The Journey to Goal Concordant Care

Advance Care Planning, Serious Illness & Goals of Care Conversations, & Consent Legislation, & Best Practice Communication Skills.

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Regional Coordinator, FH ACP
Clinical Instructor, UBC

Agenda

- 9am Introductions, Reflections & Goals
- Review of Advance Care Planning, Serious Illness and Goals of Care Conversations
- Understand ACP and Consent within the context of the Law
- Discuss Communication Skills, Review Best Practices & Practice
- 3pm Adjourn

Introductions & Reflections
Personal Learning Objective

What do you hope to learn today?

Learning Objective #1

- Review Advance Care Planning, Serious Illness Conversations & Goals of Care Conversations.
- How do they link? What populations do they best serve? What exactly do they entail? Who should engage in them?

Consensus Statement Advance Care Planning

Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

Sudore RL, Lum HD, You JY, Hanson LC, Meier DE, et al. Defining Advance care planning for adults: A consensus definition from a multidisciplinary Delphi panel. Journal of Pain and Symptom Management. 2017, May. 53(5): 821-32.

Advance Care Planning Framework

A

Healthy adults >19 years or older

Begin ACP Conversations

- **Identify Substitute Decision Maker(s)**
  - Recognize & understand **Temporary Substitute Decision Maker (TSDM)** list
  - Consider appointment of **Representative(s)**
- Consider **medical decisions preferences**
- Document of any **beliefs that impact healthcare treatments**
- Consider **Advance Directive** for any enduring consent or refusal of particular treatment
- Consider **organ donation**
- **Discuss** all above with family, SDM's, and health care providers

B

Diagnosed with chronic or serious illnesses

EVERYTHING IN A +

Continue ACP Conversations

- Review completed ACP documentation (Values, Wishes, Beliefs, **Advance Directive Representation Agreement)**
- Review and complete **Temporary Substitute Decision Maker (TSDM)** list
- Learn about illnesses and possible future complications and treatment options with healthcare team
- **Review life and healthcare values, goals, wishes, priorities** in light of new health reality

C

Identified as having 1-2 years prognosis

EVERYTHING IN A & B +

Initiate Serious Illness Conversation with healthcare providers, SDMs and family

- **Assess** illness understanding & preferences
- **Share** prognosis
- **Explore** key topics
- **Document** on ACP Record

D

Ongoing decline or transfer of location of care

EVERYTHING IN A, B & C +

- **Review Serious Illness Conversation Guide** answers and document on ACP Record
- **Shared decision making** about future medical decisions and document
- **Goals of Care Conversations** within context of immediate health issues and document on ACP Record
- **Medical Order for Scope of Treatment (MOST)** form completion by physician based on everything above and document on ACP Record
- **Discuss** these choices with family and SDMs

E

Final weeks / days

EVERYTHING IN A, B, C & D +

- **Ensure treatments are in alignment** with MOST and all previous ACP processes and documentation

F

Review

- Goal-concordance
- Family Satisfaction
- Quality Improvement

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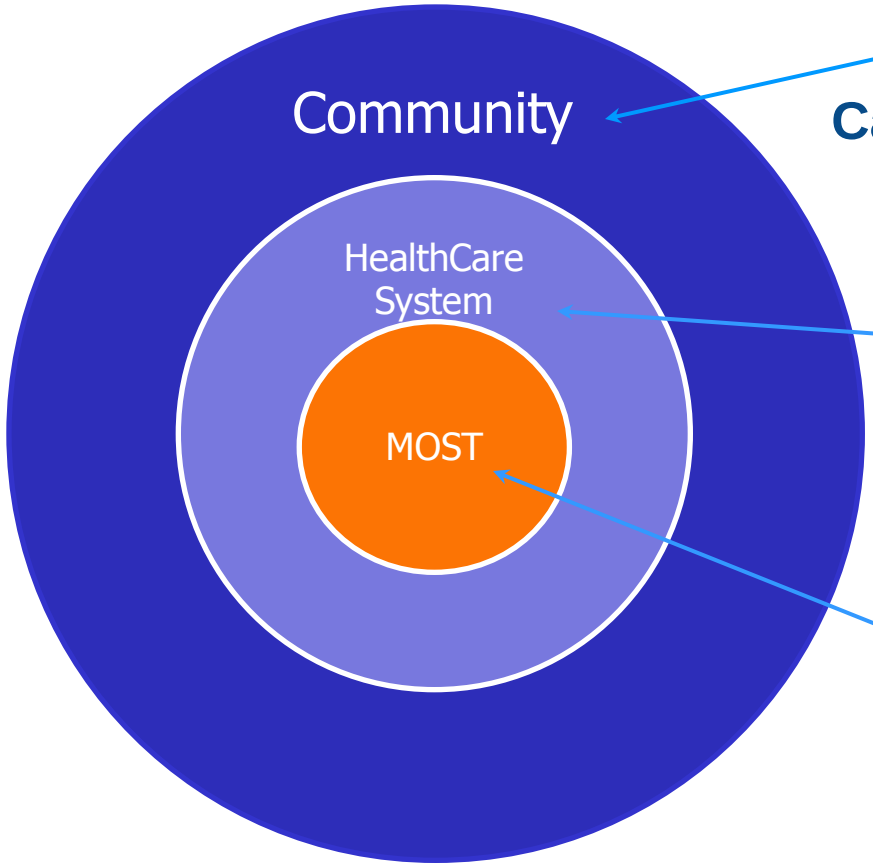
Version: January 2018

