Advance Care Planning

Office of Advance Care Planning Forum
Advance Care Planning in the Digital Space

Dr Leyton Miller
Outline

• What is advance care planning (ACP)?

• Barriers to successful ACP

• Exploring solutions

• Implementation of ACP Tracker

• Implementation of the digital ARP

• Future plans
Keep It Super Simple
Advance Care Planning (ACP)

Advance care planning promotes care that is consistent with a person's goals, values, beliefs and preferences.

It prepares the person and others to plan for future health care, for a time when the person may no longer be able to communicate those decisions themselves.

Advance Care Planning Australia, 2020.
https://www.advancecareplanning.org.au/
Advance care planning

future
health care
choices
Benefits of ACP

- Reduces stress, anxiety and depression in surviving family members
- Decreases use of intensive medical interventions with better control of mental and physical symptoms in last phases of life
- Improves patient satisfaction and quality of life
- Limits unwanted medical treatments (such as cardiopulmonary bypass, ICU admission or hospitalisation)
- Improves concordance between expressed preferences for care and delivered care, greater patient and carer satisfaction with care, less decisional conflict
- Results in fewer in-hospital deaths and ICU admissions, more hospice use, more comfort-oriented end-of-life care
- Fewer inappropriate transfers to hospital of patients living in RACFs with advanced illness

Prevalence of ACP

Australians aren’t ‘prepared’ to die - survey

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<tr>
<th>Arrangement</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Superannuation</td>
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<td>Will</td>
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<td>Organ and tissue donation</td>
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<td>File of important documents</td>
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<td>Power of attorney</td>
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<td>Income protection insurance</td>
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<tr>
<td>Advance care plan</td>
<td>5</td>
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</table>
Barriers to ACP
Barriers to ACP

Person (patient)

Clinician

System

Information sharing across domains\(^2\)
# Exploring Solutions

## System
- Access to documents
- Complexity of systems
- Perceived cost
- Information sharing across domains

## Solution
- Make documents/info available at PoC
- Easy to navigate
- Data driven
- Across jurisdictions
KISS

↑ Availability

↓ Complexity
Queensland Health

“The Viewer”

The Viewer collates data from multiple Queensland Health systems, enabling healthcare professionals to access patients' information quickly, without having to log in to different systems.

Available to:
• All Q Health staff
• Registered GPs/Specialists
• Registered RNs, midwives & paramedics
Information tabs

Previous encounters

Patient demographics

Q Health URs + more info
The Viewer

• View Only
• Machine aggregated data

“ACP Tracker”

• Authorised end user upload documents
• Clinician entered comments
Click!
Statement of Choices

RWH 111222 PATIENT, STAR (DOB: 29-Sep-1977, 43 years, Male)

Sunshine Coast Hospital and Health Service
Advance Care Planning
Statement of Choices (FORM B)

Personal Details

Details of the person for whom this form applies:

Family Name:
Given Name(s):
Address:
DOB: / / Sex: □ M □ F Medicare No:

This person's current medical conditions include:

The health impacts of the conditions listed above have been explained to me: (tick appropriate box).
□ Yes □ No If you have selected No please consult a doctor before completing this form.

A. Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR)
(tick the box you honestly and reasonably believe the person would have marked for themselves)

□ The person would want CPR attempted if it is consistent with good medical practice OR
□ The person would NOT want CPR attempted under any circumstances OR
□ Other:

Other Life Prolonging Treatments e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube
(tick the box you honestly and reasonably believe the person would have marked for themselves)

□ The person would want other life prolonging treatments if they are consistent with good medical
### Advance Care Planning comments

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Provider</th>
<th>Profession</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>20-Jul-2017</td>
<td>Hospital (outpatient)</td>
<td>Doctor</td>
<td>ACP discussion</td>
</tr>
</tbody>
</table>

**Rockhampton Hospital**

I reviewed Mr Patient in outpatients today following his recent inpatient stay. He had some questions about filling in an Advance Health Directive he bought in with him and I have gone through his medical conditions and explained some of the terms in the document. He will complete it and get it signed by a JP next week. His wife feels that he should have completed it by now but he was wanting more information first.

Entered by Student 1 (student1) on 20-Jul-2017

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<thead>
<tr>
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<th>Profession</th>
<th>Outcome</th>
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<td>Hospital (inpatient)</td>
<td>Social Worker</td>
<td>ACP discussion</td>
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**Rockhampton Hospital**

I have approached Mr Patient and his wife regarding advance care planning during his current inpatient stay and he was receptive to the idea of completing an EPOA and AHD. His wife (Im) wanted to do the documents today but he wished to discuss them with his GP and children so I have supplied a brochure and the relevant forms for him to take on discharge.

