Advance Care Planning and Serious Illness Conversations

Monday, May 11, 2020
2PM ET

What is the Imperative?

"I think what COVID has done is brought into sharp focus the need for people of all ages and all states of illness or health to actually think these things through."

- Dr. Sunita Puri, Director Palliative Medicine, University of California

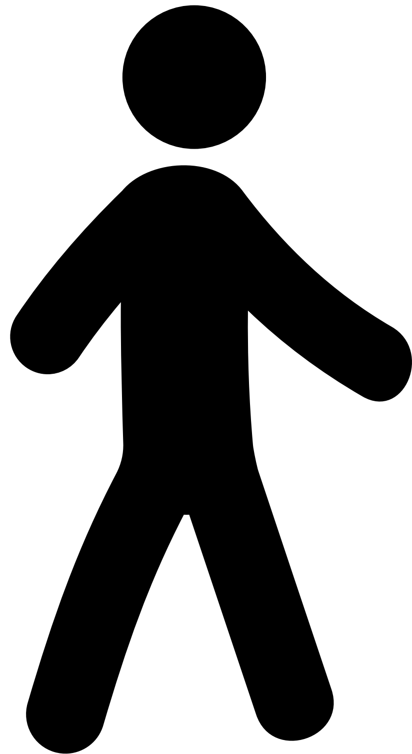
What Does Quality Mean?

- The person, their family and care providers work in partnership to communicate, plan, set goals of care and support informed decisions
- The person’s expressed wishes for care are respected
- Connections are made in a way that is individually and culturally respectful
- Providers have the education, skills and supports

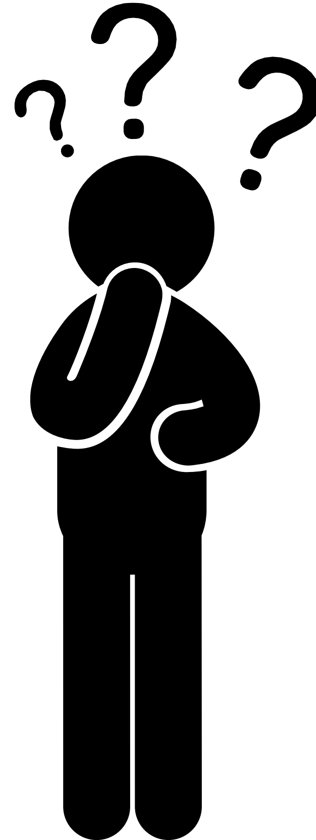
Current State In Canada

- 2019 Speak Up National Poll
  - Eight in ten Canadians have given end-of-life care some thought, but less than one in five has an advance care plan (ACP).
  - Most frequently Canadians report thinking it is important or somewhat important to talk to family or a healthcare provider about care near the end of their lives. They also most frequently report talking to family or talking to no one about end-of-life care.
  - More than half of Canadians (54%) have given some thought to care near the end of their lives; 20% have given it no thought.
  - Most frequently (36%), Canadians say they have talked to their family about their future care; 21 % say they have not talked to anyone

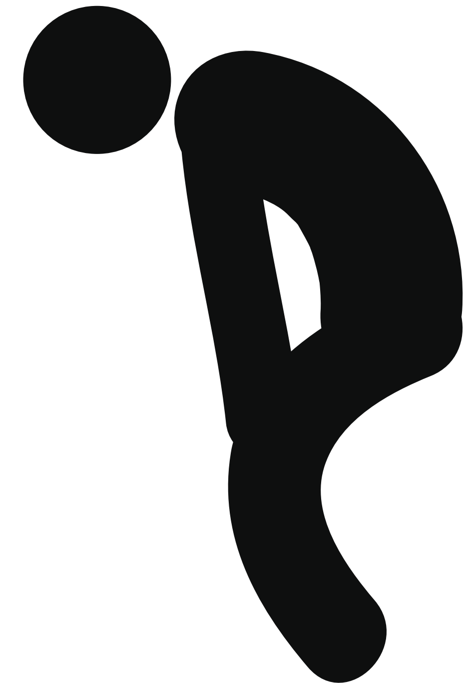
Decision Making Continuum



Healthy and at Home



Faced with Serious Illness



Faced with Treatment Decision for Self or Other

Identifying the intervention
What is a Serious Illness Conversation

It is:

- Asks patients about **values and goals** using a structured format
- **Shares prognosis**, when appropriate
- De-emphasizes treatments and procedures
- **Occurs early** in the course of a serious illness
- Provides a foundation for making decisions in the future
- Should be **reviewed/revisited** over time
- Is valuable and therapeutic even if medical decisions are not being made

