



# Planting the Seed

Introducing Advance Care Planning  
in “5 Minutes or Less”



# Presenter Disclosure

- **Presenters:** Ashley Tyrrell, Dr. Kevin Samson & Hope Latam
- **Relationships with commercial interests:**
  - **Grants/Research Support:** None.
  - **Speakers Bureau/Honoraria:** None.
  - **Consulting Fees:** None.
  - **Other:** Hope is an employee of CognisantMD

# Disclosure of Commercial Support

None.

- **Potential for conflict(s) of interest:**
  - Hope is currently an employee of CognisantMD, who's products and services are used in primary care

# Mitigating Potential Bias

The content of this presentation does not include the products and services offered by CognisantMD.



Advance Care Planning  
**Conversations Worth Having**



**Funding**



**Collaboration**

Hospice of Waterloo Region  
Hospice Wellington

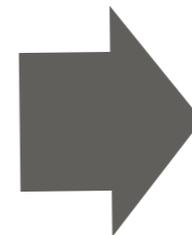
**Backbone**

3 Staff  
Steering Committee  
Volunteer Team  
Sector Champions



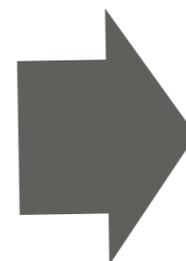
# We know we have to start talking

Only 10% of us will die suddenly



Tremendous opportunity for ACP conversations

Up to 70% of patients @ EOL are not capable of decision-making  
**42.5% of patients required decision making**

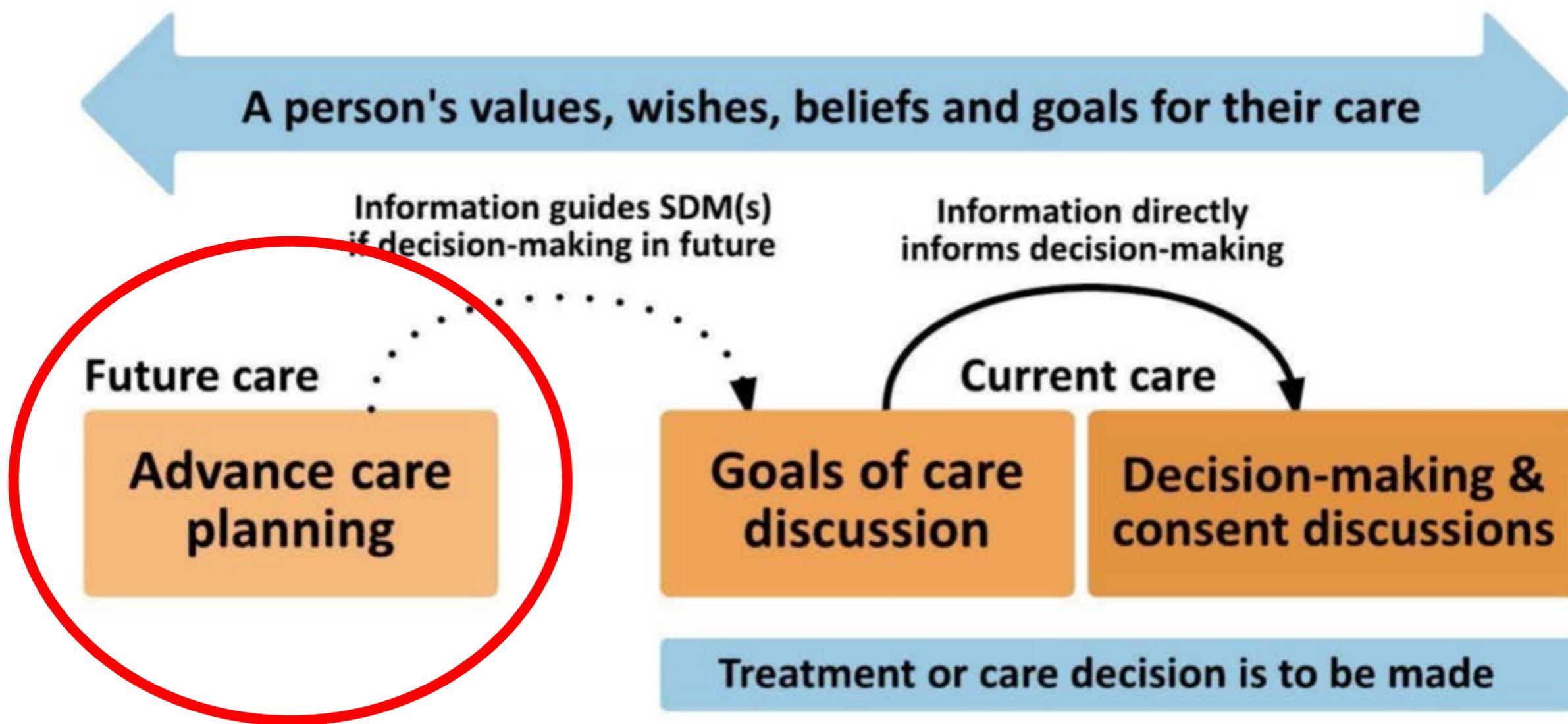


We need to 'prepare' Substitute Decision Makers



# Advance Care Planning Conversations

## Components of person-centred decision-making





# What is ACP in Ontario?

"ACP" is a process that involves the mentally capable person:

1

**Identifying** his/her future Substitute Decision Maker(s) (SDMs)

2

**Sharing his/her wishes, values and beliefs** through conversations with their SDM(s) and others



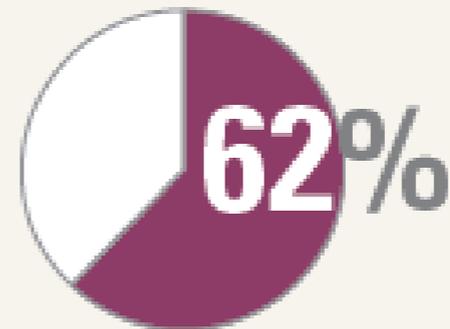
# Your patients want to talk about this



Of Waterloo Wellington residents believe that having ACP conversations **makes good sense** and will make it easier for loved ones.



Agree that **it's important** to have an ACP conversation with their substitute decision maker (SDM).



Say they have **confirmed** their SDM, **BUT** almost **40%** report they have **not talked** to their SDM.



Of respondents say that they have **never been asked** who their SDM is by their health care provider.



# Providers need some support



Of Waterloo Wellington residents believe that having ACP conversations is important.



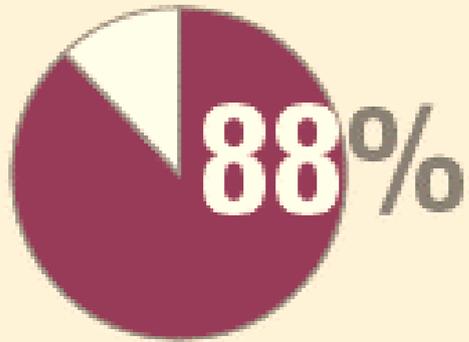
Agree that it's important to have an ACP conversation with substitute decision maker.



Say they have confirmed their SDM, BUT almost 40% report they have not talked to their SDM.



Of respondents say that they have never been asked who their SDM is by their health care provider.



Of physicians report having discussed ACP with their patients **BUT 62%** reported that they were uncomfortable with the conversation.

Need additional training & pt resources

Needs to be simple

Needs to be practical



# ACP in 5 Minutes or Less

"ACP" is a process that involves the mentally capable person:

## Start Here

1

**Identifying** his/her future Substitute Decision Maker(s) (SDMs)

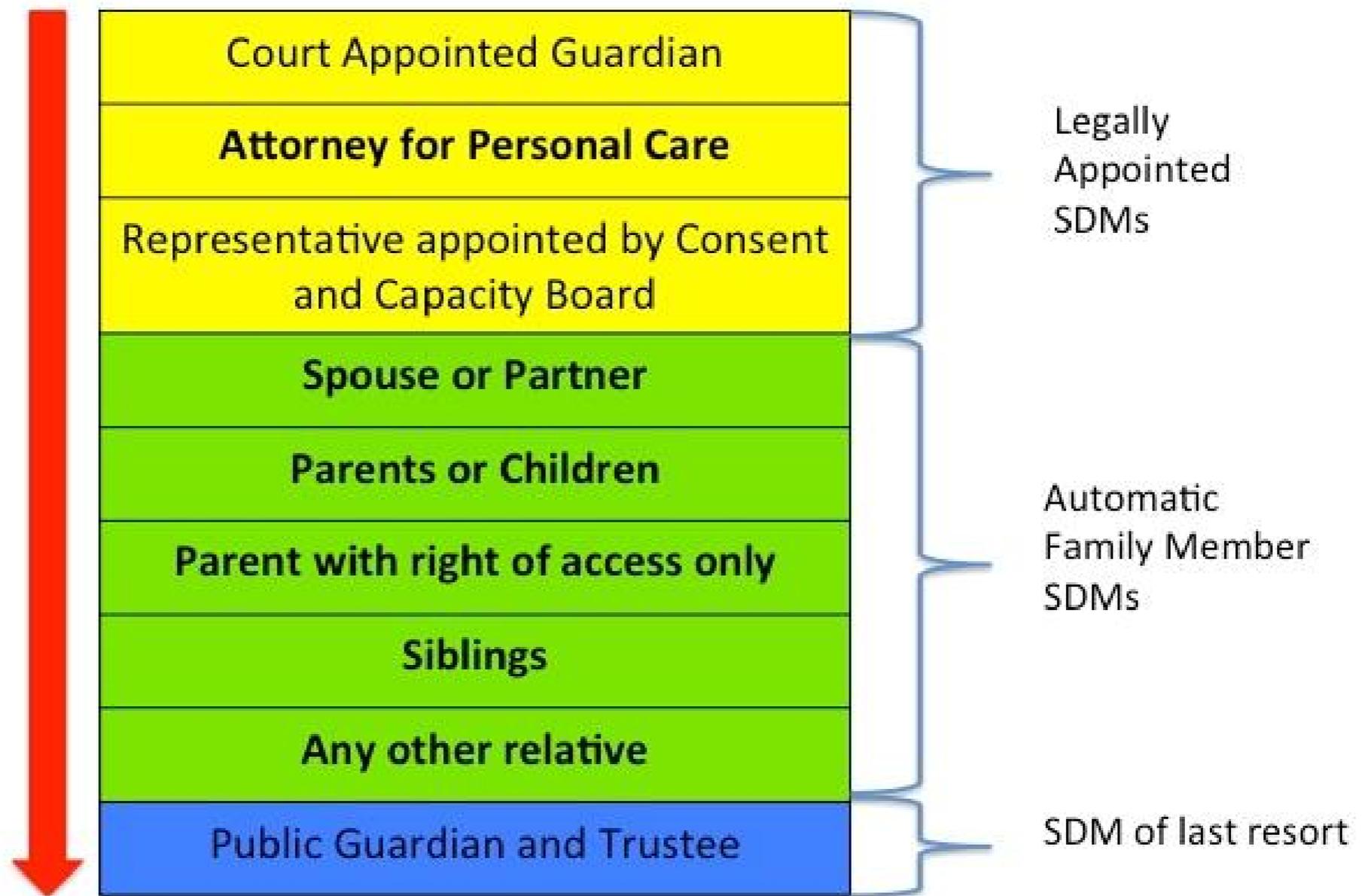
2

Sharing his/her wishes, values and beliefs through conversations with their SDM(s) and others



# Who is the Substitute Decision Maker?

## Hierarchy of Substitute Decision Makers (HCCA s.20)

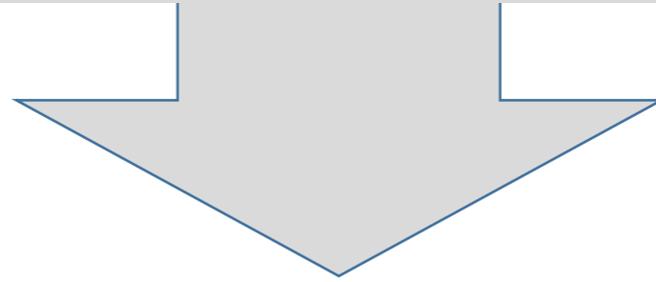


Ontario Health Care Consent Act, 1996



# Asking the SDM question

## Education is Fundamental



### WHEN A HEALTH CARE DECISION IS NEEDED →

I have a Substitute Decision Maker who understands my wishes and can make health care decisions for me if I am mentally incapable of making decisions for myself.

[www.scpww.ca](http://www.scpww.ca)

 Advance Care Planning  
Conversations Worth Having

Informal approach using wallet cards  
Simple addition added to forms



Woolwich Community  
**HEALTH CENTRE**

Interdisciplinary Team Approach

All Staff Training

Standard conversation for all patients >60 yrs

**~200 SDM conversations to date**



# Placeholder for Demo

Add SDM

Substitute Decision Maker - SDM

File

Substitute Decision Maker (SDM) Handout

Patient Name

DOB

Date Last Entered in Chart: Never done

Patient declined to discuss this with health care provider

Patient has not chosen SDM

**Substitute Decision Maker**

Name

Home Phone #

Cell Phone #

Hierarchy

Patient has shared their wishes, values, and beliefs with this SDM as they relate to their future healthcare?  Yes  No

Comments

**Supporting Documents**

Supporting documents in chart?  Yes  No

Comments

Discard

+

1. Guardian of the Person
2. Attorney named in Power of Attorney for Personal Care
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child or Parent or CAS (person with right of custody)
6. Parent with right of access
7. Brother or sister
8. Any other relative
9. Office of the Public Guardian and Trustee