Making the *MOST* of Conversations



Advance Care Planning
Capable adults do for themselves

Advance Care Planning &
Goals of care and
Serious Illness conversations.
Health care providers engage

Medical Orders for Scope of Treatment: A physician Order specifying scope of treatment in all sectors of care

Advance Care Planning Process

Five Steps Video

Videos

Guiding you through making a plan

- Advance Care Planning - Five Steps
- Advance Care Planning - Five Steps (Simplified Chinese)
- Advance Care Planning - Five Steps (Traditional Chinese)
- Advance Care Planning - Five Steps (French)
- Advance Care Planning - Five Steps (Punjabi)

http://www.fraserhealth.ca/acp

If this is what capable adults are being encouraged to do...

What should healthcare professionals be asking?

When?

By Whom?

Advance Care Planning Conversations

- How does this link to Serious Illness and Goals of Care?
- What populations do they best serve?
- Who engages in them?
- Are they consent conversations?

Serious Illness Conversations

- How does this link to ACP and Goals of Care?
- What populations do they best serve?
- Who engages in them?
- Are they consent conversations?

Serious Illness Resources

fraserhealth Better health. Best in health care.

SERIOUS ILLNESS CONVERSATION GUIDE
A CONVERSATION TOOL FOR CLINICIANS

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* • Introduce purpose • Prepare of future decisions • Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want - **is this okay?**"
2. *Assess illness understanding and preferences*	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* • Share prognosis • Frame as a "wish...worry" "hope...worry" statement • Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." **OR** *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ (*express as a range, e.g. days to weeks, weeks to months, months to a year*)." **OR** *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

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Talking About the Future: Advance Care Planning

At your next appointment, we would like to talk with you about your illness, your goals and wishes, and start to plan for the future. This is an important part of the care we provide for everyone we see.

We like to start talking about this when people are doing okay. Your illness is serious but stable, so now is a good time to talk about what lies ahead and to do some planning for the future. People who

Bring to your next appointment
If you have any of the following, please bring them with you:

- No Cardiopulmonary Resuscitation (CPR) form
- Medical Order Scope of Treatment (MOST) form
- Advance Care Plan
- Advance Directive
- Representation Agreement

Talking About Your Illness With Loved Ones and Caregivers

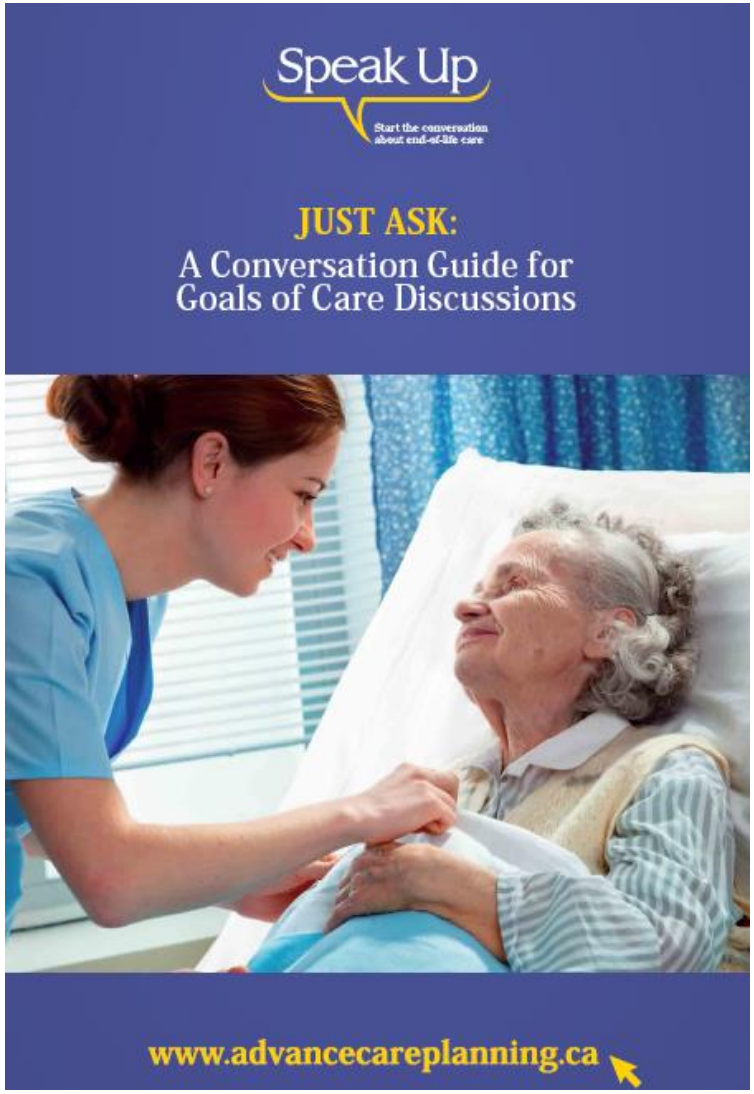
Advance Care Planning
and
Serious Illness Conversations

Goals of Care Conversations

- How does this link to ACP and Serious Illness?
- What populations do they best serve?
- Who engages in them?
- Are they consent conversations?

