VI Congreso Internacional Dependencia y Calidad de Vida
Atención integrada y centrada en la persona

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"Improving Long-Term Care: How an Advance Care Planning System Can Work"

Madrid, 23-24 de mayo de 2017
Palacete Duques de Pastrana

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6th International Conference on Advance Care Planning and End-of-Life Care (ACPEL)

ACP – Conversations Matter

September 6-9,2017

https://www.acpel2017.org/

A variety of common interpretations exists about Respecting Choices.

- An initiative to promote advance directives
- A training program for advance care planning facilitators
- An approach to improve end-of-life care
- A successful program in La Crosse, WI

These interpretations are incomplete or just wrong!!!

Respecting Choices is actually:

A program that primarily assists health organizations to redesign their processes of care and interactions so that decision making (including planning) with patients and their families is conducted as person-centered, shared decisions.

Therefore, Respecting Choices aims to create a culture of person-centered care using a shared decision-making approach.

The Desired Outcome of Advance Care Planning

To know and honor an individual's informed plans by:

- Creating an effective planning process that includes:

  --Selecting a well-prepared healthcare agent or proxy, when possible;

  --Creating specific instructions that reflect informed decisions geared to the person's state of health.
- Making plans available to treating health professionals.
- Assuring plans are incorporated into medical decisions, when needed.

Definition: Advance Directive (AD)

- An AD is a plan, made by a capable person or their surrogate, for future medical care regarding treatments or goals of care for a possible or probable event
- This plan could be expressed orally and/or in writing
  - If written, it could be in strict accord with specific state statutes or simply documentation of the plan (e.g., a physician's note)

Definition: Advance Care Planning (ACP)

ACP is a *process* of communication for planning for future medical decisions. To be effective, this process includes

Reflection on goals, values, and beliefs (including cultural, religious, spiritual, and personal);

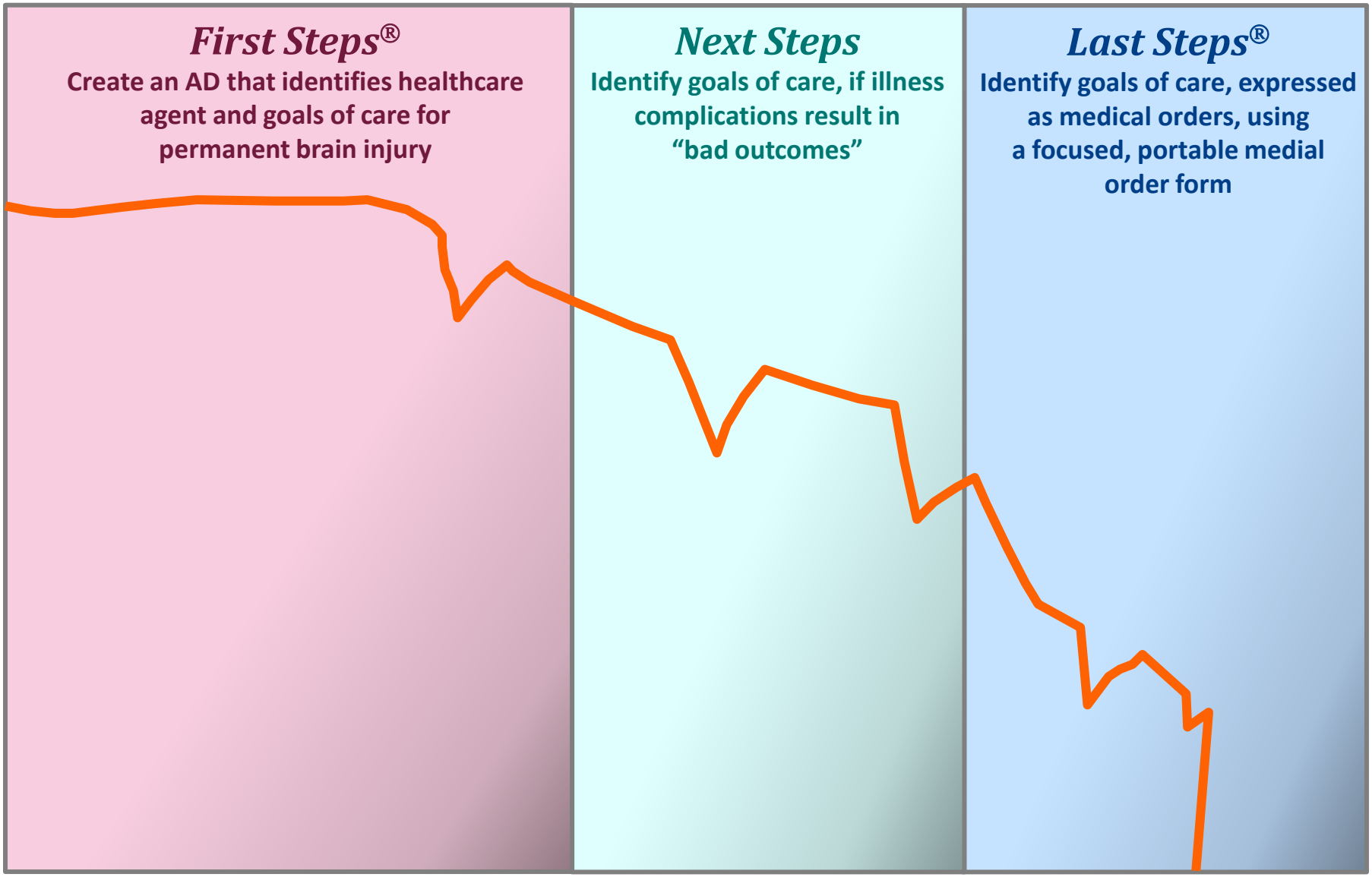
Understanding of possible future situations and decisions as well as the value of planning;

