



Advanced Care Planning – Facilitating Rich End of Life Conversations

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What is a Care Manager?

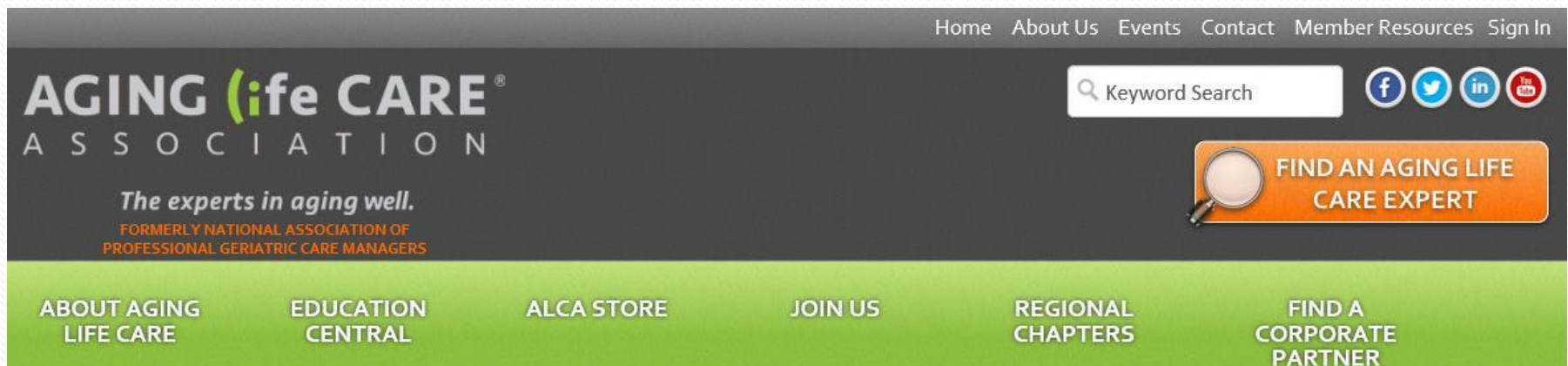
- They come from various backgrounds with Diverse qualifications, education, and experience.
- They professional who assists clients in attaining maximum functional potential and level of wellbeing
- Background - nurses, social workers, gerontologists or other health or mental health professional experienced and knowledgeable about issues of aging, disability and serious illness
- They are informed on community resources
- A problem solver who can both anticipate and respond to challenges of aging and related concerns (current and future)

What Can Care Managers Do?

- Holistically assess needs and develop a proactive **plan**
- Coordinate care and services (includes follow-up!) supporting Continuity of Care
- Act as a Liaison between client, providers, loved ones, fiduciaries, community resources, facilities, vendors, etc. (keeping everyone informed and on the same page)
- Promote health and prevent illness
- Advocate
- Monitor ongoing needs
- Link to services/resources
- Mediate family conflicts

How to Find a Care Manager

<https://www.aginglifecare.org>







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AGING (i)fe CARE[®]
ASSOCIATION

The experts in aging well.
FORMERLY NATIONAL ASSOCIATION OF
PROFESSIONAL GERIATRIC CARE MANAGERS

Keyword Search

 **FIND AN AGING LIFE CARE EXPERT**

ABOUT AGING LIFE CARE EDUCATION CENTRAL ALCA STORE JOIN US REGIONAL CHAPTERS FIND A CORPORATE PARTNER

Levels of Care

- Acute care – Hospital
- Skilled Care
 - Rehabilitation Facility • Nursing Home
- Custodial Care - ADL • Nursing Home
 - Home Care

What is Medicare?

- Health Insurance for those 65 and over as well as those with specific health conditions who are younger than 65 (e.g. ALS, End Stage Renal Disease)
- Part A – Hospital, Skilled Nursing, Hospice, some Home Health, lab tests
- Part B – Medical (e.g. Doctors' Services, Outpatient Care, Home Health, Durable Medical Equipment, Supplies, Advance Care Planning, etc.)
- Part C – Medicare Advantage (combines Parts A, B, C & D into one plan; provided by private insurance companies)
- Part D – Prescription (provided by private insurance companies)

Medicare Resources

- HICAP (Health Insurance Counseling and Advocacy Program) – through Council on Aging
- Offer free information on Medicare (bias free)
- <https://www.coasc.org/programs/hicap/>
- Hotline 800.434.0222
- OC 714.560.0424

Long Term Care

- Inability to perform the Activities of Daily Living (ADLs) without assistance
- Activities of Daily Living
 - 1. Bathing
 - 2. Dressing
 - 3. Toileting
 - 4. Continence
 - 5. Transferring/Ambulation
 - 6. Eating

