Increasing Patient’s Autonomy and Understanding Their Preferences For Care Through Advance Care Planning

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Background

At National Heart Centre Singapore (NHCS), we commonly attend to patients who are admitted for sudden cardiac arrests. Often, our patients are too ill to communicate their wishes for medical treatment. Hence, much of this responsibility lies with their next of kin and family members.

Understanding our patients’ needs and respecting their choices form an integral part of the holistic healthcare system, where patient care is beyond medical treatment. Patient’s autonomy on their preference for care and medical treatment have been identified by the Ministry of Health (MOH) as a niche area of need. Our team developed a value-added programme: Advance Care Planning.

Advance Care Planning is a process whereby patients discuss, state and document their values and wishes regarding their end-of-life medical care with healthcare professionals and their caregivers, in the event that they are incapacitated from making decisions on their own.

Previous Problem

- No processes in place to formally document patients’ care preferences at the end-of-life
- Patients’ care preferences were not formally discussed prior to the deterioration of their medical condition.

Project Goals

- Attain patient-centered standards
- Align to organisational goals
- Increase patient and staff satisfaction
- Optimise healthcare cost savings
- 93% Never heard of Advance Care Planning
- 63.4% Not considered their wishes for the sustaining treatment
- 0% had any written documentations about their wishes

Solutions & Implementation

- Customisation of Advance Care Planning for NHCS patients by setting a structured pathway for discussion of patient’s care preferences
- Involvement of doctors in screening and recruitment of patients helps medical team and patients communicate on healthcare wishes
- Formation of Advance Care Planning workgroup with the Heart Failure team to increase multidisciplinary team support for the programme
- Development of an IT system to create a standard platform for communication of patient’s wishes with multidisciplinary team across healthcare institutions
- Recruitment of a coordinator to provide a single point of contact for Advance Care Planning referrals and follow-ups

Methodology

- Patient admitted to NHCS for Cardiac Condition
- Doctor and ACP Coordinator screen and recruit suitable patient for ACP
- Medical Social Worker conducts ACP discussion with recruited patient
- Doctor accesses patient’s ACP Plan via Electronic Medical Records or medical files to know patient’s preferred treatment options
- Medical Social Worker keeps information discussed on IT System and file completed ACP form and worksheet into patient’s records

Results

Tangible Outcomes

- Medical bills savings of $208,000 from two patients with ACP
- 19 doctors, nurses and Allied Health staff trained in Advance Care Planning facilitation
- 120 patients had Advance Care Planning discussions
- 6 patient wishes fulfilled since implementation

Intangible Outcomes

- Enhancement of staff skills and knowledge in conducting end-of-life conversations
- Meets Joint Commission International (JCI) standard for respecting patient’s rights and choices

Comparison of patients with the same treatment type who passed away at NHCS in 2013

<table>
<thead>
<tr>
<th>Patient</th>
<th>ACP done</th>
<th>Length of Stay</th>
<th>Bill Size Difference</th>
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<tbody>
<tr>
<td>Late Mr Phua</td>
<td>Yes</td>
<td>21.5 days</td>
<td>$8,327.07</td>
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<tr>
<td>Late Mr Tay</td>
<td>No</td>
<td>65 days</td>
<td>$140,303.66</td>
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<td>Late Mr Yeo</td>
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<td>11 days</td>
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<tr>
<td>Late Mr Woo</td>
<td>No</td>
<td>43 days</td>
<td>$124,866.91</td>
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</tbody>
</table>

Cross-functional Teams

- Medical Social Worker
- Doctor
- ACP Coordinator
- Healthcare professional

National Heart Centre Singapore

- Meets changing needs of ageing population
- Holistic healthcare
- Improve communication
- Meet Joint Commission International standards

Agency of Integrated Care

- Improve quality of aged care
- Results to develop a national ACP framework

Family Members

- Minimize disputes
- Better coping during crisis
- Improve satisfaction from less stress

Post-Advance Care Planning Survey Findings

- 54% Patients’ experiences with medical treatment
- 70% Reflected personal values and identity end-of-life preferences
- 56% Improved health knowledge
- 80% Felt that planning for end-of-life treatment options is important
- 75% Satisfied with the ACP discussion

Project Spin-Offs

Agency of Integrated Care recognizes success of National Heart Centre Singapore’s Advance Care Planning model.

- Invited NHCS to share on the pilot implementation success with other Restructured Hospitals
- Received $208,000 in incentive payments
- Trained 19 doctors, nurses and Allied Health staff in Advance Care Planning facilitation
- Conducted 120 patient interviews and discussions
- 6 patients had their wishes fulfilled since implementation

Sustainability

- Patient Experiences
- Pre- and post-surveys
- Pre and post surveys on patient experiences
- Stakeholders’ Experiences
- Stakeholder engagement and feedback
- Partnerships with medical team
- Sharing of ACP Records
- Form filed in caseworkers
- Filing in electronic MSW system and online system
- ACP Resources
- ACP Facilitators Training
- Road shows to doctors, nurse clinicians

Recognition

- Awarded Gold at the national Team Excellence Symposium, March 2014
- Achieved 3rd place at the Best of the Best Team Excellence Symposium, May 2014

System to Measure and Sustain Results

- Monitor and evaluate results against Key performance Indicators
- Comparative Analysis and Reviews

Creative Solution Matrix Value

- Patient Experiences
- Pre- and post-surveys
- Patient and staff satisfaction
- Optimiser healthcare costs
- 93% Never heard of Advance Care Planning
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Potential Impact on Stakeholders

- Better understanding of conditions and treatments
- Increase autonomy
- Honor wishes

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