Advance Care Planning

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Welcome

- Thank you
- Please turn off or silence cell phones and pagers
- Washrooms ???
- Opportunity for reflection and to consider something new
- Informal
Objectives

- Our core objective and intention: Empower you

- Also for you to:
  - Learn about Advance Care Planning
  - Demystify Advance Care Planning
  - Promote Advance Care Planning
Key activity

- Begin the process of advance care planning for each of you
- We are not going to complete the MyVoice guidebook
Assumptions

- Every participant is a potential healthcare consumer
- The participants are not here today in a professional capacity
- We are all going to learn together
Table discussion 1

- At your tables:
  - Share with your table-mates **one goal** you hope to learn/achieve
  - As a table group, be prepared to share **one common goal** for the majority of people at your table.
Foundation of ACP

- Values
- Beliefs
- Priorities
Values, Beliefs, Priorities

- What makes your life worthwhile?
- Who or what gives you strength and support?
- What gives you meaning?
- What gives you joy?
- What represents a beautiful death - a fitting end to your life?
Reflection 1:
In 2 minutes, list your values, beliefs and priorities:

- **Values**: ie, volunteerism, independence, nature

- **Beliefs**: ie, God is all knowing, honesty is the best policy

- **Priorities**: ie, my grandchildren’s welfare, paying off my mortgage
Reflection 1:
Circle the top 5 items on your list
Advance Care Planning

A process of

- Reflection
- Conversations
- Information
- Documentation
Advance Care Planning

- When you are capable of speaking for yourself, health care providers will always speak directly with you.

- But, should there be a time when you cannot speak for yourself, your Advance Care Planning conversations and documents can ensure that your voice is heard and your wishes honoured.
Whole group discussion 1

Why would this be important?
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A process of

- Reflection
- Conversations
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Reflection 2

Write down the first thought that comes into your mind upon hearing this:
Reflection 2

- There is good news.
- You have been diagnosed with a gene that indicates you will live until the age of 125.
- Time is no longer as limited.
Reflection 2 continued

Does this news change the top 5 values, beliefs and priorities you circled?
Table discussion 2

- No need to share your personal stories, beliefs, values, etc.

- Discuss what it’s like to start the reflecting process
  - What feelings?
  - What thoughts?
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A process of

- Reflection
- **Conversations**
- Information
- Documentation
Reflection 3

Who are the people in your life who you talk with about important things?
Reflection 4

If there ever came a time when I am unable to speak for myself and direct my own medical care, the person(s) who knows me the best who would be able to speak on my behalf and I would trust to honour my wishes and make decisions based on my values, beliefs and priorities are:
Reflection 4

- Go back to your list and rank who you feel:
  - Knows you best
  - Be able to speak on your behalf
  - Trust to honour your wishes
  - Make decisions based on your values, beliefs and priorities
Who provides consent to medical decisions in BC?

1. The capable adult (19 years or older)
2. Committee of person (rare)
3. Representative (Representation Agreement)
4. Advance Directive
5. Temporary Substitute Decision Maker
Medical decision making

- Most people don’t have a:
  - Committee of person
  - Representation agreement
  - Advance Directive
Temporary Substitute Decision Maker

- A capable adult chosen by a health care provider to make health care treatment decisions on behalf of an incapable adult when care is needed.

- A TSDM is not chosen if the adult has an advance directive that addresses the care needed at the time, or if the adult has an available personal guardian or representative.
Temporary Substitute Decision Maker

The following may be a TSDM (in order):

• The adult’s spouse (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 – (ranked equally)
• The adult's grandchild – (ranked equally)
• Anyone else related by birth or adoption to the adult
• A close friend of the adult
• A person immediately related to the adult by marriage
• Public Guardian & Trustee will appoint or act as TSDM if no TSDM available, qualified or there is a dispute

*No conflict and contact with the incapable person within 12 months
Representation Agreement

Who needs one?
Representation Agreement

A legal document in which a capable adult names their representative to make health care and other decisions on his/her behalf when incapable.
Enduring Power of Attorney

- They only pertain to financial and legal matters
- Not healthcare decisions
- Can have a different people serving as Enduring Power of Attorney and Medical Representative
Representatives or Temporary Substitute Decision Maker(s)

- Roles and responsibilities are many and include:
  - Complying with the wishes or instructions of the adult
Group discussion 2

- How do these legal nuances impact your decision making?
Break
Advance Care Planning

A process of

- Reflection
- Conversations
- Information
- Documentation
ACP with physician

- Ask questions
  - What treatments decisions might I have to make down the road?
  - How might my [diabetes/heart disease] progress?
  - Discuss medical interventions such as resuscitation including the risks & benefits

- Bring a family member or friend to your appointments

- Please let your physician know of your advance care planning conversations and documents
Exercise 1

- Your neighbour has been hospitalized.

