Health Care Consent & Advance Care Planning Cross Sector Implications

October 26th 2017

SW HPC Summit

HPCO HCC ACP Communities of Practice

System Strategies to Get This Right

* Build strong leadership to:
  * Clarify confusions, dispel misconceptions and correct non-compliant information
  * Provide accurate knowledge about the **Ontario** Legal framework
  * Encourage consistent practices
  * Expect accurate language which promotes clear communication
  * Discover and utilize Ontario specific tools, supports and resources (paper & people)

How advance care planning, goals of care, consent & capacity can help achieve 2017/18 QIP targets:

For hospitals, primary care, home care & long-term care

Quality Issues and Indicators for the 2017/18 QIPs

	Issue	Hospital	Primary Care	Home Care	Long-Term Care
Effective	Effective transitions	• Readmission for select conditions **(A)** • Readmission for one of congestive heart failure, chronic obstructive pulmonary disease, or stroke (CEP) **(P)** • Readmission within 30 days for mental health and addiction **(A)** • Patient received enough information on discharge **(P)** • Discharge summaries sent within 48 h of discharge **(A)**	• Hospital readmissions for select conditions **(A)** • 7-day post-discharge follow-up (physician) **(P)** • 7-day post-discharge follow-up (any provider) **(A)**	• Hospital readmissions **(P)** • Unplanned ED visits **(P)**	• Potentially avoidable ED visits **(P)**
	Coordinating care	• Narrative • Identify complex patients (Health Links) **(A)**	• Narrative • Identify complex patients (Health Links) **(A)**	• Narrative • Identify complex patients (Health Links) **(A)**	• Narrative
	Population health	• Narrative	• Narrative • Glycated hemoglobin testing **(A)** • Colorectal and cervical cancer screening **(A)**	• Narrative	• Narrative
Patient-centred	Palliative care	• Home support for discharged palliative patients **(P)**		• End of life, died in preferred place of death **(A)**	
	Person experience	• Narrative • Patient experience **(P)**	• Narrative • Patient involvement **(P)**	• Narrative • Client experience **(P)**	• Narrative • Resident experience **(P)**
Efficient	Access to right level of care	• Narrative • Alternative level of care rate **(P)**	• Narrative	• Narrative	• Narrative
Safe	Safe care	• Pressure ulcers **(A)**, use of physical restraints in mental health patients **(A)**		• Falls for long-stay clients **(P)**	• Pressure ulcers, **(A)** restraints **(A)**, falls **(A)**
	Medication safety	• Medication reconciliation (admission) **(P)** • Medication reconciliation (discharge) **(P)**	• Medication reconciliation **(A)**		• Potentially inappropriate prescribing of antipsychotic medications **(P)**
	Workplace safety	• Narrative	• Narrative	• Narrative	• Narrative
Timely	Timely access to care/services	• ED length of stay (complex) **(P)**	• Timely access to primary care (patient perception) **(P)**	• Wait time for home care (personal support worker, nurse) **(P)**	
Equitable	Equity	• Narrative	• Narrative	• Narrative	• Narrative