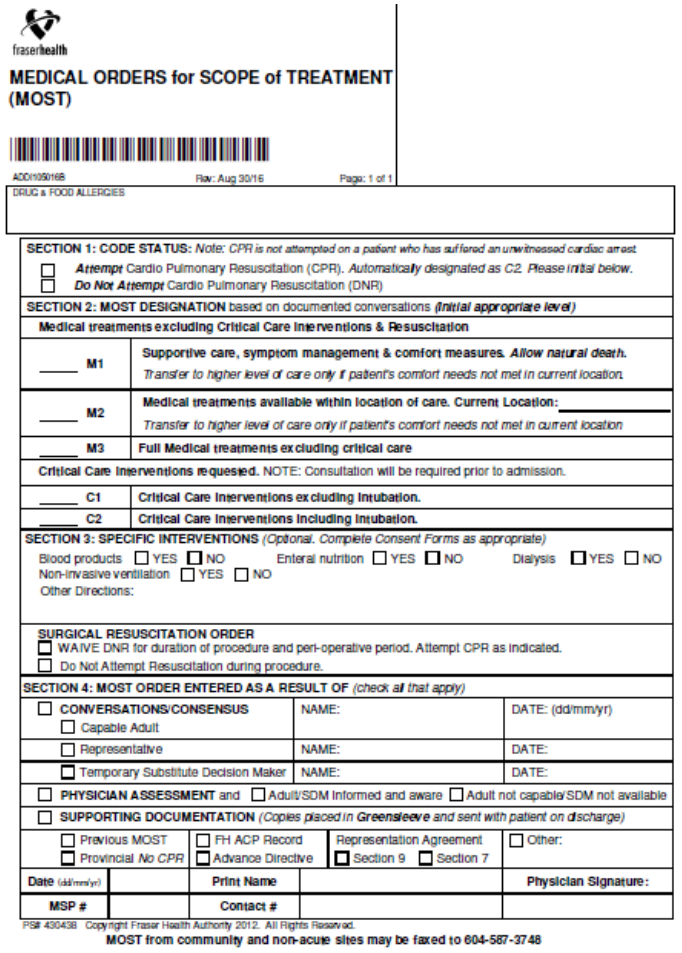
Goals of Care Conversations

- "…consist of putting prior ACP conversations about wishes into the current clinical context, resulting in medical orders for the use or non-use of life-sustaining treatments."



Making the ***MOST*** of Conversations

medical order



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MEDICAL ORDERS for SCOPE of TREATMENT (MOST)

ADDR05016B Rev: Aug 30/16 Page: 1 of 1

DRUG & FOOD ALLERGIES

SECTION 1: CODE STATUS: *Note: CPR is not attempted on a patient who has suffered an unwitnessed cardiac arrest.*

☐ ***Attempt*** Cardio Pulmonary Resuscitation (CPR). *Automatically designated as C2. Please initial below.*

☐ ***Do Not Attempt*** Cardio Pulmonary Resuscitation (DNR)

SECTION 2: MOST DESIGNATION based on documented conversations ***(Initial appropriate level)***

Medical treatments excluding Critical Care Interventions & Resuscitation

____ **M1**	**Supportive care, symptom management & comfort measures. *Allow natural death.*** *Transfer to higher level of care only if patient's comfort needs not met in current location.*
____ **M2**	**Medical treatments available within location of care. Current Location: _____** *Transfer to higher level of care only if patient's comfort needs not met in current location*
____ **M3**	**Full Medical treatments excluding critical care**

Critical Care Interventions requested. NOTE: Consultation will be required prior to admission.

____ **C1**	**Critical Care Interventions excluding intubation.**
____ **C2**	**Critical Care Interventions including intubation.**

SECTION 3: SPECIFIC INTERVENTIONS *(Optional. Complete Consent Forms as appropriate)*

Blood products ☐ YES ☐ NO Enteral nutrition ☐ YES ☐ NO Dialysis ☐ YES ☐ NO

Non-invasive ventilation ☐ YES ☐ NO

Other Directions:

SURGICAL RESUSCITATION ORDER

☐ WAIVE DNR for duration of procedure and peri-operative period. Attempt CPR as indicated.

☐ Do Not Attempt Resuscitation during procedure.

SECTION 4: MOST ORDER ENTERED AS A RESULT OF *(check all that apply)*

☐ **CONVERSATIONS/CONSENSUS** ☐ Capable Adult	NAME:	DATE: (dd/mm/yr)
☐ Representative	NAME:	DATE:
☐ Temporary Substitute Decision Maker	NAME:	DATE:

☐ **PHYSICIAN ASSESSMENT** and ☐ Adult/SDM informed and aware ☐ Adult not capable/SDM not available

☐ **SUPPORTING DOCUMENTATION** *(Copies placed in **Greensleeve** and sent with patient on discharge)*

☐ Previous MOST ☐ Provincial *No CPR*	☐ FH ACP Record ☐ Advance Directive	Representation Agreement ☐ Section 9 ☐ Section 7	☐ Other:

Date (dd/mm/yr)		**Print Name**		**Physician Signature:**
MSP #		**Contact #**		

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MOST from community and non-acute sites may be faxed to 604-587-3748

Advance Care Planning, Serious Illness & Goals of Care Conversations:

The Link

Following the teams understanding of what is important to the person, what the person is willing to go through to achieve goals and avoid fears…

What are the proposed treatments?

