Advance care Planning: See one Do one Teach one

Dr Risa Bordman MD CCFP (PC) FCFP
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At the end of the workshop you should be able to:

• Demonstrate the components of an Advance Care Plan (ACP)
• Identify strategies to incorporate ACP discussions into a busy office practice
• Teach learners about ACP and involve them in the process
• What is ACP and What it isn’t
• Brainstorm tips for busy office
• What is the evidence around ACP and learners
• How to involve learners
• Role play: preceptor, student, pt
Advance care Planning and Learners

What do you want to get out of today’s seminar?
ACP Breakdown

- Review key terminology relating to advance care planning (ACP)
- Understand the role of substitute decision makers (SDMs), Powers of Attorney (POAs)
- Understand the importance of Values-Based Practice
Emotive video

Who will speak for you?
Advance Care Planning

- A process of discussing a person’s values, beliefs, wishes, trade-offs and approach to decision-making as they pertain to future healthcare
- Appoints and prepares a substitute decision-maker (SDM) to make healthcare decisions when one is no longer capable (lacks the capacity)
Understand and Appreciating ACP

- ACP is guidance for the SDM who will be asked to give consent when the person is incapable.
- Their SDM will be required to interpret these wishes to determine if they:
  - (1) are the most recent
  - (2) were expressed when the patient was capable
  - (3) are applicable to the decision that needs to be made.
Requirements to be a SDM:

- Mentally capable
- 16 years of age or older
- Not prohibited by a court order or separation agreement
- Available
- Willing to assume the responsibility
The legal Document

Power of Attorney for Personal Care (POA-PC)

- Distinct from POA for property and finance
- Only comes into effect when a person is incapable of making specific health care decisions
- Must be completed when the individual is capable of assigning a POA
  - Ability to determine whether the proposed POA has a genuine concern for the individual
  - Able to appreciate that the POA may have to make decisions on his/her behalf in the future

Goals of Care Discussions

- Attempt to align available treatments with a person’s goals
- They are discussions about current rather than future medical care

Code Status

- Pertains only to a specific treatment plan that will or will not be initiated in the event of cardiopulmonary arrest.
Advance Directive

- General term for expression of individual’s wishes with respect to future health care decisions
- **True or false**: Knowledge of a patient’s advance directive by a healthcare provider constitutes implied consent for treatment

**FALSE**
Consent must still be obtained from SDM

http://eol.law.dal.ca/?page_id=231
Patient goals

True or False:

- The term “goals of care” refers to a patient’s preferences regarding resuscitation

FALSE

Goals of care are patient-defined e.g. Going home to sit in garden, achieving life goals, attending the wedding of a grandchild, not being a burden to others
Identification and confirmation of the SDM
Discussion of a person’s values, beliefs and what they consider to be a good life or quality of life
Discussion includes perceptions of benefits, burdens and acceptable trade-offs

What is most important to the person at this point?
Are there previous conversations such as ACP discussion that can help you define the person’s goals for care now?
How do these goals fit with available treatment options?

Look for prior capable wishes that apply to the decision to be made (e.g. from ACP or POA document)
Informed consent process
Incorporates patient values into the decision making process

Capable Patient
Capable Patient or their SDM
Substitute Decision Maker Hierarchy

- **Guardian**: court appointed
- **Attorney for Personal Care**: You choose with proper documentation
- **Representative appointed by the Consent and Capacity Board**: someone applies to the board to be your “representative”
- **Spouse or partner**
- **A child or parent** or a children’s aid society or another person who is lawfully entitled to give or refuse consent for treatment in the place of a parent
- **A parent** who only has right of access
- **A sibling**
- **Any other relative** (blood, marriage, adoption)

If none on this list are willing, able or available, the office of the Public Guardian and Trustee will make healthcare decisions. They will also step in if two or more at the same level disagree.

When should someone consider a POA-PC?

- Who the person wants to make their healthcare decisions
- More than one person are unlikely to agree
- Appoint an Attorney for Personal Care

Who the law says will make healthcare decisions
Making Healthcare Decisions

Values

- Are the risk worth the benefits to me?
- Is this plan or treatment consistent with what I want to achieve?

Evidence

- Facts
- Expected outcome
- Side effects and risks

Health Care Decisions

Values reflect those things that are important to an individual or group.

What we deem as important guides our behaviour and decisions.

Our values help each of us determine how to balance benefits with burdens.
Values-Based Practice Exercise
Complete individually
Pair and share
Evidence for ACP Discussions (moderate to high)

• Improve Patient and Family’s satisfaction with EOL care
• Reduce hospital admissions and length of stay
• More hospice care
• Decreased ICU days and outpt services
• Earlier introduction of ACP leads to:
  • reduced hospital days
  • increased hospice care

Barriers to ACP

Lack knowledge/experience/skills with:
- ACP esp. in non-chronically ill
- Treatment options
- Terminal phases of illness
- Legal components
- When to initiate discussion

Fear of:
- Depriving patient of hope
- Creating anxiety
- Damaging doctor-patient relationship

Perception that patients:
- Do not want to discuss/do not want to upset their families
- Do not wish to discuss future health problems
- Will initiate the conversation themselves

LACK of TIME

Steps for ACP in the office

- Introduce the topic
  - Help decision making
  - Pick your preferences
- Structured discussion
  - Ideally with the SDM
  - Possible scenarios
  - Values and goals
- Document pt preferences
  - Distribute
- Review and update periodically
- Apply when necessary
What would help you to initiate ACP talks?
Facilitators for ACP discussions (some evidence)

