Basque Country: Care Planning in Integrated Care Organisation

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	No
Verification of the Good Practice	No
Evaluation of the Good Practice	Yes
Type of the Good Practice	Notable practice

Part 2: Description of the Good Practice

Name of the Good Practice	Advance Care Planning in Integrated Care Organisation
Short name (Acronym)	Not applicable
URL of the Good Practice	Not applicable
Geographical scope	Local level
Country	Spain
Region(s) involved	Basque Country
Status of the Good Practice	On-goinh
Stakeholders involved	• Hospitals • Primary care centres • Specialised physicians • Nurses • Pharmacists • General Practitioners • Day care centres • Home care centres • Nursing homes • Informal caregivers • Housing organisations • Advocacy organisations • Regional public authorities • Local public authorities
Size of population covered	>100,000
Targeted audience	18-49, 50-64, 65 - 79, 80+

Summary of the Good Practice

Every human being is recognized with his or her right to make decisions regarding medical treatment, even when his/her level of competence is compromised by adverse health conditions. Advanced Care Planning (ACP) guarantees patients' right both to make decisions as well as to have those decisions respected when time comes. The general goal of this program is to promote ACP, mainly for chronic patients.

The programme states two specific goals:
1) adjusting end of life care to meet patients' preferences, and
2) improving decision making processes.

The program defines three stages:
1. Diagnostic stage, aiming at identifying the population that could benefit from the program,
2. Therapeutic stage, aiming at developing the intervention (after providing training opportunities for involved health professionals),
3. Evaluative stage, aiming at assessing both the impact of the program and the program itself.

The core intervention at the heart of the program consists of two individual semi structured interviews with the patient and one or two significant others. Previous to these meetings patients invited to participate receive a document that intends to elicit reflections about health, care, quality of life and end of life. The interviews are initially conducted by the programme coordinator along with patient's GP and Community Nurse. The program is intended to help clinicians become capable of conducting the interviews themselves.

The first meeting aims mainly at introducing the subject (Advanced Directives) and inviting the patient to reflect on his/her preferences regarding care. The second interview focuses on discussing the specific issues related to the patient him/herself and according to his/her clinical characteristics and situation.
Transferring the program to other contexts would require adjustments mainly related to cultural issues.

Key words: advanced care planning, shared decisions, chronic care, end of life care, autonomy

Good practice being part of the larger programme

No.

Challenges / problems addressed by the good practice

- End of life/critical care-related decisions compromised by patients' lack of competence
- Patients' preferences not being respected
- Paternalistic attitudes regarding health-related decision making processes

• Not enough training in communication by physicians and nurses about Advance Care Planning Talking with patients and relatives about end of life issues is not included in ordinary clinical meetings
Importance of the challenges / problems before starting to implement good practice Healthcare professionals as well as family members were often finding themselves in situations where they were to make decisions while not actually holding enough information/knowledge about patient's preferences. Often decisions were being taken by healthcare professionals, this sometimes exceeding what they thought to be their level of competence and responsibility. On the other side, family members felt overwhelmed by the burden of making difficult decisions, especially when dealing with critical and/or end of life care. Decisions to limit treatment initiatives were somehow rare, this leading to dilemmatic situations as well as to high economical costs but low- quality end of life care.
Environment before the good practice was implemented A formal/legal process of "Living Will" Registration was available for any citizen in the Basque Country. Nevertheless, this process was somehow limited to the formal/legal process of registering patient's wills and did not include any sort of previous reflection process nor was it in any way individualized or adjusted to the specific clinical condition of the patient him/herself.
Key innovative elements of the good practice and how the good practice improved situation compared to previous practice The program has not yet been formally evaluated. Nonetheless, listening to participating patients, families, GPs and Community Nurses has helped us understand how invitations to reflect and discuss values and preferences regarding treatment and care have been of much use both for all of them who now seem to share a common view of what kind of options the patient would choose for him/her when time comes. Interviews inviting to reflect and discuss have been somehow systematically introduced into some Community Care Teams' (GP and Community Nurse) agendas, and approaches to chronic care. Healthcare professionals working at secondary/tertiary levels (mainly hospitals) now start to be familiar with the program and benefit from accessing the information regarding preferences accessible through the electronic health record.

Part 3: Transferability of the Good Practice

Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)	Higher costs, improved outcomes

Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required

- 1 MD part time working as program coordinator, initial interview conductor and other colleagues' trainer and facilitator
- 4h training for interested healthcare professionals

Total budget of the Good Practice	€100.00 - €499,999
Source of funding	Regional funding

The main actions that have to be done to deploy the Good Practice

- Identify target population: elderly people, chronic patients and individuals that have an experience about illness or care.
- Teaching health professionals (mainly physician and nurses) about Advance Care Planning: specific courses and training in how to perform interviews. Community plans of communication about the relevance of shared decision making and advanced care planning
- Having conversations with patients and their relatives to elicit their values, fears and preferences.
- Write down and register documents (Advanced Directives) that help doctors and nurses to choose the best option for each patient.
- Prepare documents and videos that help people involved in the program in order to improve their intervention.
- Evaluating the results: end of life care, shared decision making, satisfaction of patients, relatives and health professionals.

