Medical Care Planning

Presented By:
Tara Ackley, LVN, CMC, CDP
Nurse Care Manager

AgeWell Care Consultants

Expert Guidance For Peace of Mind and Aging Well

What is a **Care Manager** and how can they help with my care planning needs?

Tara Ackley, LVN, CMC, CDP
Nurse Care Manager
Age Well Care Consultants
PH (949) 878-5466
Email: tara@agewellcc.com

Also known as:
~ Geriatric Care Manager
~ Certified Care Manager
~ Life Care Manager
~ Elder Care Manager

Expert Guidance for Peace of Mind and Aging Well

Certified Care Managers were initially established in 1985 as being licensed clinical professionals who have experience, knowledge and training on issues specifically related to Aging, Disability or Serious Illness. (Nurses, Social Workers and Gerontologists)

NOTE: Today, there is no licensure specifically dedicated to becoming a certified care manager.

Skill Sets include: excellent communication, advocacy for client's best care, compassionate, adaptable to change, builds trust, proactive, collaborative, offers and coordinates with local resources, multi-tasking, team player, serves as liaison, family mediator, solution oriented, offers education, supportive, leader, cheerleader, and more.

How Does A Nurse Care Manager Help?

- Assessing: Identify specific currant needs and future needs to develop a Comprehensive Care Plan
- Coordinate Care: Initiate and follow a variety of services that support Continuity of Care and Quality of Life
- Liaison Role: serve with the Client, the Family, the Physicians, the Medical Therapies, the Primary Caregivers, other professionals such as Fiduciaries, DPOA's, other Vendors, Offering consistent Communication to supports that foster teamwork, always focused on the end goal.
- Promote: Safety, Health Strategies, Quality of Life, Informed Decisions, Clarity and Peace of Mind
- Advocate: for Clients Rights and Choices, Wishes and Desires
- Monitor: the ever-changing Care Plan and hold a Long-View Perspective
- Guide and Connect: to various concierge or community services/resources
- Assist with Medications: Organize medications, track multiple refills and offer patient Education
- Ongoing Monitoring: Watching for changes in the present while preparing for adjustments for Future Planning

Find your personal Professional Geriatric Care Manager HERE:

https:/AgingLifeCare.org

Recognizes 8 Domains of Knowledge: Health/Disability, Financial, Housing, Local Resources, Advocacy, Legal, Family Support, and Crisis Intervention

AGING (ife CARE®
ASSOCIATION
The experts in aging well.

HEALTHCARE MANAGEMENT | ADVOCACY | SUPPORT

Medical Care Planning In Action

Finding Your Personal Care Navigator
Understanding Care Levels
Understand Medicare Insurance Coverage
Consider Options for Care Settings
Action for Advance Care Planning: from This Day and to the Last Day
Find Your Local Resources
Options for Long Term Care
Navigating End of Life Care

Understanding Types of Levels of Care:

1. **Acute Care: an occurrence that requires emergency care of hospitalization**
2. **Skilled Nursing Care:** A lesser level of nursing care after emergency or hospital care. Commonly referred to as Post Acute Care, Rehabilitation Care or Long-Term Nursing Care
3. **Custodial Care or Assisted Care:** the lesser level of patient care after emergency care, hospitalization, and post acute nursing care. **NOTE:** This level of care does not involve daily following by clinicians such as nurses or doctors, yet it does offer non-medical assistance for the basic activities of daily living such as bathing, dressing, toileting, personal hygiene, walking, transfer to bed or chair, incontinence and medication assistance. This sort of **Custodial Care** service is not covered by insurance and is usually provided in a private home environment, or in assisted living communities or in small licensed residential homes.

What is covered by Medicare? A-B-C-D

The traditional Medicare benefit is a federally funded health insurance benefit, designated for adults 65 and over, as well as those with specific debilitating health conditions for those younger than 65 (e.g. Amyotrophic Lateral Sclerosis, End Stage Renal Disease)

- **Part A** – Hospitalization, 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 Plans (combines Parts A, B, C & D into one plan; provided by private insurance companies). Contact a Medicare Specialist for details
- **Part D** – Prescriptions (provided by private insurance companies)

Go to
www.Medicare.Gov
for everything you need to know about your Medicare benefits.

Council On Aging
in Orange County, CA

Health Insurance Counseling & Advocacy Program (HICAP):

a local public resource where you can speak with an unbiased community person with knowledge and facts about all types of Medicare insurance plans.