"Given your goals and priorities and what we know about your illness at this stage, I recommend…"

My patient was very clear that he wanted a social life and he didn't want aggressive treatment that would prevent him from being social. Thus, I didn't recommend a ventilator or feeding tube.

Health Care Providers' Guide to Consent to Health Care

Ministry of Health
July 2011

The health care provider explains the proposed treatment or course of treatment including:

- The condition for which the health care is proposed
- The nature of the proposed health care
- The risks and benefits of the proposed health care that a reasonable person would expect to be told about
- Alternative courses of health care (and when indicated, the likely consequences of no treatment)

↓

The adult has an opportunity to ask questions and receive answers about the proposed health care

↓

The adult gives (or refuses) consent to the proposed health care

↓

A health care provider must stop or withdraw treatment if consent is later withdrawn by the adult

Documentation

- Documenting Advance Care Planning, Serious Illness and Goals of care Conversations
- Why is this so important?

ACP Record

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ADVANCE CARE PLANNING (ACP) RECORD

ACP, SERIOUS ILLNESS & GOALS OF CARE CONVERSATIONS
This is a reference and may not reflect most up to date conversations.

ADDI101231F Rev: May 2018 Page: 1 of 2

Tools to facilitate ACP conversations:
- FH Core Elements
- Serious Illness Conversation Guide (SICG)
- Goals of Care

Select most appropriate tool based on purpose of conversation, acuity/prognosis of illness, and/or treatment decision making.
See back for further details.

Previous Advance Care Planning documentation: Reviewed and copy in Greensleeve (if applicable):

☐ Advance Care Planning Record ☐ Advance Care Plan
☐ Representation Agreement ☐ Advance Directive
☐ Provincial No CPR
☐ Medical Orders for Scope of Treatment (MOST)

Type of conversation and tool utilized. (check one)	**Brief summary of key outcomes/decisions of conversation.**	**Recommendations/Next Steps**
☐ FH Core Elements ☐ Serious Illness Conversation Guide (SICG) ☐ Goals of Care (GoC)		Next steps *patient/client/resident/SDM* responsible for (eg. learn about illness, talk to family, legal/financial planning):

ACP & MOST Central Fax

- Physician offices and FHA clinics without scanning abilities fax completed MOST and ACP Records
- These are scanned into EMR
- Viewable in Meditech (thus UCI)

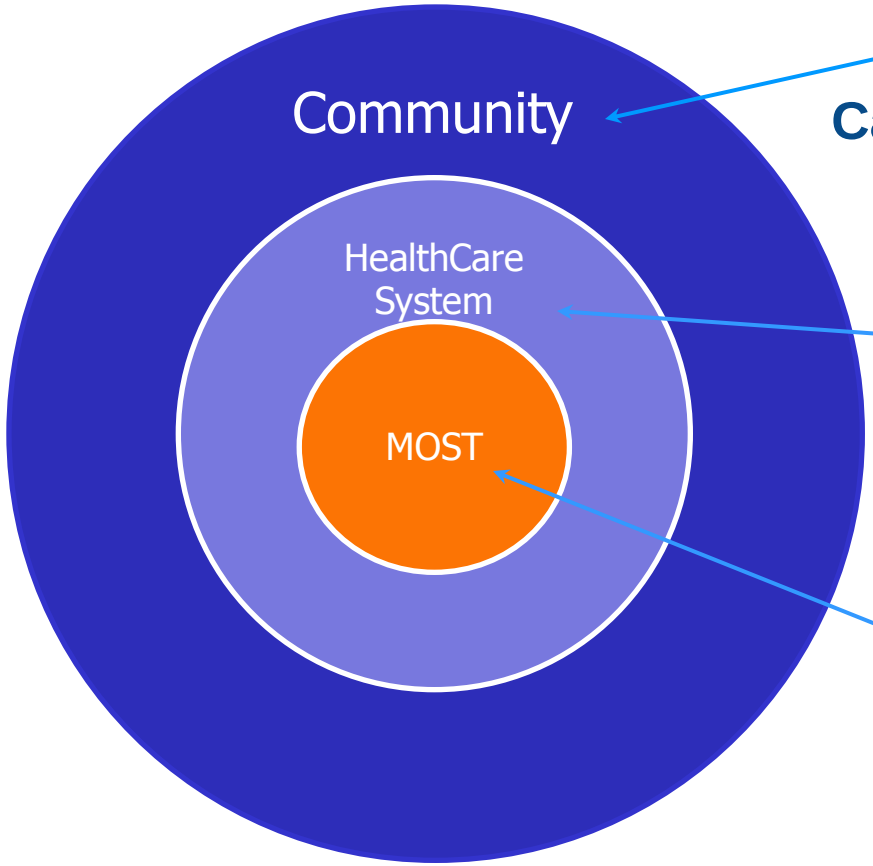
Experiences using the ACP Record

What to write?

