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Reflections on End of Life Care in Hua Mei Mobile Clinic

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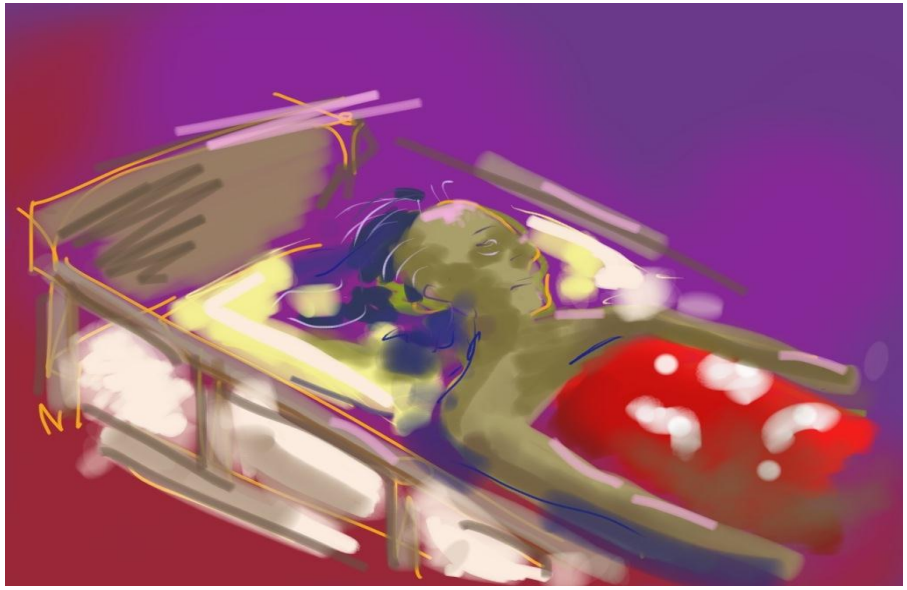

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Scope

- Hua Mei Mobile Clinic – its Function and Design
- Case Study
- Case Series of Patients in the EoL Programme
- Reflections

Hua Mei Mobile Clinic as a Long Term Care Service - *PURPOSE*

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- To support the frail older persons **to live in their homes** (until their deaths if dying at home were their wish)
- **Live among families** and other natural care-supports
- **Having access to health care** even if they are not able to come out of their homes
- To **respect and honour** their preferences
- Ultimately to instil a sense of **peace and comfort** in the older persons' lives

Hua Mei Mobile Clinic as a Long Term Care Service - *DESIGN*

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- **A Generalist health-and-social care service**
- **Long Term Care at in the community for the frailest**
- The key components that allow this Clinic to deliver on LTC in the Community
  1. **Interdisciplinary Health Team**
  2. **Primary care** approach*
     - **Community-oriented Geriatric and Gerontology training**
     - Special attention to **Transitional and Palliative Care**
     - **24H coverage**
  3. Emphasis on **Care management**, providing multi-dimensional trans-disciplinary intervention.
     - **Comprehensive assessment and care planning** using InterRAI Home Care, HMMC Initial Assessment and Care Plan Protocols
     - Use of **IT**

* Primary Care is defined has having 7 attributes (7 "C's") – First **C**ontact; **C**omprehensive; **C**ontinual; **C**ommunity-based; **C**are management; **C**ommunication towards Empowerment; **C**ost-effective

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Assessment

- Mdm M, aged 83, was admitted to HMMC in May 2007. Her poor health began in 1999 and gradually declined from being wheelchair-bound to bedbound and finally total loss of her cognitive functions.

1. Multiple chronic medical conditions:
   - Parkinson's Disease
   - Vascular dementia with BPSD
   - Rheumatoid arthritis
   - Anaemia associated with general poor condition and malnutrition
   - Cataract in both eyes
   - Pressure ulcer of lower back
   - Protein calorie malnutrition.
2. Physical Dependence
   - Bed-bound and requires total care including tube feeding
   - High risk of complications due to immobility: bed sores; pneumonia; constipation; UTI; contractures; DVT; recurrent hospitalizations
3. Caregiver Stress
4. Financial Strain

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Care Planning

- Goal Setting:
  - Based on patient's aspirations, prognosis, rehab potential, informal and formal community resources
- Needs Assessment
  - Team's assessment supplemented with interRAI HC
- Resources and Strengths
  - Social worker's assessment and team's assessment
- IDG Discussion on Care Plan
- Communication and negotiation with patient and family:
  - ACP; present care plan
- Final Care Plan

