Advanced Care Planning in Oncology

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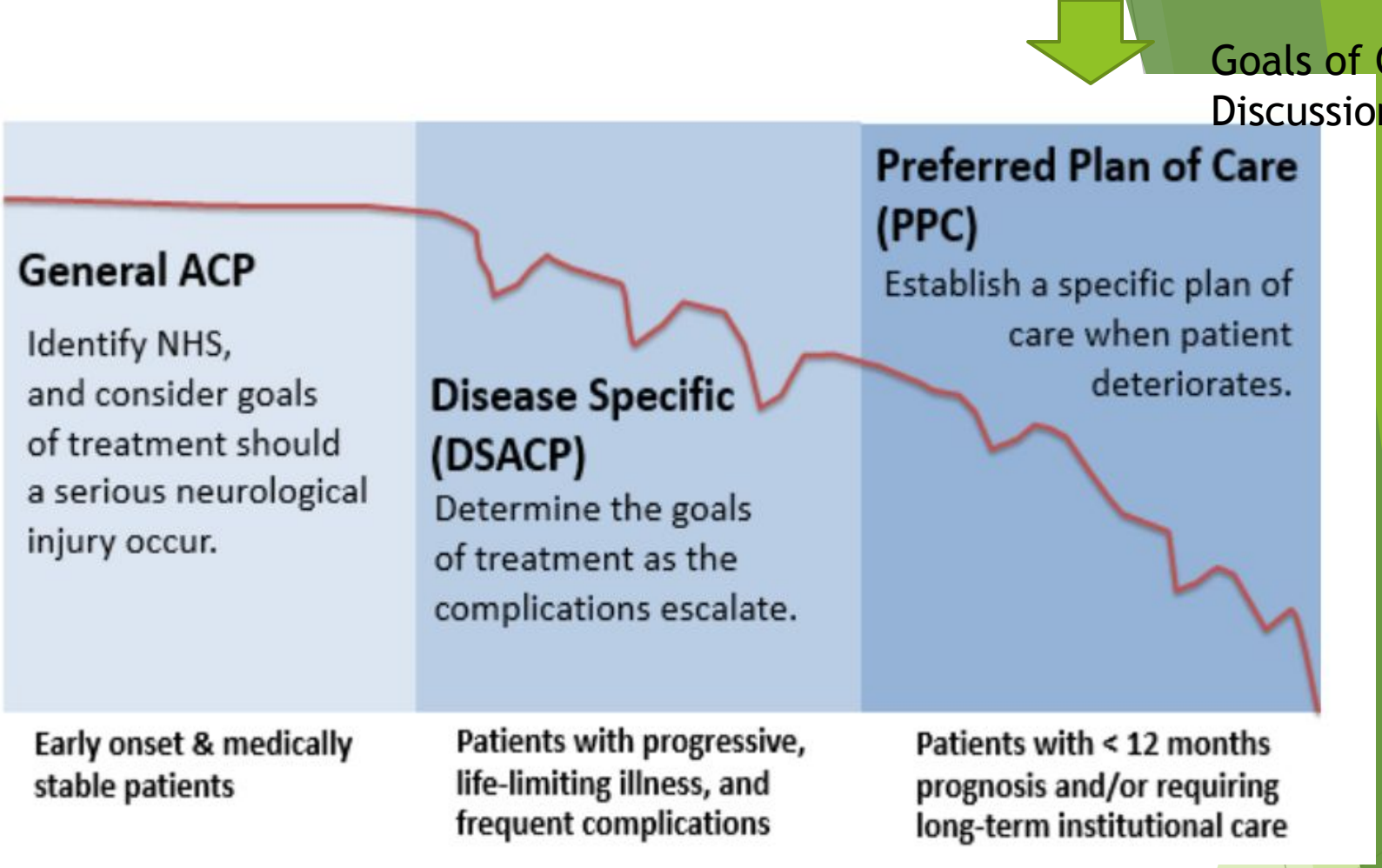
Outline

- What is ACP?
- General Structure of ACP
- Objectives of ACP
- Benefits of ACP
- Barriers to ACP
- Models of ACP/ GOC discussions
- Video