Paying for Long Term Care

- Self-Insure (Net worth, cash flow, emotional & physical health, cost)
- Die before need for LTC assistance
- Live with Children
- Transfer cost to insurance company
- Apply for government benefits

LTC - Insurance

- Determine premium
- Indemnity policy
- Inflation protection
- Comprehensive policy includes residential care, home care, respite care, adult day care, nursing home care

LTC – Insurance continued

- • Avoid Specific Disease Policies
 - Determine financial health of insurance company •
- Who will file your claim?
- Age limit or pre-existing conditions
 - 30 days to rescind insurance contract

CA Partnership Policy

- Designed to protect Californians from being forced to spend everything they have worked for on LTC and to prevent or delay dependence on Medi-Cal
- • Partners – CalPERS & Genworth
- • www.RUReadyCA.org
- • All Partnership-approved policies are required to include:
 - • Inflation Protection
 - • Asset Protection
 - • Comprehensive Care Management • Rate Increase Regulation

LTC Policy Premiums

- Elimination period – 0-90 days or more (1 year) – no benefits paid
- Age – daily reimbursement amount (\$50 - \$500 per day)
- Length of Coverage (by year or lifetime), cover home care, adult day care, nursing home care

Medi-Cal

- Provides custodial care for people with low income and limited ability to pay (includes aged, blind, disabled, young adults and children, pregnant women, persons in a skill nursing or intermediate care home)
- Assets protected – home, vehicle, burial plan, \$1,500

Options for Long Term Care

- 1. Skilled Nursing Facilities
- 2. Assisted Living ranging from small 6 beds – to large multi-level facilities of hundreds of residents.
- 3. In-Home Care

H.E.L.P. (Healthcare and Elder Law Programs Corporation)

- www.help4srs.org
- Dedicated to empowering older adults and their families by providing impartial information, education and counseling on elder care, law, finances and consumer protection



The screenshot shows the H.E.L.P. website homepage. At the top left, there is a Facebook logo with the text "Find us on Facebook". To the right is a search bar with the placeholder text "Enter keywords...". The main heading "H.E.L.P." is in large blue letters, followed by the tagline "Empowering Seniors, their families, and caregivers to make better choices." Below this is a dark red navigation bar with white text for "Home", "About US", "Healthcare", "Legal", "Financial", "Our Services", "Forms & Tools", and "H.E.L.P. Classes & Events". The main content area features the text "Have a Problem?" in blue and "Need Assistance?" in red. A dark blue button on the right contains the white text "Click here to use our Community Resource Directory".

“Your Way”



- Think about what is important
- Obtain wanted medical care and avoid unwanted medical care
- Live life the way we choose
- Help our family and friends know what we want
- Help our family and friends do what we want
- “Your Way” can be used by individuals, families and friends
- “Your Way” can also be used by attorneys, care managers and other professionals to help their clients.

ACP & POLST

- The National POLST Paradigm is an approach to end-of-life planning that emphasizes patients' wishes about the care they receive. The POLST Paradigm – which stands for Physician Orders for Life Sustaining Treatment – is an approach to end-of-life planning emphasizing:
 - (i) advance care planning conversations between patients, health care professionals and loved ones;
 - (ii) shared decision-making between a patient and his/her health care professional about the care the patient would like to receive at the end of his/her life; and
 - (iii) ensuring patient wishes are honored.

Advance Health Care Directive vs. POLST

AHCD	POLST
<ul style="list-style-type: none">• For anyone 18 and older	<ul style="list-style-type: none">• For seriously ill or frail, at any age
<ul style="list-style-type: none">• General instructions for <i>future</i> treatment	<ul style="list-style-type: none">• Specific orders for <i>current</i> treatment
<ul style="list-style-type: none">• Names medical decision maker	<ul style="list-style-type: none">• Can be signed by decision maker

- Studies show that only about 25% of Americans have recorded their medical care wishes in a legal document.

- A recent poll found that common reasons include:
 - I don't want to think about it ... morbid, depressing, bad omen
 - I think it has to involve a lawyer
 - I'm not at that age
 - I think it costs too much
 - I don't know what to write
 - I'm intimidated by the forms

Why plan?