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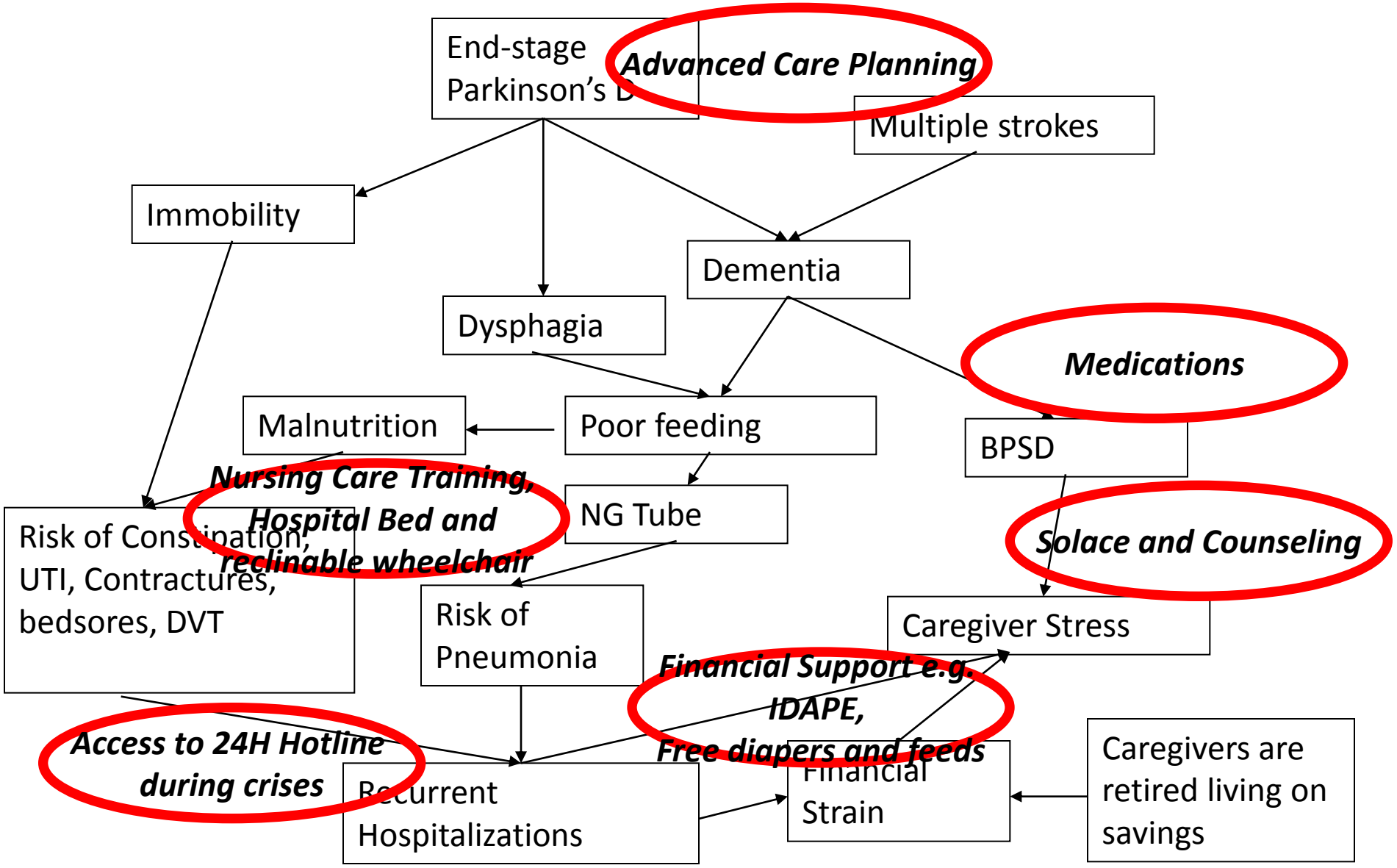
Interventions



Assimilating End of Life Care in Hua Mei Mobile Clinic

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Components

1. End of Life Care Training for Team
2. Person-centred Care and Advance Care Planning for All Patients
3. Increased resourcing based on Estimated Prognosis

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Case Series HMMC EoL Care Programme (1 Oct 10 – 30 Sep 12)

Case Load and Capacity of HMMC

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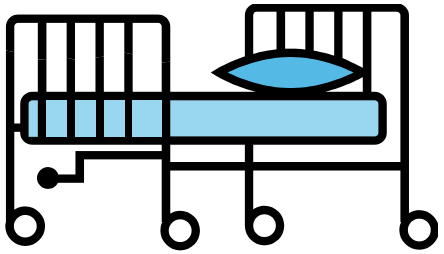
- 1 Oct 10 – 30 Sep 12
  - Total number of patients served = 160



Patients **never been** served on EoL Care Programme
= 105

Patients served on EoL Programme
= 55

Caseload for the EoL care Programme 1 Oct 10 – 30 Sep 12 (2 years)

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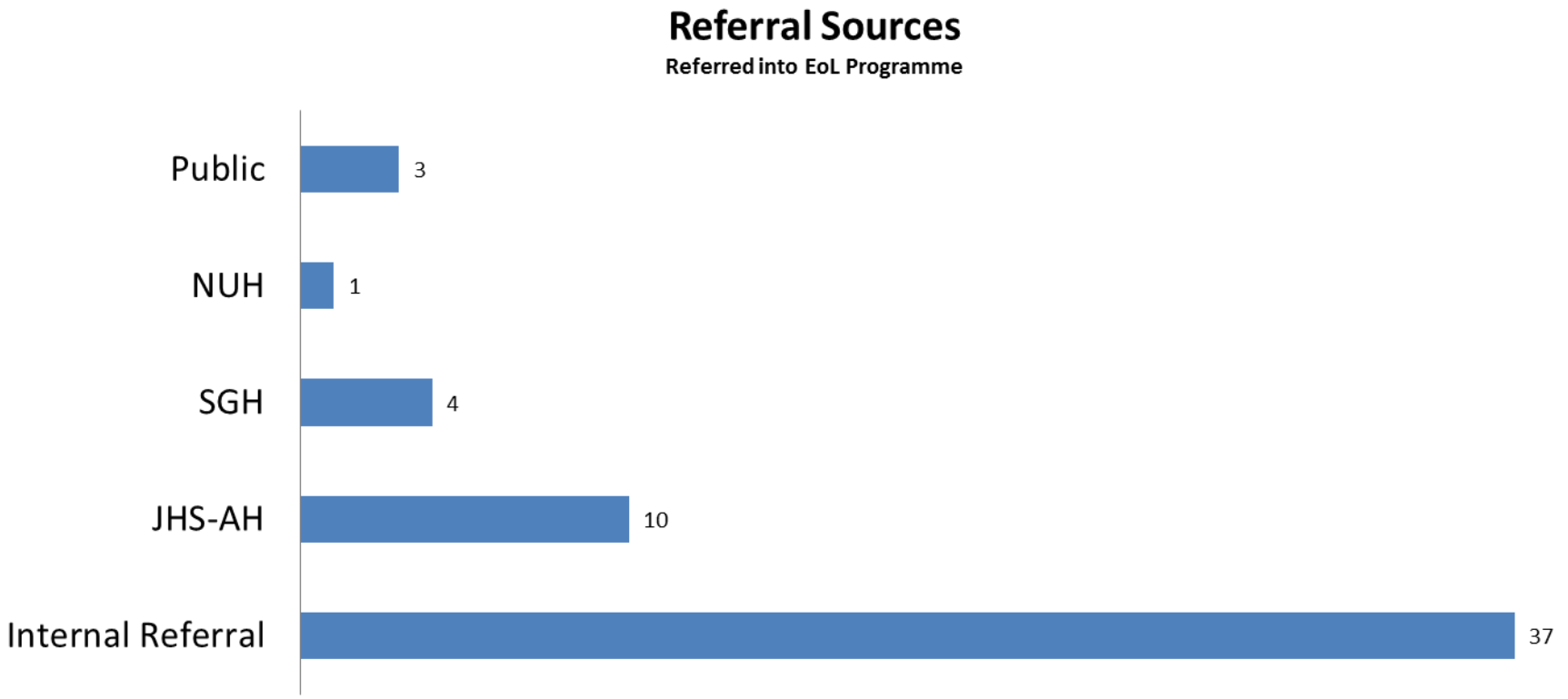
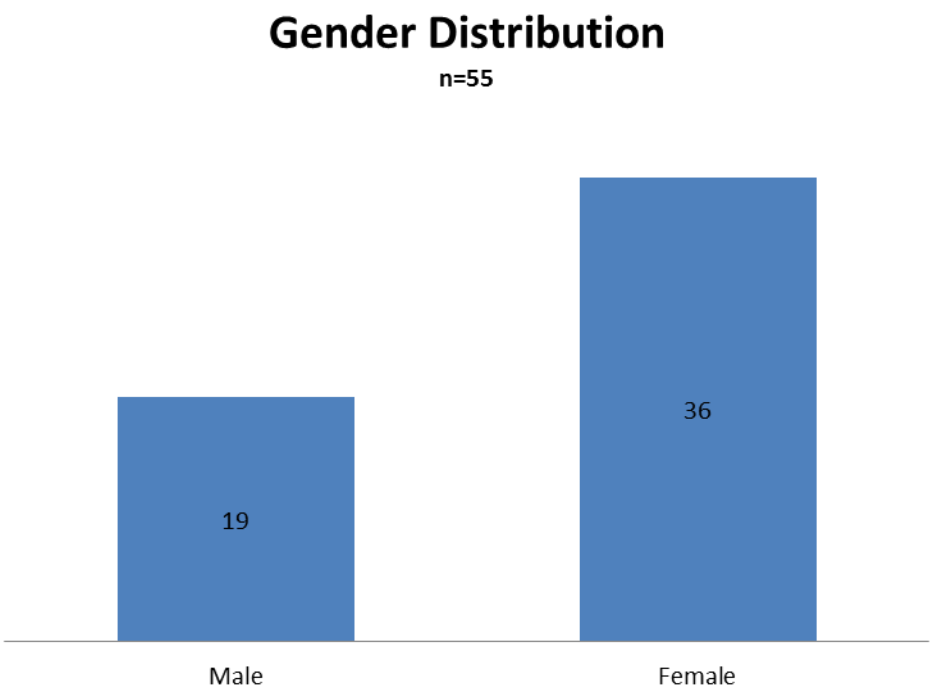