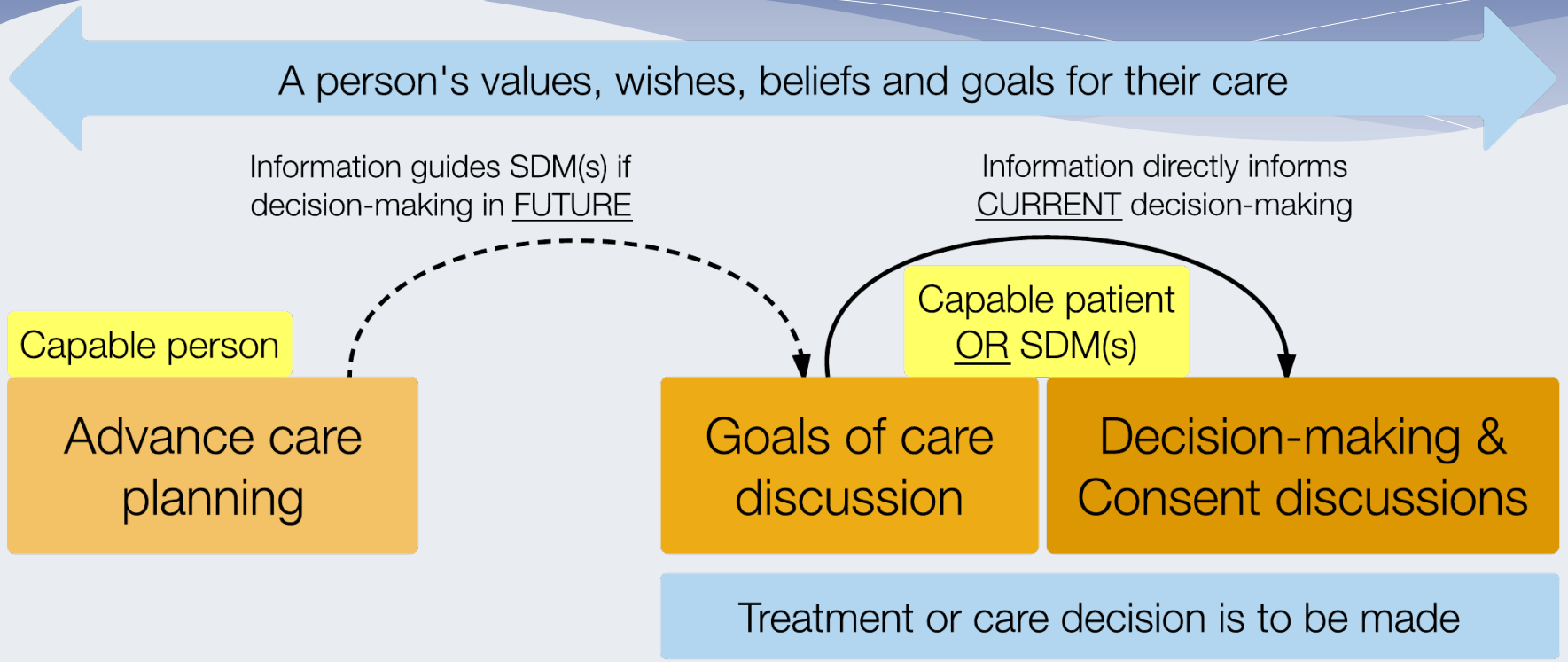
Legend: **(P)**: Priority indicator **(A)**: Additional indicator (QBP): Indicator related to quality-based procedures

2017/18 QIP Indicators & ACP, GoC, Consent and Capacity

Outline:

1. Definitions and language
2. Sector specific activities
3. Activities that cross sectors

Components of person-centred decision-making



- This figure represents the relationships between ACP, GoC & consent
- Also, how each is a distinct component of person-centred decision-making
- Organizations would do well to ensure clarity on the definitions for each

Advance Care Planning

* Series of discussions and reflections a person has with their future substitute decision–maker (SDMs) about health, values and **wishes** related to future care.
* **Purpose:** to prepare the future SDMs to make healthcare decisions in the event the person loses capacity.
* The person must have capacity at the time of an ACP conversation.
* ACP conversations are NOT consent for future care.
* If the person loses capacity, the SDM will consider these conversations in the context of the situation in the future when considering consent for healthcare decisions.
* These conversations can occur in any setting as long as they are related to future care not current care decisions

Goals of Care Discussions

* In preparation for and prior to decision-making, exploring what the person understands about their illness and the decision(s) to be made (what goals the person aims to achieve)
* Occur in the context of a healthcare decision and consent needing to be made or given
* Either a capable patient or an SDM (who will consider prior ACP conversation if they occurred) will engage in this process with healthcare providers.
* These conversations aim to align patient goals with available medical options for care.
* Multiple conversations may be required before a capable person (or their SDM) is prepared to provide informed consent for the available options.

Consent and Capacity

* In Ontario, written instructions are NOT consent to provide or withhold treatment → provision or refusal of consent must come from a person.

* Healthcare decisions require **informed consent** from a capable person (if person is not capable → SDM)
  * except in limited emergency situations as per the Health Care Consent Act.