Advance care planning

- **Process**
- That supports persons at **any stage of health**
- In **understanding** their **personal values, life goals and preferences** regarding **future** medical care.
- **International Consensus Definition of Advance Care Planning (Sudore et al 2017)**

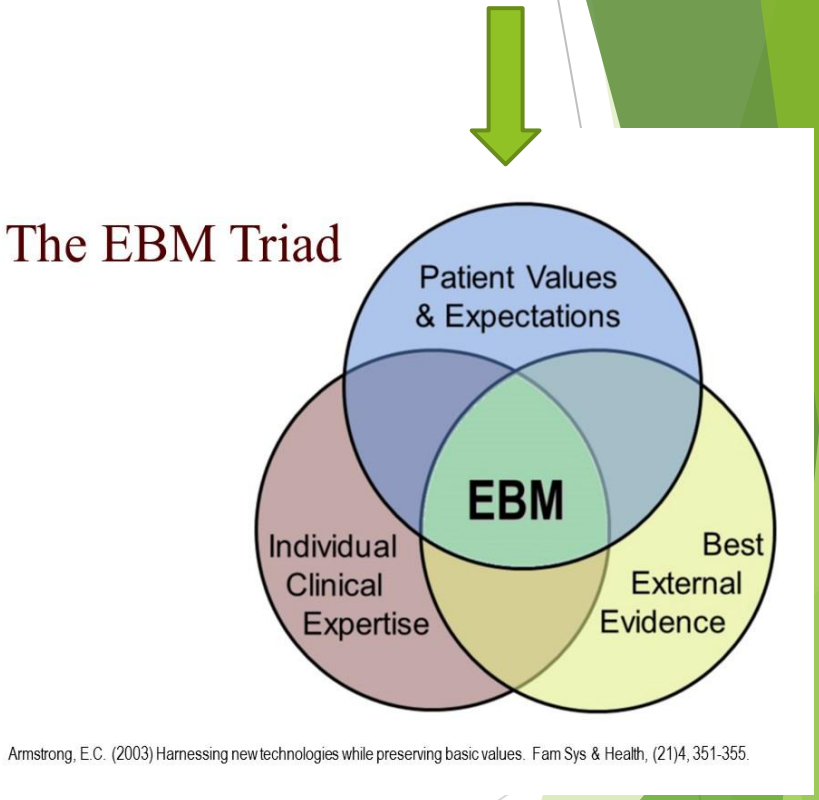


ACP according to the stages of health (When)

Nominated Healthcare Spokesperson

“Evidence-Based Medicine”

- An approach of clinical decision making by the **integration of**
- **Best Research Evidence**
- **Clinical expertise**
- **Patient’s values.**
- David Sackett etal. Evidence- based medicine. How to practice and teach EBM 2B00

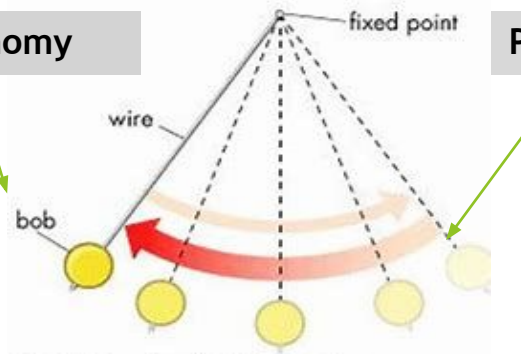


Recommended Model for Health care Planning

The physician presents all options (made no recommendation)

The patient makes his/her own choice.

