

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



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1 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.

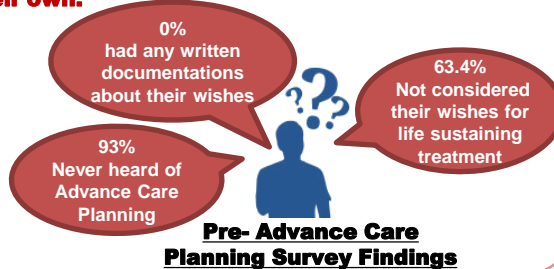
Advance Care Planning is a process whereby patients discuss, state and document their values and wishes regarding their end-of-life medical care with healthcare professionals and their caregivers, in the event that they are incapacitated from making decisions on their own.

Previous Problem

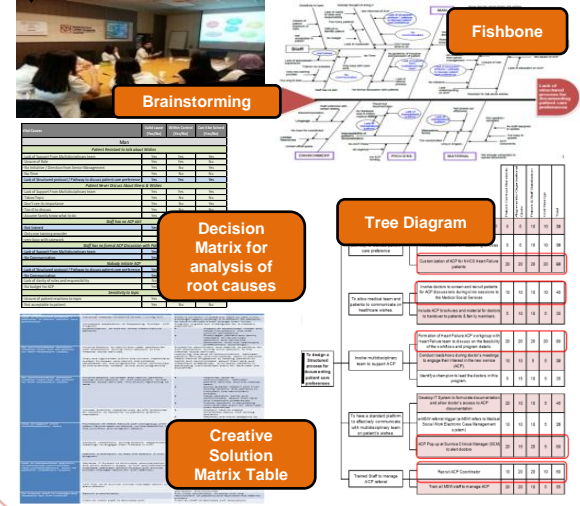
- No processes in place to formally document patients' care preferences at the end-of-life.
- Patients' care preferences were not formally discussed prior to the deterioration of their medical condition.

Project Goals

- Attain patient-centered standards
- Align to organisational goals
- Increase patient and staff satisfaction
- Optimise healthcare cost savings

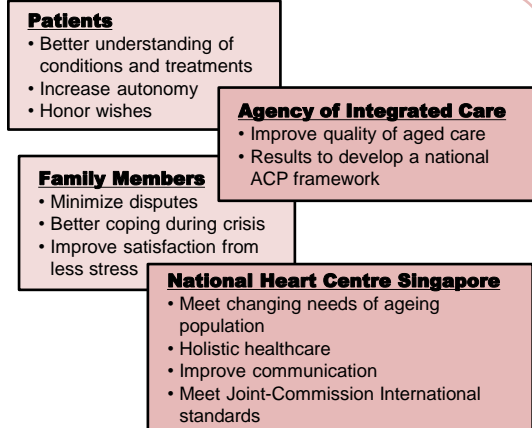
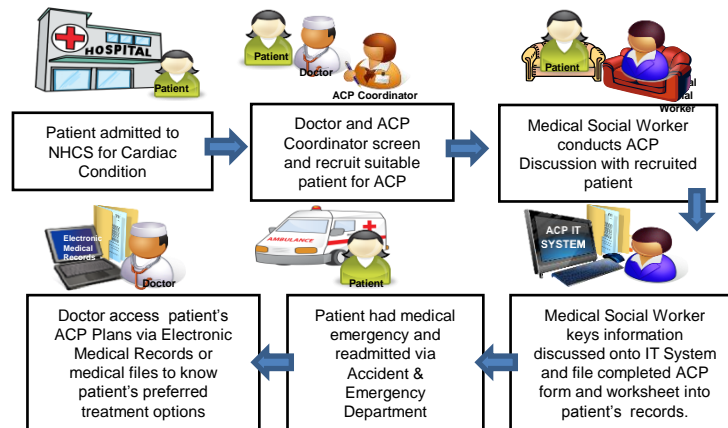


2 Methodology



3 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's 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