Go to: www.coasc.org

Call (714) 560-0424

Options for Paying for Long Term Care:

- A Long Term Care Policy may outlast the Policy Holder: Death often occurs before the need for LTC assistance
- Self-Insure (Net worth, cash flow, emotional & physical health, cost)
- Move In with Family: Live with your Children
- Transfer cost to insurance company
- Long Term Care Insurance
- Apply for government benefits

Eligibility for Long Term Care Insurance:

Proving an inability to perform the Activities of Daily Living (ADLs) without assistance.

List of basic Activities of Daily Living (ADL's):

1. Bathing
2. Dressing
3. Toileting (safely managing self hygiene)
4. Continence (control of bowel or bladder)
5. Transferring/Ambulation (safely moving up and around)
6. Eating (feeding self, swallowing)

Options for Long Term Care:

Skilled Nursing Home: provides around-the-clock care with doctors, nurses, multiple therapies, along with caregiving in a medical environment.

Assisted Living: does not provide nurses or physicians. Does offer around the clock caregiving support with caregivers in a non-medical setting.

In-Home Care: does not provide doctors or nurses. Does provide caregiving support in the private home setting from 4 hrs to 24 hours per day in a private home setting.

Advanced Life Care Planning

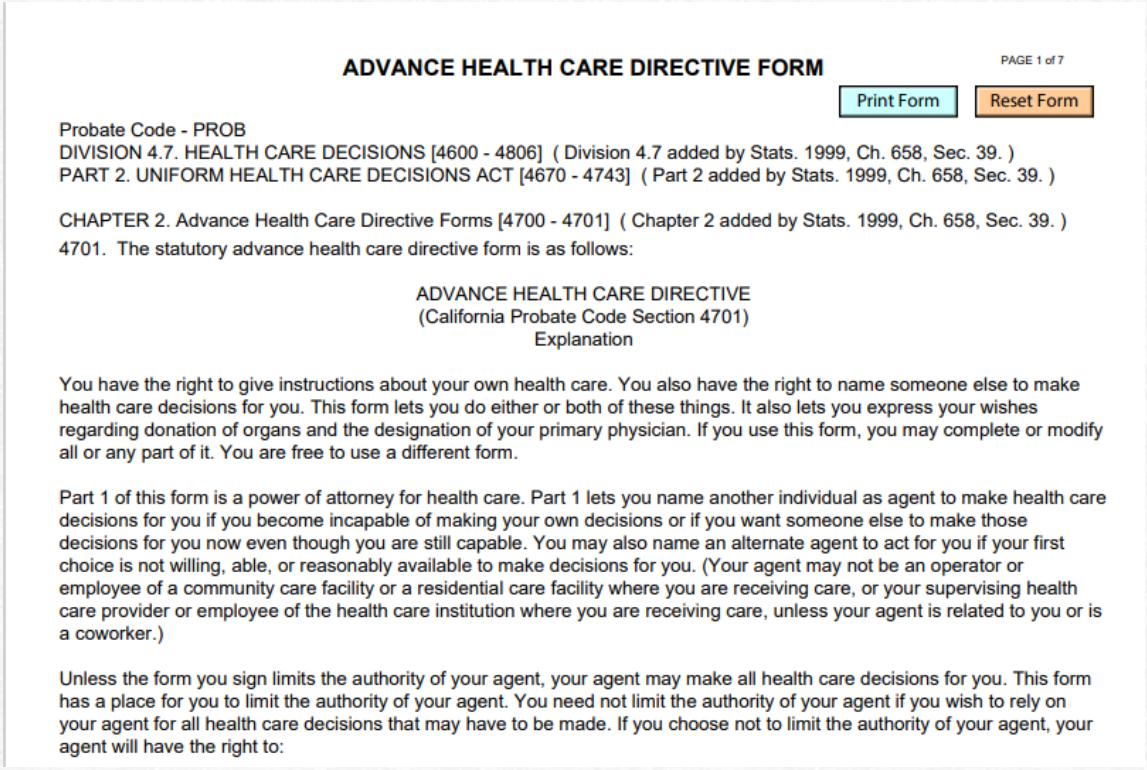
Advanced Life Care Planning

Advance Care Planning involves making a plan for your decisive healthcare wishes, in advance.

- Advance Health Care Directive (AHCD)

The AHCD Document is very important for You, your Agent, and for your first responders in an emergency

The Conversations about YOUR Preferences are even **more** important.