Issues during the implementation of the Good Practice

- Time needed to include "the conversation" in the clinical meeting
- Coordination of different levels of care: Primary care and Hospitals

Additional resources required to scale up Good Practice

No.

Basis to support sustainability of the Good Practice

It is a program that will certainly make life easier both for healthcare professionals as well as for significant others needing to make difficult decisions. It will presumably reduce costs related to non-chosen treatments. It will only need from healthcare professionals' willingness to open discussions with chronic patients. Not large volume of resources needed for quite a substantial quality of life (and end of) and care improvement.

The program is mainly focused on promoting a cultural change within the healthcare context. Providing professionals with the opportunity to access training and feel supported on their initial steps is certainly an important asset of the program when looking at the long-term sustainability of such cultural shift.

Evidence to observe the Good Practice A visit to implementation site.

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice Between one year and three years. The coordinator of the program attended a course to get the qualification as facilitator in Advanced Care Planning in La Crosse (Wisconsin, USA), organized by Respecting Choices (http://www.gundersenhealth.org/respecting- choices). This foundation is the most important centre of education in ACP. Their model has been adapted by other countries and organisations. Moreover, the coordinator attended meetings organized by The international Society of Advance Care Planning (ACPEL) http://www.acpel2015.org in order to learn from other experiences in other countries: My Voice, Five wishes, Gold Standard Framework, etc. Based on these experiences a program and a course were designed taking into account the local culture and health system.
Investment per citizens / patient / client in terms of financial resources Between €100 – €1.000 per targeted citizen / patient. 1 part-time MD + 4h training for every interested healthcare professional
Evidence behind the Good Practice Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the Good Practice Emanuel EJ, Emanuel LL. The promise of a good death. Lancet 1998; 351 Suppl 2:SII21-SII29. - Peter A.Singer MMF, Gerald Robertson LL, David J.Roy SPD. Bioethics for clinicians: 6. Advance care planning. Canadian Medical Association Journal 1996; 155:1689-1692. - Emanuel L. Appropriate end inappropriate use of advance directives. Journal of Medical Ethics 2001; 5(4):357-359. - Martin D.K, Emanuel LL, Singer P. Planning for the end of life. Lancet 2000; 356:1672-1676. - Emanuel LL, von Gunten CF, Ferris FD. Advance care planning. Arch Fam Med 2000; 9(10):1181-1187. - June Leland. Advance directives and establishing the goals of care. Primary care: clinics in office practice. 2001: 349-363. - Kolarik RC, Arnold RM, Fischer GS, Tulsky JA. Objectives for advance care planning. J Palliat Med 2002; 5(5):697-704. - Hahn ME. Advance Directives and Patient-Physician Communication. JAMA 2003;289:96. - Curtis JR. Communicating with patients and their families about advance care planning and end- of-life care. Respir Care 2000;45:1385-94.
Maturity of the Good Practice There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use.

Advance care planning improves end of life care and patient and family satisfaction and reduces stress, anxiety, and depression in surviving relatives. There are no published cost-effectiveness studies. Included studies focused on healthcare savings, usually associated with reduced demand for hospital care. Advanced care planning appears to be associated with healthcare savings for some people in some circumstances, such as people living with dementia in the community, people in nursing homes or in areas with high end-of-life care spending. There is no evidence that advanced care planning is likely to be more expensive A randomized controlled trial on the efficacy of advance care planning on the quality of end-of-life care and communication in patients with COPD: the research protocol. Couben H. BMJ 2014. The effects of advance care planning on end-of-life care: A systematic review Arianne Brinkman-Stoppelenburg, Judith AC Rietjens and Agnes van der Heide Palliat Med published online 20 March 2014 The economic evidence for advance care planning: Systematic review of evidence. Dixon J. Palliat Med
Estimated time of impact of the Good Practice Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began.
Impact observed Better care integration (economic and social). The program has not yet been formally evaluated. Nonetheless, listening to participating patients, families, GPs and Community Nurses has helped us understand how invitations to reflect and discuss values and preferences regarding treatment and care have been of much use both for all of them who now seem to share a common view of what kind of options the patient would choose for him/her when time comes. Interviews inviting to reflect and discuss have been somehow systematically introduced into some Community Care Teams' (GP and Community Nurse) agendas, and approaches to chronic care. Healthcare professionals working at secondary/tertiary levels (mainly hospitals) now start to be familiar with the program and benefit from accessing the information regarding preferences accessible through the electronic health record.
Transferability of the Good Practice Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Part 5: Your organisation

Name of the organisation	Integrated Care Organisation Araba
Address of the organisation	C/ Jose Atxotegi, s/n - 01009 Vitoria-Gasteiz, Araba
Type of organisation	Integrated Care Organisations

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