- *Prior to this health event, Mr Jones was spending his days…*

- *He states that being able to make it from his couch to the living room to watch movies is important to him*

Making the *MOST* of Conversations



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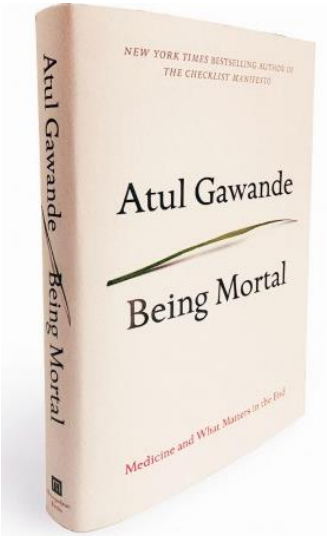
Atul Gawande

"How to Talk End of Life with Dying Patients"

"Being Mortal: Medicine and What Matters in the End"



Atul Gawande

We think conversation is, do we fight, or do we give up?

"And the reality was that it's not do we fight, or do we give up? It's what are we fighting for? People have priorities besides just surviving no matter what. You have reasons you want to be alive. What are those reasons? Because whatever you're living for, along the way, we've got to make sure we don't sacrifice it; and in fact, can we, along the way, whatever's happening, can we enable it?"

https://onbeing.org/programs/atul-gawande-what-matters-in-the-end-oct2017/

Advance Care Planning
&
The Law

Learning Objective #2

- State and explain the importance of informed consent and the link with Advance Care Planning
- State and explain key legal obligations

Consent

When meeting with patient or family/SDMs, the team should know the intention.

- Is the team clear about what treatments are being proposed and offered?
- What treatments are medically indicated - relevant and appropriate?

MOHS *Health Care Providers' Guide to Consent to Health Care* provides detailed information about consent, when it is required and not as well as steps to take for substitute consent

Pause & Pearl…Consent

- Is the **patient and family** clear about what treatments are being proposed and offered?

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Health Care Defined

- Major Health Care
  - major surgery, any treatment involving a general anesthetic, major diagnostic or investigative procedures, or any health care designated by regulation as major health care;
- Minor Health Care
  - routine tests to determine if health care is necessary, and routine dental treatment

Communication

When meeting with patient or family/SDMs, the team should know the intention.

- Is the team clear about what treatments are not proposed and offered?

- What treatments are not medically indicated - relevant and appropriate?

Pause & Pearl…Communication

- Is the **patient and family** clear about what treatments are not being proposed and offered?

Medical Treatment *Consent* Hierarchy BC

1. Capable Adult (19 yrs)
2. Committee of Person (Patient's Property Act)
3. Representative (Representation Agreement Act)
4. Advance Directive
5. Temporary Substitute Decision Maker (Health Care (Consent) and Care Facility (Admission) Act)
    1. Spouse (common law, same gender)
    2. adult children (equally ranked)
    3. Parent (equally ranked)
    4. brother or sister (equally ranked)
    5. Grandparent (equally ranked)
    6. Grandchild (equally ranked)
    7. Anyone else related by birth or adoption
    8. Close friend
    9. A Person immediately related by marriage
    10. another person appointed by PGT

*No conflict and contact within 12 months

Substitute Consent

- What are qualities you would want in Substitute Decision Maker(s)?
- Who do you talk with about important things? Who knows you the best?
- Who could honour your wishes?
- Does it follow our BC legal hierarchy?

Who's Making Substitute Medical Decisions?

- Within 48 hours of being hospitalized, almost half of all adults aged 65 or older will need someone else to help them make at least one medical decision, and almost one-fourth will need that person(s) to make all of their medical decisions

- Most SDMs were daughters [59 percent]; next sons [25 percent] and spouses [20 percent].

Torke, Alexia M., Sachs Greg A., et al, Scope and Outcomes of Surrogate Decision Making Among Hospitalized Older Adults *JAMA Intern Med.* 2014;174(3):370-377

Representatives and Temporary Substitute Decision Makers

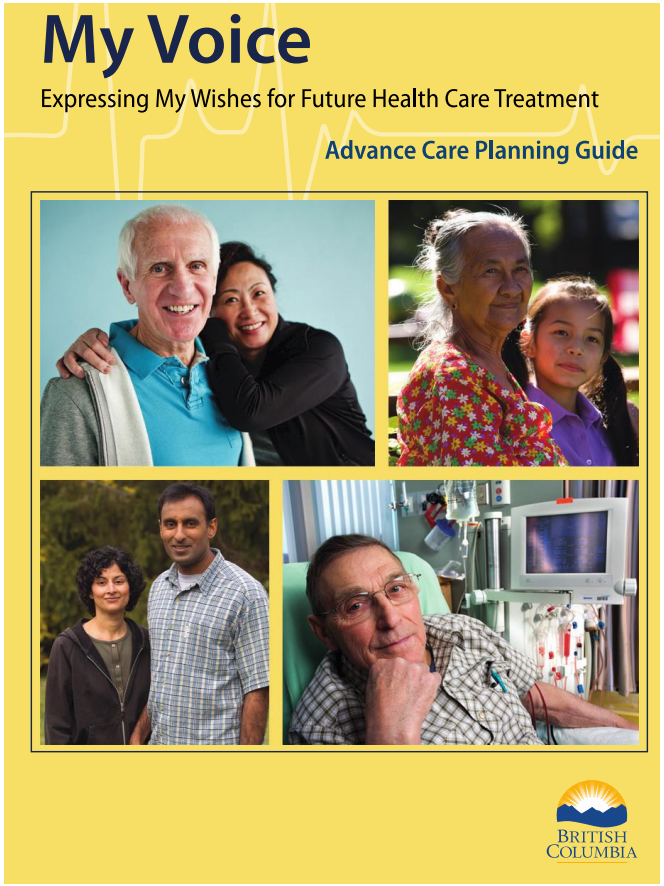
- Roles and responsibilities are many and include:
  - Complying with the wishes or instructions of the adult

Planning Tools

**Available on-line in Punjabi and Simplified Chinese*

FH Patient Education Catalogue

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



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

- Laws differ across the country
- 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
- Engaging in Advance Care Planning nor completing forms cannot be mandatory

Call Cari….