Patient Profile

n=55

- Mean Age: 87.4
- Median Age: 87
- Age range: 69 – 99



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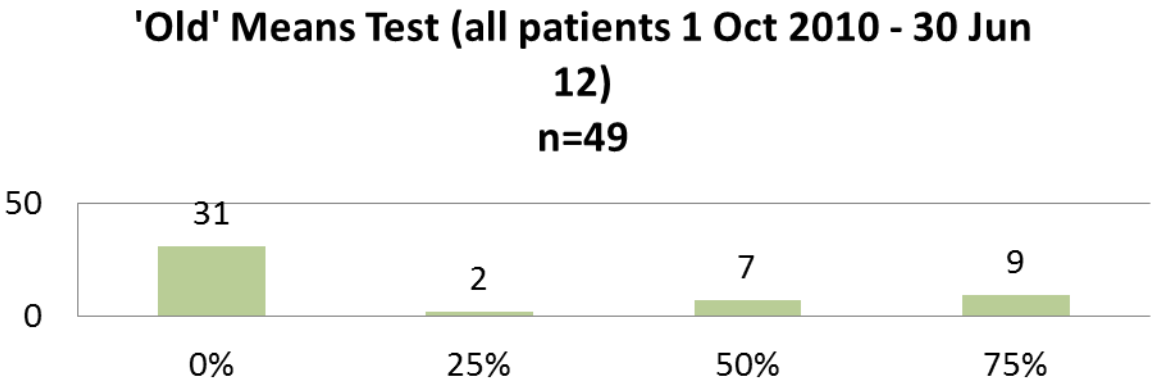
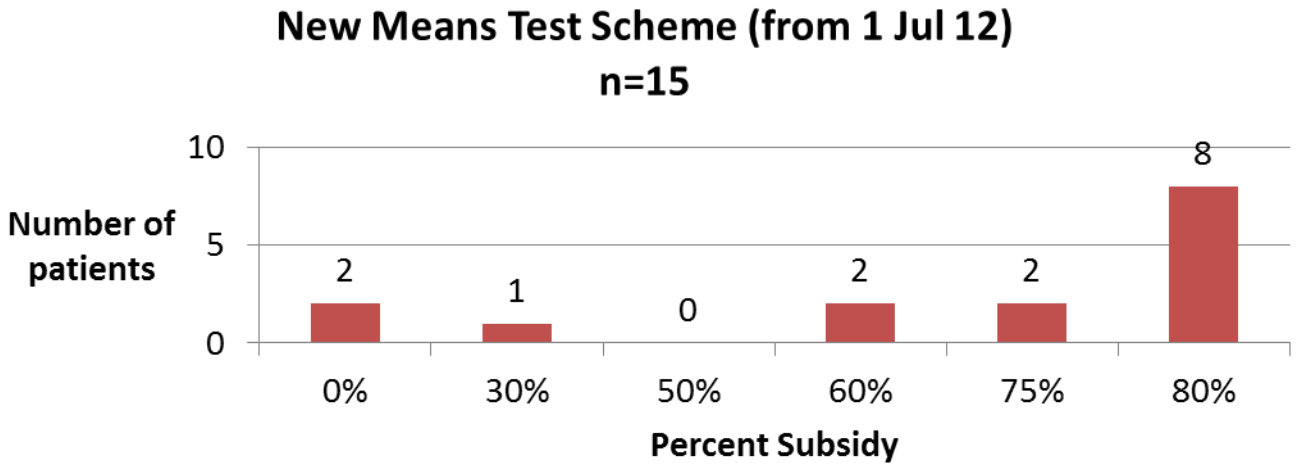
Financial Profile





