A critical review of ACP development in Singapore – reaping more benefits and addressing key challenges ahead

JCECC Symposium

Concerted Efforts in ACP: Regional and Local Experiences

24 October 2019

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Key Points

- Defining the Problem and the Pioneers
- The Structure
  - National Steering Committee and ACP National Office
  - Acute Hospitals
- The Content
  - Respecting Choices to Living Matters
- The Process
  - How did we fare over the years?

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Key Points

- New Developments
  - Beyond acute hospitals
  - Relationship of ACP to other care planning instruments
  - Utility and Relevance – the notion of care
  - From planning for advance care to planning for care in advance
- What's ahead:
  - improve health literacy and death literacy
  - coordinated effort by multi-stakeholders across planning tools
  - capability building (care plan facilitators – depth and breadth)

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Defining the Problem and the Pioneers

- 1996 Advance Medical Directive (AMD) Act
- 2008 Mental Capacity Act (MCA)
  - Office of Public Guardian (LPA)
  - Mental Capacity (Registration of PDD) Regulations 2018
  - 67,000 registered an LPA (June 2019)
  - A new online system by 2021

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Defining the Problem and the Pioneers

- In palliative care teams, doctors saw the need to have consistently good quality conversations about care options with the patients and their caregivers.
- 2011 Start of National ACP Movement
- Singapore's Ministry of Health funded the Agency for Integrated Care (AIC) to roll out ACP. The ACP National Office was formed. Tan Tock Seng Hospital was the first restructured hospital to pioneer ACP among the restructured hospitals.

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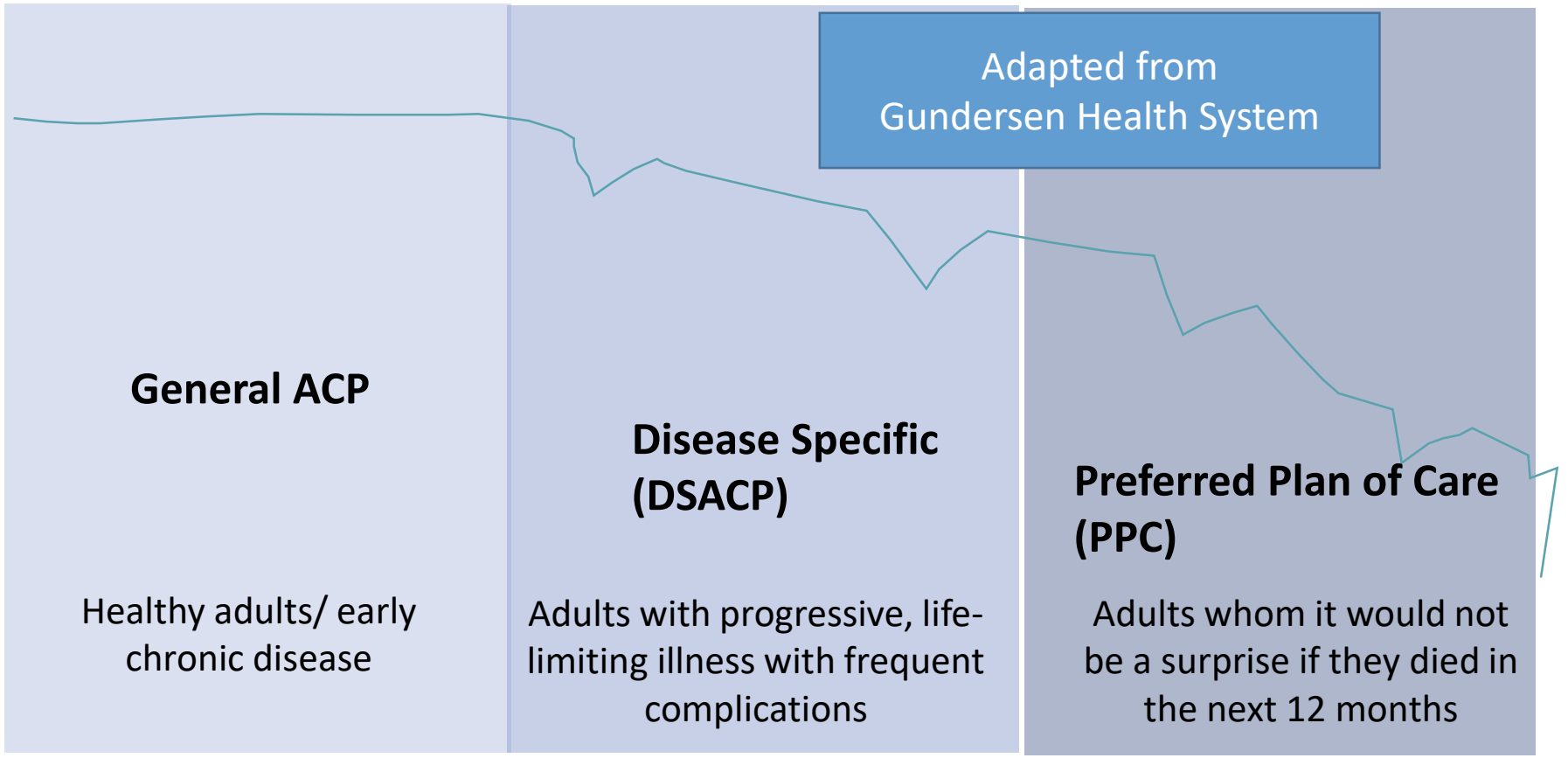
Respecting Choices to Living Matters