ACP Conversation and Communication Skills

Learning Objective #3

- Discuss Communication Skills, Review Best Practices &

Practice

Practice

Practice

Have you…

1. Thought about what matters most to you regarding your health care?
2. Documented your wishes
3. Talked with your family
4. Talked with your health care provider

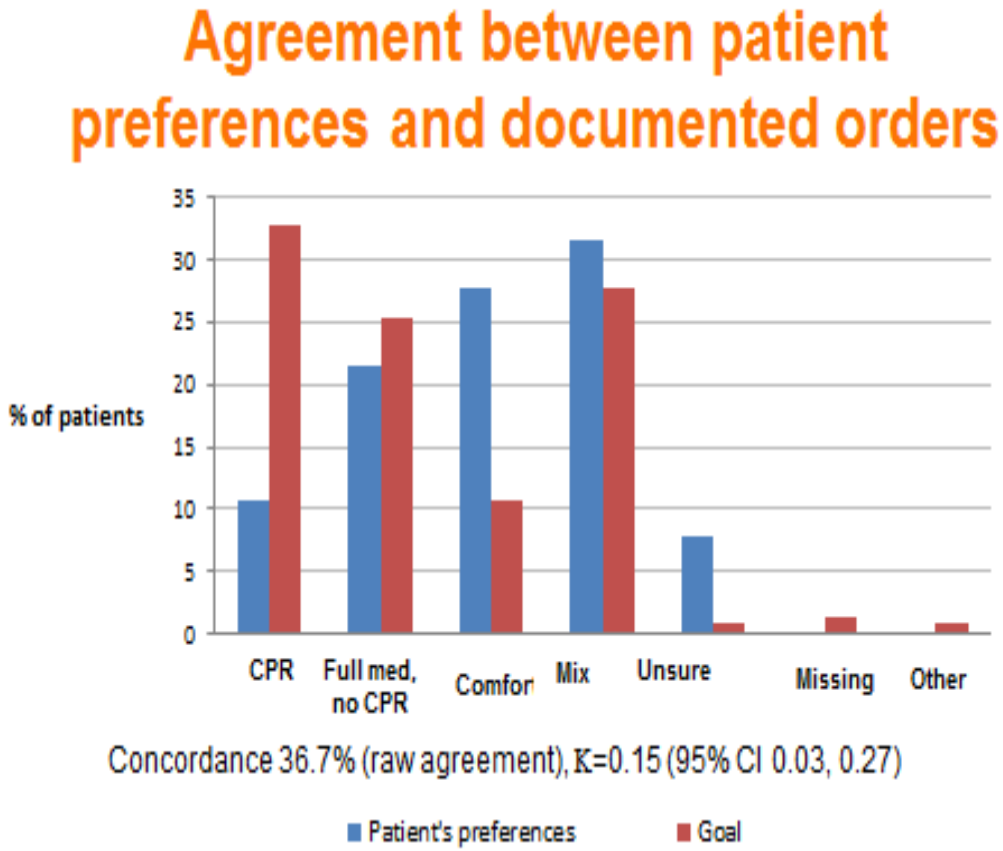
BC Public Survey

- **71%** have thought about what matters most to them regarding their health care
- **27%** have documented their wishes for their health care
- **49%** have discussed this with their family
- **10%** have discussed this with their health-care provider

Data from a survey of 500 British Columbians, September 2016

National Research: ACCEPT Study

Poor alignment of the person's wishes compared to documented orders



Heyland, Barwich et al. Failure to Engage: JAMA Int Med 2013

Variety of Conversation Tools

1. Fraser Health's Core Elements
   - Developed in focus groups with 200 front line clinicians
2. Respecting Choices
   - Internationally recognized, evidence-based program in Wisconsin. Pioneer, began in 1990
3. Serious Illness Care Program
   - System-level intervention centered around a Serious Illness Conversation Guide. Began 2015.

FHA Core Elements of ACP Conversations

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).

Respecting Choices

1. Assess understanding of medical condition
2. Assess hope of current treatment plan
3. Provide information on disease progression
4. Assist in developing questions for physician
5. Explore fears and concerns
6. Provide information on risks of complications