Discussion of these reflections and decisions with those who might need to carry out the plan.

Advance Care Planning

- Is most effectively done in stages
- Does not attempt to plan for ALL possibilities in a single document, which is both impossible and unnecessary

Stages of Advance Care Planning Over an Individual's Lifetime



The Relationship of ACP to ADs

- The success of an AD is directly tied to the quality of the planning process
- If the person planning does not understand, reflect on, or discuss their options adequately, the plan has a high probability of failure

For ACP to Be Successful…

Plans must be

- Created — high prevalence is essential
- Specific enough for the clinical situation
- Accurately reflect the individual's preferences
- Understandable to those making decisions
- Available to the decision makers
- Incorporated into decisions, as needed

(Fagerlin & Schneider, 2004)

The Importance of a System

Advanced Cardiovascular Life Support (ACLS): A Reliable System

- All individuals who desire CPR and are found pulseless/non breathing
  - Are quickly identified and a team notified
  - Are cared for by team members who
    - Are certified in ACLS
    - Know their role and responsibility
    - Have the equipment to perform their role
  - Have the quality of resuscitation reviewed; errors are identified and corrected
- Now, imagine what happens if any part of this system fails?

What would an ACP System looks like in Long-Term Care?

- Starts with high quality planning conversations. This would likely mean training nurses and/or social workers (who work with the physician) to assist with planning.
- Need a set of standardized planning documents to:

  1) document the how of decision-making and the goals of care for all residents;

  2) record medical orders for emergency care for those with advanced illness.
- Reliability of documents being with and staying with residents even when they move.
- Training of physicians to know how and when to incorporate the written plans into decisions.
- Ability of long-term care facilities to meet a wide range of palliative needs as needed

What does the data suggest?

Effective ACP systems in nursing homes can:

- Increase the prevalence of planning to very high levels.
- Improves satisfaction with care.
- Decreases utilization of hospital services.
- Decreases negative, emotional symptoms in close family members after death.

To be Effectives requires:

- Quality planning processes that involves family.
- Appropriate documentation and communication of the plan.
- Competent and skill palliative services in the nursing home.

Why use ACP Facilitators?

- Our common experience worldwide, starting at Gundersen Health System, is that most physicians do not have the time needed (and some are not willing) to provide planning for future healthcare decisions that is need by patients/residents.
- Patients do not come to decisions with clear and well articulated ideas about their values and goals of care. It takes considerable skill to assist people through a process of interaction to reach the level of clarity, accuracy, and completeness to make decisions that reflect what patients actually want.
- Discussions among family are challenging when an outside, independent, trained guide isn't available.

Thank-you