Flexing Your Core: the Palliative Workout ECHO

Care Planning, Collaborative Practice and Advocacy

August 19th, 2025

AGENDA ITEM	NOTES
Introductions, Objectives	**Session Facilitators**: Alixandria Baxandall, Island Health & Sue Bartnik, **BScN, BC-CPC** **Learning objectives:** 1. Identify the importance of determining a person's goals for their care at end of life; ACP. 2. Discuss ways to anticipate, identify and address supportive care needs of the person and family in collaboration with the circle of care. 3. Considers ways to advocate for incorporation of the person and their designated family or caregivers' values and beliefs into caring.

Session Key Points and discussion	**Overview**
	• This session focused on deepening the understanding and practical use of Advanced Care Planning (ACP) and advocacy in palliative care, guided by the Palliative Care Framework. It emphasized two core components:
	  ○ Care Planning & Collaborative Practice
	  ○ Advocacy
	• The framework advocates for a holistic, person-centered, and equity-informed approach to care, encouraging healthcare professionals to consider the values and wishes of patients in their care decisions.
	
	Advanced Care Planning (ACP) vs. Medical Orders for Scope of Treatment (MOST)
	• The presentation provides an overview of Advanced Care Planning (ACP) and how it differs from Medical Orders for Scope of Treatment (MOST).
	• The concept of anticipatory care planning is briefly introduced as a forward-looking process that helps patients prepare for potential future health changes, with ACP serving as a key guiding tool in this effort.
	
	Video Discussion- The session used a video resource to outline ACP in three stages:
	1. **Think**: Reflect on what matters most to you. Decide who should make decisions on your behalf if needed.

2. **Talk**: Engage in conversations with loved ones and healthcare providers. Discuss scenarios and preferences gradually.
3. **Plan**: Document preferences and ensure they are accessible to emergency responders and care teams. Plans should be reviewed and updated regularly.

Comments from participants focused on the importance, challenges, and strategies related to Advanced Care Planning (ACP), particularly in healthcare settings.

Key Themes:

- **Encouraging ACP Conversations**: Many healthcare providers are hesitant to initiate ACP discussions, despite evidence that most patients want to have them.
- **Aligning Medical Care with Life Values**: ACP should go beyond treatment options to include life goals and personal meaning.
- **Barriers to ACP**: Fear, discomfort, and misconceptions can hinder ACP. For example, many people speak to financial advisors before doctors about end-of-life care.
- **Effective Engagement Approaches**: Starting with topics like financial planning can ease patients into ACP discussions. Interactive methods also help identify knowledge gaps.
- **Cultural & Community Sensitivity**: Community traditions and experiences, especially among Indigenous populations, require respectful, informed engagement. One case shared by a nurse highlighted how lack of planning led to family conflict and property loss.

<u>Goals of Care vs Advance Care Planning (ACP)</u>

- While ACP is preparatory, Goals of Care discussions are real-time conversations tied to immediate medical decisions (e.g., after a new diagnosis or hospitalization). A useful model distinguishes:
- **Preparing**: If no decision is required now (ACP/anticipatory planning).
- **Deciding**: When immediate choices must be made (goals of care).
- Clinicians must navigate privacy concerns, cultural norms, and relational discomfort while maintaining a safe space for honest dialogue.

The Importance of Emotional Intelligence and Cultural Respect

- Creating space for emotionally complex conversations requires clinicians to:
    - Acknowledge discomfort openly.
    - Use empathy and cultural humility.
    - Address dynamics such as grief, fear, trauma, or historical mistrust.
- These qualities help build trust, leading to more meaningful, patient-centered outcomes.

Anticipatory Care Planning and Multidisciplinary Approach

- Anticipatory care planning proactively addresses potential health events, allowing patients to maintain control and quality of life.
- Effective planning is:
  - **Multidisciplinary**: Involving physicians, nurses, social workers, counselors, and spiritual care providers.
  - **Collaborative**: With clearly defined roles for initiating and following up on care plans.
  - **Inclusive**: Engaging everyone from dietitians to Indigenous navigators who may have unique community connections.