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A department of Gundersen Lutheran Medical Foundation
RESPECTING CHOICES®
An advance care planning system that works.

National Steering Committee & ACP National Office

- Hospitals
- Community Care Providers
- Grassroots Civic groups
- Religious groups
- General public

- Facilitator training
- Advocacy training
- Certification
- Publicity and patient education

Engagement

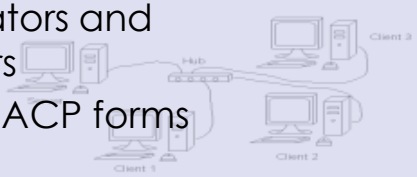
Training & Education

ACP Office in AIC

System Infrastructure

Quality Improvement

- Develop ACP IT system
- Maintain central registry of facilitators and instructors
- National ACP forms



- Track Programme KPIs
- Report progress to funders
- National standards & guidelines

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Milestones

>16,000 plans were lodged by 2019

2009 Training by visiting faculty from Respecting Choices

2011 - Set up of National Steering Committee, ACP National Office. Build centralised IT system, design conversation templates

2012 - training of ACP facilitators, mainly from acute hospitals, set up of ACP offices in acute hospitals

2013 - ACP for paediatric population, roll out to community healthcare providers (nursing homes, community hospitals, social care agencies etc.)

2014 - Training of ACP advocates

2015 - ACP for dementia

2017 - 2020 ACP in primary care, ACP awareness in the community, ACP accessible via NEHR system, >2000 facilitators

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Respecting Choices to Living Matters

6 elements that distinguished the advance care planning programme in La Crosse from other efforts:

1. Treats advance care planning **as an ongoing process**, not as an event designed to produce a product

2. Shifts the focus on end-of-life decision-making away from the completion of the document toward facilitating **discussion about values and preferences**

3. Shifts the locus of advance care planning away from hospitals and physicians into the **community** and **specifically to the family unit**

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Respecting Choices to Living Matters

4. Team approach is far more successful than placing the responsibility on only one professional group - extensive training of **non-physician groups** & community volunteers: nurses, social workers, physician assistants, nurse practitioners, chaplains, clergy, and volunteers with professional backgrounds

5. Refocuses discussion of preferences **away from autonomy toward personal relationships**. Rather than ask a patient what he or she wants, they reframe the question as, "How can you guide your loved ones to make the best decisions for you?"

