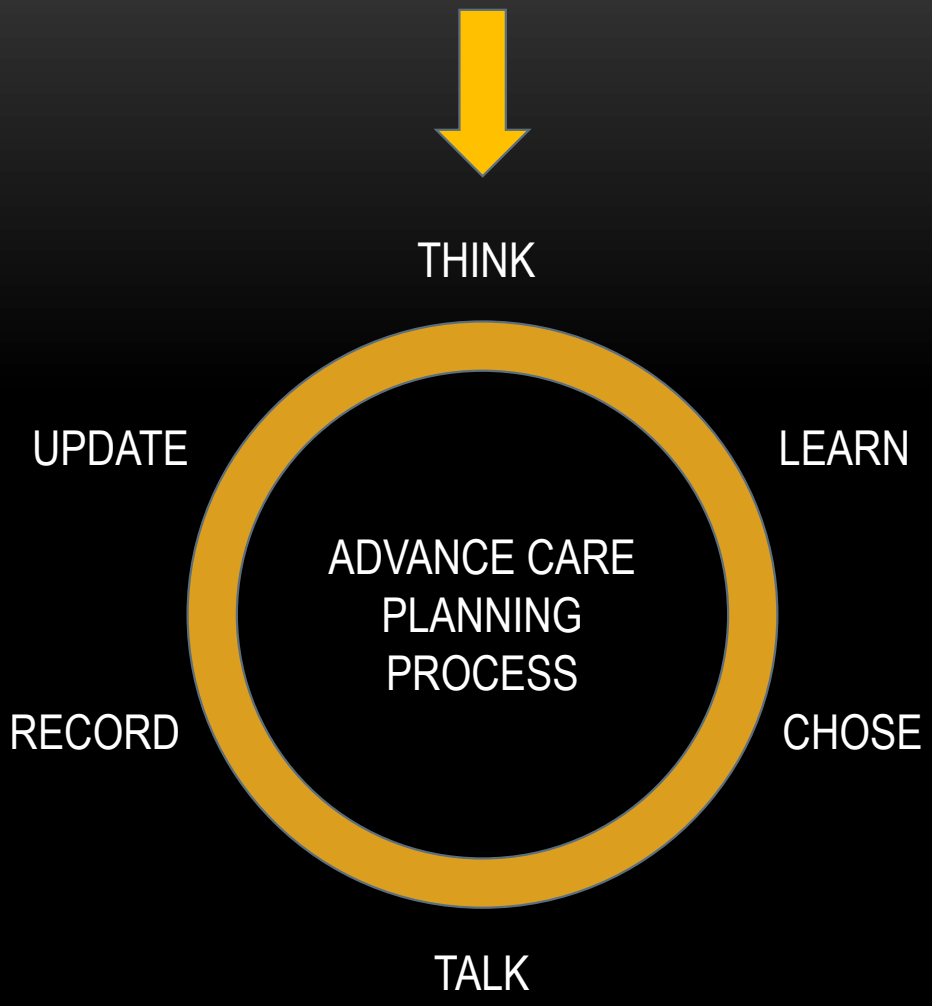
- Atul Gawande

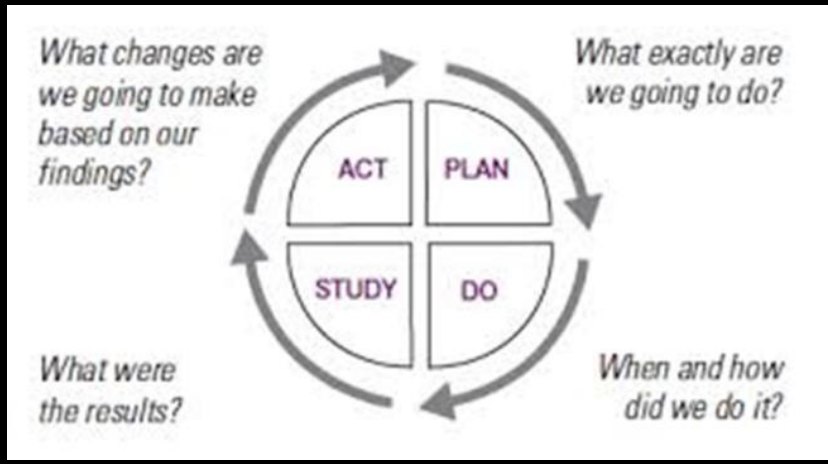
LIFE TRAJECTORIES








THINK
UPDATE
LEARN
ADVANCE CARE PLANNING PROCESS
RECORD
CHOSE
TALK


What changes are we going to make based on our findings?
What exactly are we going to do?
ACT
PLAN
STUDY
DO
What were the results?
When and how did we do it?

ESSENTIAL COMPONENTS OF ACP

- Respect patient care goals, values, wishes and beliefs
- Include the substitute decision maker (SDM)
- Undertaken with a **CAPABLE** person, SDM and health care professional
- Recognize SDM cannot make an advance care plan on behalf of an incapable patient, timely.