Autonomy



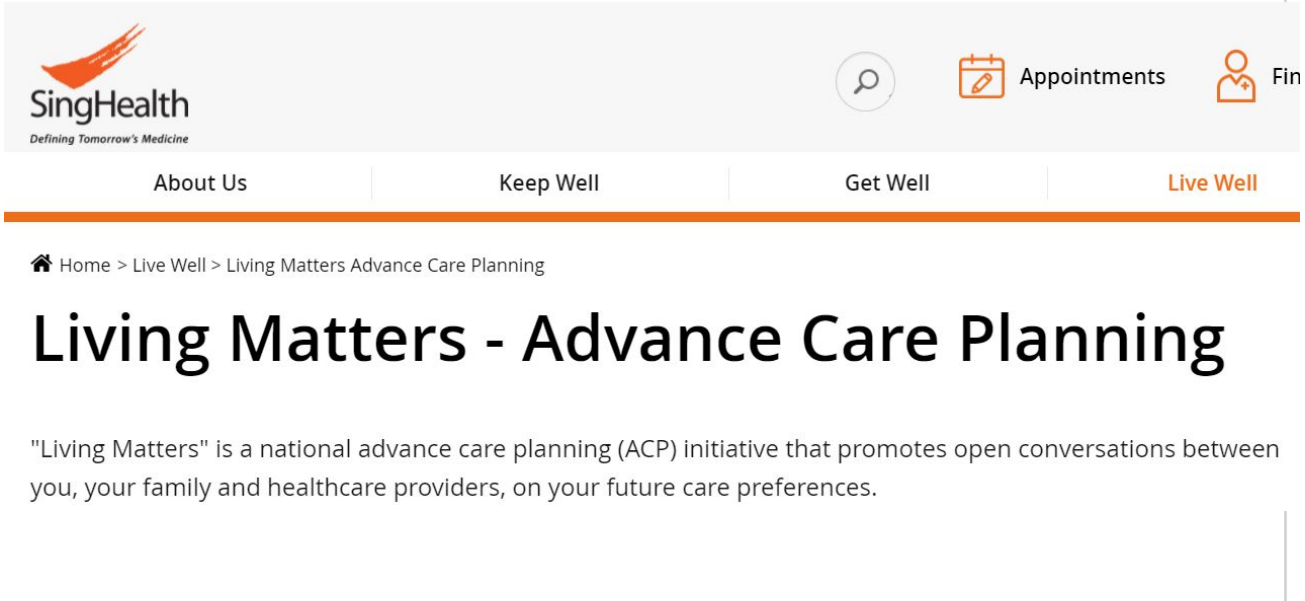
Paternalistic

The Physician explains all options and makes a recommendation.

Partnership in Care Planning

- **is a collaborative process**
- **patients and clinicians to make plans for health care together**