Scenario Overview:

- Michael, a 76-year-old man with colon cancer, is rushed to the ER for urgent pain and symptom management.
- His condition deteriorates rapidly, rendering him non-responsive.
- Present are his wife of 12 years (Joanne) and two adult children from a previous marriage.
- A conflict arises between Joanne and the adult children about Michael's treatment preferences.

Key Discussion Themes:

1. Anticipated Issues:

- **Lack of Advance Care Planning**: Uncertainty about whether Michael has an advance directive or designated decision-maker.
- **Family Disagreement**: Risk of care delays and emotional distress due to disagreement between Joanne and the adult children.
- **Risk of Unwanted Interventions**: Potential for Michael to receive care he wouldn't have chosen.
- **Long-term Family Impact**: Possibility of enduring rifts within the family.

2. Questions to Explore with the Family:

- Has Michael previously expressed his care preferences or goals of care?
- Do all family members understand the seriousness of his condition?
- What emotional factors (e.g., fear, grief, past trauma) may be driving disagreement?
- Is there a history of conflict or strained relationships?

3. Multidisciplinary Team Involvement:

- **Suggested Team Members**:
  - Physicians
  - Nurses
  - Social Workers
  - Spiritual Care
  - Counselors

- Pain & Symptom Management Team
- Ethics Committee (if needed)

- **Goals**:
  - Facilitate communication
  - Address emotional and social needs
  - Ensure patient-centered, compassionate care

4. Importance of Emotional Intelligence and Respect:

- Acknowledging underlying emotions (e.g., fear, loss of control)
- Emphasizing mutual respect and love for Michael as a unifying theme
- Encouraging empathetic, open dialogue between family members and the care team

5. Takeaways:

- Early and clear advance care planning is critical.
- Understanding the broader emotional and relational context is key to resolving disputes.
- Multidisciplinary collaboration enhances both patient care and family support.
- Proactive communication and shared goals can mitigate conflict.

<u>Care Planning & Advocacy</u>

Principles of Effective Care Planning:

- **Dynamic & Adaptable**: Plans must evolve with changing health and life conditions.
- **Person-Centered**: The patient's wishes must remain central, even in the absence of written directives.
- **Proactive**: Conversations should occur before crises, not during them.
- **Shared Across the Team**: Clear documentation and communication are vital.
- **Legal Awareness**: Knowing the legal tools and requirements can help start meaningful dialogue.

Advocacy in Clinical Practice

Advocacy takes place on multiple levels:

- **Patient-Level**: Supporting autonomy when patients can't speak for themselves.
- **Team-Level**: Ensuring the patient's voice is heard within the care team.
- **System-Level**: Working toward broader changes in healthcare access and equity.

Clinicians are encouraged to act as resource detectives, supporting patients with relevant services and partnerships.

Final Reflections and Call to Action

These conversations are not one-time events, but an ongoing process. Success in care planning and advocacy relies on:

	• Deep respect for cultural context and personal identity • Courage to engage in difficult discussions • Strong collaboration across disciplines • Continuous reassessment of care goals and needs • Care plans should be regularly reviewed and adjusted as needed, maintaining flexibility to accommodate changes in condition or patient preference. • Attendees were encouraged to initiate a difficult conversation around goals of care or advance care planning, applying what they learned to real-world interactions.
Resources	ACP • **https://www.advancecareplanning.ca/** • **https://www.bc-cpc.ca/acp/** • **www.fnha.ca/acp** • **Regional Health Authority – ACP resources** • **'My Voice' - ACP guide-https://www2.gov.bc.ca/assets/gov/people/seniors/health-safety/pdf/myvoice-advancecareplanningguide.pdf** • **www.SeniorsFirstBC.ca** Advocacy • BC.211.ca • Family Caregivers of BC https://www.familycaregiversbc.ca/ • Canadian Virtual Hospice CareHub https://carehub.life/ • Regional Health Authority Quality Office/Ethics team • Patient Voices Network – www.patientvoicesbc.ca • Seniors Abuse & Information Line (SAIL) - all **604-437-1940** or Toll-Free at **1-866-437-1940**
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