

# **Cari Hoffmann, RSW**

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## **Learning Objectives**

- Describe who Healthcare Professionals should initiate these conversations with.
- Describe the components of effective Advance Care Planning conversations.
- Increase comfort with initiating and engaging in Advance Care Planning conversations.



# Foundation of ACP Promotion

- Fraser Health ACP initiative based on the Respecting Choices® model:
  1. Curriculum for health care professionals
  2. Comprehensive public education (including web site, toll free number, My Voice Workbook©, etc.)
  3. Focus on the **conversation**, not the document
  4. System supports
- Focus on values, goals, and beliefs; engaging in *shared decision making* and planning for *incapacity* not just end-of-life care



# Our experience in the Renal Program Fraser Health Pre Pilot (2004)

## Nephrologists reported:

- Initiated ACP conversations with 10% - 20% of patients
- Only with seriously ill patients or those who expressed an interest

## Patients reported:

- 34% had ACP conversations



# Post Pilot for families and pts:

- Patients expressed *relief* and *gratitude* for being able to express and record their choices for future healthcare
- Family members expressed decreased conflict with the patient's decision
- 86% of patients discussed future healthcare wishes with family/friends following discussion with healthcare provider
- 71% completed My Voice workbook
- 100% of choices were honoured



# September 2008-September 2009

Two Clinical Resources Nurses hired to implement and imbed into practice:

| Indicator  | Baseline            | Target               | Actual (Sept 2009)                   |
|--|---------------------|----------------------|--------------------------------------|
| Proportion of Hospital deaths will decrease          | 95% hospital deaths | 70% hospital deaths  | 64% hospital deaths                  |
| ACP notes present in 50% of pt charts                | 80                  | 160                  | 158                                  |
| Completed DNRs and My Voice will be updated          | 0                   | 100%                 | 100%                                 |
| ACP training workshop will be delivered to each site | 0                   | 80% of regular staff | 130 staff attended                   |
| Education Sessions for Staff will be provided        | 0                   | 3 sessions/year      | MDs: 3 sessions<br>Staff: 2 sessions |



# Additional Results

- Formal link with Hospice Palliative Care
  - HPC service overview offered to renal staff at all sites
  - Admit patients to hospice
  - Provincial and acute CPR/DNR policy review



# Renal Program Today... six years later

- Part of routine care and assessment in Community Visits, Kidney Care Centres and Dialysis Units
- Development and delivery of one hour education sessions/video to further imbed into routine practice



# Throughout Fraser Health today

- Across many programs and with a variety of disciplines, there has been a significant shift with Advance Care Planning
- ACP Program in FH has front line support and we are challenged to meet demand for education and support





# Settings for ACP Conversations

- Primary Care: at point of screening, diagnosing
- Community clinics: pre-dialysis
- Dialysis: In-hospital or community
- Community visits: in patient homes
- Transplant discussions



# Who should HCP initiate these conversations with?

- **Ideally:**  
Healthy Capable Adults to create awareness and normalize ACP
- **More Imperative With:**  
Capable Adults with Chronic Diseases before they are acutely ill
- **Absolutely:**  
Capable Adults with Life Expectancy Less Than 12 Months



# Listening is a key clinical service

“The main problem with [clear] communication, is the illusion that it has taken place.” George Bernard Shaw

- We are always sending and receiving messages
- Learn how to listen



# Communication is a procedure – an intervention

- Good communication can be learned; Fraser Health curriculum focuses on skills-based exercises for health care professionals
- Mastering good communication requires practice and experience
  - Open ended questions
  - Listen to the stories
  - Explore the stories
  - Summarize (reflect back) the stories



# Exploration

## **First:**

- Explore adult's goals, values, beliefs, concerns and priorities — these must be at the heart of the conversation/plans.

## **Second:**

- Explore adult's treatment options/decisions/priorities:
  - Life-style changes,
  - Pharmacologic interventions,
  - Resuscitation,
  - Dialysis,
  - Transplant.



# Successful Conversations include:

1. Capable adult readiness to talk
2. Healthcare Professional prepared to:
  - Initiate conversations and follow up
  - Explore and clarify statements
  - Elicit beliefs, values, goals and quality of life
  - Assess understanding of medical condition



# Opening the Advance Care Planning Conversation

- Let the adult (and substitute decision-maker) know that Advance Care Planning discussions are a routine part of good healthcare:

*“We can’t respect your choices if we don’t know about your values, goals and beliefs.”*



# Opening the conversation

- “Our first priority is providing the best care...it is difficult to predict when your health will change...it is important to talk about future healthcare choices that might need to be made...”
- Allow time for reflection.





