2.3 Implementation of ACP I

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The Advance Project: an Australian national program to support nurses to initiate advance care planning in General Practice

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Background: Primary care has been advocated as an ideal setting to initiate advance care planning (ACP). Few studies have examined the role of general practice nurses (GPNs) in promoting/initiating ACP. The Advance Project evaluated initiatives to address this gap.
Methods:
This Australian Government-funded program aims to increase GPNs' confidence in initiating conversations with patients/carers about ACP during routine health assessments with older and/or chronically ill patients using a structured interview. This is part of a broader program enabling GPNs to identify patients at risk of deteriorating and dying and to assess these patients' palliative/supportive care needs. Identified needs are then addressed in consultation with General Practitioners. The program includes a suite of resources and multi-component training (online, face-to-face and individual tele-mentoring). Pre/post/follow-up surveys and qualitative interviews collected GPNs' perspectives about the training/resources and barriers to implementation in clinical practice.
Results: As of 31 December 2017, 823 GPNs enrolled in training and 536 completed one or more training components. 27 workshops were held across Australia, including 182 regional/rural participants. 585 pre-training, 384 post-training, and 125 follow-up surveys were received. 20 GPNs were interviewed. There were significant improvements in GPNs' confidence, comfort, knowledge and attitudes towards initiating ACP post-training that was sustained at follow-up. Participants were significantly more likely to have had ACP discussions with their patients at follow-up (81%) compared to baseline (55%, $p<0.001$).
Discussion/conclusion: GPNs can have an important role in initiating ACP. The evaluation informed refinement/expansion of the resources/training to support team-based initiation of ACP in general practice
http://www.theadvanceproject.com.au

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Regional (central) versus institutional: Competing strategies for nationwide ACP implementation

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Background: Implementing ACP in nursing homes is often essentially done by educating selected n/h staff as ACP facilitators. Recent German legislation covers ACP offered to nursing home residents, and offers an alternative strategy for implementation, i.e. cooperation of participating n/hs with a regional (central) partner that employs a team of facilitators. Which of these two strategies should be preferred?
Methods: 1. Follow-up of facilitator training effectivity in Germany in 2015-2017, 2. review of the literature, 3. theoretical analysis of the competing rationales.
Results: Of some 270 facilitator trainees attending our ACP courses, only few report ongoing practice as an ACP facilitator. A number of important publications describe facilitators and barriers, or essential elements, of successful ACP implementation, but few if any compare regional versus institutional implementation strategies of ACP yet. Similarly, while regional ACP coordination is described as an important precondition for sustainable ACP implementation, it requires significant resources on top of institutional implementation. A comparative analysis yields a number of strong reasons why regional may well beat institutional implementation strategies, referring to staff aptitude, team building, regional coordination, economic efficiency, and both sustainability and expandibility. Arguments that have been raised against qualifying external staff can be shown not to consider sufficiently the potential of creating regional (central) facilitator teams.
Conclusion: Regional implementation of ACP, characterised by regional (central) facilitator teams cooperating with nursing homes and other institutions, has yet rarely been described, but poses a substantial potential when compared to conventional institutional implementation strategies that deserves scientific evaluation.

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Creating momentum and consistency with a national five year strategy in New Zealand

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Background: The development of ACP in New Zealand was driven by the ACP Cooperative, a grass roots organisation of clinicians. The Cooperative's aim was to drive consistency and address the barriers to ACP implementation. Over time, the lack of an official mandate and funding threatened the sustainability of the work of the

Cooperative.
Method: In 2017 the Cooperative partnered with the Health Quality & Safety Commission – a crown agency tasked with supporting the public health sector to improve the quality and safety of services. Together they presented a business case to the district health boards (DHBs) to agree to a national programme with a clear mandate and funding. The DHBs agreed to a five-year strategy and roadmap of national and local actions aimed at increasing ACP activity and addressing sustainability. The key strategy workstreams and their aims are:
-promotion: that future health care planning and end of life discussions are normalised in society
-resources: ACP is accessible to all regardless of language, literacy level or cultural beliefs
-education and training: we have workforce and community prepared to have conversations and use ACPs
-monitoring and evaluation: we know care is based on what matters to consumers
-implementation: we are maximising value for DHBs
Result: a national mandate, strategy and specified actions have resulted in an increase in ACP activity; increased governance with decision-making being supported by a representative Steering Group; wider national stakeholder engagement and buy in from agencies in and outside of the health sector.

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Shared Care Planning: A new model to integrate Advance Care Planning into community. The Basque Country experience
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In the Basque Country, a project has been implemented based on community education, the training of health and social workers. It tries to elicit the individual's preferences and encourages them to take part in planning their care. Writing down advance directives is not the main aim.
The target population is chronic patients, elderly people and anyone at the end of life. The project also includes everyone who wants to think about the process of dying and needs to have a conversation related to this topic.
The project started in 2014 as a bottom-up project and it has grown into a top-down project performed in the whole Basque Health Service.
Results: More than one hundred conferences and debates have been taking place in neighborhood associations, cultural centers, libraries or educational centers. More than five thousand people have attended these activities. One thousand workers have attended a basic training course, more than 500 workers have been trained as SCP facilitators and more than 700 doctors and nurses have participated in conversations with patients and families helped by an SCP facilitator. In 75% of cases, the citizens asked to be included after attending a conference; only 25% of participants were included because of a doctor or nurse's invitation. Many support documents have been created in order to explain the project and to make it easier to understand.
The keystone is the training of health and social workers in order to answer citizens' requests and to integrate the conversations into everyday care.