Functional Status

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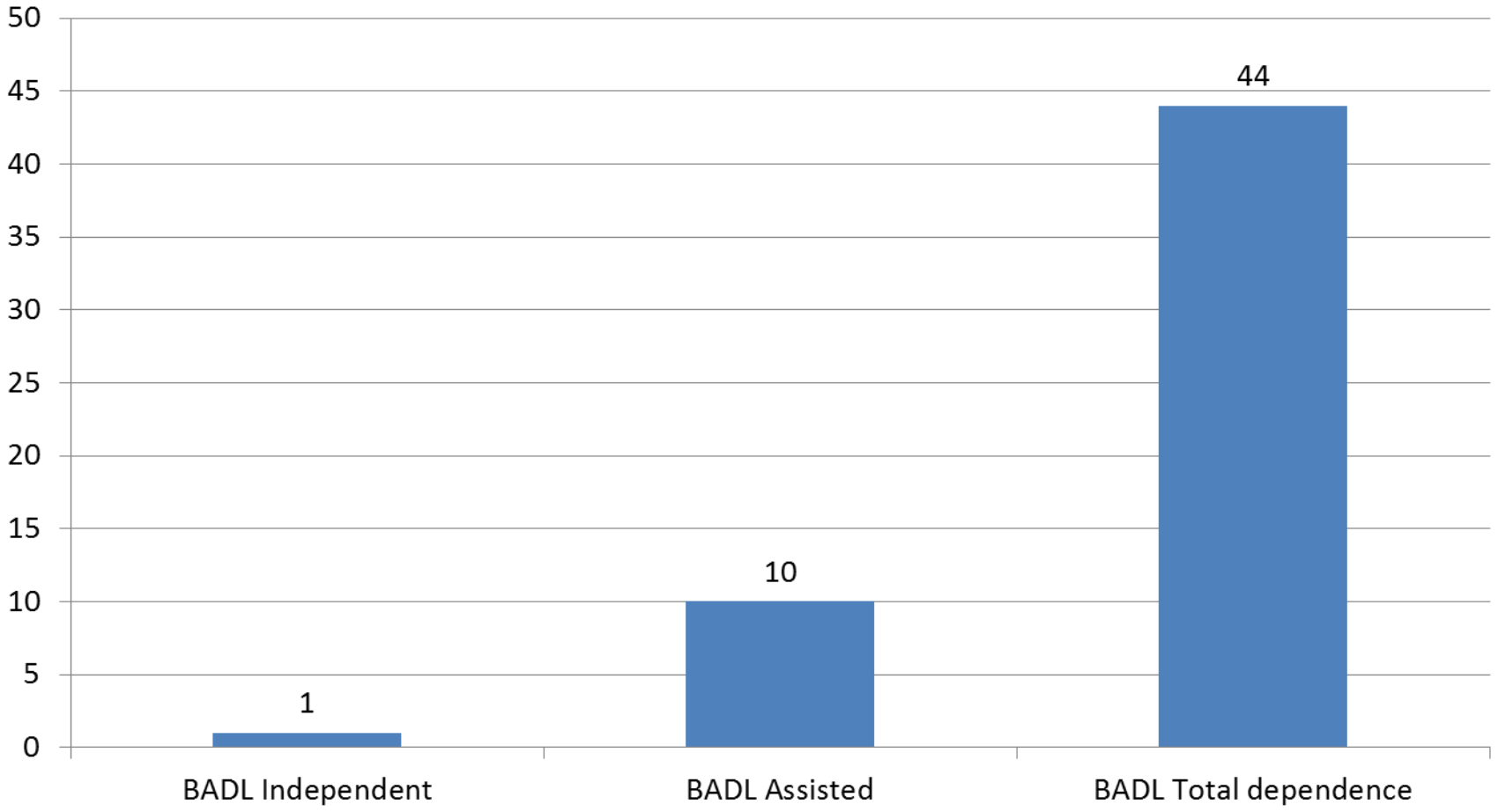
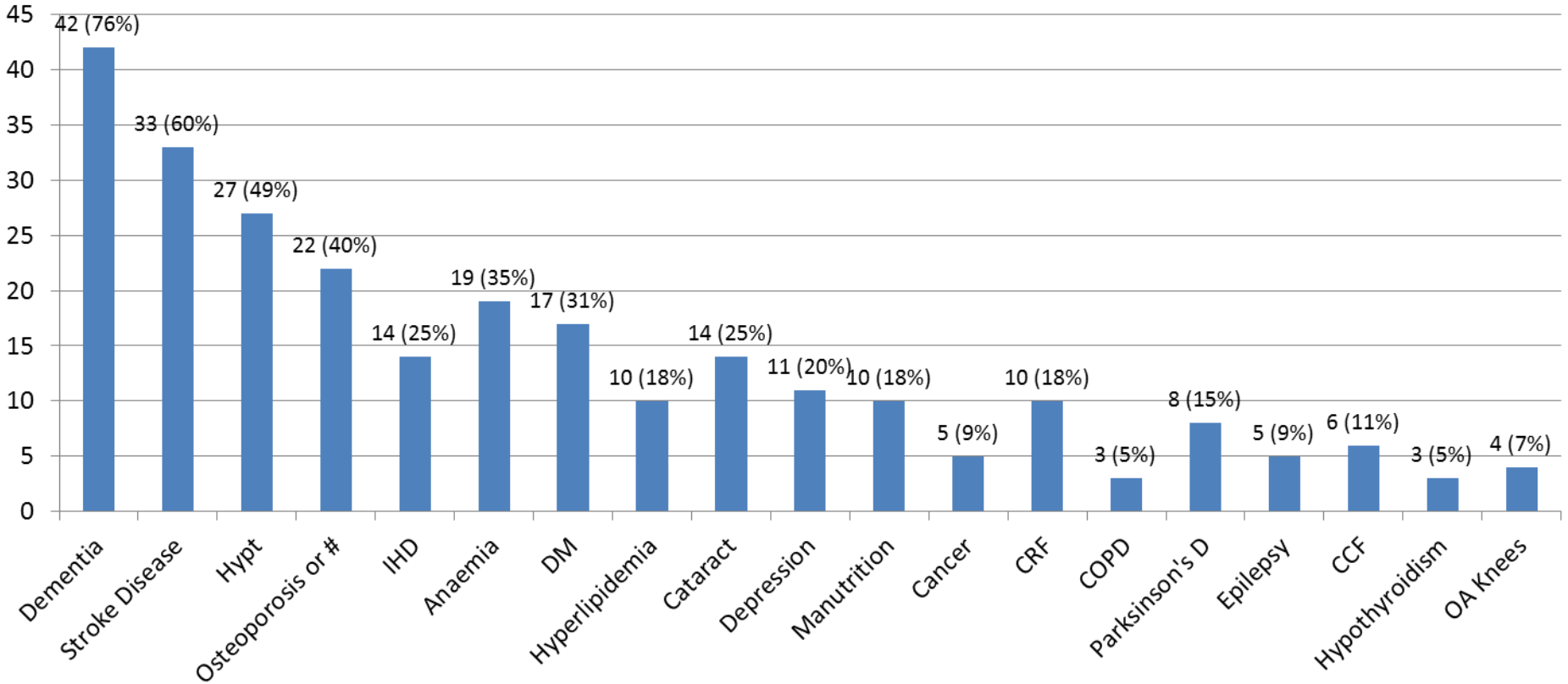