ADVANCE HEALTH CARE DIRECTIVE FORM

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Print Form | Reset Form

Probate Code - PROB
DIVISION 4.7. HEALTH CARE DECISIONS [4600 - 4806] (Division 4.7 added by Stats. 1999, Ch. 658, Sec. 39.)
PART 2. UNIFORM HEALTH CARE DECISIONS ACT [4670 - 4743] (Part 2 added by Stats. 1999, Ch. 658, Sec. 39.)

CHAPTER 2. Advance Health Care Directive Forms [4700 - 4701] (Chapter 2 added by Stats. 1999, Ch. 658, Sec. 39.)
4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)
Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

SAMPLE: From the State of CA - DOJ

Sources for Advance Health Care Directive

1. **State of CA Department of Justice**

   https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf

2. **CA Medical Association**
   https://www.cmadocs.org/store/info/productcd/AHCD_ENG/t/advance-health-care-directive-kit-english 1-800-786-4262

3. **Veterans – Contact local VA office for an advance directive specifically for veterans**

   https://www.va.gov/contact-us/#contact-your-local-va-facility

Have it . . .“Your Way”

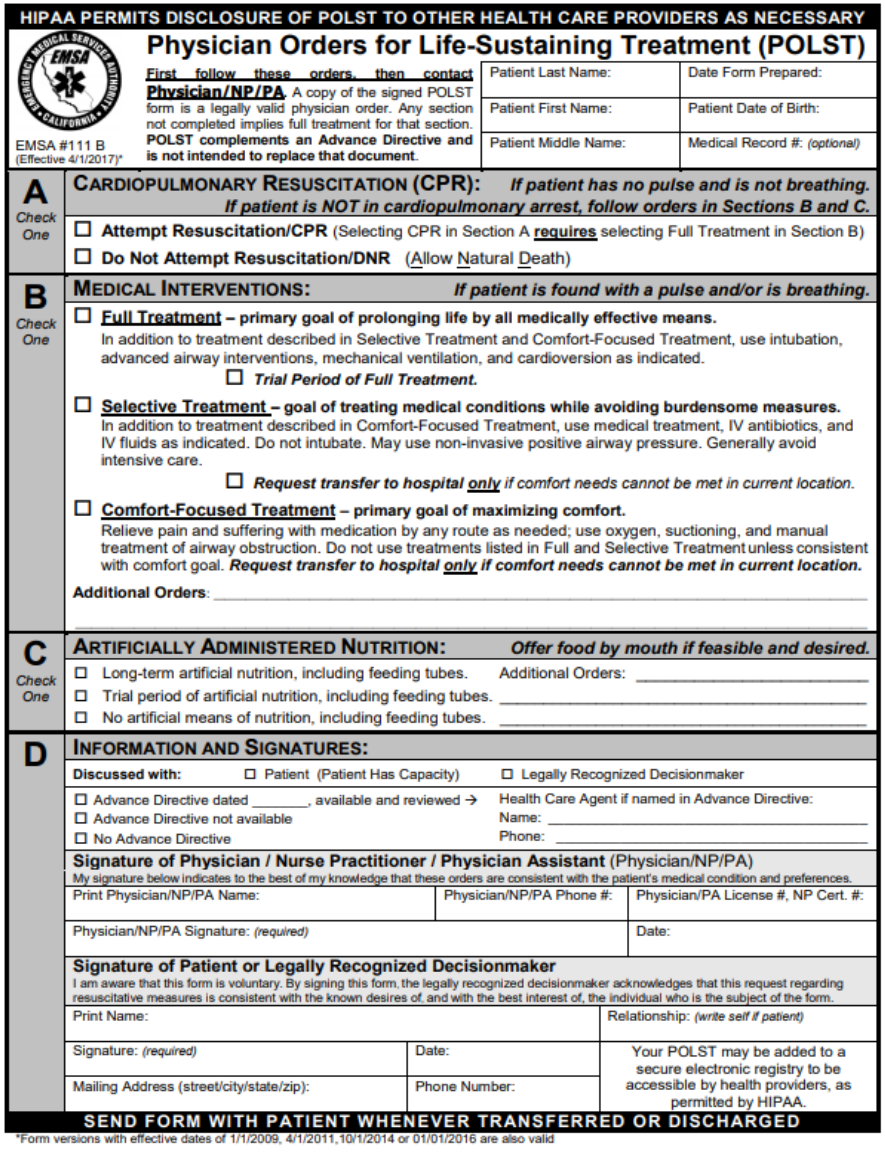
- Think about what is really important to you.
- Obtain wanted medical care and avoid unwanted medical care.
- Live life the way YOU choose.
- Help your family and friends know what you want and carry out steps to support what you do want.
- The “Your Way” workbook can be used by individuals, families and friends.
- The “Your Way” workbook can also be used by attorneys, care managers and other professionals to help their clients
- Go to https://www.help4srs.org/your-way/