ROLE OF SDM

- 70% of decisions made in the last week of a person's life are NOT made by the person him or herself
- ACP is a opportunity for the patient to share with the SDM and medical professional what is important to them
- Prepares the SDM for future decision based on patients values and beliefs
- Advocate for the patient with health care professionals

(Dr. Nadia Incardone)

BENEFITS OF ACP

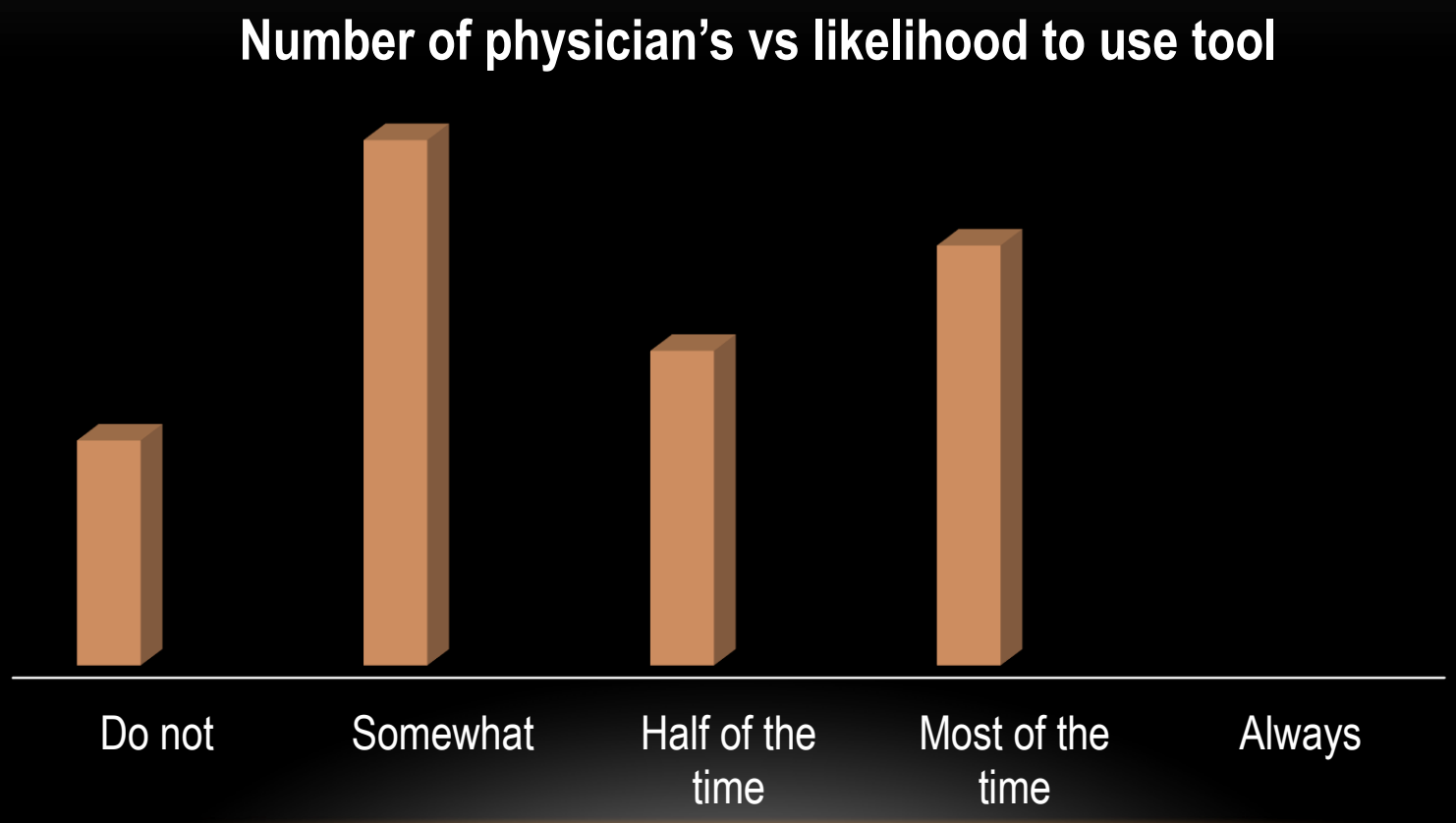
- Improves patient and care giver experience (Heyland et al., 2013)
- Decreases care giver distress (Write et al., 2008)
- Decreases unwanted investigations, interventions and treatments (Detering et al., 2010)
- Decreases hospitalizations and admission to critical care units (Speak up, 2016)
- Decreases costs (Zheng et al., 2009)
- Identifies SDM and assists with communication regarding wishes and beliefs