Entered by Student 1 (student1) on 01-Jul-2017
ACP Tracker - TESTING, ROGER BOB (DOB: 01-Jan-1990, 30 years, Male)

Advance Care Planning documents

<table>
<thead>
<tr>
<th>Date</th>
<th>Document type</th>
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<tbody>
<tr>
<td>01-Apr-2019</td>
<td>Administrator</td>
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<tr>
<td>01-Apr-2019</td>
<td>Guardianship Order</td>
<td>Financial and personal including health care</td>
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<tr>
<td>22-Jan-2018</td>
<td>Statement of Choices</td>
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Advance Care Planning comments

<table>
<thead>
<tr>
<th>Date</th>
<th>Service provided by</th>
<th>Profession</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>28-Oct-2019</td>
<td>Other</td>
<td>Other</td>
<td>ACP discussion</td>
</tr>
</tbody>
</table>
ACP Tracker → ieMR

Weekly ACP Tracker launches
-ieMR, Health Provider Portal and The Viewer-
January 2020 - December 2020

Access to the ACP tab in ieMR Menu went live
Barriers

System

- Access to documents
- Information sharing across domains
  - Document available at PoC
  - Accessible by Q Health Staff, GPs, Specialists, RNs, paramedics
  - Further information (comments) even if no document
  - Integrates into discharge summaries

- Complexity of systems
  - Single sign on
  - Simple interface

- Perceived cost
  - Leverage existing systems
  - Data for cost analysis
Success?

ACP Tracker – Jan 2018

• >59,000 documents uploaded
• >150,000 comments entered
• >550,000 launches last 5/12

• Feedback – improved clinical outcomes
THREE MINUTES
Time = Brain
Time = Brain

29,038
Statement of Choices forms
Mean age: 79yrs
Time = Brain
ARP
Acute Resuscitation Plan
Acute Resuscitation Plan (ARP)

For adults at risk of an acute deterioration

Clinical assessment and appropriate treatment options should be guided by good medical practice, which includes discussions with the patient and/or their substitute decision-maker(s).

- This ARP form is for use in all Queensland Health facilities (e.g., hospitals, aged care and other residential facilities).
- The Quick Guide attached to this form contains important information and should be read prior to completing the form.
- If there is insufficient room on this form to record information, please cross-reference with the progress notes.

1. Clinical assessment

Record details/assessment of relevant medical conditions relating to the patient’s physical and mental health. This section may include clinical reasons why resuscitation planning is necessary.

2. Capacity assessment

☐ I believe that the patient has capacity* to consent to and/or refuse medical treatment.
☐ I believe that the patient does not have capacity to consent to and/or refuse medical treatment.

If there is a change in capacity, this form must be reviewed.

Details of assessment:

* A patient with capacity can understand information about their medical treatment and treatment options, weigh the benefits, risks and burdens of each choice and freely and voluntarily make and communicate a decision. Please refer to the information and consultation guidelines for further information.

3. Resuscitation management plan

If an acute deterioration or critical event occurs, it is clinically indicated to:

Provide e.g. ventilation, IV fluids, supportive therapies

Not provide e.g. defibrillation, intubation, antibiotics

There is further documentation in the progress notes on the following date:

If a cardiac or respiratory arrest occurs, it is clinically appropriate to:

CPR ☐ Provide ☐ Do not provide

A decision not to provide CPR does not limit other treatment or care.

Acting on the Resuscitation management plan: If this section differs from Section 4 (Patient choices), follow an appropriate dispute resolution process (see Section 4 in Quick Guide). If the dispute remains unresolved, or this section to incomplete or unclear when a resuscitation decision is required, attending clinicians should exercise their clinical judgement based on the circumstances, and document this.

4. Patient choices

The patient has the following views and wishes about their end-of-life care: (e.g. CPR, pain management options, living and visiting arrangements, spiritual and/or cultural support). Discuss the views and wishes of patients who have impaired capacity with their substitute decision-maker(s). Record the dates and times of discussions.

Has the patient participated in advance care planning? ☐ Yes ☐ No

Provide details:

5. Consenting details

Complete this section, irrespective of the patient’s capacity.

Patients with capacity can provide their own consent. For patients with impaired capacity, consent must be obtained from a substitute decision-maker(s), in the order below:

The patient has:

1. Advance Health Directive (AHD) ☐ Yes ☐ No
2. Tribunal-appointed Guardian ☐ Yes ☐ No
3. Attorney(s) for health matters under Enduring Power of Attorney or AHD ☐ Yes ☐ No
4. Statutory Health Attorney ☐ Yes ☐ No
5. If no to all, the Public Guardian must be contacted for consent. Ph: 1300 753 634

Name/relationship to patient, phone number, location of original AHD:

6. Clinician authorisation

This ARP form remains valid:

☐ For this admission

☐ Until date: / /

☐ For this and subsequent admissions

Consultant / medical officer’s name:

Signature: Date: / /

Authorising medical officer’s name*: if applicable:

Dr

If changes are required, this form must be voided and a new ARP form completed.