6. Works with hospitals and area physician offices to ensure that completed advance directives are **available in patient's charts.**

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>8 Years of implementing ACP

Results From October 2011 to December 2012, a total of 154 preferred plans of care were completed with patients and/or next-of-kin. Five ACP plans were revised. Medical team was aware of patients' ACP plans in 75% of 67 readmissions. Medical interventions and initial place of care in event of deterioration were congruent with patients' stated preferences in 98% and 94% of readmissions respectively. Preferred place of death was honoured 74% upon death of patients.

Raymond Ng (2013)

J Pain Symptom Manage. 2018 Aug;56(2):213-221.e4. doi: 10.1016/j.jpainsymman.2018.05.007. Epub 2018 Jun 20.

Advance Care Planning in a Multicultural Family Centric Community: A Qualitative Study of Health Care Professionals', Patients', and Caregivers' Perspectives.

Menon S[1], Kars MC[2], Malhotra C[3], Campbell AV[4], van Delden JJM[2].

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

Implementing Advance Care Planning in Acute Hospitals: Leading the Transformation of Norms

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Challenges of ACP in acute-care settings

- Hospital culture – curative norms, absence of a culture that support patients' preferences
- Lack of organisational priority and leadership – e.g. infection control is more urgent than acp as a new iniative, hence little investment in structure, process and procedures etc. No buy-in from physicians

Challenges of ACP in acute-care settings

- Lack of shared purposes and goals – what are the objectives of acp, and how is acp different from DNR and extent of care (EOC)?
- Work practices – inappropriate resourcing, lack of accountability and feedback, pigeonhole of acp practice

Beyond Acute Hospitals

Hospitals may not be the best and only place to initiate ACP conversations.

We need multiple touch points and a layered network of different professions to engage the whole community in these conversations across timeline as health status and social circumstances change.

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Utility & Relevance to the Community – the Notion of Care

- Medical and Nursing Care by healthcare professionals
- Personal Care (Activities of Daily Living – transfer, feeding, toileting, mobility etc.)
- Practical Care (Financial, Banking, Housework, etc.)
- Social, Relational & Spiritual Care (Family members as caregivers, not being a burden, keeping the family cohesive, funeral matters)
- Estate and Organ Donation (Caring for the future generation, legacy)
- Levels of needs and length of care