50%

*not able to make
own medical
decisions*

- *Default – treat aggressively even if not desired*
- *It's hard even for family members to predict patient wishes*

Source: Gundersen Lutheran Medical Foundation, 2002

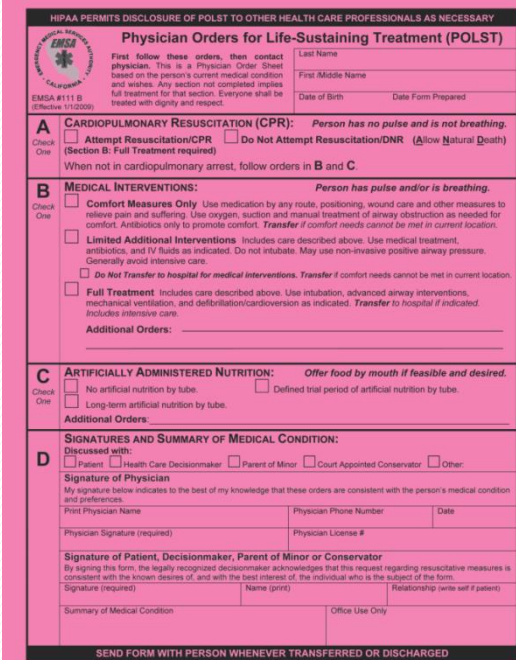
Advance Directives & the POLST Paradigm

Download your states specific forms here”

<http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289>

Review your states POLST Paradigm program status here

<http://www.polst.org/programs-in-your-state/>



The image shows a form titled "Physician Orders for Life-Sustaining Treatment (POLST)". At the top, it states "HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY". The form is divided into several sections:

- Section A: CARDIOPULMONARY RESUSCITATION (CPR):** Includes checkboxes for "Attempt Resuscitation/CPR" and "Do Not Attempt Resuscitation/DNR (Allow Natural Death)". A note specifies "Person has no pulse and is not breathing." and "(Section B: Full Treatment required)".
- Section B: MEDICAL INTERVENTIONS:** Includes checkboxes for "Comfort Measures Only", "Limited Additional Interventions", and "Full Treatment". A note specifies "Person has pulse and/or is breathing." and "Transfer if comfort needs cannot be met in current location.".
- Section C: ARTIFICIALLY ADMINISTERED NUTRITION:** Includes checkboxes for "No artificial nutrition by tube" and "Defined trial period of artificial nutrition by tube". A note specifies "Offer food by mouth if feasible and desired.".
- Section D: SIGNATURES AND SUMMARY OF MEDICAL CONDITION:** Includes checkboxes for "Patient", "Health Care Decisionmaker", "Parent of Minor", "Court Appointed Conservator", and "Other". It also includes fields for "Signature of Physician", "Physician Name", "Physician Phone Number", "Date", "Physician Signature (required)", and "Physician License #".

At the bottom, it says "SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED".

Hope is not a plan

When the plan is unclear, the default is to treat aggressively.

Family may be left with

- Uncertainty and stress
- Guilt or depression
- Financial concerns



Advance care planning tools

Conversation Tools

- Go Wish Cards
- The Conversation Project's Starter Kit
- CCCC's Advance Care Conversation Guide
- CCCC's Finding Your Way
- The last 2 are found at www.coalitionccc.org



the conversation project

Why create an Advance Health Care Directive?

- A way to make healthcare wishes known if you are unable to communicate
- Allows a person to do *either or both* of the following:
 - Appoint a decision maker -- a healthcare agent.
 - State instructions for future healthcare decisions.

Which document do I use?

- No single form for any state - Several to choose from
- Available from
 - Hospital social services or chaplaincy
 - Caring Connections (caringinfo.org)
 - 5 Wishes (27 languages translated)
 - <http://www.agingwithdignity.org/five-wishes.php>

Who do I choose as my agent?

- A person you trust to make the decisions **you** want
- Someone who is:
 - familiar with your values
 - willing and able
- *Does not have to be your closest family member*
- *Tell others who you chose*
- *Select an alternate*



What makes an Advance Directive legal?

- Your signature and the date
- The signatures of two witnesses or a notary
- If you are in a nursing home, the signature of the patient advocate or ombudsman

What types of instructions can be included in an Advance Directive?

- Where you would like to be when you die
- MD preference
- Accepting or refusing life-sustaining treatment
- Quality of life considerations
- Organ/tissue donation instructions

What do I do when I have completed my Advance Directive?

- Give a copy to your decision maker.
- Make copies for loved ones.
- Discuss it with doctor; get it in your medical record.
- Keep a copy yourself.
- Take it with you to the hospital.
- Photocopies are *just as valid* as the original.

Where do I keep my completed POLST form?

The original stays with you!

- At home:
 - Keep in easy-to-find location
 - Give to emergency medical services
- At a nursing home or hospital:
 - Filed in medical chart
 - Goes with you if you are transferred

Summary – POLST

- A voluntary form that transforms patients' wishes concerning medical treatment into medical orders.
- Is durable across the entire healthcare continuum
- Stays with the patient: Home, SNF, Hospital and during EMS transport.
- Is Valid for any patient!