Recommendations for review, if applicable: (e.g. will the ARP apply during planned surgery?)

Other clinicians involved in the development of this ARP form and/or provided with a copy: (e.g. Emergency Department team, Palliative Care Service, GPs, allied health and nursing professionals)

Form continues over page
• Clinical assessment
• Capacity
• Advance care planning (ACP)
• ACP documents
• Decision makers
• CPR
• Other treatments
• Authorisation
Time = Brain

ARP
Rapid access to Acute Resuscitation Plans improves the likelihood that the clinical response to an acute deterioration will be appropriate and align with a patient’s wishes.
<table>
<thead>
<tr>
<th>Accessibility of Chart</th>
<th>Pre iEMR (Total N=183)</th>
<th>Post iEMR (Total N=129)</th>
<th>Statistical Significance</th>
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<tbody>
<tr>
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<td>N</td>
<td>N (%)</td>
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<tr>
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<tr>
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Vivanti, A., McCamley, J., Observations of Electronic Medical Record Implementation on Time Taken to Access Charts by a Dietetic Department. Nutrition & Dietetics 2018; 75 (Suppl. 1): 68–121
Data
Q1 2020

>2,000 ARPs *scanned* into ieMR

- Clinical Assessments
- CPR preferences
- Capacity details
- Treatment preferences
- Advance Care Planning discussions
- Decision Makers
**Resuscitation management plan**

If a cardiac or respiratory arrest occurs, it is clinically appropriate to:

**Do NOT Provide CPR**

A decision not to provide CPR does not limit other treatment or care

If an acute deterioration or critical event occurs, it is clinically indicated to Provide:

- Airway suction, high-flow oxygen, IV, nasopharyngeal airway, oxygen, medications for comfort, antibiotics, IV access

Do Not Provide:

- Intubation & ventilation, defibrillation, ECLS / ECMO

**Acute Resuscitation Plan/Paediatric ARP**

<table>
<thead>
<tr>
<th>Active ARP/PARP</th>
<th>Status</th>
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<th>Modify</th>
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<tbody>
<tr>
<td>Acute Resuscitation Plan</td>
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<td>CAMPOS, GAMA SMO</td>
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<tr>
<td>Inactive ARP/PARP</td>
<td>Status</td>
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<tr>
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<td>29/11/2018</td>
<td>CAMPOS, GAMA SMO</td>
<td>Superseded</td>
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</table>
New ACP Tracker mPage

Advance Care Planning documents

Date | Document type | Details
--- | --- | ---
02-Mar-2017 | ACP Note | 
02-Mar-2017 | Enduring Power of Attorney | Financial
12-Jan-2017 | Statement of Choices | 
28-Oct-2016 | Guardian | Personal not including health care
16-Feb-2016 | Acute Resuscitation Plan | 
16-Feb-2016 | Advance Health Directive | 
13-Feb-2016 | Advance Health Directive | Health care including mental health

Advance Care Planning comments

Date | Service Provider | Profession | Outcome
--- | --- | --- | ---
06-Dec-2017 | Hospital (outpatient) | Doctor | ACP documents completed

Princess Alexandra Hospital
I reviewed Mr Patient in outpatients today – I note that he has a recent unplanned admission at RBWH last month. He has with him a completed Statement of Choices done with his GP and I have taken a copy for our records as well as sent it to the Office of Advance Care Planning. He said he is happier knowing he has had the opportunity to discuss his wishes with his family especially given his recent unplanned admission.

Entered by Leyton Miller (miller) on 17-Jul-2018

24-Nov-2017 | Hospital (inpatient) | Nurse | ACP discussion

Royal Brisbane & Women’s Hospital
Mr Patient was identified by the medical team as being suitable for advance care planning – with his permission I discussed the process of ACP with him and he was happy to engage. I have provided him with a brochure and a Statement of Choices and he will go through it with his family and GP following discharge.

Entered by Victoria Sinclair (sinclain) on 17-Jul-2018
KISS

↑ Availability

↓ Complexity
Work to be done

• ARPs → ACP Tracker

• Increase awareness

• Data entry for external parties

• Evaluate the data/outcomes
Thanks

• Team at The Viewer
• QH eHealth Team
• Queensland Health Office of Advance Care Planning staff


