Advance Care Planning and the Social Work Role: Relationships – You, Me, We. A Canadian Perspective

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Lina Gagliardi & Robin Forbes have no actual or potential conflict of interest or financial disclosures in relation to this presentation.
Objectives

✓ To understand why this is an important issue: WHY NOW?

✓ To describe the Social Work role as clinical leader in facilitating advance care planning

✓ To learn about Sunnybrook Health Sciences Centre and University Health Network (Princess Margaret Site) Advance Care Planning (ACP) initiatives

✓ To illustrate how ACP can still be helpful for those patients receiving active oncology treatment or where a person’s prognosis is unclear
Recent Headlines

Just ask: discussing goals of care with patients in hospital with serious illness

John J. You MD MSc, Robert A. Fowler MD MS, Darcen K. Heyland MD MSc; on behalf of the Canadian Researchers at the End of Life Network (CARENET)

Disregard of Patients’ Preferences Is a Medical Error

March 27, 2014

Why it’s never too early for an advance-care plan

By Sandra Martin

There are good reasons why everyone -- including those in the prime of life -- should get their end-of-life wishes down on paper

Academia and Clinic

Redefining the “Planning” in Advance Care Planning: Preparing for End-of-Life Decision Making

Rebecca L. Sudore, MD, and Terri R. Fried, MD

Annals of Internal Medicine
National Framework for Advance Care Planning

- **1. Engagement**
  - Engage the healthcare system
  - Engage the legal system
  - Engage healthcare professionals/providers
  - Engage the general public

- **2. Education**
  - Education and training of professional providers
  - Education of the general public

- **3. System Infrastructure**
  - Policy and program development
  - Tools to support conversations and documentation

- **4. Continuous Quality Improvement**

Advance Care Planning In Canada: National Framework. 2012. Canadian Hospice Palliative Care Association
Why is this important?

National data reveals:
- Advance care planning is done poorly in Canada
- Advance care planning takes place near the End of Life
- ACP happens in a crisis situation
- In 2004, 70% Canadians had not prepared a Living Will or Advance Directive

Demographics & Chronic Disease Management
- Aging population
  - Most Canadians die of chronic illnesses and live with these illnesses for many years

Social Responsibility
- 86% of Canadians have not heard of advance care planning
- Of those who did make a plan, only 30% had their wishes recorded in their medical files

(Canadian Hospice & Palliative Care Association, JAMA Internal Medicine, 2014)
University Health Network

New Patients by Disease Group 2014

- New Cancer Patients in 2014 Total 17,460
ACP Initiative at Princess Margaret

Goals of ACP working group

1. Increase awareness of ACP initiative

2. Optimize current opportunities for ACP discussions and documentation

3. Build capacity to effect culture change and sustainable ACP service
ACP Initiative at Princess Margaret

ADVANCE CARE PLANNING GIVES PATIENTS’ POWER OVER THEIR FUTURE

1/27/2015

Robin Forbes, UHN social worker and Advance Care Planning Champion, reviews a Power of Attorney Kit with Dwayne Dulling, a patient at Princess Margaret Cancer Centre. (Photo: UHN)

“Planning is bringing the future into the present so that you can do something about it now.”
- Alan Lakein, Writer

It is hard to argue against the advantage of planning ahead when it comes to any aspect of life. And there is
ACP Initiative at Princess Margaret

- Speak up posters
- ACP champion lanyards
- Standardized resources

WHAT IS MOST IMPORTANT TO YOU FOR YOUR HEALTH CARE?

THINK
about what's right for you. What are your values, wishes, beliefs and understanding about your care and specific medical treatments?

LEARN
about your diagnosis and treatment options.

DECIDE
who will make medical decisions on your behalf should you become incapable of doing so. Think carefully about who you feel would understand, honour and follow your wishes.

TALK
about your wishes. It's important to discuss your wishes with your loved ones, your family physician and your health care team.

RECORD
your wishes. It's a good idea to write down or make a recording of your wishes.

Ask your health care team for more resources or information about advance care planning.

WWWADVANCECAREPLANNINGCA
Princess Margaret Cancer Centre
Patient Resources

- Power of Attorney Toolkit
- Speak Up Workbook
- Making Health Care Decisions for Other People
- UHN Brochure (multiple languages)
- www.advancecareplanning.ca
Documenting ACP in the Electronic Patient Record
ACP Initiative at Princess Margaret

The Road Show
Individualized to peer group and programs

1) Increase knowledge
   ➢ What does ACP mean
   ➢ Clarify POA, SDM and role of each
   ➢ How to start the conversation

2) Normalize ACP and identify as a priority for all patients

3) Review ethical and legal obligation

4) Take action
   ➢ Identify how to start and follow up with ACP process
     (documenting in EPR, use of Speak up resources, POA Kit)
We will diminish patient's hope if we offer them the opportunity for advance care planning and convey a message that the health care team has ‘given up’ on them.

