Advance care planning in elderly care-concerted efforts through medical social collaboration

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Why we need EOL care?
Who need EOL care?

What is EOL?

What is ACP?
HA guideline

- ACP is a process of proactive communication to bring out a patient's wishes and preferences regarding end-of-life care,
- and is being recognized as an integral part of care for patients with advanced progressive diseases.

Components of ACP conversation

1. Clarify understanding of illness
2. Patient’s values
3. Goals of care
4. Treatment options which are desired or not desired
5. Identify patient’s wishes
6. Identify proxy health care decision maker
Benefits of ACP

• Communicate future wishes
• Improve patient and family satisfaction
• Alleviate anxiety in relatives
• Prepare for end of life care and death
• Avoid prolongation of dying
• Strengthen personal relationships
• Relieve burdens placed on family

ACP is key to good end of life care
It informs care plan and guides care delivery

Target groups for palliative care

Disease requiring palliative care for adults:
• Cancer
• Alzheimer’s and other dementia
• Cardiovascular disease excluding sudden deaths
• Cirrhosis of the liver
• Chronic obstructive pulmonary disease
• Kidney failure
• Multiple sclerosis, Parkinson’s disease
• Rheumatoid arthritis
• Drug-resistant tuberculosis

Elderly may be complex due to multi-morbidity, mostly with dementia
End of Life Care

Patient are likely to die within the next 12 months

1) includes imminent death
2) those with
   a) advanced incurable conditions
   b) general frailty and co-morbidity expected to die within 12 months
   c) existing conditions with risk of dying from a sudden acute crisis
   d) life-threatening acute conditions

General Medical Council, UK 2010

Triggers for ACP discussion

1. Recent serious illness/major surgery
2. Worsening symptoms/functional decline
3. New diagnoses of life-limiting conditions
4. Irreversible deterioration in the patient’s health status
5. Loss of response to complications from disease-specific treatments
6. Expressed desire of the patient or the family to discuss ACP
End of Life Care in Hong Kong

- 90% HK deaths in HA
- 50% who died in Medical beds from RCHE (old aged homes)
- Frequent hospital admission in last few months
- Lack of advance care planning

Opportunity to improve care through advanced care planning (ACP)

MEDICAL SOCIAL COLLABORATION FOR ELDERLY END OF LIFE CARE

Slide courtesy of HAHO Geriatric Subcommittee
Medical Social Collaboration for Care of Elderly at End of Life

- Surprise question – life expectancy of 6 to 12 months
- Elderly at End of Life are characterised by Medical & Social (Care) Needs
  - Frail and functionally dependent
  - Dementia
  - Multi-morbidity
  - Recurrent hospitalisations
- Medical social collaborative care model from ACP to Care Delivery
  - Multi-disciplinary (with Palliative Care Team)
  - Inter-sectoral (with RCHE staff & NGOs)
- 2015: HA's CGAT (community geriatrics assessment team)
  End of life program for elderly in residential care home for elderly
- 2019: JCECC End of life program for those living at home

**“Enhancement of CGAT Service for EOL Care in RCHEs”**

**2015**

- Objective
  - Provide coordinated & appropriate care to terminally ill residents in RCHEs
- Scope
  - Advance care plan
  - On-site support
  - Direct clinical admission
  - Psychosocial/spiritual support
  - Empower RCHE staff
Case Identification & Clinical Referrals – Criteria

- Prognostication
- Surprise question
- Challenging in elderly
- Any existing tools for screening we could use?

Hospital Admission Risk Reduction Program for the Elderly (HARRPE Score)

Risk Prediction Score

Hospital Admission Risk Reduction Program for the Elderly living in the community (HARRPE Score)

- Predicts probability of readmission eg 0.4 means 40% chance of readmission within 28 days
- Automated and available - Used for HA programs eg Integrated care model and Patient Support Call Centre.
- Clinical observation: suggested higher scores correlated with mortality
Hypothesis tested in Study by using HARRPE Score to identify High Risk Elderly for Advance Care Planning

Objective (1) To correlate HARRPE scores with mortality

![Graph showing mortality rate within 6 months in patient at different HARRPE score ranges: 36%, 59%, and 67% for >0.4-0.5, >0.5-0.6, and >0.6 HARRPE score ranges, respectively.]

