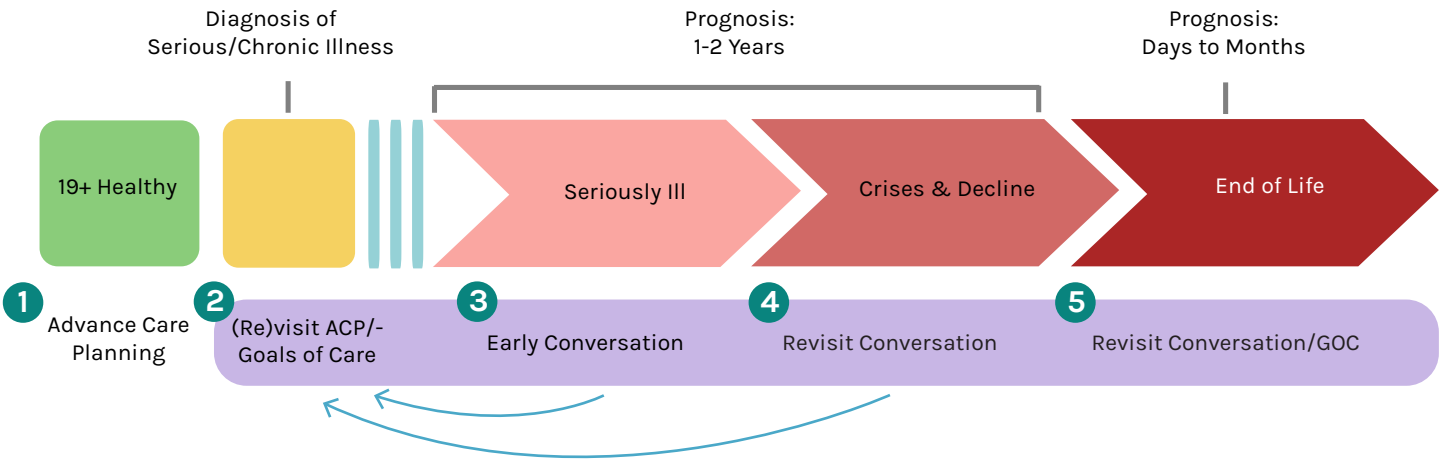
Continuum of Conversations

This is a graph that shows a patient's illness journey through various stages of health progression and change.



1. Advance Care Planning

Anyone 19 years or older regardless of their health can do Advance Care Planning (ACP). This includes a patient's wishes and preferences for future care in the event there is an acute episode or health deterioration. Examples of what a patient may consider when completing ACP: Who will manage my finances? Who will be my substitute decision maker? Who is going to take care of my belongings?

2. (Re)visit ACP/Goals of Care

It is common that people get busy with life and may not have a chance to complete their ACP earlier. When they get diagnosed with a serious or chronic illness, conversations about their previously completed ACP or goals of care may be revisited. These wishes will be reviewed in the context of the illness trajectory provided by their health care team. They may be going through various treatments and interventions (as represented by the blue bars).

3. Early Conversation

There comes a time when the patient's illness will continue to progress and they become seriously ill. That is a time to have an early conversation which includes a discussion about the current condition, what to expect in the future, and the patient's values, goals and worries as the illness progresses. The goals of care conversation will inform treatment and interventions recommended by the health care team so that the care provided reflects that patient's wishes.

4. Revisit Conversation

When there is a crisis or decline, it will be helpful to have previously expressed wishes available and revisit the conversation. The goals of care discussion will focus on current situation and include any updated course of treatment and interventions.

5. Discuss goals of care (GOC) for current situation, and use it to revisit treatment and intervention wishes

At the end of life, previously expressed wishes will be revisited again to ensure treatment and intervention plans are aligned with the patient's wishes.

Consider Specialized Palliative Care Services for more complex needs at anytime of illness trajectory (if available)

A palliative approach to care and specialized palliative care services and can be introduced at any time of a patient's illness trajectory. If a patient's wishes is to focus on quality of life and symptom management, palliative care services can be introduced even as early as diagnosis (the yellow bar represents diagnosis).