Diagnoses Distribution

n=55



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Advance Care Planning

- 54 out of 55 patients received ACP
  - Either in person or through presumed health proxy if absent mental capacity (None of the patients have officially elected a Donee as per MCA)

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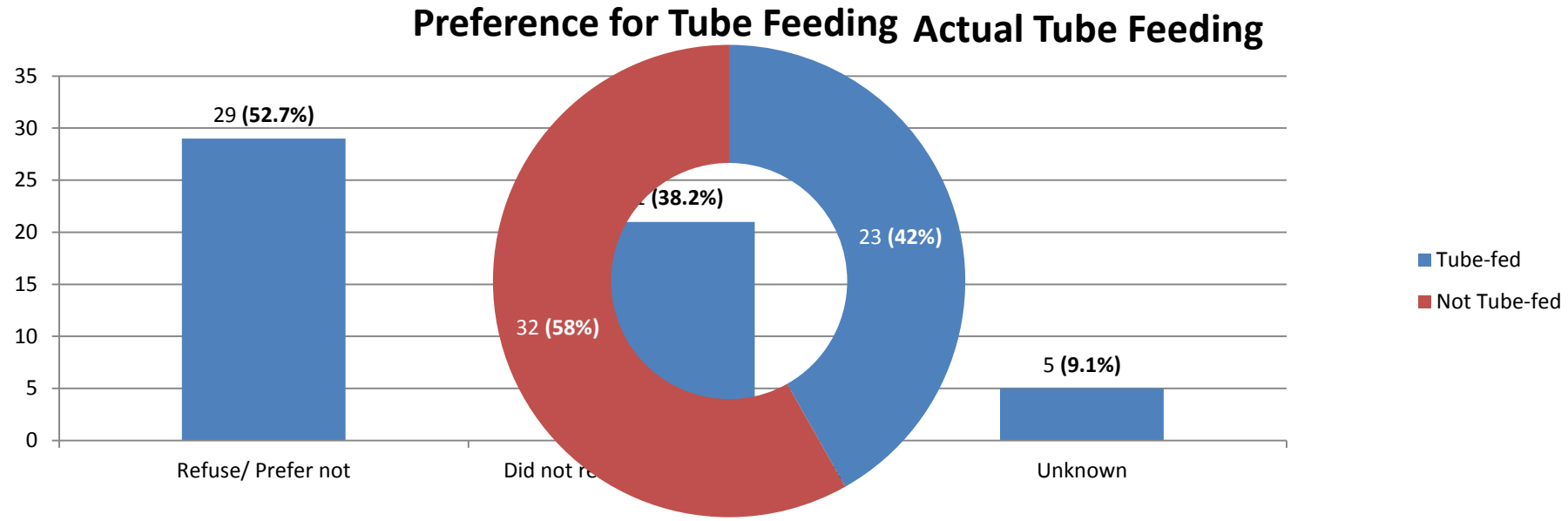
Tube Feeding n=55



2 patients had NG Tube Insertion against their wishes in the hospital before their deaths

Preference for Place where Death Occur

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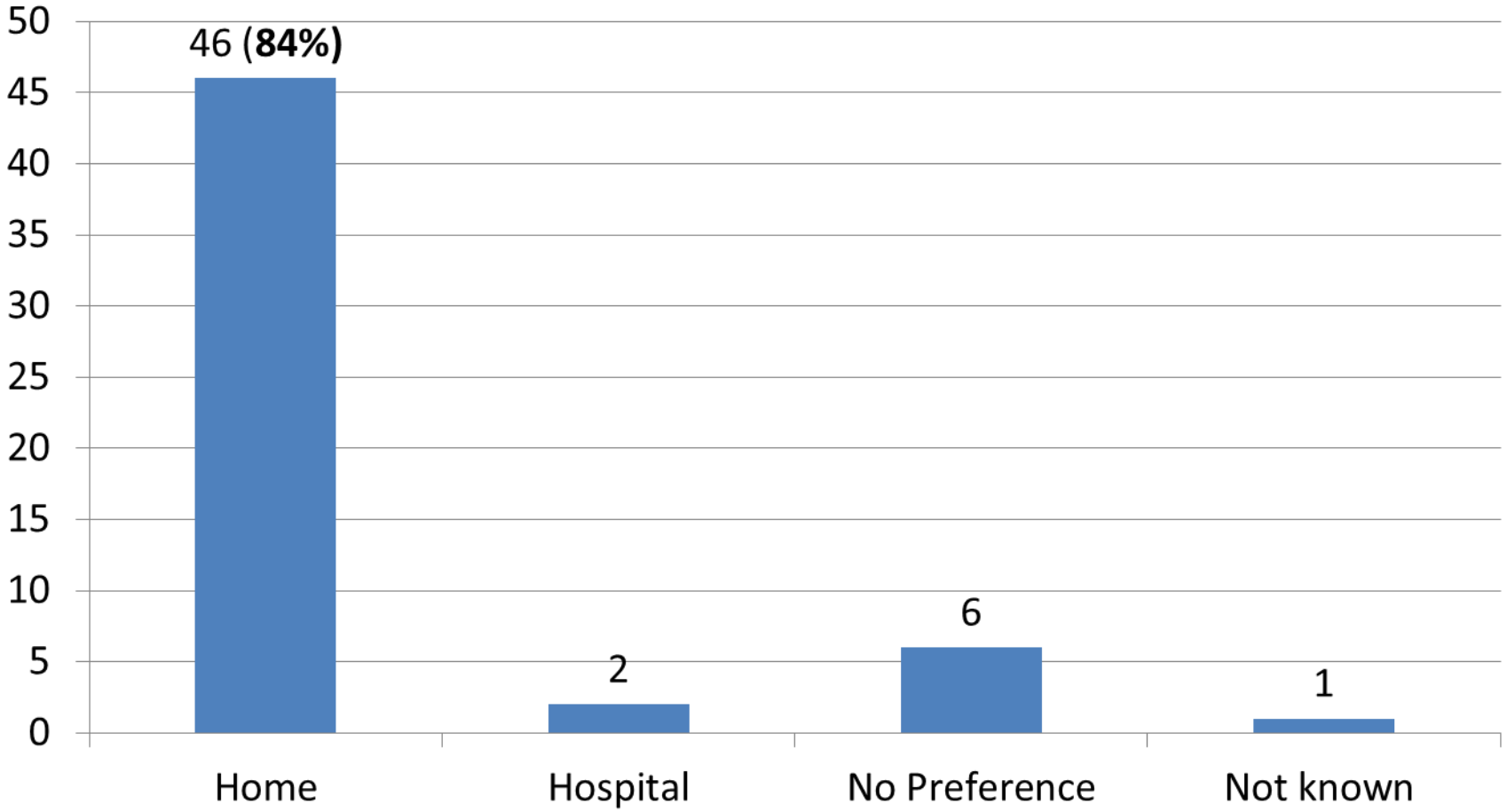