Objective (2) To test its practical use by CGAS Nurses in case identification for ACP and CGAS EOL Program in Residential Care Homes of the Elderly (RCHE)

- Daily HARRPE LIST
- Daily HARRPE Score > 0.4
- RCHE Cases Under HKEC CGAT cover
- Meet EOL criteria
- Visit Patient at RCHE or ward
- Check patient’s medical history in CMS which under CGAT FU
- Contact RCHE and patient’s relative for EOL introduction
ACP in RCHE setting – engage relative and RCHE staff

- Engage relative & RCHE carer to formulate the advance care plan
- Respect what patient would have chosen according to relative or best interest principle for medical treatment and other wishes

Medical social collaboration for CGAS End of Life Program

RCHE staff help
- Identify eligible patients
- Conjoint efforts in ACP
- Keeps ACP for resident
- Ensures ACP is brought to HA
- Monitor and alert CGAS for timely symptom management
- Contact CGAS EOL nurse & ward based EOL Hotline
- Facilitate communication with relatives
ACP - Nurse Provides Education to Inform Choice for Treatment Options

ACP – Doctor does the ACP and DNA_CPR orders with Documentation and updates Electronic Alerts in HA's CMS Patient Records
CMS Alert

Documentation and EOL folder – communicated to hospital wards and A&E dept
Multidisciplinary (with Palliative care) Case Conference

Subsequent to ACP – supporting relatives in ward setting
CGAS admission to designated EOL beds with trained staff

- Trained staff with expertise in geriatric care end of life
- Flexible visiting hours
- Life story book by Ward A3 & B3 at RTSKH

Future Enhancement
Medical Social Collaboration

- 2018-19 Government funded SWD – NGO led MOSTE (multi-disciplinary outreach support team for elderly) to RCHEs
- Engage MOSTE social worker to collaborate in CGAS EOL care

Objectives
- Arrange volunteers to visit RCHE EOL patients
- Eg To facilitate life story book and better understanding of the person, assist in ACP process
Medical-social collaboration with MOSTE: Project On Life Story Booklet

Medical
- ACP / EOL care
- Training
- In-patient

Social
- Volunteer network
- Home visit
- Community

循道衛理中心安老院舍外展專業服務試驗計劃
(Methodist Center)

社會福利署銅鑼灣綜合家庭服務中心
(Integrated Family Service Center)

Values and personal wishes - ACP Form
End of Life for Elderly living at Home
Mediccal social care with JCECC and HK Society of Rehabilitation

2019

- Objective
  - Provide coordinated & appropriate care to terminally ill elderly living at home

- Scope
  - Advance care plan
  - On-site support
  - Home personal care
  - Psychosocial/spiritual support
  - Practical support eg transport
  - Respite care
Medical social collaboration for Elderly living at Home (JCECC)

Conjoint ACP

Formulate ACP & Care Delivery

Medical & Geriatric with Palliative Care

Social worker

Family / Patient

JCECC Social worker

Social worker from HKSR (JCECC) visit elderly in ward

JCECC Referral Form

Referral Form for Jockey Club End-of-Life Community Care Project [JCECC]

Patient Information

Name: __________________________
Gender: __________________________
Age: ________
Contact No: __________________________

Family Member Information

Name: __________________________
Relationship: __________________________
Address: __________________________

Diagnosis

1. Cardiovascular Disease: ________
2. Respiratory Disease: ________
3. Neurological Disease: ________
4. Oncology: ________

Mental Health

1. Depression: ________
2. Anxiety: ________
3. Dementia: ________
4. Substance use: ________

Medical Background

1. Current medications: __________________________
2. Allergies: __________________________
3. Past medical history: __________________________

Psychosocial Background

1. Psychosocial needs: __________________________
2. Support services: __________________________
3. Mental health services: __________________________

Recommended Services

- Physical Care
- Psychological Care
- Social Services

- Personal care
- Emotional support
- Family support

- Home visits
- Counseling
- Support groups

- Referrals: __________________________
- Other: __________________________
EOL Care—Only one chance to get care right

Building capacity through co-care for a good death

- Background - Mdm Chan has advanced dementia, gangrenous left foot along with multimorbidity and is totally care dependent. This year, she had 4 admissions for infected foot with cumulative hospital stay of 155 days. Her daughter declined operation for amputation with each hospitalisation. A community nurse provided care of her foot
- Seen at geriatric outpatients, she agreed to an advance care plan (ACP) and referral to NGO providing home based end of life support.
- Co-care begins with conjoint ACP
  - NGO social worker and HA geriatrician conjointly completed the ACP with her at GDH. Social worker could explore values and geriatrician explain treatment options
- Care delineation
  - Medical
    - Titration of pain relief and foot care by geriatrician and community nurse, working closely with NGO. Community nurse contacted the geriatrician for symptomatic treatment such as infection or pain.
    - Coordinated Admission to designated bed, where flexible visiting and other end of life care protocols, access to psychosocial and spiritual care for appropriate care.
  - Social - NGO's nurse and social worker provided home care, transport and psychosocial support at home
- Multidisciplinary input at interdisciplinary palliative care and geriatrics case conference. Her daughter appreciated deeply the end of life care support for her to care for her mother, without recourse to admissions.

Slide courtesy of Dr Carolyn Kng RTSKH
Video sharing

- https://drive.google.com/open?id=1LBmfoHzRH6HSCo6k4wBMHVnYFeqC54aY
Summary

1. Right patient
2. Right time
3. Individualized
4. Realistic care goal
5. Integrate relevant services and resources
6. Balance from ‘over-medicalising’ EOL care
7. Innovate with care models bridging medical social interface
8. EOL care – only one chance to get it right

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