賽馬會安寧頌
JCECC
Jockey Club End-of-Life Community Care Project

Advance Holistic Care Planning :
The Conceptualization of a New Inter-disciplinary, Tiered and Multi-stage Model

(Presentation on Oct 24, 2019)

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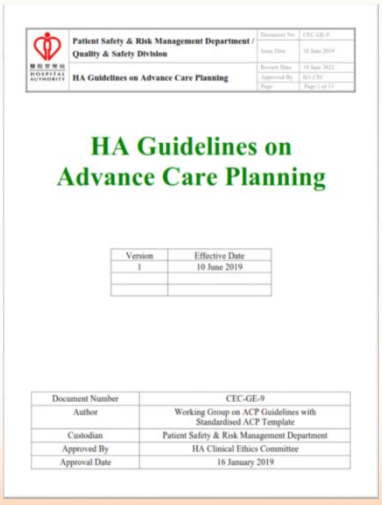
合作夥伴 Project Partner:

Advance Care Planning: A timely topic

JCECC Jockey Club End-of-Life Community Care Project

HA Guidelines (June 2019)


Patient Safety & Risk Management Department / Quality & Safety Division
HA Guidelines on Advance Care Planning

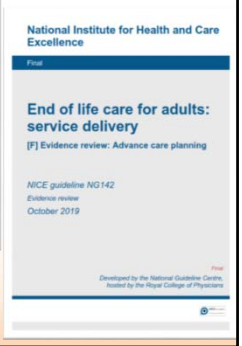
HA Guidelines on Advance Care Planning

Version	Effective Date
1	10 June 2019

Document Number	CEC-GE-9
Author	Working Group on ACP Guidelines with Standardised ACP Template
Custodian	Patient Safety & Risk Management Department
Approved By	HA Clinical Ethics Committee
Approval Date	16 January 2019

NICE Guidelines (Oct 2019)


NICE
End of life care for adults: service delivery
NICE guideline
Published: 16 October 2019


National Institute for Health and Care Excellence
End of life care for adults: service delivery
[F] Evidence review: Advance care planning
NICE guideline NG142
Evidence review
October 2019

Advance Care Planning

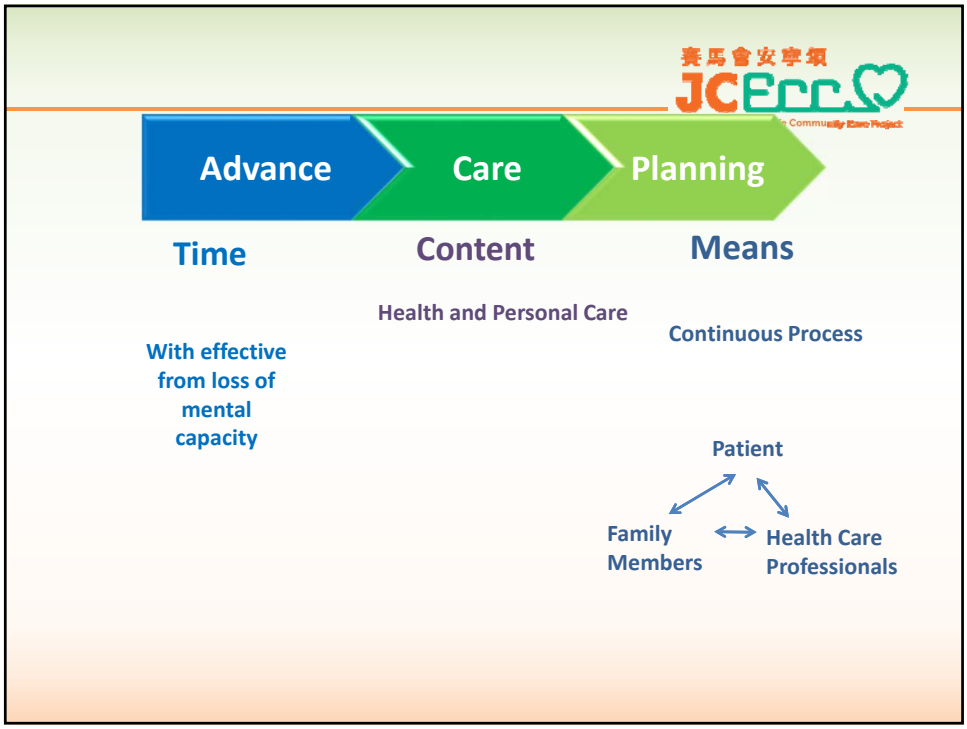
- "Advance care planning (ACP) is an overarching process of proactive communication regarding end-of- life care. Through this process of communication, a patient with advanced progressive disease, his/her health care providers, and his/her family members and caregivers can consider ahead of time what kind of care is appropriate when the patient can no longer make a decision. ."