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Deaths

- 1 Oct 2010 – 30 Sep 2012
  - No. of Non-death Discharges = 4
  - Deaths = 36

Places where Deaths Took Place n= 36

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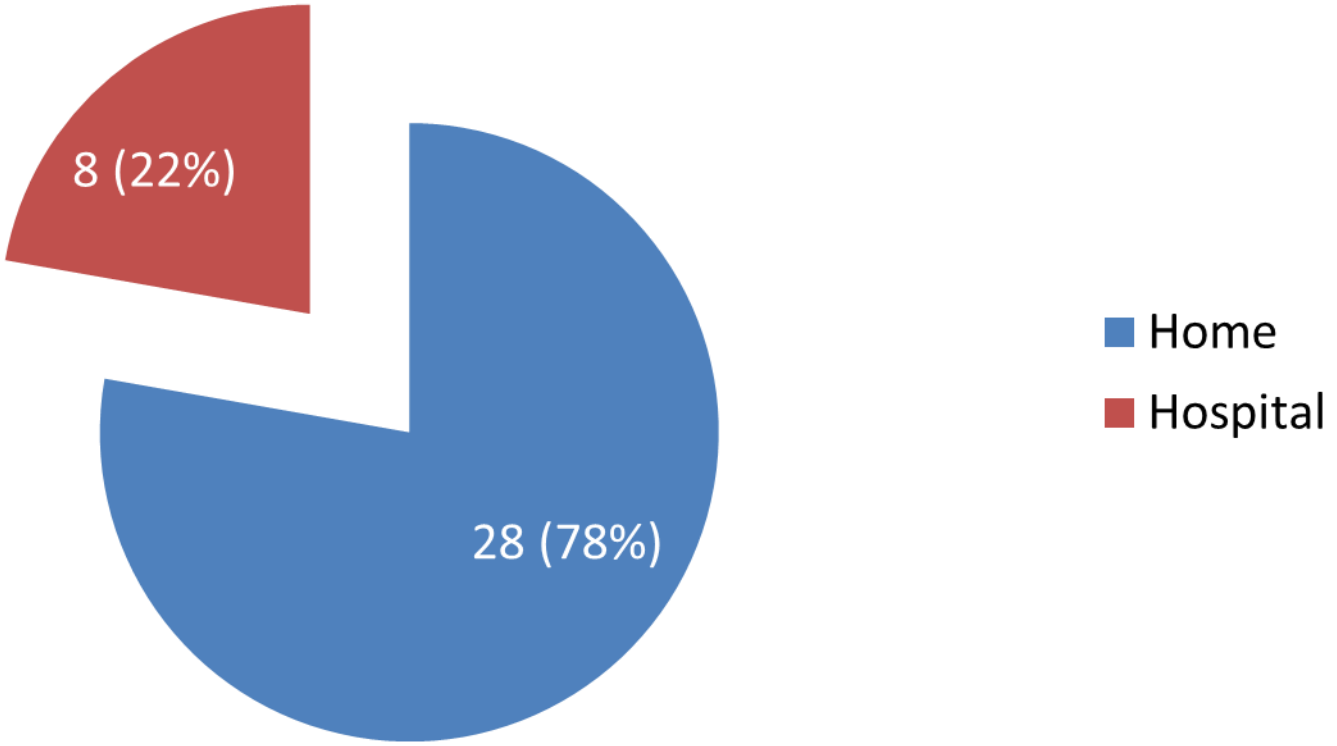

Number of Deceased who died in a Place against their Wishes = 5
3 were due to care givers' choice
2 lived alone

Symptoms in the Last Week before Passing (n=36)