* When considering decisions to be made for an incapable person, the SDM is to consider (HCCA s21)
  1. The person's prior capable wishes that are possible and applicable to the healthcare decision
  2. The best interest of the person

Capacity

Definition (HCCA s 4):

* **Ability to understand** the information that is relevant to making a decision about the treatment, admission, or personal assistance service as the case may be,

AND

* **Ability to appreciate** the reasonable foreseeable consequences of a decision or lack of decision

Capacity

* Presumed
* Decision and time specific
* Must be assessed by the provider offering the treatment (or delegated to a member of the team)
* Includes an assessment of a person's insight into their health status and health related needs
* Does not assess the reasonableness of a decision but instead how well-reasoned a decision is (i.e. can they demonstrate a logical thought process)

Duties of Health Practitioners when getting Consent to Treatment

Determine who is health decision maker

* Capable Patient or
* Incapable Patient's highest ranked SDM

Provide Information about:

Illness

and

Treatment(s) options offered

(Risks, benefits, side effects, alternatives, what may happen if refuse treatment)

Discuss Goals of Care

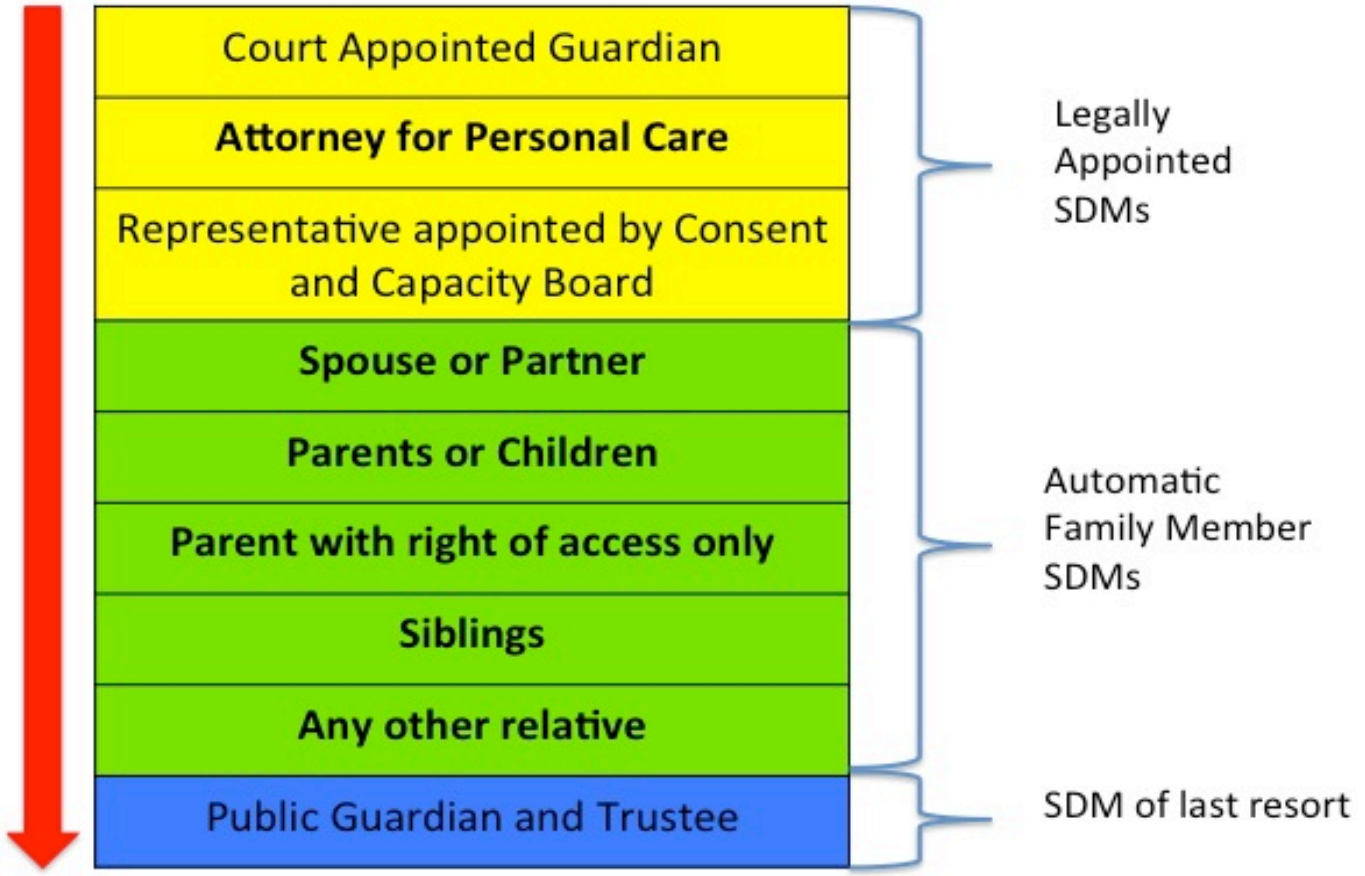
Get Decision (informed consent or refusal)

from Patient or Incapable Patient's highest ranked SDM

Substitute Decision Maker Hierarchy

Confirm automatic SDM(s)