(HA, 2019, p. 3)

Advance Care Planning

- "ACP is an overarching and preceding process for expressing preferences for medical and personal care, which in turn will shape the care for the patients thereafter and at the end- of-life."

(HA, 2019, p. 4)



Optimal Timing of Initiating ACP is Inconclusive

Triggers for initiating or reviewing ACP discussions:
(Mullick et al., 2013, p.3)

- Patient initiates the conversation
- Diagnosis of a progressive life limiting illness
- The diagnosis of a condition with a predictable trajectory, which is likely to result in a loss of capacity, such as dementia or motor neuron disease
- A change or deterioration in condition
- Change in a patient's personal circumstances, such as moving into a care home or loss of a family member
- Routine clinical review of the patient, such as clinic appointments or home visits
- When the previously agreed review interval elapses

Optimal Timing of Initiating ACP is Inconclusive

- It's always too early, until it's too late (IOM, 2015, p.125)
- Knowing when **NOT** to proceed discussion is important: when doing so might cause disproportionate levels of distress (Mullick et al., 2013, p.3)

Palliative Care should be Holistic

Lancet Commission Report (Knaul et al., 2018)

The Lancet Commissions

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report

Executive Summary

- **Highlights the needs in psycho-social-spiritual care**

Palliative care should be responsive to suffering of any kind and should seek to prevent and relieve not only physical and psychological suffering but also social and spiritual suffering of patients and their families.[67]

(Knaul et al., 2018, p.1401)

Advance Planning Umbrella


National Institute for Health and Care Excellence

End of life care for adults: service delivery

[F] Evidence review: Advance care planning

NICE guideline NG142

Evidence review

October 2019

http://www.allwhitebackground.com/umbrella.html

An advance care plan may be just one document the person has under their Advance Planning umbrella. Others may include: Goals and Wishes, Advance decision to refuse treatment (ADRT) DNACPR, Lasting Powers of Attorney, Funeral Wishes and Wills. These may have been in place for some time and will need considering when discussing and creating advance care plans for people entering their last year of life.

(NICE, 2019, October, p. 5).

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Components of ACP

- Medical care only?
- Other care
  - Financial and assets arrangement
  - Responsibility transfer
  - Psychosocial care
    - completion of unfinished businesses
    - reconciliation
    - life review
    - transfer of life wisdom and skills
  - Spiritual care
- Know how to "titrate" information over time (Mullick et al., 2013, p.3)

New Concept (Chow, in preparation)

Advance → **Holistic** → **Care** → **Planning**

Time	Content	Means
From Healthy to End of Life, with effective from loss of mental capability	From physical care to **Psychosocial and spiritual care**	**Inclusion of Social Care Professionals**

Interdisciplinary Advance Care Plan

- **Holistic Care requires an inter-disciplinary team**

https://sourcesandsolutions.files.wordpress.com/2013/06/interdiscipline.jpg

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Other Theoretical Framework

Individualised Choice:

- Three Classification of Prevention (Gordon, 1983; IOM, 1994)

Time Factor: Readiness

- Transtheorectical Model (TTM) (Prochaska & Diclemente, 1983; Norcros, Kerbs & Prochaska; 2011)