4 Results

Tangible Outcomes

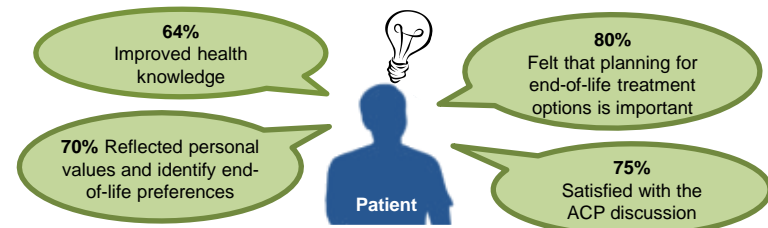
- Medical bills savings of \$208,000 from two patients with ACP.
- 19 doctors, nurses and Allied Health staff trained in Advance Care Planning facilitation
- 120 patients had Advance Care Planning discussions
- 6 patient wishes fulfilled since implementation

Intangible Outcomes

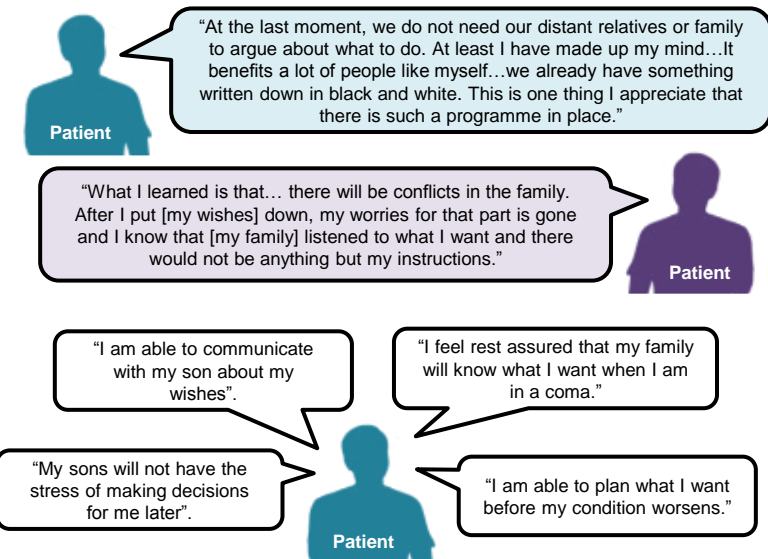
- Enhancement of staff skills and knowledge in conducting end-of-life conversations
- Meets Joint-Commission International (JCI) standard for respecting patient's rights and choices

Comparison of patients with the same treatment type who passed away at NHCS in 2013					
Patient	ACP done	Length of Stay	Length of Stay Difference	Bill Size	Bill Size Difference
Ventricular Assist Device Implant					
Late Mr Phua	Yes	21.5 days	- 43.5 days	\$ 8, 327.07	- \$ 131, 976.59
Late Mr Tay	No	65 days		\$ 140, 303.66	
Transplant					
Late Mr Yeo	Yes	11 days	- 32 days	\$ 48, 896.98	- \$ 75, 969.93
Late Mr Woo	No	43 days		\$ 124, 866.91	

Post- Advance Care Planning Survey Findings



ACP Programme Participants' Testimonials



5 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 post pilot implementation success with other Restructured Hospitals

Sharing of the Advance Care Planning programme at international conferences (e.g. Barcelona, Canada and Melbourne)

Extension of Advance Care Planning to other cardiac disease groups (e.g. Electrophysiology, Adult Congenital Heart Disease)

Learning model for other SingHealth institutions

Research collaboration with Duke NUS on impact of Advance Care Planning

6 Sustenance

Governance & Control

- Monitor and evaluate results against Key performance Indicators
- Formalise Policies & Procedures

Patient Experiences

- Pre and post surveys
- Regularly monitor and remap patient experience

Stakeholders' Experiences

- Stakeholder engagement and feedback
- Partnerships with medical team

Sharing of ACP Records

- Form filed in casenotes
- Filing in electronic MSW system and online system

ACP Resources

- ACP Facilitators Training
- Road shows to doctors, nurse clinicians

7 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