- She is an 82 year old woman, widow for 10 years, no children

- Retired elementary school teacher

- She was active: gardening, bridge club, symphony

- Invited you to Easter, Thanksgiving, and Christmas dinners annually

- You were listed as Next of Kin and are called by the ER nurse
Exercise 2 continued

- You arrive at the ER
- Your neighbour fell, fractured her right hip, hit her head
- Was conscious upon arrival, but now has lost consciousness
- The physician asks what you think they should do for her.
Exercise 2 continued

At your tables, discuss the following:

- What do you do?
- What planning before this hospitalization would have helped you and your neighbour?
Dying is changing

- Healthcare decisions are complex due to advances in medical technology
- Up to 50% of persons cannot make their own decisions when they are near death
- Health professionals typically treat when uncertain of treatment wishes
- Most of us will die under the care of health professionals; 80% of us will die of a chronic disease
Why is this important?

- 33% increase in deaths over 2004
  - 2/3 will die with 2 or more chronic diseases after yrs in state of “vulnerable frailty”
  - Only 20% will die with a recognizable “palliative” phase

- At time of death (Silviera et al. NEJM 2011; 62:1211-1218):
  - 42.5% of pts required decision making (DM) and 70.3% lacked decision making capacity
  - With Advance Care Planning support: 92% opted for limited or comfort care
Organ System Failure Trajectory

(mostly heart and lung failure)

Begin to use hospital often, self-care becomes difficult → Time ~ 2-5 years, but death usually seems “sudden”

Death
Questions to ask your physicians

› Which health conditions are easily treatable? Which are not?
› How will any frailty make treatment risky?
› How can symptoms be safely and effectively managed?
› Will the proposed treatment improve or worsen function (or memory)?
› Will the proposed treatment require time in hospital? If so, for how long?
› Will the treatment allow more good quality years, especially at home?
› What can be done to promote comfort and dignity in the time left?
Advance Care Planning

A process of

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Advance Directive

- A capable adult’s written instructions
- That speak directly to their health care provider about the health care treatment the adult consents to, or *refuses*.
- It is effective when the capable adult becomes incapable
- Only applies to the health care conditions and treatments noted in the advance directive.
Group discussion 3

- Who needs an Advance Directive?
Advance Directive

- After informed consent and shared decision making
- Clear understanding of options and possible consequences of choice
- Enduring refusal of a particular treatment
- Not useful if too general: for example, I want to die at home
- Can be too restrictive and cause more distress for family if a wish cannot be granted
Code status

- **Cardiopulmonary resuscitation (CPR)** is an emergency procedure used to revive someone when their heart and/or lungs stop working unexpectedly.

- CPR can include repeated compressions to the person’s chest and rescue breathing to inflate the person’s lungs and provide oxygen.

- Provincial No CPR form.
Fraser Health MOST form

- A physician order
- Patient signature is not required
- Completed as a result of ACP conversations with the patient, representative, or TSDM
- Patient may keep a copy
- Respected by BC Ambulance
Fraser Health Greensleeve

- Provincial No CPR
- Advance Care Plan
- Advance Directive
- Representation Agreement
- Fraser Health MOST form
Advance Care Planning

A process of

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- Conversation
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Exercise 3

- Future action plans
- Write down some actions you will take in relation to your advance care planning.
- Consider what you will do, who you will do it with, what information you need, and what documents you’ll complete.
Table discussion 3

- At your tables, share your action plans
  - Are there common actions?
  - What actions do you feel might be the most satisfying? Challenging?
  - What supports do you feel are needed to move your action plans into ACTION?
Resources

- [www.advancecareplanning.ca](http://www.advancecareplanning.ca) (it is Canadian; it has a great workbook to explore your values for Advance Care Planning)

- [www.engagewithgrace.com](http://www.engagewithgrace.com) (it is Californian: it is short and sweet to get you or others thinking about Advance Care Planning)

- [www.theconversationproject.org](http://www.theconversationproject.org) (it is American; It is more geared toward persons who worry the conversation will be challenging to start with loved ones)
Resources

- [www.fraserhealth.ca/your_care/advance-care-planning/resources/](www.fraserhealth.ca/your_care/advance-care-planning/resources/)

- Click “Provincial My Voice Advance Care Planning Guide” link for the “My Voice” booklet
Contact Information

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Evaluations

A great big THANK YOU