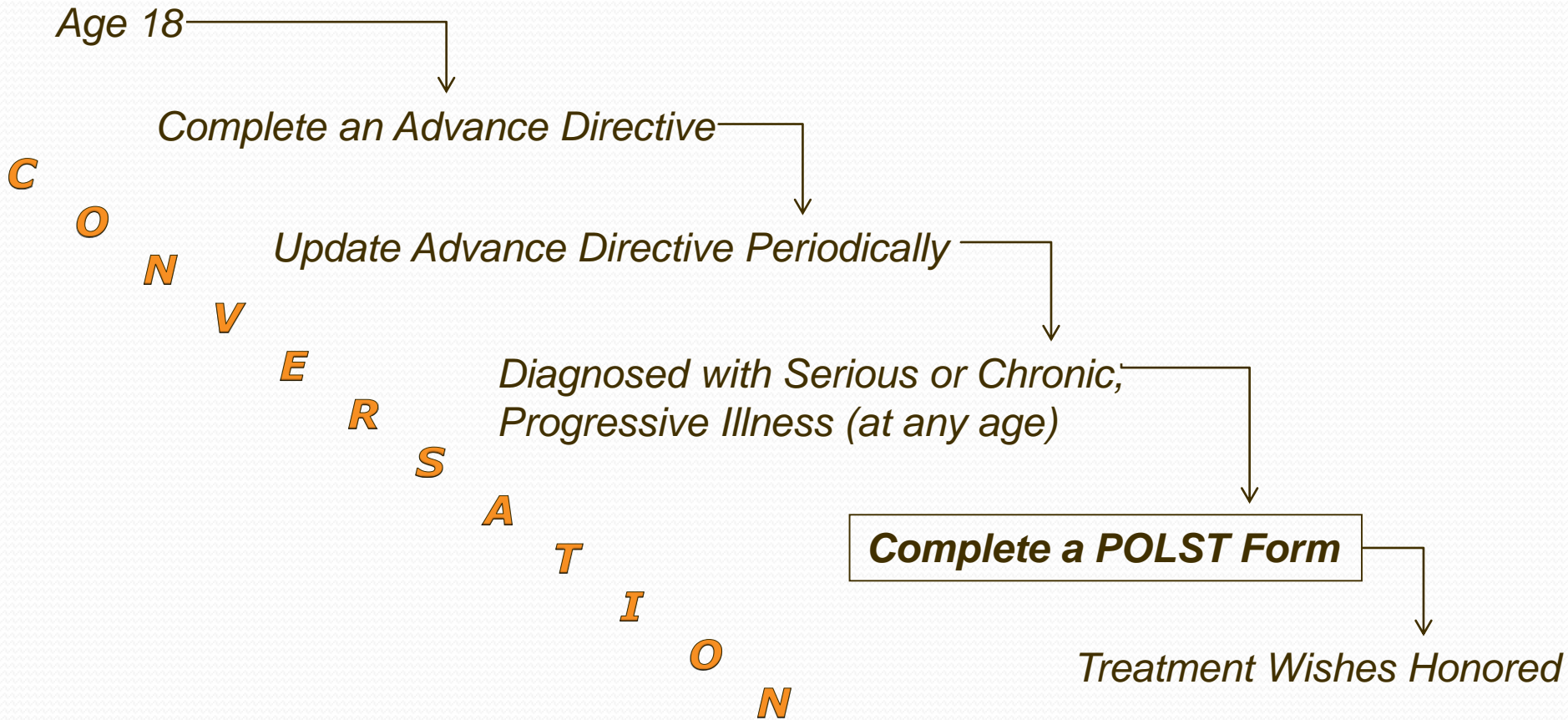
POLST continued

- Social Workers, case managers, nurses and other health care workers may help a patient complete POLST. **Just remember the physician must be involved in the conversation at some point to validate the wishes expressed.**
- Remember this is legally a Physician Order and must be followed.
- Although, it can be changed/updated according to the situation or patients desires.
- This does not completely replace a DPOA, it is still helpful to have an agent named for surrogate decision-making.

What happens if you don't have an Advance Directive?

- A physician or medical team will pick someone to make choices for you.
- This may be the person who is most available
 - The person who brought you in
 - The most vocal person
 - The person who visits the most often

Advance Care Planning Continuum



Palliative Care vs Hospice Care

- What is the difference?
- National Hospice and Palliative Care Organization
- www.nhpco.org
- Center to Advance Palliative Care www.capc.org

- Michael J. Demoratz, PhD, LCSW., CCM.
- Direct/Mobile – 949-355-6000
- mdemoratz@gmail.com
- Resources
- Being Mortal
- <https://www.youtube.com/watch?v=lQhI3Jb7vMg>
- www.capc.org Center to Advance Palliative Care
- www.polst.org National POLST Paradigm
- www.coalitionccc.org Coalition for Compassionate Care of California
- www.theconversationproject.org Conversation Project