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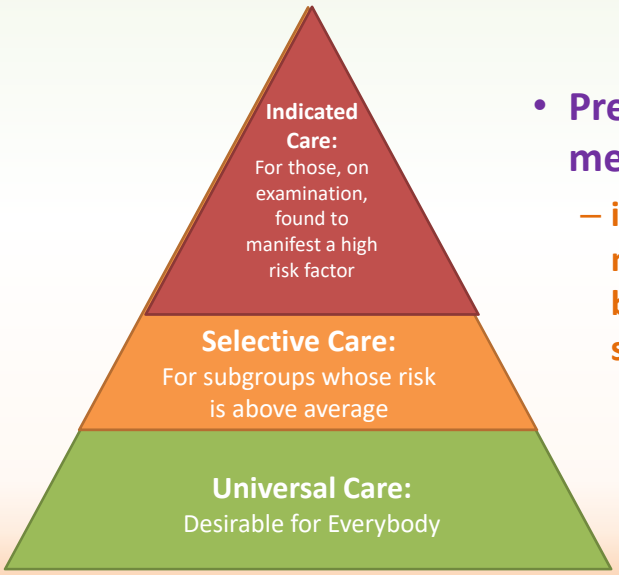
Three Classification of Prevention
(Gordon, 1983; IOM, 1994)



- **Preventive measures:**
  - involve those not motivated by current suffering
    (Gordon, 1983, p.108)

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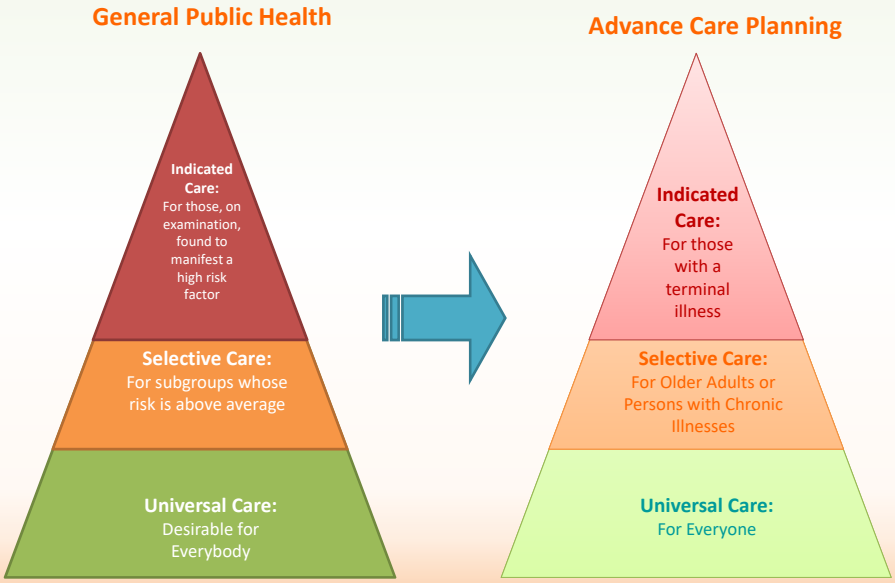
A Tiered ACP Model



Transtheoretical Model (TTM)

(Prochaska & Diclemente, 1983; Norcros, Kerbs & Prochaska; 2011)

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Transtheorectical Model (TTM)

(Prochaska & Diclemente, 1983; Norcross, Kerbs & Prochaska; 2011)

Precontem-plation	Contem-plation	Prepara-tion	Action	Mainten-ance
- Has no intention to change behaviour in the foreseeable future	- Aware that a problem exists and seriously thinking about overcoming it but not yet made a commitment to take action	- Intend to take action in "the next month" and report some "baby steps"	- Modify their behaviour, experiences, and/or environment to overcome their problem	- Work to prevent relapse and consolidate the gains gained during action
- Avoid topics of death and dying - Perceive no need of ACP	- Curious about what ACP is, but do not take any action	- Want to communicate with family and professional	- Participate in ACP - Document ACP or sign AD	- Regular review of ACP - Review when condition changes