- Alexander A Kon, Shared Decision Making Continuun, Jama 2010
- NHS England Shared decision making summary guide 2019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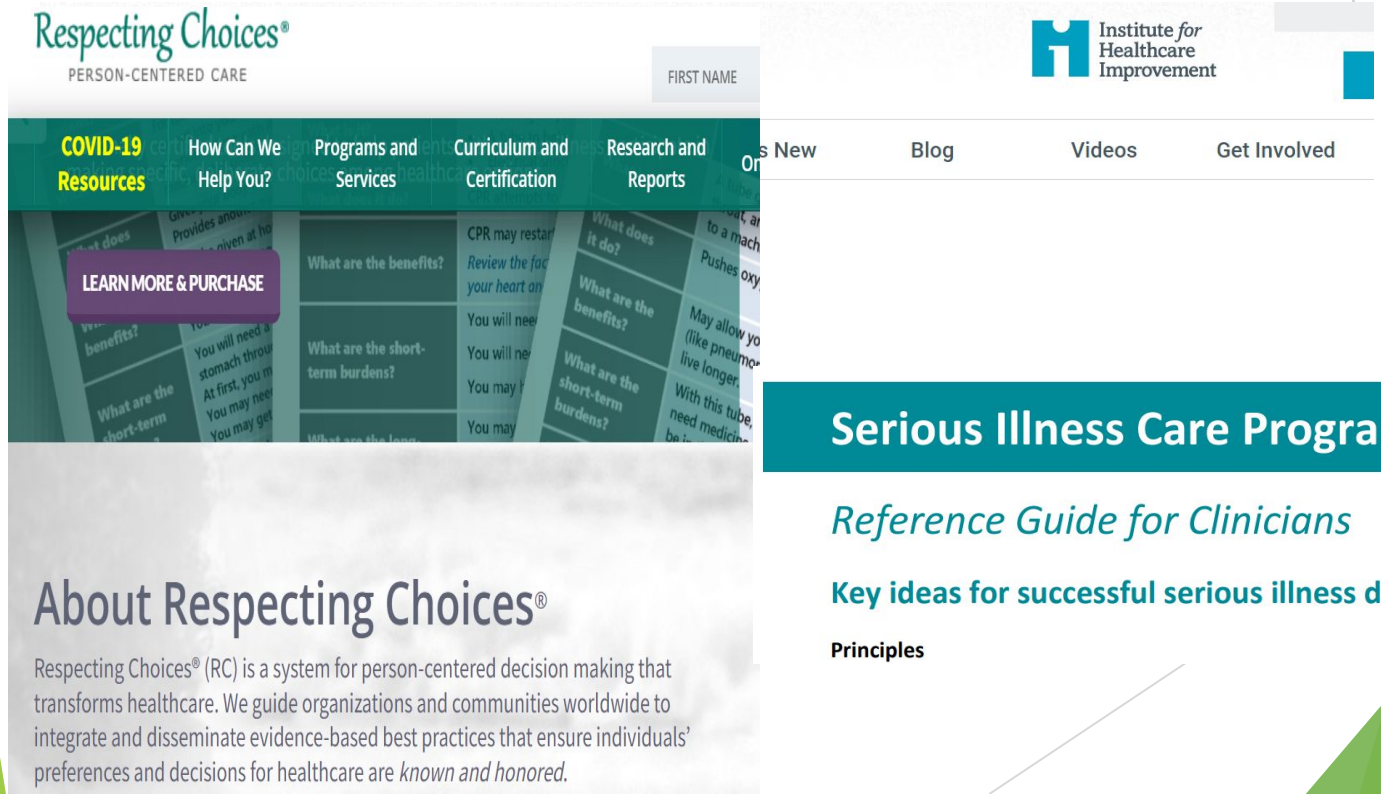
Living Matters - Advance Care Planning
"Living Matters" is a national advance care planning (ACP) initiative that promotes open conversations between you, your family and healthcare providers, on your future care preferences.


My Care Plan
HOSPITAL SELAYANG
Name:_____
Date:_____
Palliative care
WE CARE
WE SUPPORT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About Respecting Choices®
Respecting Choices® (RC) is a system for person-centered decision making that transforms healthcare. We guide organizations and communities worldwide to integrate and disseminate evidence-based best practices that ensure individuals' preferences and decisions for healthcare are known and honored.

Institute for Healthcare Improvement

Serious Illness Care Program
Alberta Health Services
Reference Guide for Clinicians
Key ideas for successful serious illness discussions
Principles

General structure of an ACP discussions

- 1. Assessment/ realignement of understanding
- 2. Exploration values and preferences
- 3. Recommendation for Future Health Care Decision

- Eg: REMAP and Serious Illness conversation

Awareness of ACP

Regions/ Countries	Year	Sample size	Not familiar with ACP
Mid -Atlantic	2017	1400	30%
Asian American	2018	212	59.7%
Singapor	2017	110	85.6%

Main Objectives of ACP

- 1. Honoring Autonomy
- 2. To help ensure concordance between preferred and delivered care
- 3. Improve the quality of life of patients and family, as it might decrease concerns about the future
- Institute of Medicine: Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC, National Academies Press, 2014

Relational autonomy

- Highlights the social context of an individual
- Acknowledges the central role of others in decision-making, including physicians and family members..

Advance care planning in Asian culture

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Abstract

Ageing has been recognized as one of the most critically important health-care issues worldwide. It is relevant to Asia, where the increasing number of older populations has drawn attention to the paramount need for health-care investment, particularly in end-of-life care. The advocacy of advance care planning is a mean to honor patient autonomy. Since most East Asian countries are influenced by Confucianism and the concept of 'filial piety,' patient autonomy is consequently subordinate to family values and physician authority. The dominance from family members and physicians during a patient's end-of-life decision-making is recognized as a cultural feature in Asia. Physicians often disclose the patient's poor prognosis and corresponding treatment options to the male, family member rather to the patient him/herself. In order to address this ethical and practical dilemma, the concept of 'relational autonomy' and the collectivism paradigm might be ideally used to assist Asian people, especially older adults, to share their preferences on future care and decision-making on certain clinical situations with their families and important others. In this review article, we invited experts in end-of-life care from Hong Kong, Indonesia, Japan, South

