Enhancing advanced care planning in patients with Substance Use Disorders

Collaborative Community AOD QI project

Chloe Turner and Dr. Aarti Ganapathi
South East Sydney Local Health District

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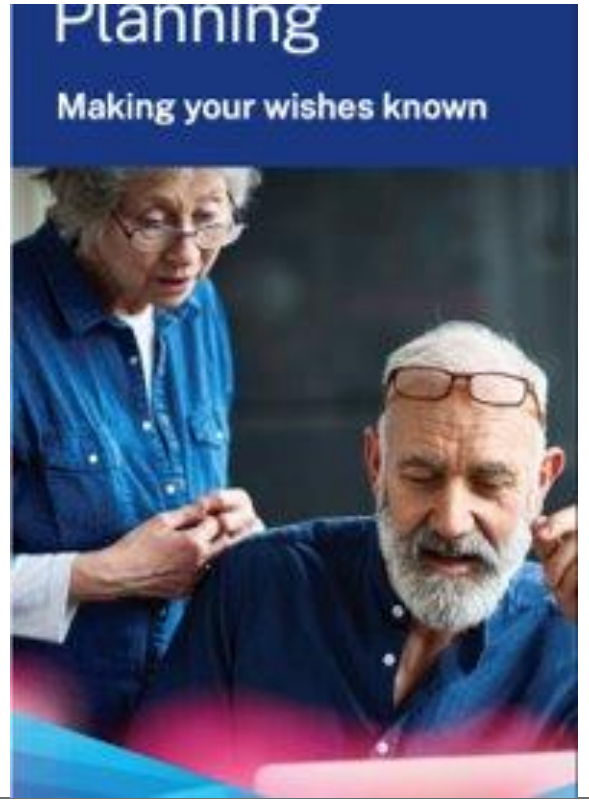
Katherine’s story

Advanced care planning (ACP)

ACP is a structured process that enables individuals to reflect on, discuss, and document their values and goals for future healthcare.

Aims: to ensure care aligns with patient wishes, support shared decision-making, and improve the quality and appropriateness of end-of-life care.

Evidence demonstrates that early ACP engagement is associated with improved alignment of care to patient values and greater recognition of physical, psychological, and existential distress.



Problem statement

The problem: ACP discussions are not being initiated by AOD staff with appropriate clients.

Our staff are skilled and trained to have difficult conversations…including on end of life care discussions!

	Cause of death	Age range at death	Timeframe engaged with service	Primary SUD	ACP discussion had (Y/N) and which team	Interval between discussion and death
1	Acute pancreatitis	55-59	1-2 years	Opiates Cannabis	No	N/A
2	Mouth SCC, pulmonary fibrosis and sepsis	80-84	3-5 years	Opiates	Yes – Palliative care during hospital admission	4 weeks
3	Metastatic colorectal cancer	50-54	>10 years	Opiates	Yes- AOD	4 months
4	Decompensated liver cirrhosis from alcohol use disorder	45-49	1-2 years	Alcohol	No	N/A
5	Decompensated liver cirrhosis from Chronic Hepatitis C	45-49	>10 years	Opiates Stimulants	Yes- palliative care	1 week
6	End stage COPD	60-64	5-10 years	Opiates	Yes – palliative care	3 months- transferred to pall care unit
7	End stage COPD and COVID-19	55-59	5-10 years	Opiates Stimulants	No	N/A
8	Ischaemic heart disease	55-59	3-5 years	Opiates Cannabis	No	N/A
9	Hepatocellular carcinoma	60-64	1-2 years	Alcohol Stimulants Opiates	No	N/A
10	Metastatic small cell lung cancer	65-69	5-10 years	Opiates	Not documented- care elsewhere	N/A

QI: increased ACP discussions had by AOD staff

Goals

Increase the number of ACP discussions had with patients who have SUD initiated by AOD staff.

Resources need to be adapted to AOD sector

What is advance care planning?

Advance care planning means making decisions about the care you want.

This plan will help if you cannot communicate anymore.

You might not be able to make a decision if you are very sick or have a serious injury.

Advance care planning means talking with your

- family

Making decisions about medical treatment

If you are dying you can decide if you want to have medical treatment.

Some people decide they do not want medical treatment even if it might help them live longer.

Some people who are dying want to have these medical treatments.

Why does it matter? “Talking about this now means decisions can be made about your future healthcare”

“Do you feel like you have a good understanding of your health? How does your current health impact your life?”

Goals and quality of life. “What does it mean for you to live well? What are your goals around your health/life at this time?”

Involving friends or family

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Patient eligible for conversation

Table 2: Eligibility criteria for ACP discussions in patients with SUD

(1) Person who has an advanced/chronic or life limiting illness (such as Cirrhosis Child Pugh C, Severe end stage COPD, End stage kidney disease, Severe cardiac failure, Cancer)
(2) Significant clinical even: recent hospital admission, clinical deterioration, escalating uncontrolled symptoms with any of the criteria defined in (1)
(3) If the clinician would not be surprised if the person died within 12 months.
(4) Changes in living arrangement: Impending transition to a residential aged care facility or other major shift in care setting.
(5) Risk of cognitive decline: Early signs of dementia or cognitive impairment with current capacity to express values and preferences.
(6) Aged 50 and over?

Scope of project

	In Scope	
Facilities/services	Drug and alcohol services of SGH, TSH and The Langton Centre (Ambulatory care and Opiate treatment program), Hospital C/L	
People	AOD staff across SESLHD	
Technology and systems	Cerner (eMR)	
Processes	Identifying appropriate patients to have ACP discussions with, staff training on how to have ACP discussions, material tailored to AOD sector. Referral pathways, establishment D and A Palliative care team	