https://respectingchoices.org/

Serious Illness Conversation Guide

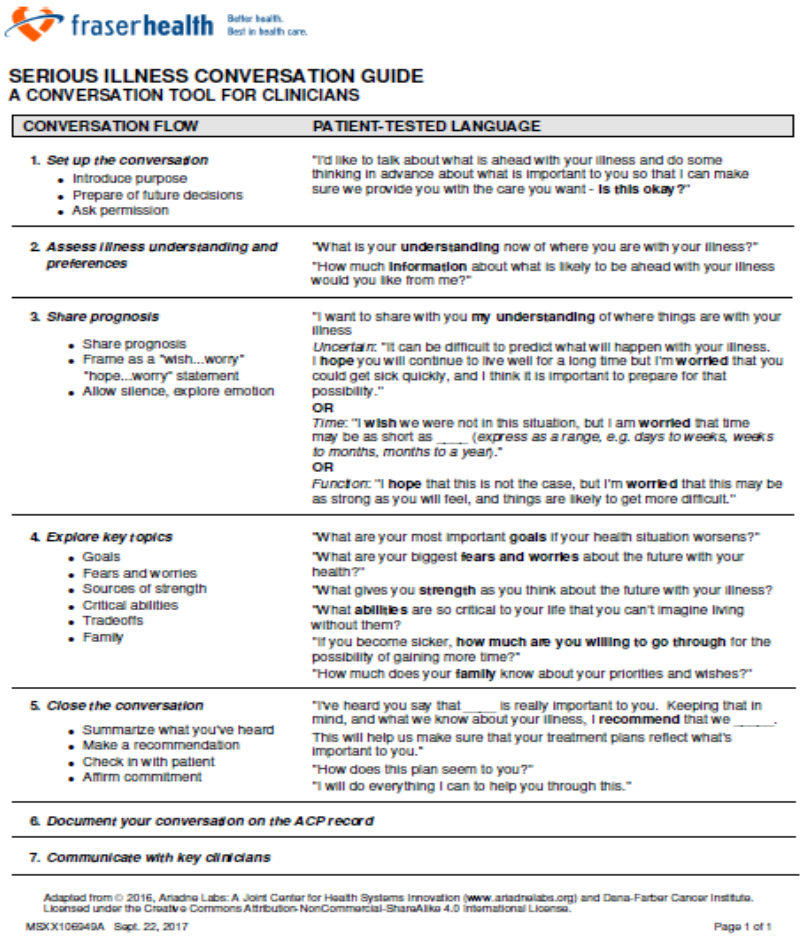
1. Set up Conversation
2. Assess illness understanding and information preferences
3. Share prognosis
4. Explore key topics:

- Goals, Fears and worries,
- Sources of strength,
- Critical abilities,
- Tradeoffs,
- Family.

5. Close the conversation (make recommendation)
6. Document on ACP Record
7. Share with Key Clinicians

https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

Forms on Demand – Alerts and Directives



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A CONVERSATION TOOL FOR CLINICIANS

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2. ***Assess illness understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share prognosis*** • Share prognosis • Frame as a "wish...worry" "hope...worry" statement • Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." **OR** *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ____ (*express as a range, e.g. days to weeks, weeks to months, months to a year*)." **OR** *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. ***Explore key topics*** • Goals • Fears and worries • Sources of strength • Critical abilities • Tradeoffs • Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness? "What **abilities** are so critical to your life that you can't imagine living without them? "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. ***Close the conversation*** • Summarize what you've heard • Make a recommendation • Check in with patient • Affirm commitment	"I've heard you say that ____ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ____. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation on the ACP record***	
7. ***Communicate with key clinicians***	

Demonstration Case Description

SETTING: Clinic, one month after hospitalization for COPD exacerbation - 68 year-old retired salesman - Chronic Obstructive Pulmonary Disease (COPD), on steroids and home oxygen; diabetes, chronic kidney disease; chronic hip pain - Two hospitalizations this year, each for complications of COPD; two ED visits - Declining functional status at home, despite short stays in rehab - Spouse very involved, 28 yr old daughter lives locally

As you prepare to meet with Mr. Smith, you consider the following: - Mr. Smith has COPD and multiple co-morbidities - Given the hospitalizations and declining functional status, you are worried that he will have a harder time managing at home and that something serious could happen quickly, so you want to begin a conversation

Goal: Explore Mr. Smith's values and goals using the Conversation Guide

Demonstration

https://www.youtube.com/watch?time_continue=1&v=fhwa9f5O_U4

Respecting Choices
Initial Conversation

Watch DVD
Choose Health Care Proxy
(Substitute Decision Maker)

Watch DVD
Explore Experiences

Watch DVD
Explore "Living Well"

Skills Based Practice Exercises

"Those who discuss ACP more frequently with consumers are significantly less likely to:

1. think the conversation is upsetting…
2. think that such discussions are only for people with <6 months to live…
3. think ACP discussion take too much time…
4. feel that they do not know enough or…
5. think it is the physician's responsibility…"

Hazelett et al, Factors Associated With Advance Care Planning Discussions by Area Agency on Aging Care Managers, Am J Hospice Pall Med 2013 v30(8) p759-763.

Debrief Practice Exercises

- What went well?
- What would you do differently next time?

Resources

Call Cari….for Consults, Form and Policy Development, Questions about ACP, Substitute Decision Making…

Integrated Risk Management

- Provides risk consulting and advisory services to clinical and non-clinical programs and services in FHA

- Developed FH Consent for Health Care Policy & Forms

Consent for Health Care Policy & Forms

A **Consent for Health Care policy** has been approved by FH Executive and the Health Authority Medical Advisory Committee (HAMAC). It comes into effect on September 1st to coincide with changes to BC's consent legislation that comes into force on that same date.

The new policy replaces any previous policies, and contains three new regional forms that replace numerous existing and outdated forms. Samples of these new forms are provided below:

1. **Consent to Health Care**
2. **Refusal of Blood Components/Product Administration**
3. **Confirmation of Substitute Decision Maker**

These forms are available through normal forms ordering processes: *Forms on Demand (FOD), Stores* and *Print Shop*. In FOD, the new forms can be found under the "*Consents & Waivers*" category and existing chart packs.