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Multi-stage ACP Model

Precontem-plation	Contem-plation	Prepara-tion	Action	Mainten-ance
- Avoid topics of death and dying - Perceive no need of ACP	- Curious about what ACP is, but do not take any action	- Want to communicate with family and professional	- Participate in ACP - Document ACP or sign AD	- Regular review of ACP - Review when condition changes
-Avoidance - Lack of Motivation - Lack of awareness of need/impact	- Lack of information	- Lack of accessibility - Lack of time - Lack of skills	- Lack of communication - Lack of consensus	- Lack of system

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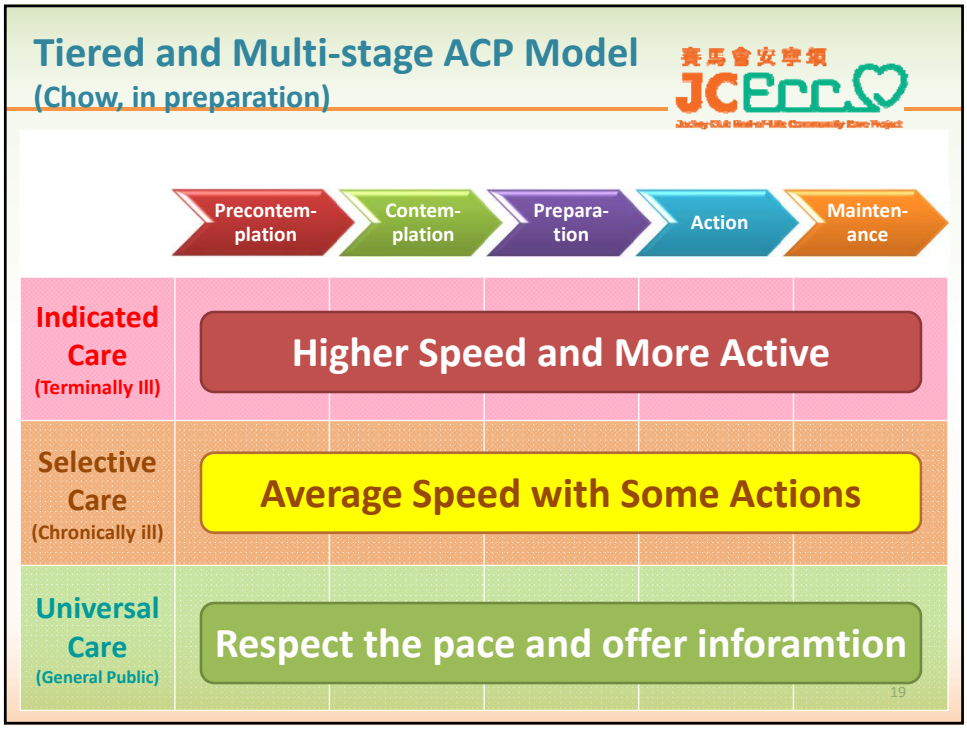
Tiered and Multi-stage ACP Model (Chow, in preparation)



Tiered and Multi-stage ACP Model (Care preferably by Health Care Professionals) (Chow, in preparation)

	Precontem-plation	Contem-plation	Prepara-tion	Action	Mainten-ance
Indicated Care (Terminally Ill)	Clarification of Value, Beliefs and Goals, Motivational Interviewing	Information giving related to health care plan	Accessibility to appropriate health care professionals	Participation in ACP with family members and health care professionals, documentation of discussions	Regular review by health care professionals
Selective Care (Chronically ill)	Active Psycho-education (Sharing of Real Stories)	Information giving related to social & health care plan	Accessibility to appropriate social care professionals	Participation in ACP with/without family and social care professionals	Review when condition changes
Universal Care (General Public)	Passive Psycho-education (Life and death education)	Information giving related to social care plan	Accessibility to contacts of social care professionals	Referral to appropriate health and social care professionals	Review when condition changes