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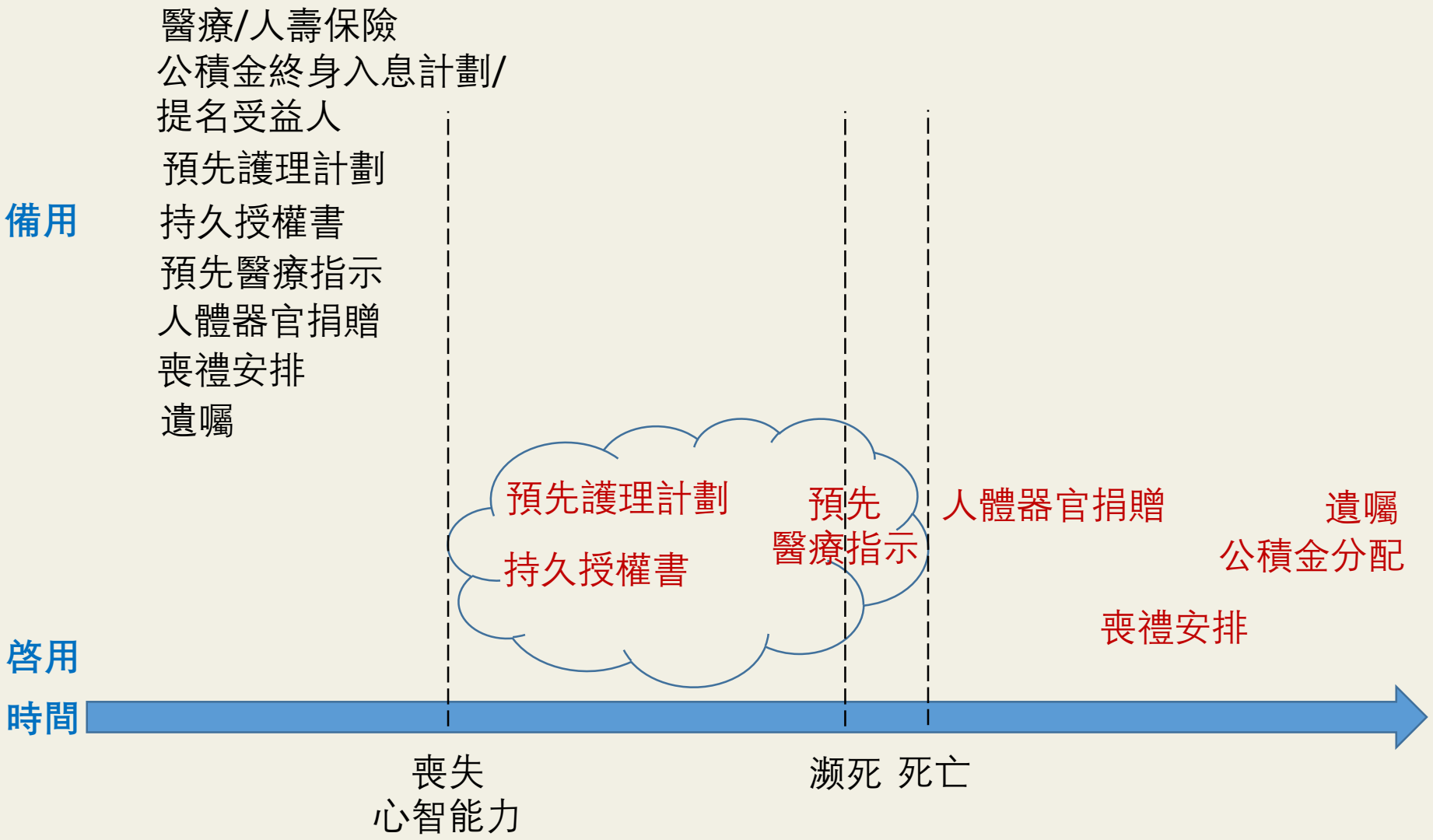
規劃晚期照顧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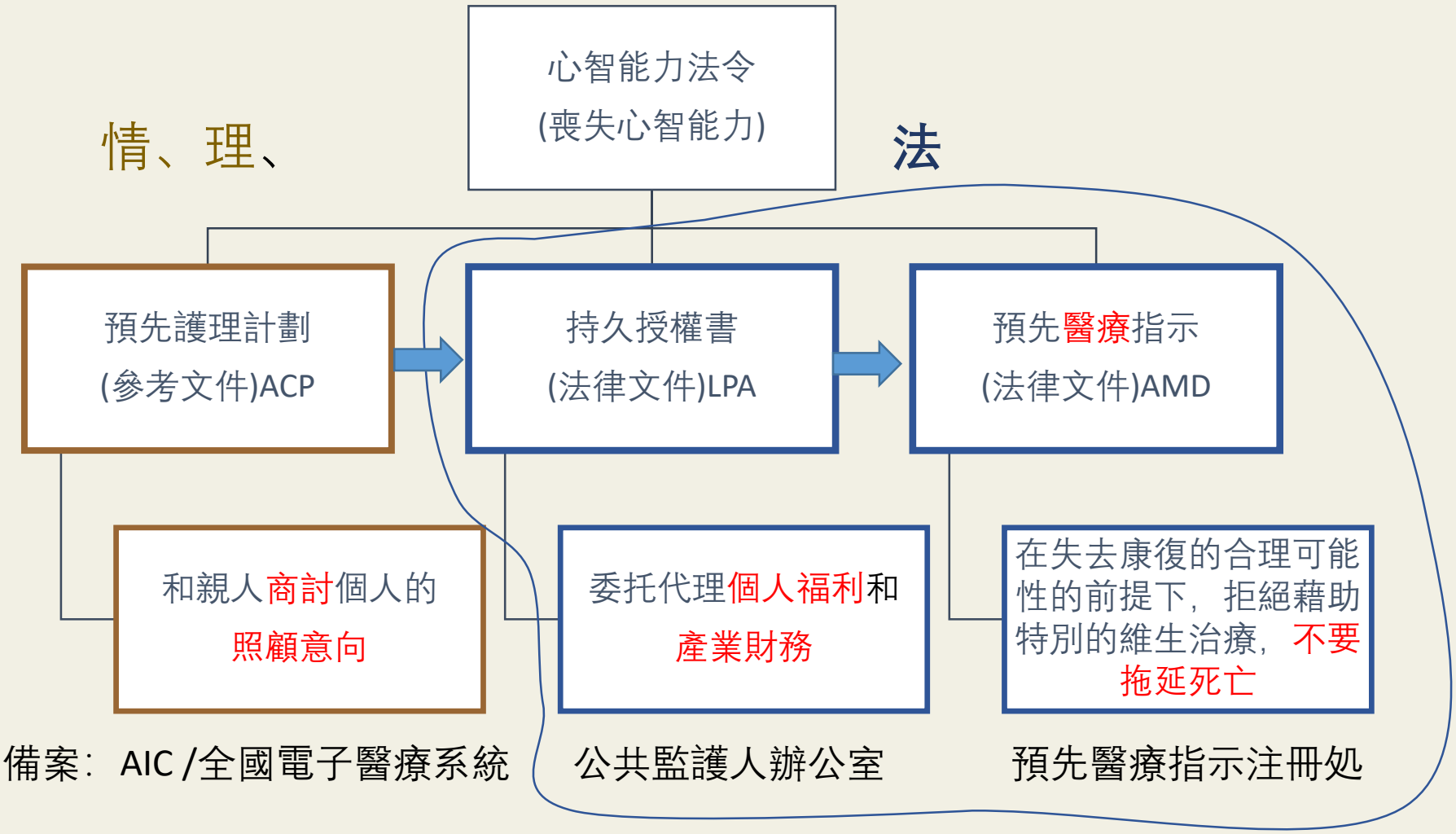
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在失去康復的合理可能性的前提下，拒絕藉助特別的維生治療，不要拖延死亡
備案：AIC /全國電子醫療系統
公共監護人辦公室
預先醫療指示注冊処