STEP ONE : NEEDS ASSESSMENT
ADVANCE CARE PLANNING BASELINE SURVEY

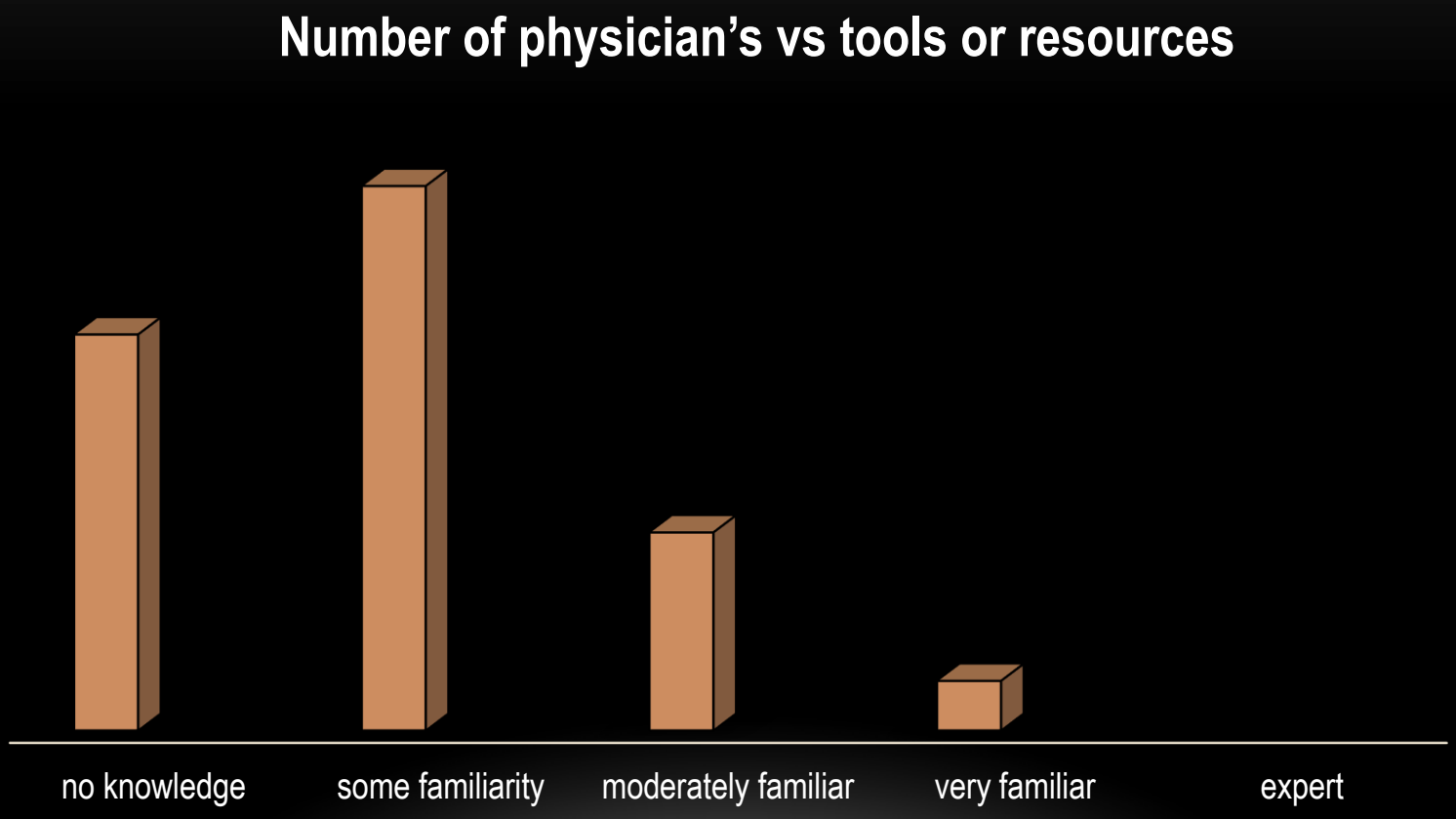
WITH YOUR HELP, WE WERE SUCCESSFUL AT REACHING A RESPONSE RATE OF 68% FROM THE SURVEYS.

THANK YOU FOR YOUR TIME

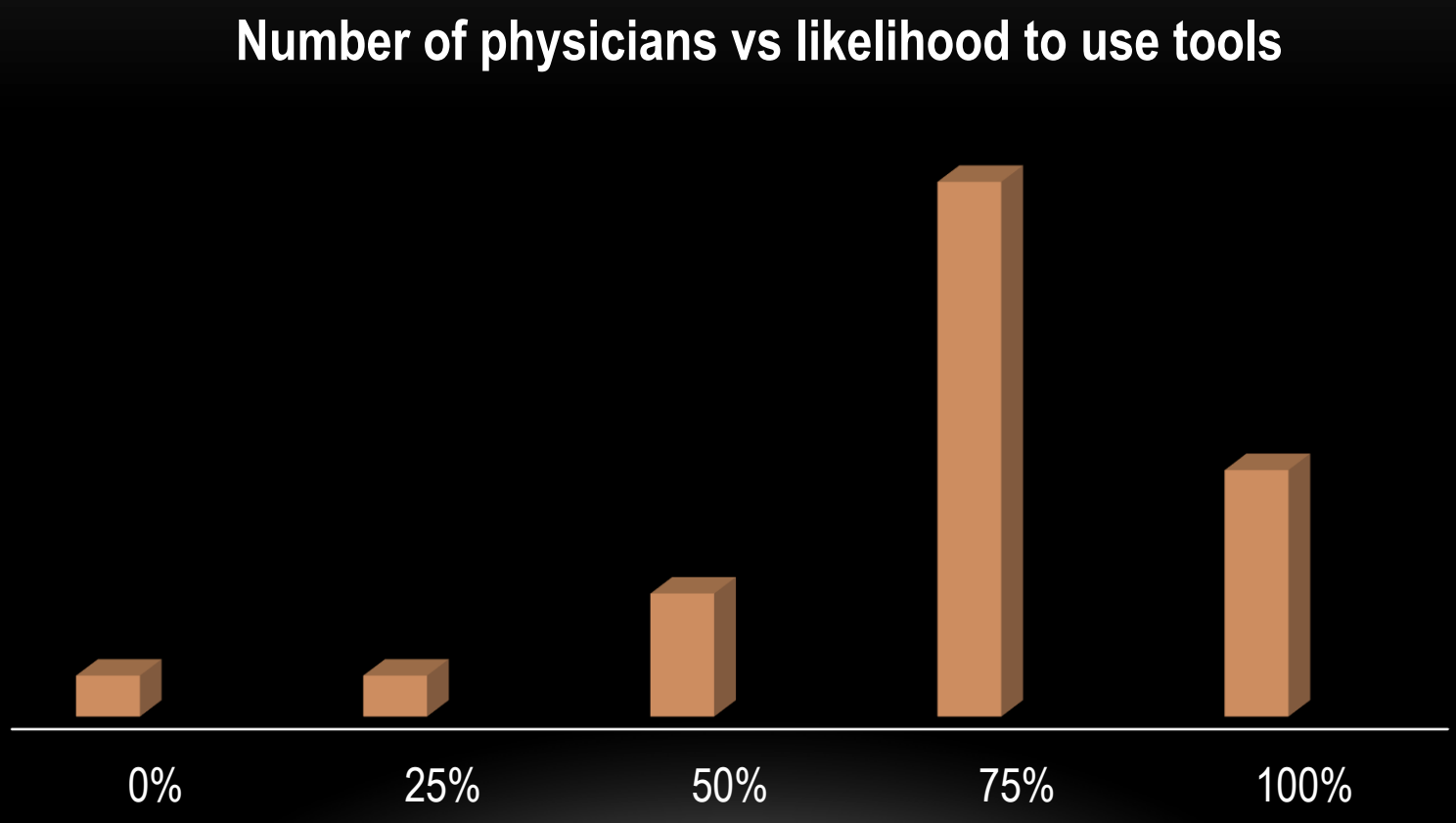
HOW LIKELY IS TFHT TO DISCUSS ACP WITH PATIENTS WITH A HIGH LIKELIHOOD OF MORTALITY WITHIN 1 YEAR