Examples of Psychoeducation

- **Mini-Movie**

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Examples of Psychoeducation

- **Communications card**

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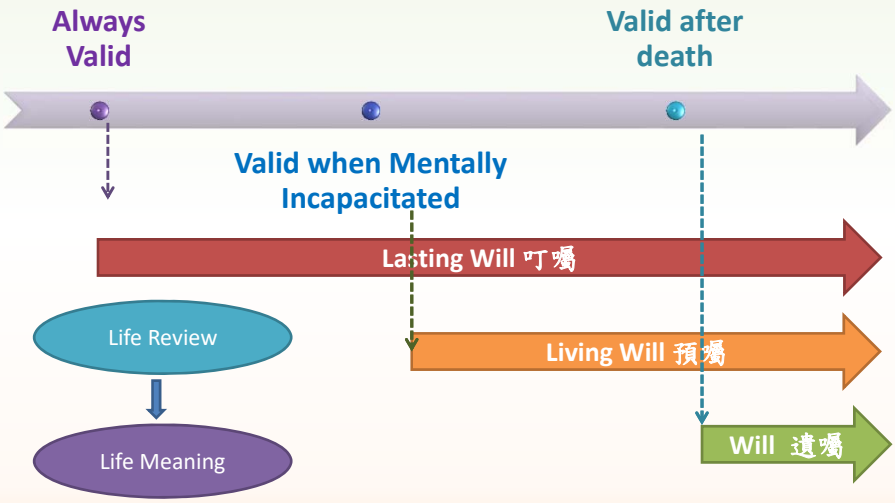
Reflections in Promoting Advance Care Planning among Chinese (Chow, in preparation)

- *Assumption #1*
- Death is a taboo topic in particular for Chinese: talking means attracting
  - Best utilization of the golden opportunity
  - Two Lives and Three Wills 二人三囑 (Centre on Behavioral Health, 2008)
    - Two Lives: Life review 人生回顧and Life meaning人生意義
    - Three Wills: Lasting Will 叮囑, Living Will 預囑and Will 遺囑

Three Wills Two Lives (二人三囑)



(Project ENABLE, 2005)

Three Wills Two Lives (二人三囑)

Lasting Will 叮囑

- Personal care
- Secret recipes
- Practice Wisdom

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Three Wills Two Lives (二人三囑)

Living Will 預囑

- Place of care
- Who to care and who to ask?
- Preference of care
  - Comfort care, treatment or treatment for a while
  - Surrogated decision-makers

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Three Wills Two Lives (二人三囑)

Will 遺囑

- Organ donations
- Body donations
- Will
- Funeral arrangement
- Burial arrangement
  - Green burial
  - Scattering ashes to memorial garden or to the sea
- Responsibilities

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Reflections in Promoting Advance Care Planning among Chinese (Chow, in preparation)

- *Assumption #2*
- Dying is a family event
  - Involvement of family as early as possible
  - Individual family members might have very different perspectives
  - Facilitation of family communications and negotiations
  - Facilitation of patients in articulating their values

Reflections in Promoting Advance Care Planning among Chinese (Chow, in preparation)

- *Assumption #3*
- Trust in health care professional is crucial
  - Suspicion towards saving of resources
  - A trustful relationship with one health care staff will be generalized as a trustful relationship with the health care team

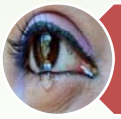
Reflections in Promoting Advance Care Planning among Chinese (Chow, in preparation)

- *Assumption #4*
- Advance care planning is a process that accepts changes over time
  - Reduction of push in signing very formal paper unless requested by the patients
  - Use of other means of documentation or substitute decision makers
  - Periodical checking with the preferences and values
  - Reemphasis that validity starts only when the patient is incapable to communicate or make decision. Patients are reminded that they can always indicate new preferences

Reflections in Promoting Advance Care Planning among Chinese (Chow, in preparation)

- *Assumption #5*
- Advance care planning is a respecting patients' autonomy and choices
  - Role of health and social care professionals as information providers and planners
  - Patients sometimes determine not to make decisions and respect the decision of family members or professionals

Chinese Wisdom (Wang, 2018)



感動 (Moving)

衝動 (Impulse)

行動 (Action)

運動 (Movement)

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Thank you

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