Planning for Advance Care to Planning for Care in Advance

- Structure: National ACP Body works with National Bodies of other care planning tools (AMD, LPA, Central Provident Fund, Organ Donation etc), Central Portal, Partnerships with the community
- Content: ACP, AMD, LPA, CPF, MTERA, Funeral, Will
- Process: conversations – everyone, documentation - target older adults and the sick; multiple conversations
- Resources: training health and social care workers, literacy in the community, use of IT

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Planning for Advance Care to Planning for Care in Advance

- Planning for Advance Care 規劃晚期/重症照顧
  - Mental capacity as a key driver
  - Medically focused

- Planning for Care in Advance 提前規劃照顧
  - Care conversations as purposeful in itself
  - More than medical
  - Include other planning tools

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Improve Health and Death Literacy

- Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
- Death literacy is defined as a set of knowledge and skills that make it possible for individuals to gain access, to understand and act upon end-of-life and death care options.

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Coordinated Effort by Multiple Stakeholders

- All health and social care workers – ACP-informed practice (routine care for elders)
- Trained ACP facilitators in community social care agencies, community health facilities and acute hospitals (ACP, DSACP, PPC)
- Depth of conversation driven by care needs, readiness of the clients, skills of the facilitators
- An online form completed by different professionals across settings (doctors, nurses, social workers/allied health professionals)?

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Capability and Capacity Building

- IT enhancement and integration
- Healthcare and social care workers
- Breadth – different care planning tools
- Depth – General ACP to Preferred Plan of Care

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ACPi Conference 2021

ACP in Cultural Diversity: More Similar than Different

9-11 April 2021

Singapore

For more information, email:

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Thank You

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