Advance Care Planning

Canadian Hospice Palliative Care Webinar
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Webinar Overview

- Advance Care Planning in Canada project
- The meaning and importance of advance care planning.
- National Framework: Core Elements
- Tools
- Speak Up: Start the Conversation about end-of-life care
National Project

Advance Care Planning in Canada: National Framework and Implementation

• Is a project of the Canadian Hospice Palliative Care Association
• In its third year
• Overseen by a national Task Group – interprofessional and representing many jurisdictions
National Task Group

• ACP Experts/Communications experts
• Alberta Health Services - Calgary Area
• Canadian Bar Association
• Canadian Cancer Society
• Canadian Hospice Palliative Care Association
• Canadian Lung Association
• Canadian Medical Association
• CNA: Palliative Care Nurses Interest Group
• Canadian Society of Palliative Care Physicians
• CARENET
• College of Family Physicians of Canada
• Fraser Health, British Columbia
• **Funders: The GlaxoSmithKline Foundation and The Canadian Partnership Against Cancer**
Advance Care Planning in Canada – Long Term Project Goals

• To raise the awareness of Canadians about the importance of advance care planning and to equip them with the tools they need to effectively engage in the process.

• To prepare professionals/health care providers with the tools they need so they can facilitate and engage in the process of advance care planning with their clients.
Project Activities

- Needs assessment – literature review and environmental scan to identify the components of a *National Framework* and tools
- Developing draft *National Framework* through national consultation
- Review of existing tools for professionals to facilitate ACP with patients and families
- Two national roundtables to seek guidance on *Framework* and tools development
- Speak Up – a national awareness campaign
- Research activities
Advance Care Planning (ACP) is a process of reflection and communication. It is a time when a person (who is capable) reflects on their values and wishes, and lets others know their future health and personal care preferences in the event that they become incapable of consenting to or refusing treatment or other care.
Advance Care Planning: Definition

- A **process** of reflection and communication about values, beliefs and goals of care
- A **process** of planning for a time when a person cannot make their own medical decisions
- A **process** that involves discussions with healthcare professionals and significant others
- A **process** that may result in an advance directive
Advance Care Planning is not meant to be:

- One conversation about treatment options with a physician or other healthcare professional
- Strictly refusal of medical treatments
- A document/form family or healthcare professionals are unaware of nor have access to
- Conversations with only a closest family member that are not shared with others
Why is ACP Important?

Individuals who engage in advance care planning and/or appointed a substitute decision maker:

- Are much more likely to have their end-of-life wishes known and followed
- Have family members who had significantly less stress and depression
- Are more satisfied, as were their families and substitute decision makers
- Have fewer life-sustaining procedures and lower rates of intensive care unit (ICU) admissions
- Have a better quality of life and death
- Have less costly care in last weeks of life

What is the need in Canada?

2004 Ipso-Reid poll
- 70% of Canadians had not prepared a living will or advance care plan,
- 47% of Canadians had not designated a Substitute Decision Maker to make healthcare decisions for them if they are unable.
- Less than 44% of respondents had discussed end-of-life care with a family member
What is the need in Canada?

• Few strong pockets of ACP expertise across Canada.

• Most provincial and territorial governments have established legislation related to advance directives, but there are only a few areas in Canada that have established ACP programs within their organizations or jurisdictions.

• Focus often on documents rather than conversations.

• Language used with regard to ACP varies across jurisdictions, provinces/territories and care settings continues to vary significantly. This can cause confusion among the public and in the care setting.
ACP National Framework
Goal

• To provide a **model** for advance care planning that can be used to guide related activity, program development, and practice **across Canada**.
ACP National Framework Overview

1. Engagement
   - Engage healthcare professionals/providers
   - Engage the general public

2. Education
   - Education and training of professional providers
   - Education of the general public

3. System Infrastructure
   - Policy and program development
   - Tools to support conversations and documentation

4. Continuous Quality Improvement

Speak Up
Start the conversation about end-of-life care
Research

- CARENET is a partner
- Setting the agenda for ACP research in Canada
- ACCEPT Study:
  - Multi-centre study
  - Daren Heyland and Doris Barwich, Co PIs
  - Funded through the CIHR
  - Evaluate how advance care planning, a process of documenting and communicating end of life care wishes, can improve the quality of end of life care for seriously ill Canadians and their family members and at the same time, reduce costs for our health care system
Speak Up

- National advance care planning campaign

- Includes Advance Care Planning Day – April 16, 2012

- Provides a web portal with resources for the public, professionals and community organizations/agencies
Target Audiences

- Health care professionals
- Community health-related organizations/associations
- Individuals – middle aged and seniors
- Caregivers
- Media
- Policy/decision makers
Website

For:
• Patients and families
• Professionals
• Community organizations / agencies / programs
• Researchers

www.advancecareplanning.ca
Toolkits for patients and families

- Why plan for end of life care?
- What is advance care planning?
- Naming a substitute decision maker
- Workbook to assist in having the conversations
- Wallet card to name substitute decision maker
Toolkits for patients and families

Tips on how to make a plan
• Think about what’s right for you
• Learn about end of life care options and treatments
• Determine who will make decisions on your behalf
• Have/begin the conversation
• Write down your wishes
• Review your plan regularly
In Case of Medical Emergency

I have a Substitute Decision Maker who can speak for me if I am unable to communicate my wishes regarding medical care:

Substitute Decision Maker: ____________________________________________________________

Tel: __________________________________________________________

Alternative Tel: __________________________________________________________

Relationship to me: __________________________________________________________

Signature: ___________________________ Date: ________________
Hot off the Press!

Advance Care Planning Workbook
Advance Care Planning Workbook

- What ACP is and why it is important
- The process of advance care planning
- Definitions of terms such as CPR, informed consent, feeding tube, life support, ventilation
Advance Care Planning Workbook

• Questions to help explore values
  – What do I value most in terms of my mental and physical health? (For example, being able to live independently, being able to recognize others, being able to communicate with others)

  – What would make prolonging life unacceptable for me? (for example, not being able to communicate with those around me, being kept alive with machines but with no chance of survival, not having control of my bodily functions)

  – If I were nearing death, what would I want to make the end more peaceful for me? (for example, family and friends nearby, dying at home, having spiritual rituals performed, etc.)
Toolkits for agencies – get involved!

- Campaign kit
- Templates for posters, ads, news releases
- Bookmarks
- Wallet cards
- Broadcast PSA script
- FAQs on advance care planning
- Articles for newsletters or websites

- **New ACP Video**
- [View Video](#)
Toolkits for Professionals

- About advance care planning
- Tools to get the conversation going
- Tools to facilitate advance care planning
- Resources in different jurisdictions
- References/research materials
Advance Care Planning
Resource Commons

The Advance Care Planning Commons enables each of us to share resources and to learn from each other’s experience.
Advance Care Planning Resource Commons

• A repository for sharing and uploading resources.

• Provides professionals – health, legal and planning with the resources they need to learn about advance care planning and to effectively engage in ACP.
Facilitating Advance Care Planning: An Interprofessional Education Program

Educating Future Physicians in Palliative and End-of-Life Care

Speak Up
Start the conversation about end-of-life care
Social Marketing

- Online presence and promotion
- Website promotion via links, news stories, sharing sites, etc.
- Facebook / Twitter presence
- Videos / Youtube channel
Media and Partnerships

- Media pitches / story backgrounders
- News releases
- Radio shows
- Partnerships with NGOs, governments and service providers
It’s about conversations.
It’s about decisions.
It’s how we care for each other.

www.advancenutritionplanning.ca