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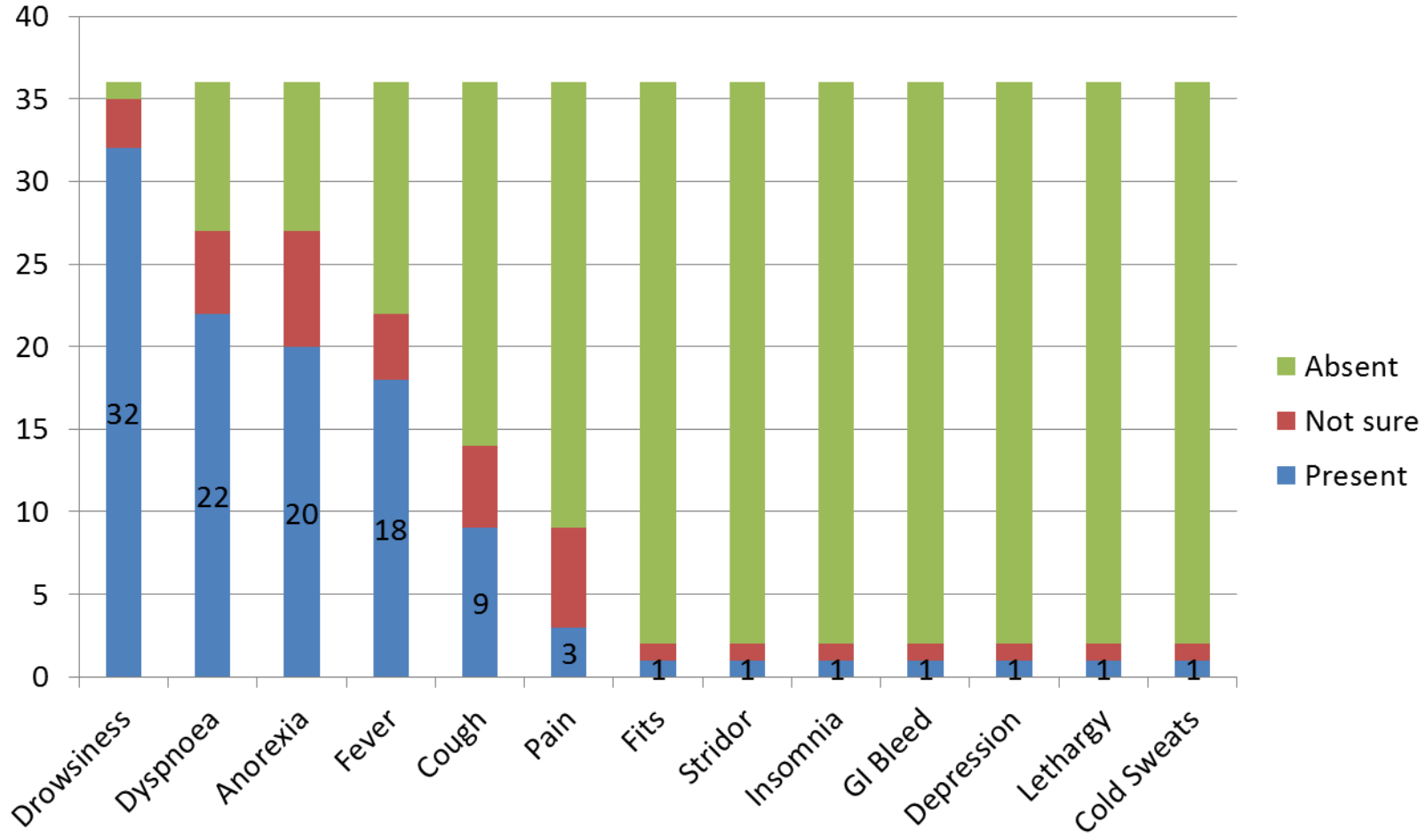

Cause of Death

n=36

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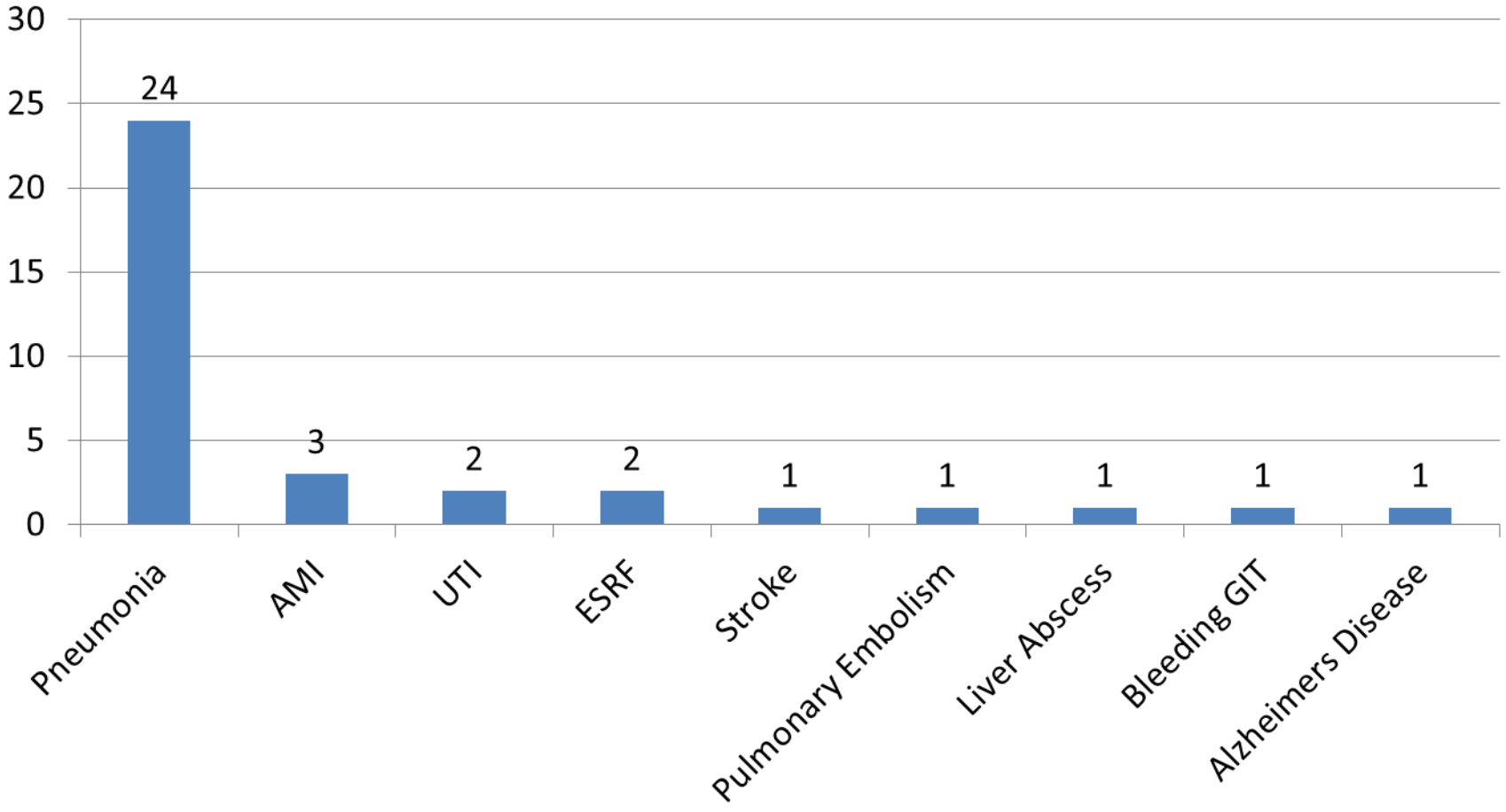

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Average Prognosis (Days)

- After admission into EoL Care Programme, death occurred after 173 days (5 months 22 days) on average.

Utilization Rate of Hospitals before Death after Admission to EoL Care Programme

n=36

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Service Utilization			Remarks
Acute Hospital Admissions	Total	25 admissions	
	Mean	1.5 per patient-year	25/36 *365/173
Length of Stay in Acute Hospital	Total	235 days	
	Mean	9 days	235/25 (discharges)
A&E Attendances	Total	25 attendances	
	Mean	1.5 per patient-year	25/36 *365/173
SOC Attendances	Total	6 attendances	
	Mean	0.4 per patient-year	6/35*365/173 (excluded 1 outlier with 22 SOC attendances)

Feedback by Telephone

(conducted Nov 2011 and Oct 12)

Phone survey among the Main Caregivers of Patients who have passed on from the Programme

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- Questions

  Q1. Do you feel supported by the team during this period?