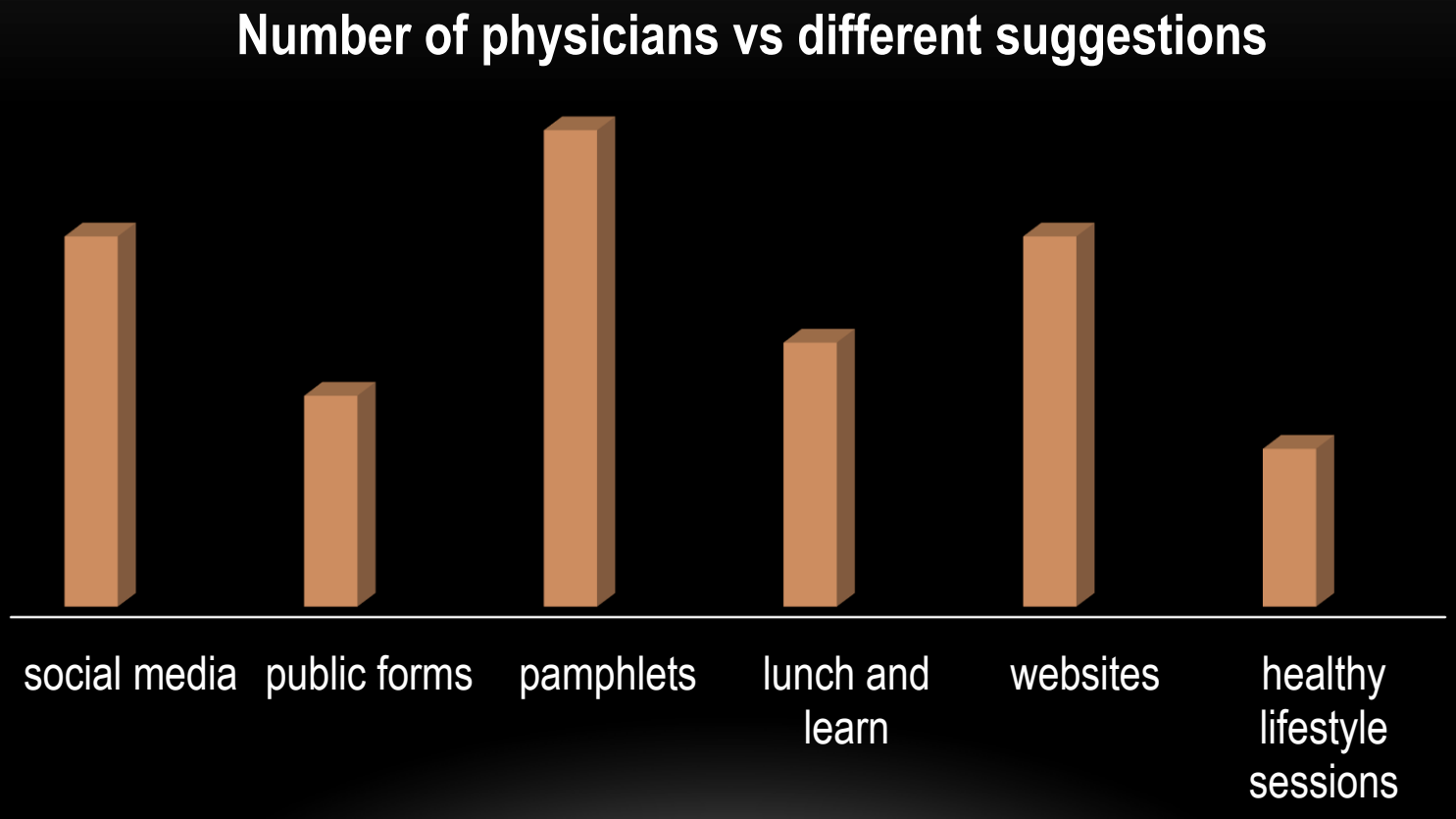
TFHT PRIMARY PROVIDERS AWARENESS OF ACP TOOLS OR RESOURCES



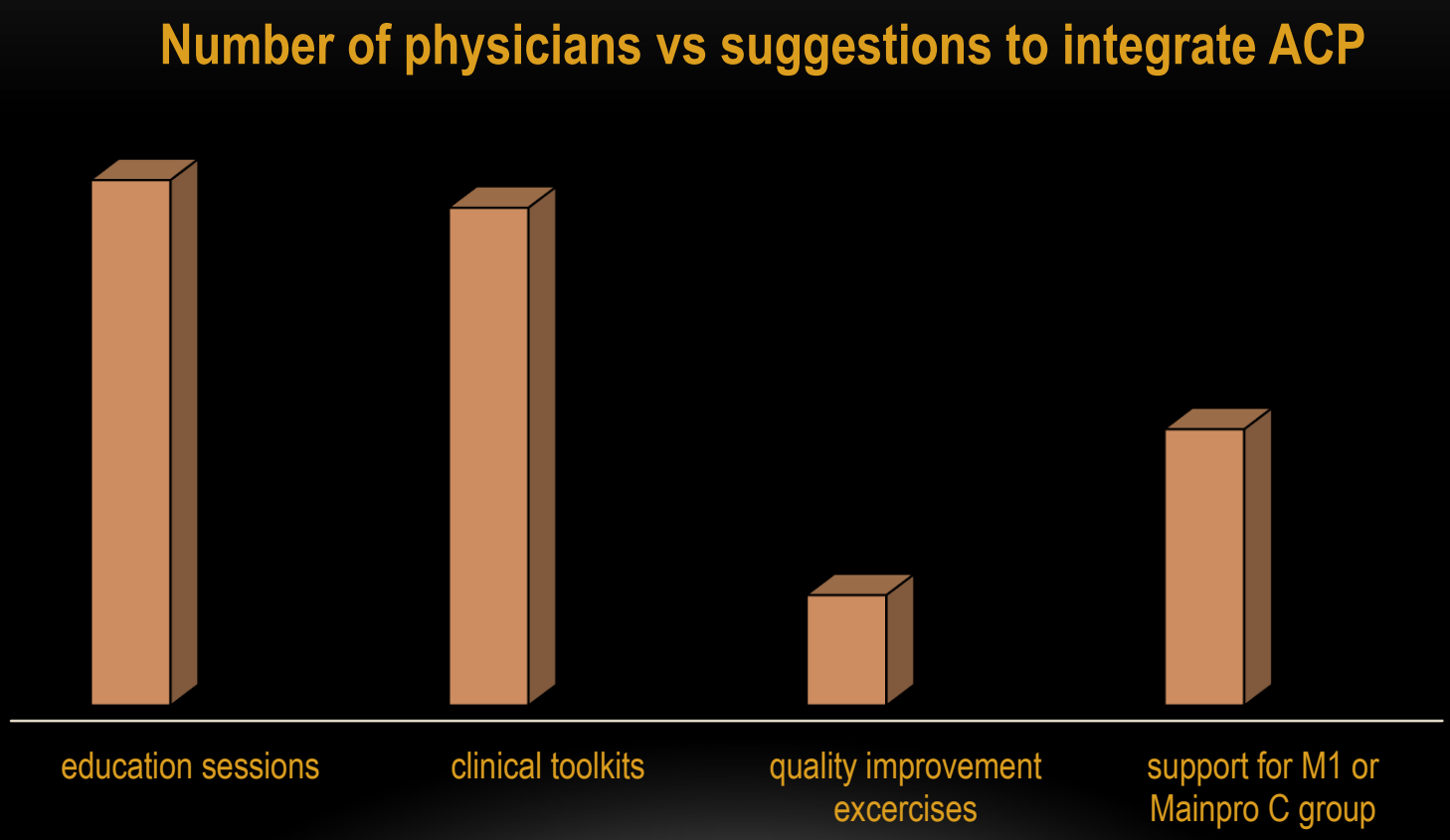
LIKELIHOOD TO APPLY ACP TOOLS INTO THE CLINICAL SETTING REPORTED BY TFHT



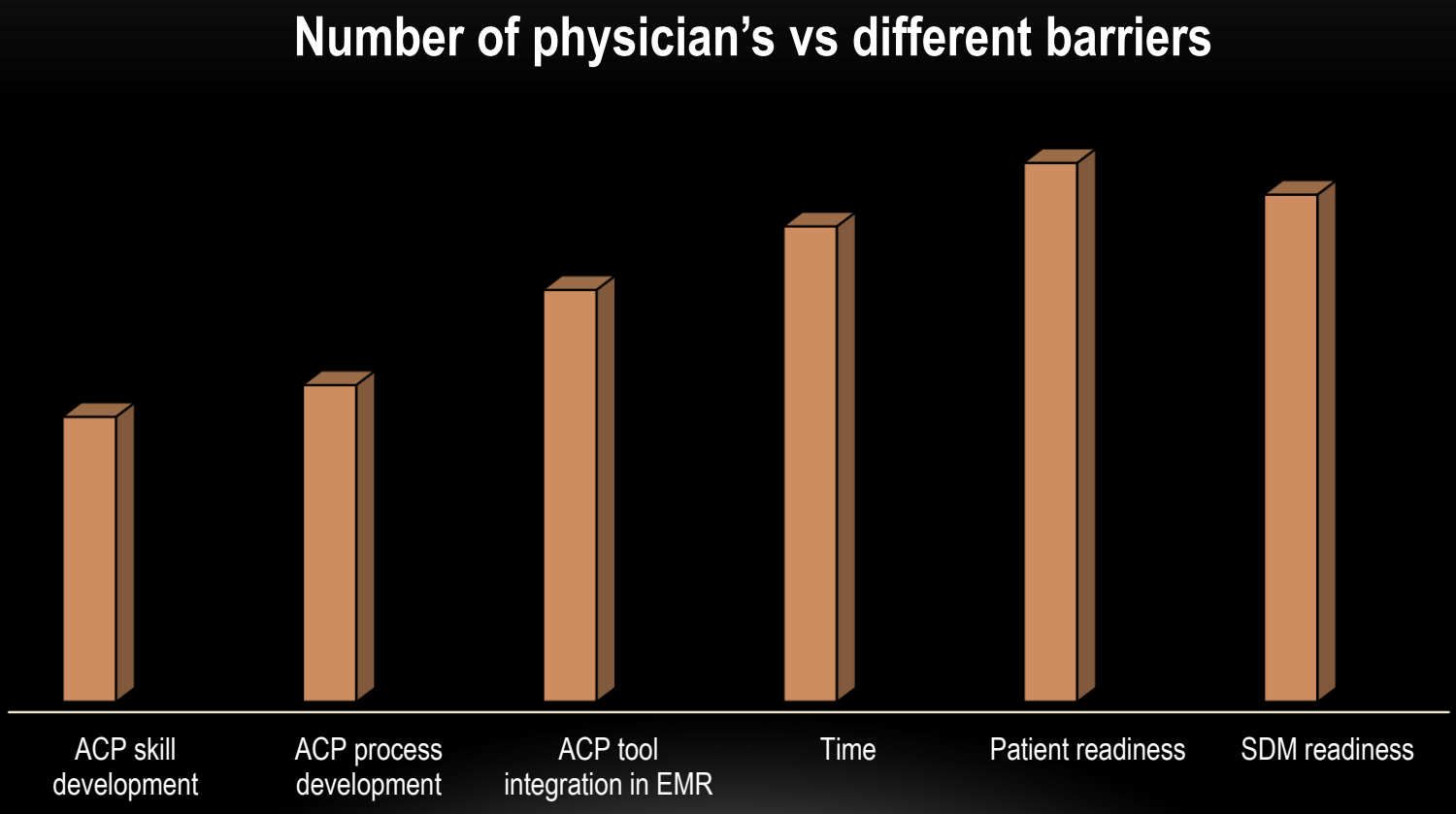
TFHT IMPLEMENTATION SUGGESTIONS FOR ACP PUBLIC EDUCATION EFFORTS



NEEDS FOR INTEGRATING ACP IN PRACTICE REPORTED BY TFHT PRIMARY PROVIDERS



BARRIERS INTEGRATING ACP IN PRACTICE REPORTED BY TFHT PRIMARY PROVIDERS