Choose someone else and **Prepare** a *Power of Attorney for Personal Care* document



Ontario Health Care Consent Act, 1996

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P = priority indicator A = additional indicator

Summary: Relevant Indicators

* **Hospital**
  * 30 day re-admission for select conditions
  * Patient received enough information on discharge
* **Primary care**
  * 30 day re-admission for select conditions
* **Home care**
  * Hospital re-admissions
  * Unplanned ED visits
  * Patient died in preferred place of death
* **Long-term care**
  * Potentially avoidable ED visits
* **Across healthcare sectors**
  * Patient-centred person experience
  * Access to right level of care
  * Identifying complex patients

Hospital: 30 day readmissions

* Repeat admissions can be anticipated as diseases progress. How well do the patients/their care network understand this?
* Most relevant for chronic progressive conditions (COPD, CHF, Diabetes, and certain GI diagnoses)
* ACP or GoC cannot prevent all re-admissions BUT
  * *Exploring illness understanding and the person's values, can help clarify best options and wishes regarding future interventions and hospitalizations especially as illness progresses and transitions to end of life*

Hospital: Patient received enough information on discharge

* BOTH person focused GoC conversations (for decisions about current care) and ACP conversations (considering potential future care) begin with ensuring the patient's and/or SDM's understanding of their illness
* Improved quality of these conversations in the hospital has potential to increase patient perception of how much information they received and provide them with a better idea of what to expect after discharge

Primary Care: 30 day readmission for select conditions

* Early discussion of ACP or GoC after discharge from hospital to address values and beliefs especially since aspects of medical care may have more meaning
  * patients can see impact medical interventions on quality of life for example
* ACP or GoC conversations focus on illness understanding (especially of chronic progressive illnesses), as well as address fears that may send people to ER
* Consider engaging the patient in these discussions at their 7 day post-discharge visit
* Document and communicate GoC and preferred setting of care with family, caregivers, SDM, specialists

Homecare: readmission and unplanned ER visits

* There is an important role for ACP and GOC discussions to determine if a person's goals now or in the future can be met by ongoing management in the community.

* Family, caregivers and SDM present to discuss illness understanding, what care in the community is likely to entail as diseases progress.

Homecare: Patient died in preferred place of death

* Currently this QIP only applies to patients who are already receiving palliative care in the community
* Focus for improvement
  * Who is having ACP and GoC conversations? Role for interprofessional HCPs?
  * What is the quality of ACP and GoC conversations?
  * How are these wishes communicated to different care providers?
  * Is there routine documentation as to a person's preferred place of death?
  * How well informed is the person/SDM and caregivers with regards to what a death in the home may look like?

LTC: avoidable ER visits

* LTC facilities that utilize Level of Care forms:
  * These forms are **NOT** consent to transfer nor for any specific treatment(s)
  * LTC HCP must discuss transfer/specific treatment with the capable resident or the SDM
  * Ideally the discussion would focus on the person's GoC in this specific instance and if a transfer/treatment will address those goals
* For all LTC facilities:
  * When residents are capable, create a process for having GoC conversations and plan to revisit with any change in health (includes informed consent for treatment or care plan)
  * If/when the resident is incapable, explore SDM(s) understanding of the resident's condition and potential course of progression
  * As condition progresses, start to explore with capable resident or the SDM the preferred setting for end-of-life care
  * Consider if the person's goals for care can appropriately be met within the LTC environment
  * Consent from capable resident or their SDM for transfer and/or treatment

Across Healthcare Sectors: Patient-Centred Person Experience

Hospital: Patient experience

Primary Care: Patient involvement

Home Care: Client experience

Long-Term Care: Resident experience

* Narrative metric that considers patient satisfaction with care
* The purpose of ACP and GoC conversations is to involve the patient (or their SDM) in their own healthcare
* Person-centred components
  * Exploring what the person (or SDM) understands about the illness (NB this is not the same thing as asking the HCP what they have told the person)
  * Exploring the person's goals, fears and hopes for medical care (some may not be possible, some may need to be adapted to options that are available, and together take steps to minimize fears)