# Results

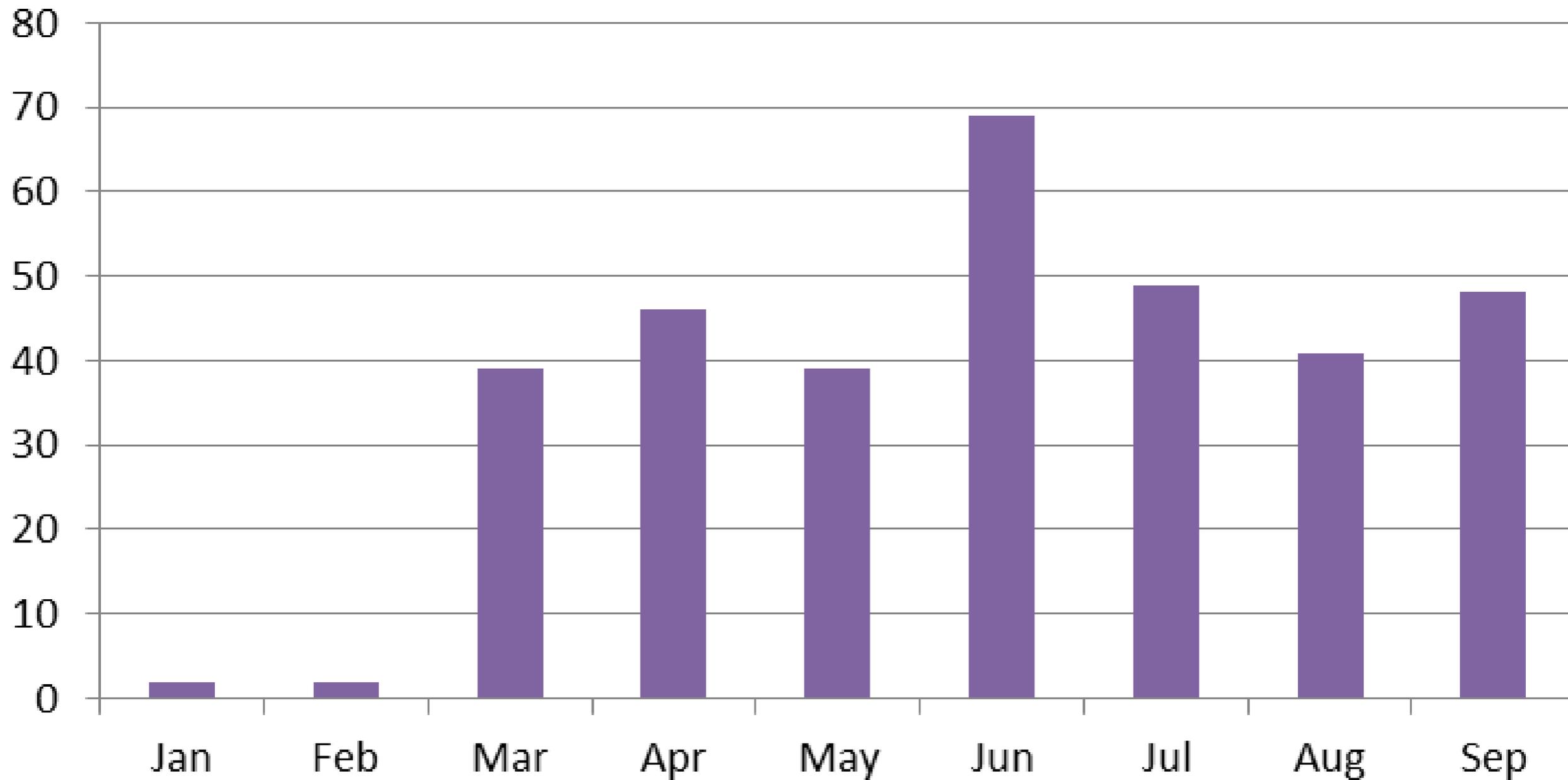
Piloted in 4 FHTS (spread ongoing)

~10 Non-FHT teams using tool (spread ongoing)

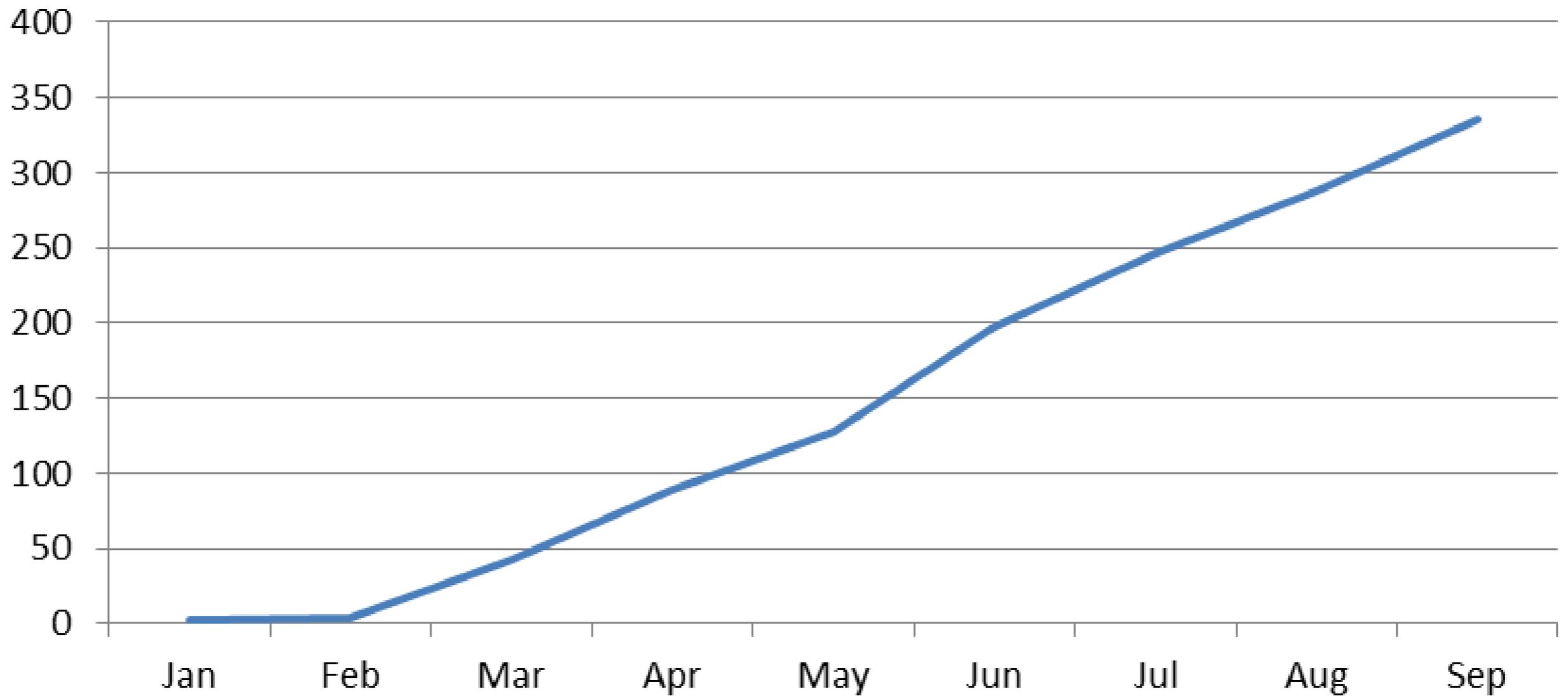
The tool is helping your colleagues:

- to have Advance Care Planning conversations with patients
- to improve documentation of Substitute Decision Maker(s)

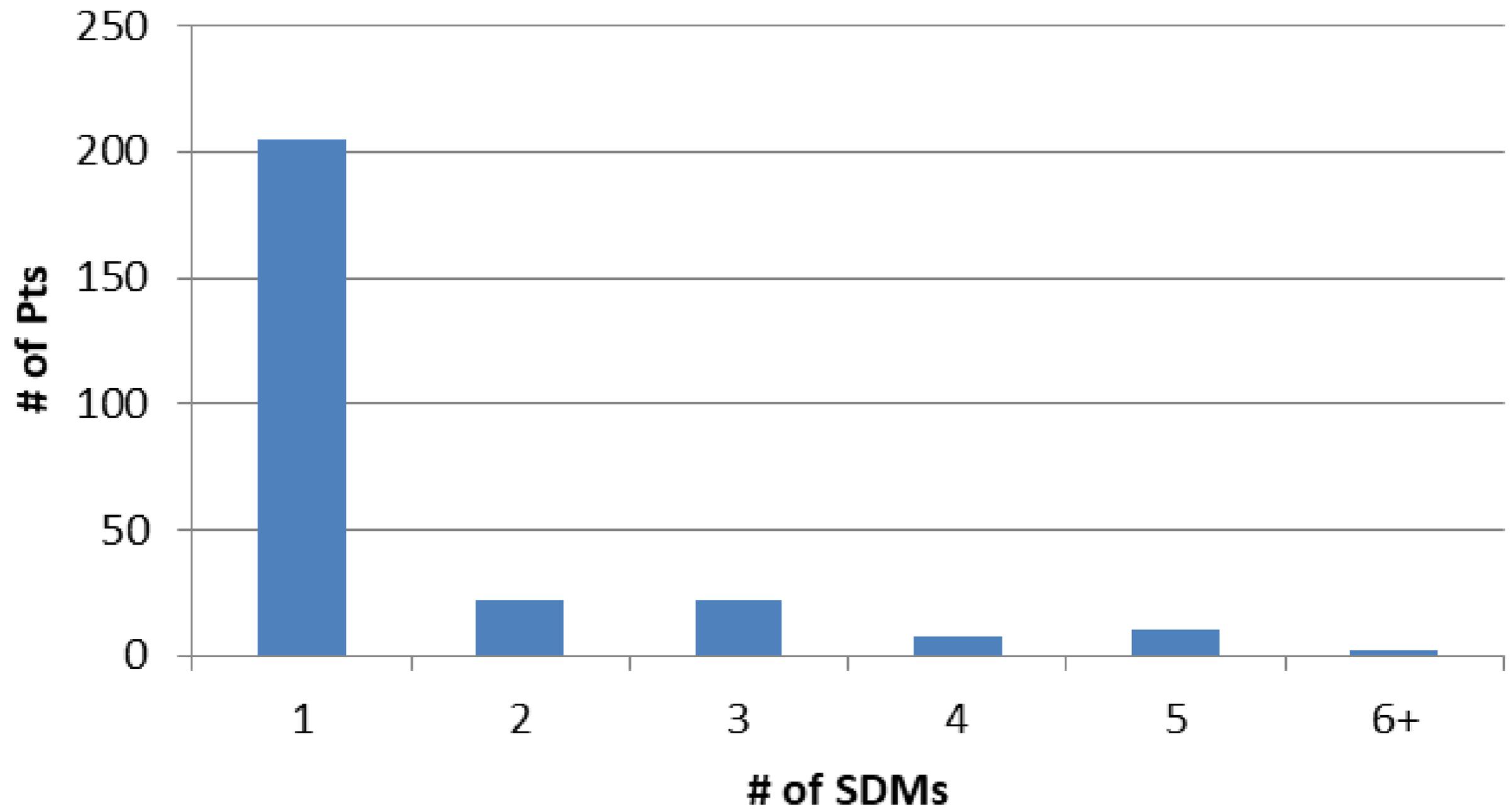
# # of Pts with SDM per Month



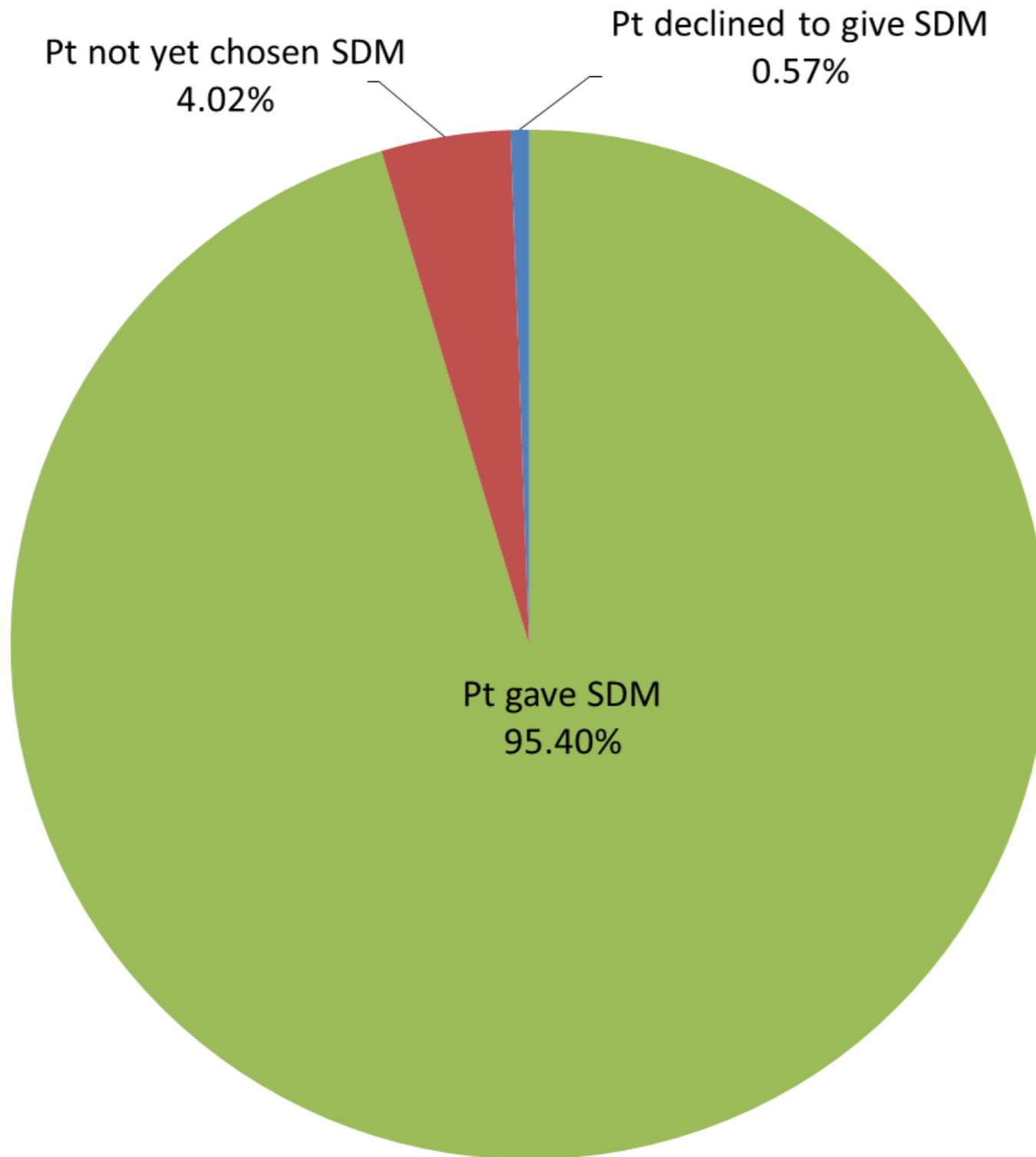
# Total # of Pts with SDM Recorded



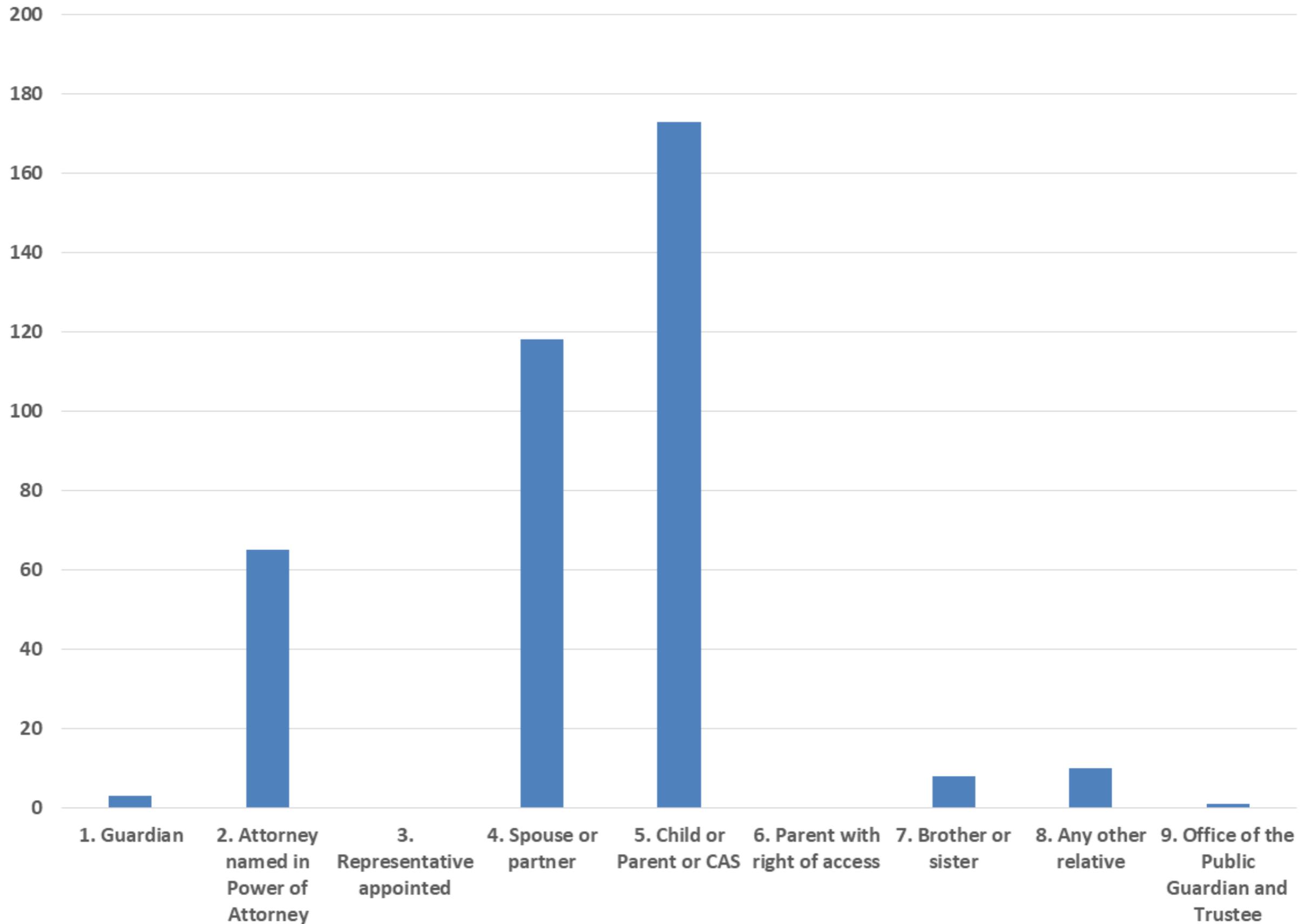
# # of SDMs per Patient



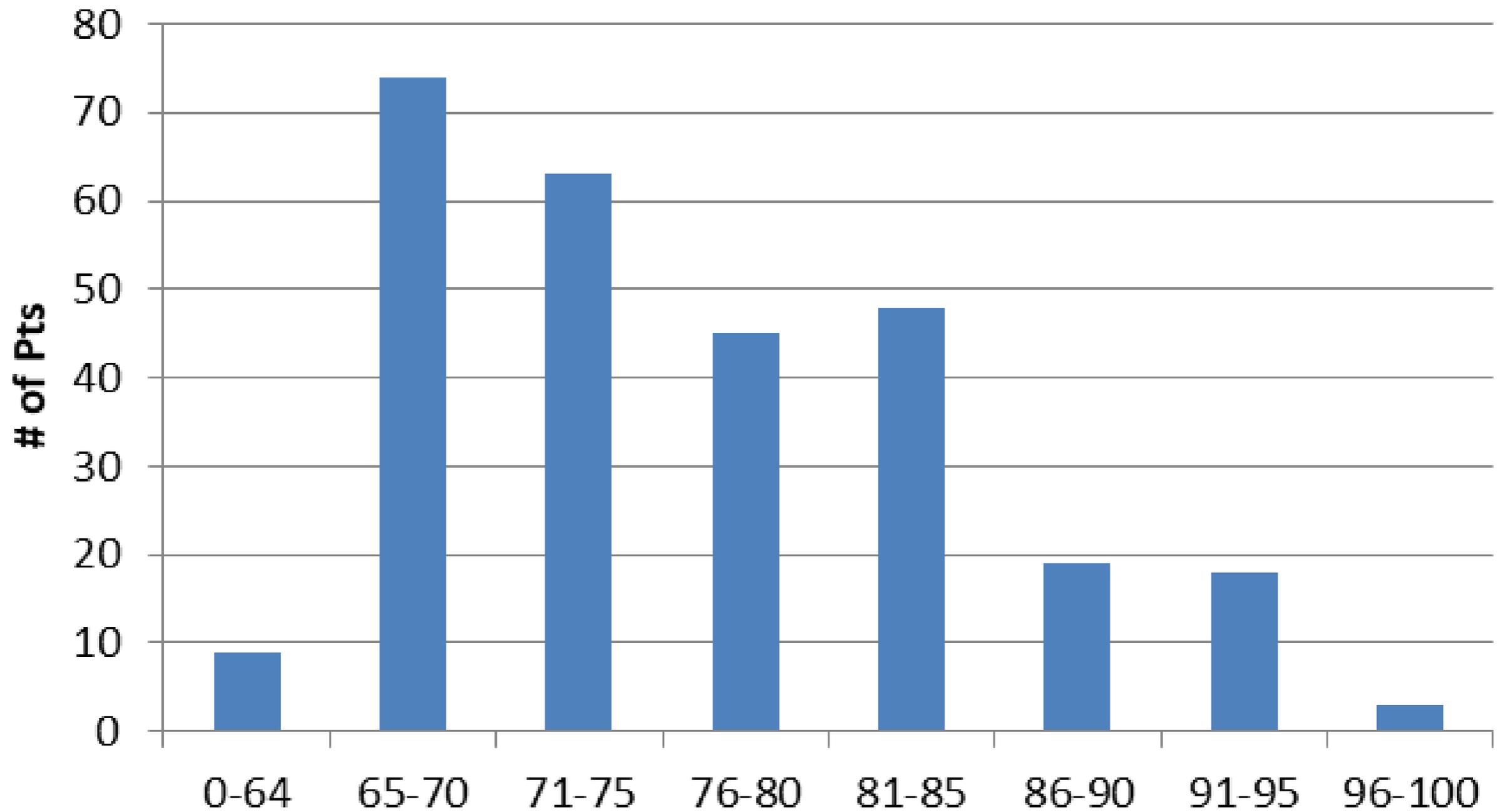
# Patients with SDM Recorded



# Hierarchy Choices



# Age of Patients with SDMs





## Feedback from providers

### **The most helpful thing about the tool is/are:**

*The Stop light functionality helps to inform me about asking these key questions during the patient's annual health review*

*It is great for starting the conversation with patients and for documenting SDM*