CHALLENGES IDENTIFIED BY TFHT PRIMARY PROVIDERS

- Lack of knowledge
- Lack of tools
- Time
- Process development
- Patient comfort level in completing an ACP
- SDM comfort level
- Organization

CHALLENGES ASSOCIATED WITH ACP IN RESEARCH

Time

Readiness

Knowledge

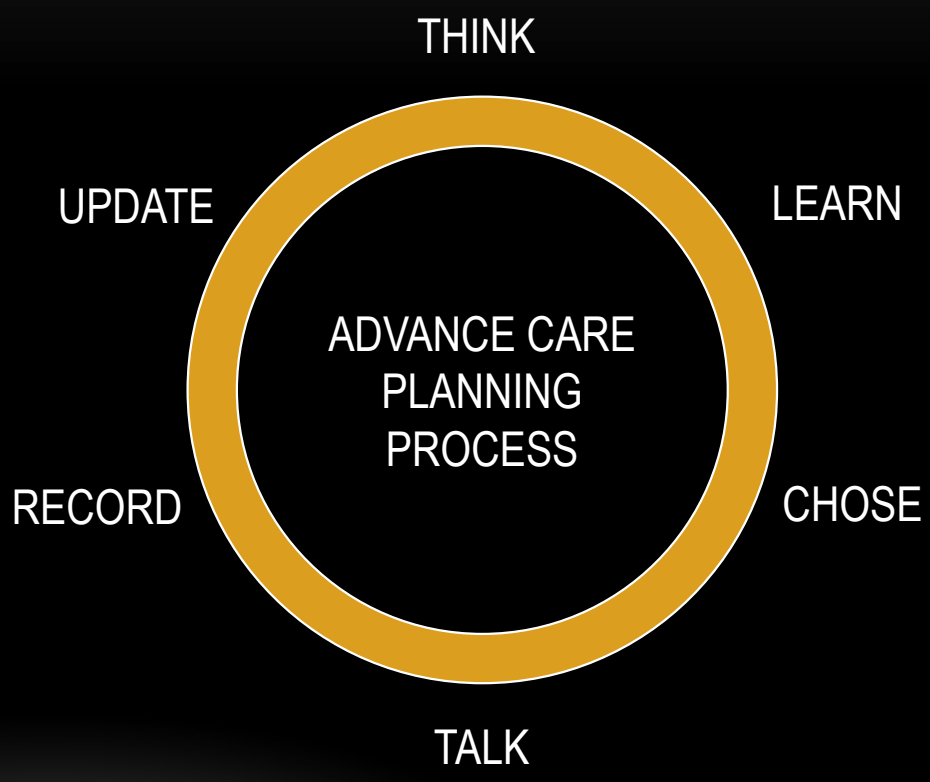
Tools

Addressing the challenges with ACP and time constraints

- ACP is a **process**, not everything can be complete at once
- Give the patient homework to think about and understand their wishes on their time
- Involve the health care team to initiate ACP conversations

FITTING ACP INTO PRACTICE

- Outline a process for identifying key patients
- Assess patient capacity
- Introduce topic and assess readiness
- Facilitate ACP conversation with SDM present
- Provide information
- Document
- Update



POSSIBLE INCLUSION CRITERIA / SEARCH

- Which patients would we invite and discuss ACP?