Benefits of ACP

- The benefits of ACP have been widely published.
- **Lower rates of ventilation and resuscitation**
- **Lower Intensive care unit** admission
- **Decreased cost of care** at the end of life
- Patients who have participated in ACP are **much more likely to have their end of life wishes known and followed.**
- Have **better quality of life**
- Higher **Palliative Care referrals**
- Family members of patients who died had significantly **less stress, anxiety and depression**
- Increased **Patient and family satisfaction was higher** in the intervention group.
- *Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA 2008*
- *The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. BMJ 2010*

Disparity between “wants and provision

- Despite evidence on the positive effects of ACP
- Frequency of ACP conversations between patients remains low
- Rates of documentation of ACP with an oncologist have been **as low as 10%**
- Dow LA, The complex relationship of oncology patients, their physicians, and advance medical directives. J Clin Oncol 2010

Disparity between “wants and provision”

- Survey of 189 oncology outpatients
- Most patients agreed it was important to discuss end of life wishes with
- family (85%) **->(30%)**
- doctors (70%) -▫**(11%)**
- formally record wishes (73%)—>(**15%)**
- Medical oncology outpatients’ preferences and experiences with advanced care planning: a cross-sectional study Amy Waller
- Waller et al. BMC Cancer (2019)

Barriers to ACP

- 117 Health care professionals
- 68% of oncologists accepted this discussion as their responsibility in patients with advanced cancer ($P < .01$)

- 1. **Lack of time**
- 2. **Perceived patient's readiness** :Religion, Educational level, Personality type, Age, and Disease status.
- 3. **Insufficient physician training** in end-of-life communication

- **Perspectives of Health-Care Providers Toward Advance Care Planning in Patients With Advanced Cancer and Congestive Heart Failure,** American journal of hospice and palliative medicine 2016

ADVANCE CARE PLANNING (ACP) DISCUSSION

2nd Virtual Facilitator Training Workshop

4th December 2021
9AM - 1PM
Saturday
Zoom

Highlights:

- Key concepts of ACP
- Structural approach in ACP discussion
- Demonstration of ACP process
- Communication cheat sheet
- Real time virtual role plays