Integrated Risk Management Contact

INTEGRATED RISK MANAGEMENT TEAM

Below is a list of the IRM Team and the responsible areas for each team member:

SITE/PROGRAM	IRM CONTACT
• Burnaby Hospital & Burnaby Health Services	
• Chilliwack General Hospital & Fraser Canyon Hospital & Chilliwack/Hope/Agassiz Health Services	
• Delta Hospital & Delta Health Services	
• Eagle Ridge Hospital & Tri-Cities Health Services	
• Langley Hospital & Langley Health Services	**Douglas Clouden** **IRM Consultant** **Direct: (604) 587-4668** douglas.clouden@fraserhealth.ca
• Peach Arch Hospital & South Surrey/White Rock Health Services	
• Ridge Meadows Hospital & Maple Ridge/Pitt Meadows Health Services	
• Mental Health and Substance Use	
• Primary Health Care and Chronic Disease Management	
• Rehabilitation Services	

Integrated Risk Management Contact

SITE/PROGRAM	IRM CONTACT
• Abbotsford Regional Hospital and Cancer Centre & Mission Memorial Hospital & Abbotsford/Mission Health Services	
• Surrey Memorial Hospital & Jim Patterson Outpatient Care and Surgery Centre & Surrey Health Services	
• Royal Columbian Hospital & New Westminster Health Services	**Kimberley Shier** **IRM Consultant** **Direct: (604) 587-4415** kimberley.shier@fraserhealth.ca
• Contracted Residential Care	
• Hospitalist Services	
• Maternal, Infant, Child and Youth	
• Pharmacy Lower Mainland	
• Professional Practice	
• Public Health	

Advance Care Planning Intranet

FHpulse

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Advance Care Planning

Click here to view the table of contents.

The Journey to Goal Concordant Care

Advance Care Planning (ACP) is an overarching process for incapacity planning, and health care providers' advance care planning, goals of care and serious illness conversations.

It is a process that supports and encourages capable adults to talk over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and substitute decision maker(s), in advance of a situation when they are incapable of making health decisions.

The process of Advance Care Planning is detailed in the following framework as well as on the Conversations page:

Click the image to enlarge.

What I Do Matters.

MOST and ACP Policy & Patient Resources

Title*	Medical Orders for Scope of Treatment and Advance Care Planning - Clinical Policy
Status*	Released
Link to CDST*	Medical Orders for Scope of Treatment and Advance Care Planning - Clinical Policy
Related Resources	**Appendices:** **A** Medical Orders for Scope of Treatment - Pre-Printed Order **B** Advance Care Planning Record - Form **C** Greensleeves (Information Sheet) **D** Accessing a Scanned Chart in EMR: Step-by-Step Guide **E** Physician Assessment re Benefits of CPR **F** Emergency Treatment Involving an Adult 19 Years of Age or Older **G** Serious Illness Conversation Guide - Form **Patient Education:** Talking About Your Illness with Loved Ones and Caregivers: Advance Care Planning and Serious Illness Conversations - Booklet PS #265583 Talking About the Future: Advance Care Planning PS #265582 Making Informed Decision about CPR STORES ITEM #350960 Medical Order for Scope of Practice or MOST: What is it? Should I have one? STORES ITEM #436874

Fraser Health Resources

- Intranet – under Clinical Programs
- Internet
  http://www.fraserhealth.ca/acp
- 1-877-TALK-034 (1-877-825-5034)
- advancecareplanning@fraserhealth.ca

Fraser Health Advance Care Planning Education

- ACP and MOST on-line modules and Education sessions

- **http://learninghub.phsa.ca/**

Provincial Resources http://www.seniorsbc.ca/legal/healthdecisions/

- Provincial My Voice Guide:
  - Includes Advance Directive and Representation Agreement forms
- Provincial Introductory Brochure
- Provincial Aboriginal Brochure
- Provincial Informational Videos

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

- Doctors of BC (BCMA)
  - https://www.bcma.org/news/advance-directives

What if my heart and lungs stop?

- What are the chances of surviving? Healthlink BC: Should I receive CPR and Life Support?

www.healthlinkbc.ca/health-topics/tu2951

What kinds of treatments can help me live longer?

- When would I want that? When might I not?
- Healthlink BC: Should I Stop Treatment That Prolongs My Life?

www.healthlinkbc.ca/health-topics/tu1430

Getting food by tube. What are the benefits and risks?

- Healthlink BC:
- Should I Have Artificial Hydration and Nutrition?

www.healthlinkbc.ca/health-topics/tu4431

Videos

- Dr Doris Barwich "Health care consent laws have changed – what you need to know"
  http://www.youtube.com/watch?v=a-HFLkL5IRk
- Fraser Health Advance Care Planning
  http://www.youtube.com/watch?v=-M31-NiH3yU
- Speak Up! Advance Care Planning
  http://www.youtube.com/watch?v=2aOX9abJhio
- Atul Gawande How to Talk EOL with a Dying Pt
  http://www.youtube.com/watch?v=45b2QZxDd_o&NR=1

www.advancecareplanning.ca

What I Do Matters.

Thank you! Closing Thoughts…