  Q2. Are there any other areas that we could have supported you better?

  Q3. Do you feel that the patient had a good death?

  Q4. Is there anything else that you would like to share with me?

Q3. Do you feel that the patient had a good death?

n=36

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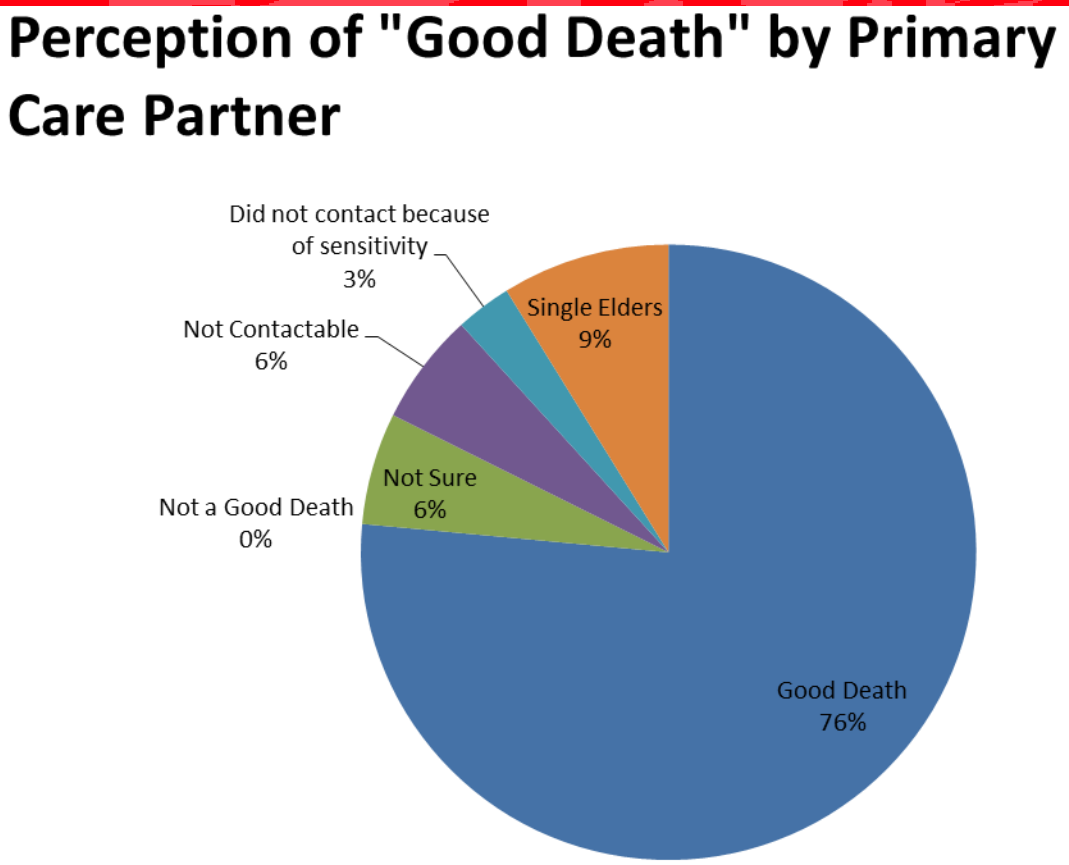

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Discussion

- This is our first attempt in codifying End of Life Care in a 'generalist' Home-based Long Term Care service
  - It is possible to deliver on palliative care for the long-term chronic sick population by a generalist non-hospice team
  - A cost-effective study might be helpful to establish if this could be a sustainable model of palliative care

- Majority of our patients suffer from Dementia and Cerebrovascular Diseases
  - A strong therapeutic relationship, person-centred care planning and timely communication family is pivotal
  - Nursing skills transfer and social workers' inputs in supporting informal care are the main interventions
  - Geriatric and psychogeriatric competencies are useful

- With ACP, timely communication and the focus on psychosocial support, majority of patients
  - can die in a place of their choice,
  - need not receive Tube Feeding against their wish,
  - are perceived to have died a good death by their families

- Specialist symptom management skills appear not to be an important competency-requirement
  - The mainstay of palliative care in home-based LTC seems to be the domain of visiting community nurses and social work care managers
  - Nevertheless, the support of doctors within the care team is crucial. These doctors need not be specialists in Palliative Medicine.
  - However, specialist Palliative Medicine consultation should be available from time to time

- Prognostication based on the American Medicare Local Coverage Determinations appear fairly accurate – as the average lifespan after admission falls within 6 months. May have implications on resource allocations
  - E.g. For Alzheimers Disease:
    - FAST 7a + 1 episode of fever within 1 year

Similarities and Differences between HMMC and most Home-based Hospice Programmes

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Similarities	Differences
Emphasis on Quality of Life – person-centred, rather than disease-centric	Trajectory of life and debility difficult to predict for the very frail. May be very long-drawn for years. Terminal stage not clear-cut
Multidisciplinary team in assessment, care planning and care delivery	Having multiple co-morbidities is the norm. Dementia is very common.
Emphasis on Symptom Management	Pain is less pronounced and may be less common
Focused on counseling and communication, and supporting informal care partners	As the terminal is not well-recognized, ethical dilemmas such as decision for tube-feeding and hospitalizations are frequently encountered

Advantages of Assimilating EoL Care within a Primary Care-LTC Service

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- Most older persons die in a frailty, 'dwindling' trajectory[1]. It would be too costly to provide specialist palliative care service for all of them.
- A primary care-LTC empowered and enabled to provide EoL Care may reduce the need for hospitalization[2]
- Minimizes the need for patients to switch between care settings and primary care providers
  - Therapeutic rapport between patient/ family/ care teams can be harnessed to improve quality of care

1. Lunney JR et al Profile of older Medicare decedents. J Am Geriatr Soc. 2002; 50:1108-1112
2. Report on the National Strategy for Palliative Care Oct 2011: Pg 24 Fig 6

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Thank You

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1. The late Dr Quek Hwee Choo for consistently conducting ACP and caring for the patients and their families
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