# Opening the conversation

- “Have you heard of Advance Care Planning?”
- “One of my roles is to help our team understand how we can best respect you, and what you value and believe in.”
- “Talking about this before we get sick helps our family members know what decisions to make in time of stress or crisis.”
- “I’ve done it myself”



# General Comments

- “ACP involves thinking about what your healthcare choices would be if you were ever in a condition that would leave you unable to speak and make your own decisions.”
- “I have some materials, on our next visit we can talk about this.”



## Assess understanding of medical condition:

- Realistic information about the benefits/ burdens, risks/possible complications of treatments (dialysis, pharmacological interventions, transplant)
- Where possible, a description of how this person's disease is likely to progress and what treatments he/she might face in the future
- “Tell me about your diabetes/high blood pressure/kidney disease?”
- “What do you hope this treatment will achieve?”



## Explore living well/quality of life:

- “What do you expect in the future? What worries you most right now? What matters most to you?”
- “Do you value down-the-road benefits or do you have more immediate concerns about side effects/impact on daily life?”
- “What is the effect on your physical, psychological and social functioning?”



# Review Substitute Decision Maker roles and responsibilities

- “We would need to talk with a SDM if you were unable to speak with us. Who do you talk with about your health, concerns and beliefs?”
- “Could they honour your choices? Have you talked enough?”
- “It is important that they be included in these discussions”



# Explore Experiences:

- “Do you know anyone who has been on dialysis/had kidney disease/had a kidney transplant?”
- “Have you or anyone in your family/friends had any experiences in ICU?”
- “Have you heard of CPR? Known anyone who has gone through this experience?”



# Because wishes can change over time...

- Focus on ACP conversations that occur over time, as opposed to a signed document
- Stress that as long as the person is capable of communicating their wishes and understanding treatment choices, they will be asked to provide consent
- Re-visit the conversation and the document routinely



- Skills Based Practice Exercises





- Debrief Practice Exercises

What did you find or have you found to be one of the most powerful questions?



# Canadian Resources

- Educating Future Physicians in Palliative Care and End-of-Life Care. 2007. *Facilitating Advance Care Planning: An Interprofessional Educational Program – Curriculum Materials and Teacher's Guide*. [http://www.afmc.ca/efppec/docs/pdf\\_2008\\_advance\\_care\\_planning\\_curriculum\\_module\\_final.pdf](http://www.afmc.ca/efppec/docs/pdf_2008_advance_care_planning_curriculum_module_final.pdf)
- Cross-cultural considerations in promoting advance care planning in Canada. Andrea Con for Health Canada. 2007. [http://www.bccancer.bc.ca/NR/rdonlyres/E17D408A-C0DB-40FA-9682-9DD914BB771F/28582/COLOUR030408\\_Con.pdf](http://www.bccancer.bc.ca/NR/rdonlyres/E17D408A-C0DB-40FA-9682-9DD914BB771F/28582/COLOUR030408_Con.pdf)
- The Glossary Report. Janet Dunbrack for Health Canada. 2006. [www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2006-proj-glos/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2006-proj-glos/index_e.html)



# Canadian Resources

- ACP Project:  
[http://www.chpca.net/projects/advance\\_care\\_planning/advance\\_care\\_planning\\_index.html](http://www.chpca.net/projects/advance_care_planning/advance_care_planning_index.html)
- Environmental Scan:  
[http://www.chpca.net/projects/advance\\_care\\_planning/acp\\_environmental\\_scan\\_sept\\_9\\_09.pdf](http://www.chpca.net/projects/advance_care_planning/acp_environmental_scan_sept_9_09.pdf)

Contact: Louise Hanvey [lhانvey@bruyere.org](mailto:lhانvey@bruyere.org)



# Fraser Health Resources

- “My Voice” Workbook© in English, Chinese & Punjabi
- “Information Booklet for ACP” brochure in English, Chinese and Punjabi
- “Making Decisions About CPR” brochure in English, Chinese and Punjabi
- ACP Wallet Card
- Posters in 7 languages
- E-book “Planning in Advance for Your Future Healthcare Choices”
- Web site: [www.fraserhealth.ca](http://www.fraserhealth.ca)
- Toll free: 1-877-825-5034



# Fraser Health Resources

- Two 30 minute on-line ACP education modules; regular education sessions
- Greensleeves for patient medical files
- Advance Care Planning Record
- ACP Referral Card
- Educational DVDs in English, Punjabi & Chinese
- Green document holder for home use
- One hour Renal specific education dvd and curriculum



# Questions?