- Accumulated skills
- Longstanding doctor-patient relationship
- Anticipated health problems in future
- Personal conviction
- Home better than office setting
- Reimbursed appropriately
- Ability to engage with other HCPs about ACP
- Hospital policy supporting/requiring advance directives
- **Younger GP** more likely to engage in ACP
Use computer-decision aid
  • www.makingyourwishesknown.com
  • Greater student knowledge, skill, satisfaction
  • Patient satisfaction was higher

Train with SPs
  • Emotionally challenging but satisfying
  • Surprised by openness/resistance

Use EMR reminder
  • increased students discussing ACP (17%)
ACP + Resident QI Projects

Stamp in PHE
- increased time, incomplete PHE, capacity

EMR reminder + handout
- Health provider comfort, motivation

Email (sign, letter) to >65 with COPD/CHF
- Use multiple modes communication, some just aren't ready

Mail handout to pt>50
- Negative feedback about the handout: unclear, confusing, stress provoking
- Booked 30 minute session with residents
- Then book with staff
  - Time was challenge to book, pts wanted to discuss more pressing matters

ACP and Learners

Bottom Line

- Learners are very engaged and can help out considerably
- Learners are good motivators and usually have more time
- EMR alerts are helpful
- While mail outs/emails/posters have some uptake the HCP initiation of conversation is more successful
- Limited resources should have a target group
Starting the ACP conversation with learners

- Who?
- What?
- Where?
- When?
- Why?

What works for you?
Getting started with a learner

- **Prepare** the learner
- Outline process for **identifying** patients
- When will it be done?
  - PHE, life expectancy, diagnosis, random?
- Who will **introduce** the topic
  - Student/staff/brochure/you
- Assess **capacity** to participate in an ACP conversation
- Introduce topic and assess **readiness**
  - If not ready, assess readiness to discuss SDM
Stepwise approach

• Introduce the topic
  • What does pt know?

• Provide resources on choosing SDM
  • Speak Up Canada
    http://www.advancecareplanning.ca
  • In many cases this is how far it will go.

• Provide ACP workbook and encourage review prior to next appointment

• Encourage SDM presence for next appointment

• ACP discussion
1. What is your **understanding** of your illness? What have you been told?

2. What **information** is important to you?

3. What brings **quality** to your life? What do you **value**?

4. If critically ill or if EOL, what **worries & fears** come to mind?

5. What **trade offs** are you willing to make for the possibility of added time?

6. If you were **near the end** of your life, what would make this time meaningful?
- The offer to discuss
- Readiness to engage
- Information to help SDM: values, beliefs and trade-offs, rather than specific treatment options
- Name of SDM
- Actual ACP
KEEP CALM AND ROLE PLAY

Teacher/Learner/Pt Encounter
The Case

Jamie is booked for a 15 min appointment. She is a 75-year-old woman with a long history of congestive heart failure. Jamie is here today with her son and daughter requesting a refill of her prescriptions.

Cast (work in groups of 5)
Jamie: patient
Son
Daughter
Preceptor
4th Year medical Student
• ACP informs future goals of care discussions
• ACP is values-based
• ACP not a one-time discussion
• Learners can have an active role in getting things started
  • but don’t have to finish it
Resources

• Speak Up ACP Canada
  www.advancecareplanning.ca
• Use your provincial workbook
• American website to explain and create ACP
  www.makingyourwishesknown.com
• QI approach to ACP from CancerCareOntario
  www.cancercare.on.ca/pcs/primcare/qitoolkit
Thank you

risa.bordman@utoronto.ca
• Use computer-decision aid vs standard package
  • www.makingyourwishesknown.com
  • Greater student knowledge, skill, satisfaction
  • Patient satisfaction was higher

• Train with SPs, interactive module then use same computer-based tool with a pt
  • Then wrote an essay
  • Emotionally challenging but satisfying
  • Surprised by openness/ resistance
  • Too time consuming: pt should do ACP exercise first then discuss

• Use EMR reminder increased students discussing advanced directives (17%)

Common questions about choosing a spokesperson

- Why do I need a spokesperson?
- Who should I entrust to be my spokesperson?
- What does a spokesperson do?
- What happens if I don’t choose a spokesperson?
- What questions should I ask my spokesperson?
- How do I designate a spokesperson?
- How can I cancel or change my designated spokesperson?
- Do doctors have to follow the decisions of my spokesperson?

Treatments | Kidney

- Kidney Dialysis
  - Filters waste products from blood stream
  - Typically is administered 3 times per week lasting 4 hours per treatment
  - Is not painful, but can make patients feel tired

- CPR
- Mechanical Ventilation
- Feeding Tube
- Hospice & Palliative Care

Medical Conditions
Organizing Your Priorities
Reviewing Your Choices
Defining your personal core values

Independence  Spirituality  Dignity  Courage  Loyalty
Risk-taking  Longevity  Wellness  Equality  Family
Friendship  Happiness  Wealth  Power  Integrity
Physical strength  Autonomy  Health  Vitality  Self-reliance
Clear-mindedness  Challenge  Empathy  Honour  Hard Work
Perfection  Authenticity  Curiosity  Respect  Fairness
Truthfulness  Balance  ____________  ____________
Status  Love  ____________  ____________

1. Consider the list of values above. Circle the ones that are important to you. If there are values missing from the list, feel free to add on the blank lines. This list reflects your personal values.

2. Consider your list of personal values and identify the 4 that are the most important to you. Write these core values in the boxes below.

3. Consider your personal list of core values. Try and assign a rank to them with 1 being the most important value.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Value</th>
<th>Brief Explanation (i.e. what does this value mean to you?)</th>
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4. Pair up and share how you’ve described your top 4 and discuss how this could be used by your SDM to guide decision-making.