**False**

Studies show that patients feel more empowered and more hopeful when they are able to engage in advance care planning. If health care providers tell and show the person that the team is not giving up on their care, the individual should feel more supported.
N= 29

- I feel more confident when talking to patients about ACP
  - 27/29 agree or strongly agree

- I am able to apply ACP knowledge in my clinical practice
  - 28/29 agree or strongly agree
Barriers and Facilitators to Implementation

• Skill and comfort level in discussing ACP
• Culture/Political Environment
• Time factor
• Whose role is it?
• Financial constraints
Future Directions

- Recruit more champions
- Develop metrics in EPR
- Comprehensive documentation
- Develop goals of care template
- Continue to champion ACP and coach and mentor staff
Opportunities

Increase awareness and education about ACP with patients & substitute decision makers earlier in their illness trajectory

Improve the continuum of Quality of Living & Dying through empowering patients

Maximize scope of Social Work practice given competencies in Hospice and Palliative Care
OCSWSSW Scope of Practice/Competencies in Hospice & Palliative Care

SW Scope of Practice
✓ To achieve optimum psychosocial and social functioning

✓ 2.1 Competence
College members are committed to ongoing professional development and maintaining competence in their practice.

ALIGN with:

Advocacy
Assessment
Care delivery
Care planning
Community capacity building
Evaluation

Decision Making
Education and research
Information Sharing
Interdisciplinary teamwork
Self-reflective practice
### Appreciative Inquiry: Transforming SW Practice

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<thead>
<tr>
<th>Problem Solving</th>
<th>Appreciative Inquiry</th>
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<tbody>
<tr>
<td>Felt need, identification of problem(s)</td>
<td>Appreciating—valuing &quot;the best of what is&quot;</td>
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<tr>
<td>Analysis of Causes</td>
<td>Envisioning what might be</td>
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<tr>
<td>Analysis of possible solutions</td>
<td>Engaging in dialogue about what should be</td>
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<tr>
<td>Action Planning (treatment)</td>
<td>Innovating what will be</td>
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<tbody>
<tr>
<td>We are not having conversations with each other about future care</td>
<td>What are we already doing in SW practice to support this work</td>
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<tr>
<td>Community/people don’t know language or decision making protocol or expectations of SDMs</td>
<td>Mobilizing therapeutic SW/pt relationship to support the pt/SDM relationship through ACP conversations</td>
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<tr>
<td>Education</td>
<td>Knowledge translation</td>
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<tr>
<td>Intro to ACP near End of Life</td>
<td>Normalize ACP conversations</td>
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Launch, Methodology & Evaluation

**Celebratory Launch**
AUGUST 2015
✓ Senior Leadership support and celebration

**Debrief Sessions**
✓ Implemented in September 2015

**Measurement**
✓ QI = 2 PDSA cycles utilizing tracking tool/clinician
✓ # of ACP conversations documented in electronic patient care system
✓ Debrief sessions on qualitative feedback
Methodology

**Education/Training**

- 2 Education Workshops (March and June 2015)
- Facilitators: 2 Physician leads developed and facilitated training

**Participants**

25 Social Work Clinicians across all programs

- Inpatient (across all sites, ie Trauma, Medicine, Cardiac, Oncology, Surgery)
- Odette Ambulatory Cancer Centre (focused continuity)
- Nephrology SW team (outpatient clinics)
Methodology:

Initial Implementation Proposed

Social Worker will ask patients “if you could have an ACP conversation, would you want to speak to someone about ACP?” > education opportunity

After PDSA Cycle this was changed to

Social Worker will ask patient “ Do you have a Power Of Attorney for Personal Care OR clarifying Substitute Decision Maker (SDM)

THEN: We also ask “Have you and your decision maker had a conversation about your wishes and values for future care decisions?”

If No: Offer opportunity to have a discussion with SDM OR recommend follow up with GP and document in ACP Tab (e.g. SW offered to facilitate a conversation and….)
Enablers to support the ACP Conversation

Clinicians Guide to ACP Conversations

Patient/Client Guide to learn about ACP Conversations
  - Values Exercise to promote self reflection

Education Pamphlet

Conversation Template

Electronic Documentation ** Sunnycare
(content developed by Dr. J. Myers & Dr. N. Incardona, LHIN Leads)
Results to Date

Debrief Sessions: Comments from the field

Positive feedback:
- ACP conversation elements embedded into SW assessment standard
- Clinicians highlight that ACP adds an important dimension to quality care = therapeutic relationship
- Better segue when SW begins by exploring SDM contact, etc.
- Utilizing Conversation Template headings to document helpful

Areas for further development:
- Pt prognosis continues to be “the comfort zone”
- Physicians unaware of ACP more focused on Goals of Care
- Competing SW roles in acute care (quality vs length of stay)
- Caseload size = impacts ability to have robust conversations
- Double Documentation
Future Direction

- Interprofessional Corporate Strategy Developed
- 3 sub ACP Working Groups created
  - ACP Facilitator Training (summer/fall 2016)
  - ACP Patient/Family Awareness & Education (organizational inquiry)
  - ACP Staff Awareness & Education (organizational inquiry in process)
- Unit specific education on ACP/SW role initiative (in process)
- Access to ACP/GofC tab to other professions (complete)
- Physician Engagement & Simulation/Education (Feb/March 2016)


www.advancecareplanning.ca
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