Take the opportunity to talk about Advanced Care Planning.

Criteria / Triggers

- Surprise question
- Age 75 +/-
- Number of chronic conditions
- Recurrent hospital encounters
- General indicators PPS / Frailty score
- Condition severity
  - ICD-9 codes
  - CNS
  - Liver

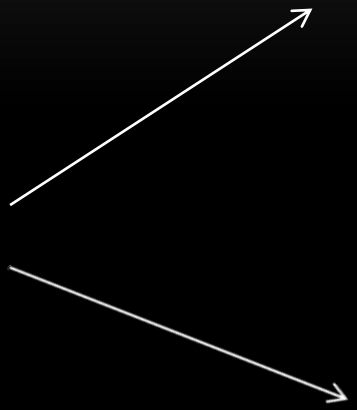
Assess ACP Readiness

- Invite for the initial conversation
- Assess readiness, capacity
- Provide patient with handouts, information, websites

- This appointment can be initiated by a team member

READINESS FOR ACP

Stage	What the person thinks about ACP
Pre-contemplation	Patient does not know about ACP or has not considered ACP.
Contemplation	Patient may be aware of the pros and cons regarding ACP but does not appear ready to take any actions.
Preparation	Patient prepares to engage in ACP through review of educational materials or discussions with others.
Action	Patient has discussed their wishes with others, identified their SDM and may request further information.
Maintenance	Patient has consistent ACP wishes and may to revisit these when health circumstances change.



Patient can decline

- Record on EMR **ACP_ Declined**
- Ask at another time

Patient can accept

- Give the patient literature
- Definitions of key terms
- Homework so patient can think about wishes
- Online resources

If the patient chooses to accept,

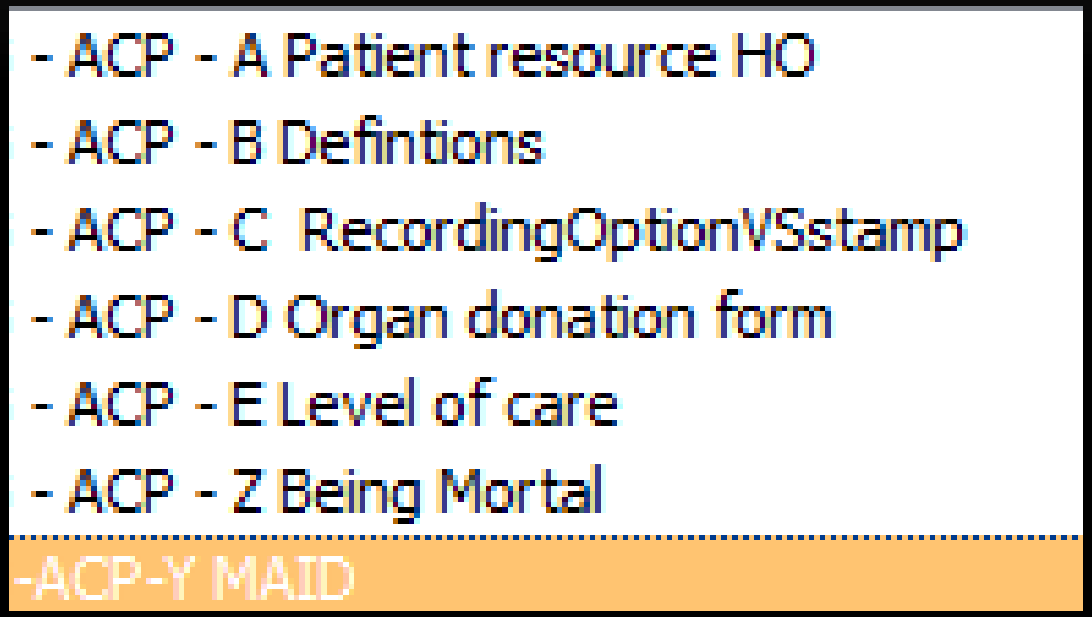
Process for the second appointment:

- 45- 60 minutes appointments with the SDM
- Identify what are the most important goals for care
- + / - other legal documents
- If the patient comes in with forms this should be charted in personal section and scanned onto EMR
- Record **ACP_Completed** once ACP is finished for tracking purposes

→ Direct patient to file a copy of the completed documentation :
at home
local hospital,
emergency services,
SDM(s),
others

Think K code

HANDOUTS FROM EMR (TELUS)



ADVANCED CARE PLANNING - Paule Demo - p. 1/2

☐ Discussed health condition with patient

THINK: What makes your life meaningful?

What do I value most about my mental and physical health?

☐ Being able to live independently
☐ Having my privacy
☐ Having family and friends nearby
☐ Be able to recognize others
☐ Being able to still do my hobbies
☐ Being able to communicate with others
☐ Keeping my dignity

Other:

What would make prolonging my life UNACCEPTABLE for me?