It is not:

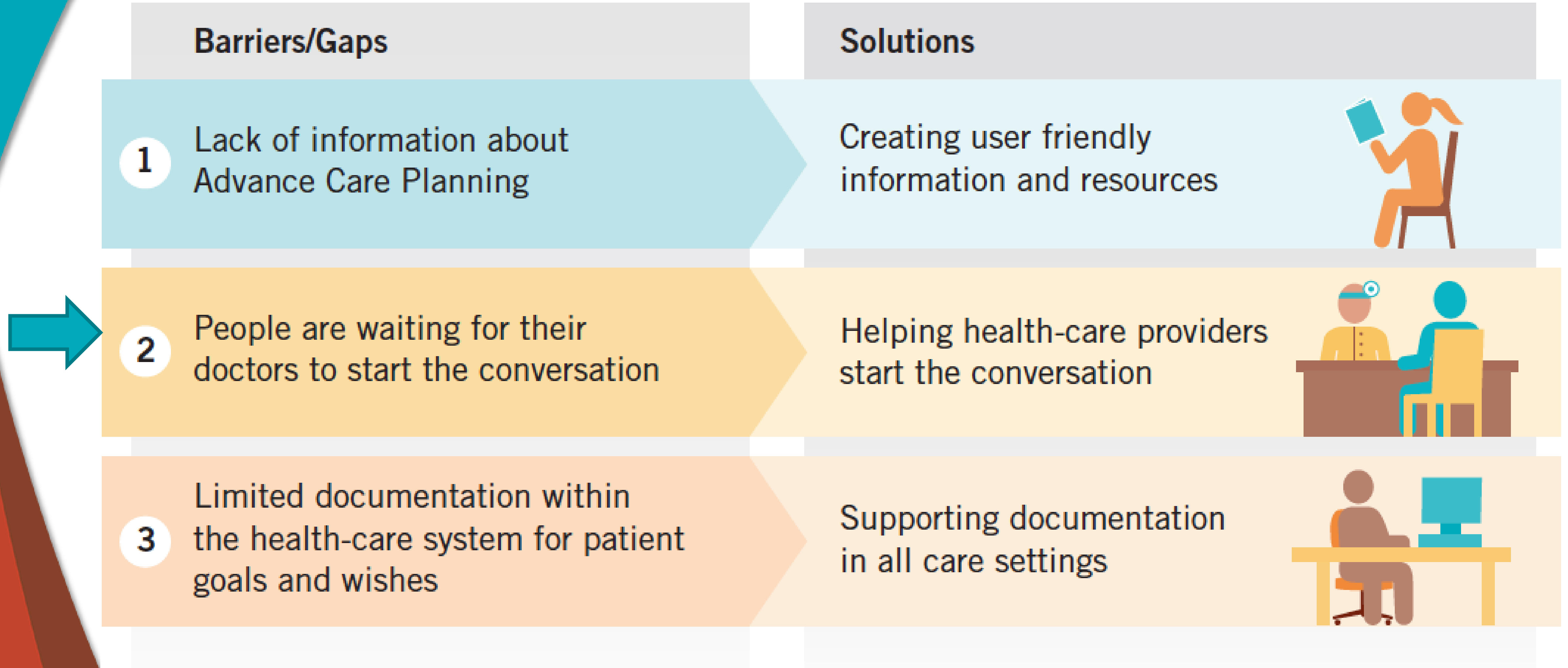
- A conversation solely focused on medical decisions
- A code status conversation
- A MAiD discussion

BUT

- Can be used to inform medical decisions/care planning, *when* appropriate
- Are valuable even if a patient is already DNR/No CPR
- Can and should come before a conversation about medical orders
- Can be used even if a patient has as formal Goals of Care/ or Medical orders related to levels of care as a way of revisiting values, goals, and decisions