*Reminds me to discuss and I can provide take home information for the patient*

*The SDM tool is a reminder to start the conversation. It is also a way to document the conversation*



## Feedback from providers

**As a result of the Advance Care Planning program my practice has changed in the following ways:**

*I am engaging patients in more meaningful discussions, and thus bringing up more underlying issues, and family history issues that have also changed my decision making process...*

*We now have close to 100 patient that have a documented SDM on their charts*

*Reminded of the importance of having the discussion earlier than when someone is already dying Being able to document in the patients file Educate patients*

*Conversations are "normalized" as part of periodic health examinations. I have initiated conversations more since the tool became part of my EMR.*



## Next Steps

- Continue to spread tool to other primary care offices
- Increasing interest for a tool to support more fulsome conversations



# Resources available to you

- [www.acpww.ca](http://www.acpww.ca)
- SDM Video about the Hierarchy
- Installation Demo Video

**WHEN A HEALTH CARE DECISION IS NEEDED**  
I have a Substitute Decision Maker who understands my wishes and can make health care decisions for me if I am mentally incapable of making decisions for myself.  
www.acpww.ca

**Speak Up**  
Start the conversation about your health care wishes.

**Advance Care Planning Ontario Edition**  
It's about conversations.  
It's about decisions.  
It's how we care for each other.  
www.advancecareplanning.ca

**My Health, My Wishes.**  
**My Substitute Decision-Maker (SDM)**  
A Substitute Decision-Maker (SDM) is a person who will make health and personal care decisions for you. An SDM will only make decisions for you if you are not capable of making them for yourself.  
This guide will help you understand the process of identifying or naming an SDM.

Distributed by:  
**HealthLink**  
East Toronto HealthLink  
Let's Make Health Change Happen

Advance Care Planning  
Conversations Worth Having  
www.acpww.ca Updated February 2016



# Thank you

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Waterloo Wellington NP Clinic