Across Healthcare Sectors: Access the right level of care

* Narrative metric – what is the patient/SDM/caregiver experience?
* Do they feel that their healthcare needs have been met? (i.e. do they feel that they received the right care in the right place and right time)
* Improving the patient experience in this area can be done by addressing the following:
  * Exploring the patient/SDM understanding of the illness
  * Addressing patient goals in relation to what is possible and available offered treatments
  * Addressing expectations for the future and progression of illness

This is particularly relevant for patients with chronic and progressive illnesses but the general principles are applicable to all patients

Across sectors: Identifying & coordinating care for patients with complex issues

* Coordination of communication between sectors
  - One sector picks up where the last left off…e.g. start with discussion of identifying SDM in hospital…follow up with values, beliefs, wishes discussion in primary care or home-care, reviewing decisions (all sectors) etc.
  - Use of consistent tools and terminology for ACP, Goals of Care across all sectors
  - Where does documentation live? With the patient? Their SDM? → How will the most recent version travel with the patient to the time and place they require care?
  - Shared communication on plan of care or treatment plan

This does **NOT** mean getting 'advance consent for treatment' that may occur in another sector! ACP prepares the SDM for potential future decision making; it is **NOT** advanced consent!

NEW - HPCO ACP HCC GoC Resource Guide

What is the ACP HCC GoC Resource Guide

* New, easy to read comprehensive manual providing explanations of all elements of patient – centred decision making.
* The manual produced under the leadership of Judith Wahl, Barrister and Solicitor, Dr. Jeff Myers & Dr. Nadia Incardona
* Format:
  * Available Online at Speak Up Ontario - Winter 2018
  * Updatable - added to and changed as new questions and issues arise.
  * Will include explanations, diagrams and quick reference checklists and templates

NEW - HPCO ACP HCC GoC Resource Guide

ACP HCC GoC Resource Guide Consultation Process

* Resource Guide production is being done through a collaborative process
* Core chapters will be available in **draft in November 2017** for review and feedback.
* Additional sections will be made available for review and feedback as they are written.
* The review is being conducted by the HCC ACP Leadership CoP
* If you are **interested in participating in this review process** to offer feedback, please contact:
  * Deanna D'Souza
  * HPCO Decision & Project Support Specialist
  * ddsouza@hpco.ca.

NEW – E-learning Module

* Following the completion of the HCC ACP GoC Resource Guide, we will implement an integrated on-line training and education program based on the foundational concepts.
* The training will provide for a certificate in HCC ACP for health service providers in Ontario if successfully completed.
* Available at Speak Up Ontario - Winter 2018

New - Educational Videos & Resources

* Expansion of the online resources for health service providers and the general public:
  * Additional informational videos, and downloadable materials (Ontario centric)
  * Creation of Ontario specific doodles ideal for waiting rooms
* Planned topics include:
  * What is hospice palliative and end-of-life care?
  * What is health care consent?
  * What is advance care planning and why is it important?
  * Sharing your health care wishes.

Educational Resources – Archived Webinars

2016 Basic Education Series:

* LHIN Staff - June 1, 2016
* Provincial Associations - July 19, 2016
* Health Links and Community Partners - September 28, 2016
* Long Term Care Homes - October 7, 2016
* Hospitals - November 18, 2016
* Community Care Access Centres - December 9, 2016

2017 Basic Education Series:

* General Session – January 13th, 2017
* Regional HPC Networks – February 10th, 2017
* Senior Friendly Hospitals – February 22, 2017
* LTC Corporations and Compliance Officers – March 10th, 2017
* Primary Care – March 10th, 2017
* Lawyers and Legal Clinics – May 12th, 2017
* Clinical Ethicists and Social Workers – June 9th, 2017

NEW - 2017 & 2018 Advanced Education Series

2017

* Basic Conversation Skills (Part One and Two)
  * September 29, 2017
  * October 27, 2017
* Forms and Templates within the Ontario Legal Framework
  * November 24, 2017

2018

* New topics for winter 2018 will be announced later this year

Ontario needs to GET THIS RIGHT

* 100% of us will die
* ACP, GoC Conversations and Consent are relevant to 100% of Ontarians
* It is **NOT** a matter of **IF** we get this right, it is now about **HOW** and **WHEN** we get this right
* Advancing this work will require a system wide approach
* A coordinated effort at provincial, regional and community levels is required for success

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