Participant feedbacks

95% gained solid knowledge & confidence in conducting ACP

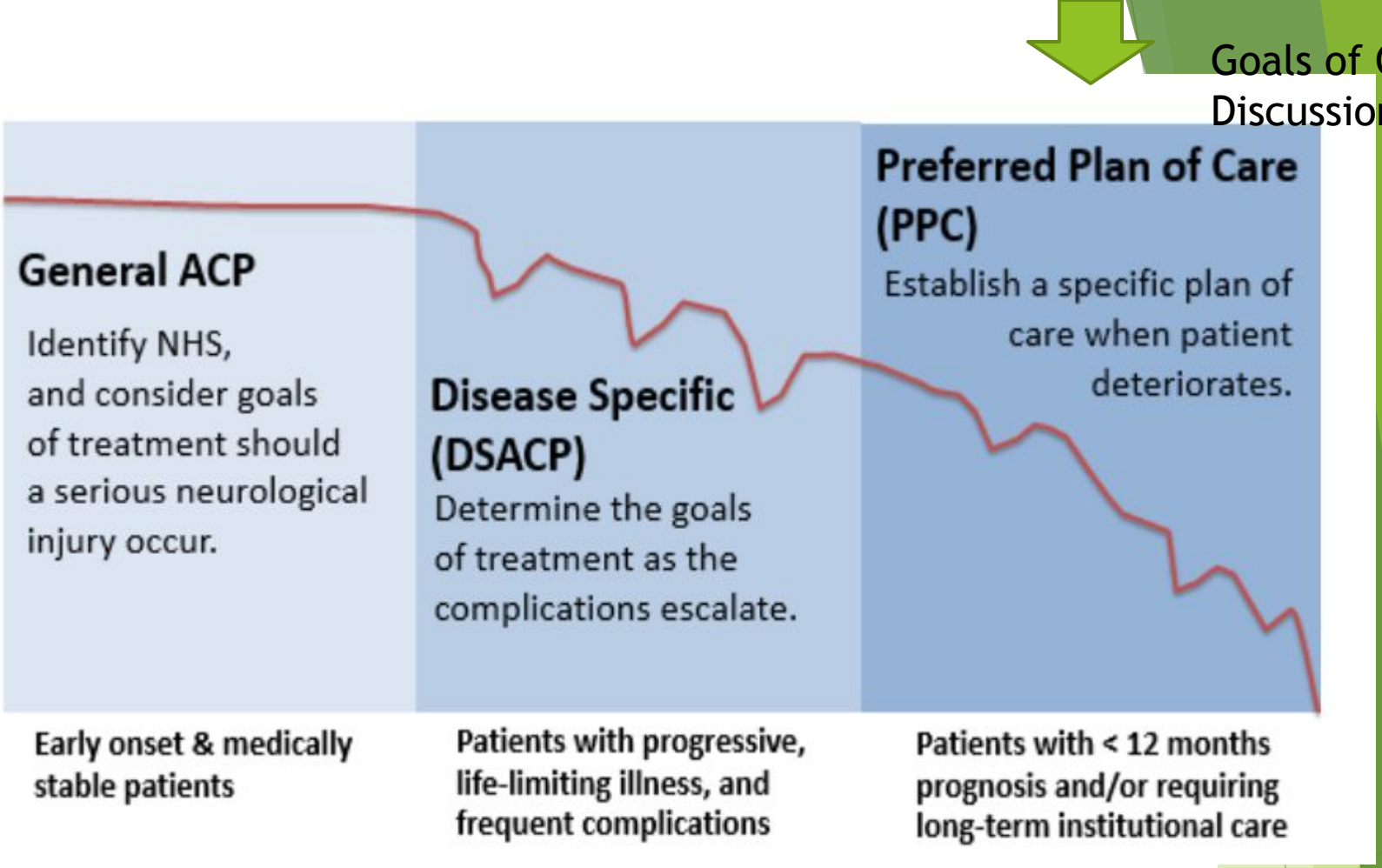
89% considered changing their practice

Only 20 places available.
Register now!

Co-organized by Queen Elizabeth Hospital Palliative Care Unit & Medical Society

Time	Topic	Speaker
0800-0830	Registration	
0830-0930	Introduction – What is ACP?	Dr. Richard Lim
0930-1030	Ethical issues at the end of life and ACP (+ Case discussion)	Dr. Tan Hui Siu
1030-1050	Tea break	
1050-1200	Practical –Making my own advance care plan & Demo	Dr. Richard & team
1200-1230	Goals of care discussion	Dr. Siow Yen Ching
1230-1300	Handling families insisting on inappropriate treatment	Dr. Richard Lim
1300-1400	Lunch	
1400-1530	Pratical communication skills - ACP discussion in various settings - Goals of care discussion	Dr. Richard Lim & Team
1530-1630	- Achieving a good death – caring for patients at the end of life	Dr. Richard Lim & Team
1630-1645	Q & A	Dr. Richard Lim

Goals of Care Discussion



ACP according to the stages of health (When)

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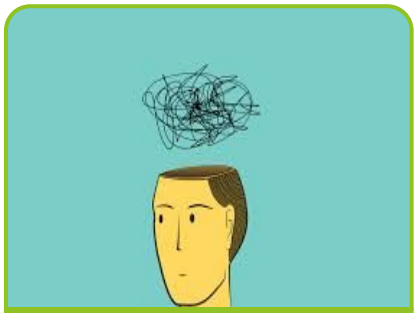
A SUGGESTED APPROACH TO DISCUSSING GOALS OF CARE