☐ Being in a coma with little or no possibility of waking up
☐ A loss of privacy
☐ Having to stay in bed but still able to communicate with others
☐ Not being able to communicate with others
☐ Losing control of my bodily functions
☐ Being kept alive with machines with no chance of survival
☐ Being a burden to family members
☐ Being in pain

Other:

The following medical terms were discussed:

Allow natural death - Cardiopulmonary resuscitation (CPR) - Comfort measures - Dialysis

End-of-life care - Feeding tube - Health care provider/Health care professional - Health condition

Informed consent - Intravenous (IV) - Life support with medical interventions - Palliative care

Power of Attorney/Power of Personal Care - Substitute Decision Maker - Symptoms

Terminal illness - Ventilator

Comments:

DECIDE: Who will speak on your behalf?

Who is your Power of Attorney?

Relationship:

Contact number:

Contact email:

Who is your substitute decision maker?

Relationship:

Contact Number:

Comments:

ADVANCED CARE PLANNING - Paule Demo - p. 2/2

TALK: Start the conversation

☐ Discussed ideas on how to start conversations with subsitute decision makers and family

RECORD: Document your plan (paper, online, video, audio)

www.advancecareplanning.ca

What are your goals of care, given your current health status? Complete form as applicable

☐ Level 1 - Supportive/Comfort Care
☐ Level 2 - Limited Therapeutic Care
☐ Level 3 - Transfer to Acute Care Hospital
☐ Level 4 - Transfer to Acute Care with CPR

View Advanced Directives/Care Guidelines form - File copy on chart and give original to patient

For the following items,'Y' means 'Yes' and 'N' means 'No':

☐ DO NOT RESUSCITATE (DNR): complete form as applicable ('Y' means 'Do Not Resuscitate')

View DNR form example - File copy on chart and give original to patient

☐ ORGAN DONATION - complete form as applicable

View organ donation form - File copy on chart, give copy to patient, mail original

☐ Would your above stated goals of care apply if you were in a persistent vegetative state?

Comments:

Signatures:		**Dates:**
Physician:		
Patient:		
Substitute Decision Maker:		

Personal Field in Patient CPP from the EMR (Telus)

ACP_Completed Nov 1st 2016 or ACP_Declined

DNR_Completed Nov1st, 2016

Organ_Donation_Completed Nov1st, 2016

SDM John Doe 705-268-0000

Level_Of_Care Score 1-4=

PATIENTS WE PILOTED

ILLNESS UNDERSTANDING

- Patients who retain accurate information/understandings of their illness significantly less likely to receive invasive Tx in the last 2 weeks of life
- Inaccurate illness understanding alone significantly impacts patient outcomes

CLARIFYING QUALITY OF LIFE, BELIEFS AND VALUES

- What brings quality to your life?
- What are things you value?
- What is important in your life, and what brings it meaning?

Identifying what is good life

Knowledge

Lack of awareness or familiarity with available practice tools
Lack of awareness of GAP between Ideal vs Current Practice
PDSA (assess, amend, audit & feedback)- timed review
Physician Management Institute Courses
Icemen 2016 – dedicate time
NOAMA project, 4 year cycle
LEG involvement
Mainpro+ certification requirements
Build on Proactive Interdisciplinary Health Review (PIPA)

Attitude

Discomfort with ACP topic
Lack of belief in one's ability to engage efficient office ACP
Lack of motivation to change
Commitment to Life Long Learning
Confidence in self directed professional behaviours
Limited self perception of clinical lead, organization spread

Behaviour

Difficult to recall and have resources readily available when needed
Case-load, clinical time versus admin time
Protected time
Self–directed, self reflection limitations

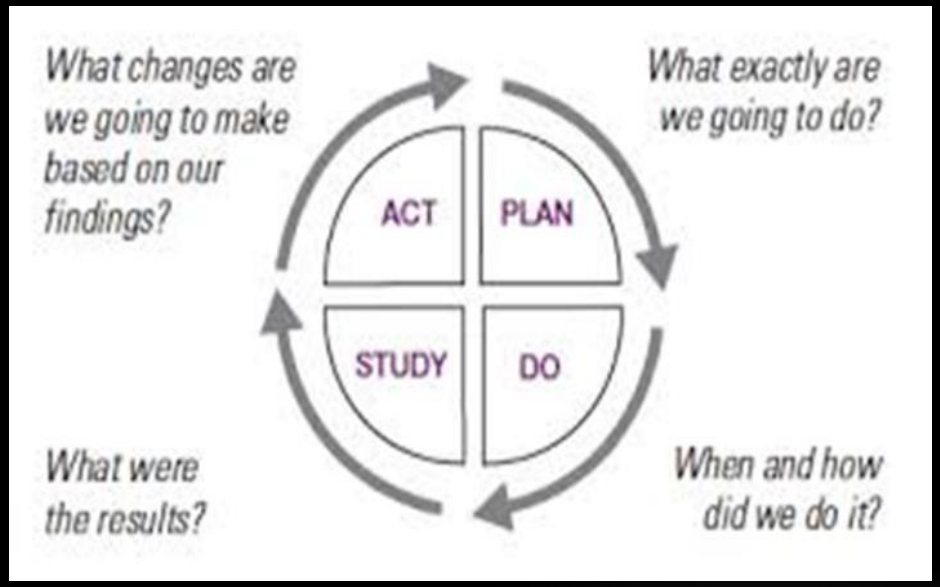
Personal goal met – not perfect but something

Organizational

Time or opportunity to implement recommendations
Commitment – support
Role conflict
9-5
Asking for and receiving help
Recognizing skill set
Finances
Who does the work, dedicated resources
Engagement, response rate

DIALOGUE

- Where should we go from here?



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