BC Centre for Palliative Care

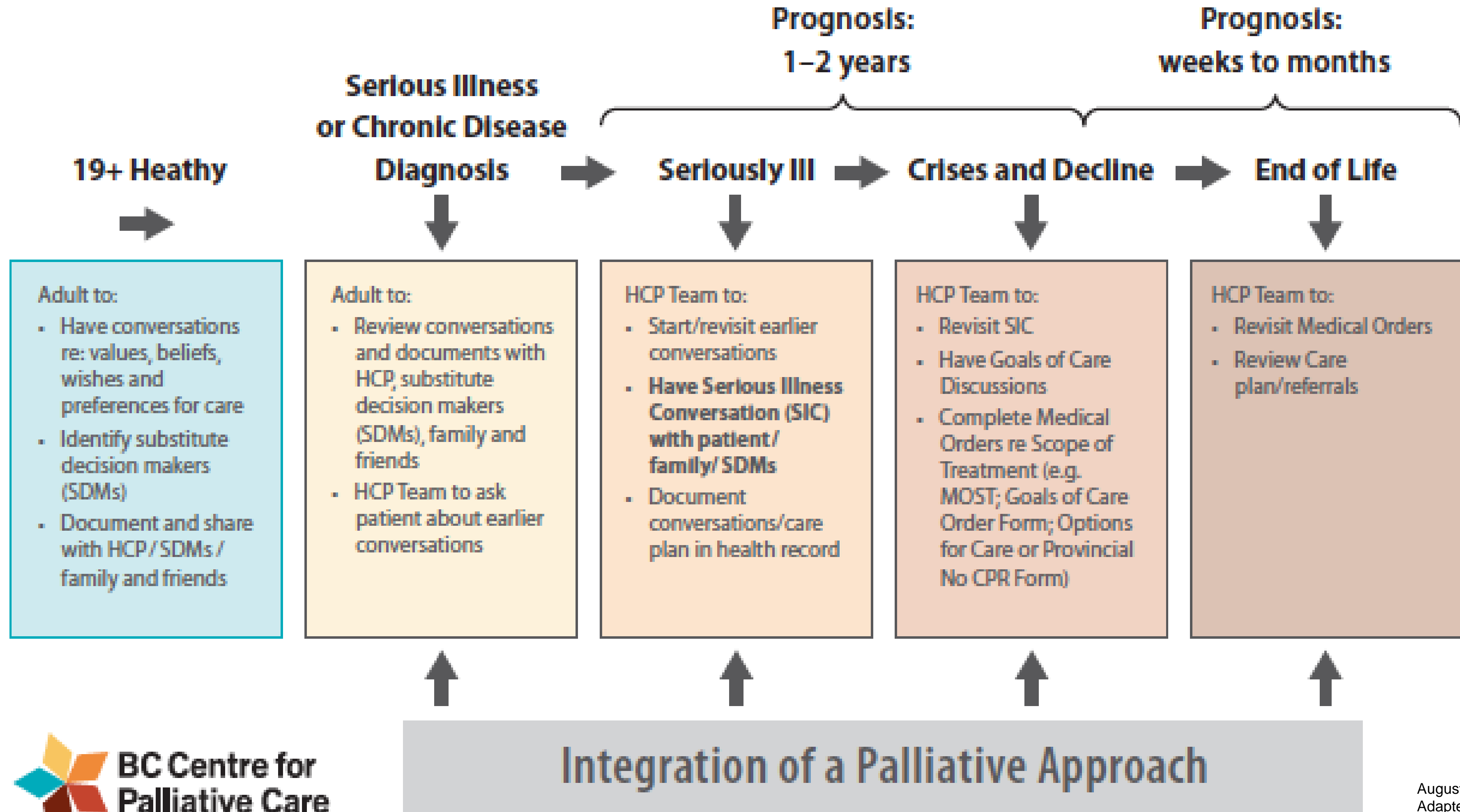
Identifying the gap



BC Centre for Palliative Care

Advance Care Planning for Adults in BC

“ More, Better, Earlier Conversations”



August 2017
Adapted from Ariadne Labs
Draft in Development

Implementation is a Journey

Serious Illness Conversations Initiative Implementation Roadmap for B.C.

ARIADNE LABS Adapted from Ariadne Labs

PHASE ONE: BUILD FOUNDATION

1

PHASE TWO: PLAN IMPLEMENTATION

2

2

PHASE THREE: LAUNCH FACILITATOR TRAINING

3

PHASE FOUR: EXPAND, SUPPORT & EVALUATE

4

BC Centre for Palliative Care

1 Hour ZOOM
Just in Time
Education

- ⇒ Learn how to use the Serious Illness Conversation Guide in the Time of COVID-19
- ⇒ Practice skills using the COVID-19 Conversation Guide

Serious Illness Conversations in the Time of COVID-19

For more information email Elizabeth Beddard-Huber ebeddard-huber@bc-cpc.ca or Gillian Fyles gfyles@bc-cpc.ca

Additional Resources

- Improving communication and decision-making during serious illness - Webinar
- Resource Links
  - Speak Up Canada (English and French)
  - Compassionate Communities (English and French)
  - BC Center for Palliative Care (English)
  - Ariadne Labs – Serious Illness Care (English)
  - Canadian Virtual Hospice (English and French)
  - Pallium Canada (English and French)
  - Champlain Hospice Palliative Care Program (English and French)