REMAP: A Framework for Goals of Care Conversations

Julie W. Childers, Anthony L. Back, James A. Tulsky, and Robert M. Arnold

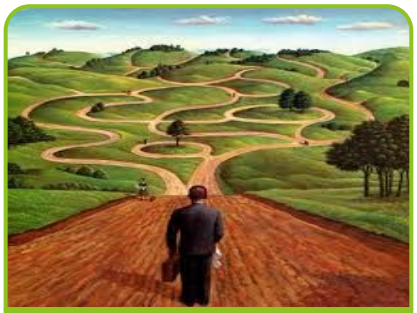
- **R** e-frame
- **E** xpect emotion
- **M** ap out patient values
- **A** lign with values
- **P** roceeding to the next steps

J Oncology Practice (2017)



R:
Understanding

M: Expectation



P: Plan
together

Reframe

- **Helps to justify the need to re-evaluate the goals of care**
- Seeks to assess **patient's understanding** and, if necessary, to provide new information.
- GOC discussion is necessary because **current therapies are not working.**

Expect Emotion

- Most patients will have an emotional reaction to thinking about disease progression
  - verbally
  - nonverbal reactions such as crying.
- **Reflective statements** that name or acknowledge the presence of emotion
  - help the patient feel heard.

Map Out Patient's value

- Intentionally **Step back to explore the patient's values** before discussing therapeutic choices
- Eg,
- ***Given this situation, what is most important to you now?***
- ***Can you help me to understand what matters to you most?***
- ***What concerns you most now?***
- **Does not focus on treatments** but to explore what matters most to the patient
- **Patient's values allows the clinician to develop a patient-centered treatment plan** that is most likely to achieve the patient's goals

Align with Values

- Verbally reflects back what she has heard from the patient, including any ambivalence.
- **More reflections and summaries.**

PROPOSE A PLAN

- **The clinician proposes a medical plan that has the best chance of maximizing patient's values and goals**
- Using both information about
  - **Her values** and
  - **His knowledge of the feasibility of medical treatments that would help her achieve her goals.**

Serious Illness Conversation

Serious Illness Conversation Guide

Conversation flow		Patient-tested language
1. Set up the conversation • Introduce purpose • Ask permission	Set Up	*"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"*
2. Assess illness understanding & information preferences	Assess	*"What is your **understanding** now of where you are with your illness?"* *"How much **information** about what is likely to be ahead with your illness would you like from me?"*
3. Share prognosis • Frame with a "wish...worry", "hope...worry" statement • Allow silence, explore emotion	Share	Prognosis: *"I want to share with you **my understanding** of where things are with your illness..."* Uncertain: *"It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."* Time: *"I **wish** we were not in this situation, but I'm **worried** that time may be short as_ (express as a range e.g. weeks to months, months to a year)."* **OR** Function: *"I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel"*
4. Explore key topics • Goals • Fears & worries • Sources of strength • Critical abilities • Trade-offs • Family	Explore	*"What are your most important **goals** if your health situation worsens?"* *"What are your biggest **fears and worries** about the future with your health?"* *"What gives you **strength** as you think about the future with your illness?"* *"What **abilities** are so critical to your life that you can't imagine living without them?"* *"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"*
5. Close the conversation • Summarize what you've heard • Make a recommendation; check in with patient • Affirm your commitment to the patient	Close	*"I've heard you say that ____is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we _____. This will help us make sure that your treatment plan reflect what's important to you"* *"How does this plan seem to you?" "I will do everything I can to help you through this."*
6. Document your conversation & 7. Communicate with key clinicians		

Video

- 1. Right now what is your understanding about at where you are at with your illness?
- 2. In terms of talking about your illness, what information about what might likely happen in the future that you would like to have from me?
- 3. If your health were to worsen, what is your most important goals?
- 4. What is your biggest fear and worry about your health?
- 5. What ability is so critical to you, that you cannot imagine living without them?
- 6. If you were becoming sicker, how much are you willing to go through for the possibility to have a bit more time?
- 7. What if it meant by coming back to the hospital?
- 8. Summary
- 9. After hearing what you say, my recommendation for you……

Task

- 1. Do a GOC discussion for one of your patients before CNY- ReMaP
- 2. Do an ACP for yourself – My Care Plan