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

- 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

(POLST)
Physician Orders For
Life Sustaining Treatments

www.capolst.org



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B *Check One*

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
☐ Trial period of artificial nutrition, including feeding tubes. _____
☐ No artificial means of nutrition, including feeding tubes. _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

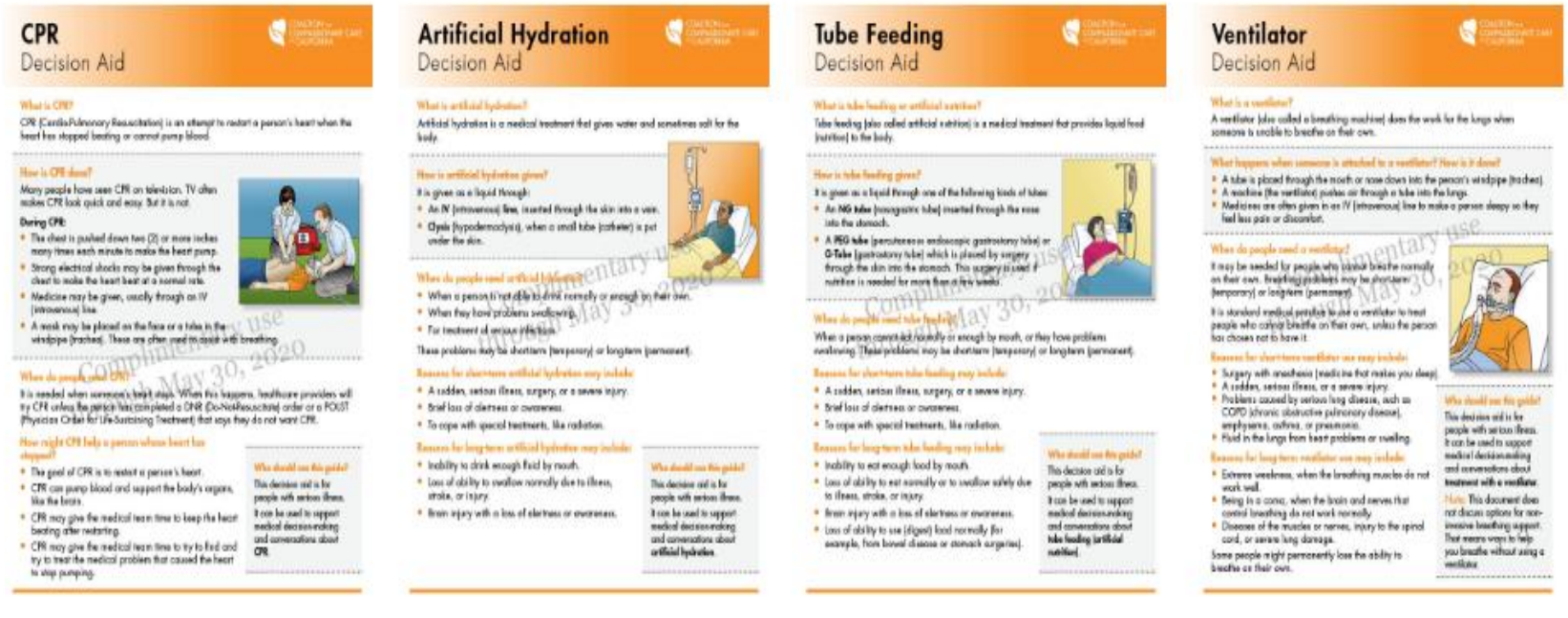
*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

Coalition for Compassionate Care of California

Support to explore patient wishes for care towards end-of-life, express these wishes and have wishes honored (www.CoalitionCCC.org)

- Helping you make knowledge-based decisions.

Healthcare Decision Aids



Palliative Care & Hospice Care

- How are these services different?
- Palliative Care is an insurance-based benefit that help you manage symptoms that are associated with a chronic or progressive disease while Hospice Care is an insurance-based benefit that helps support the management of symptoms associated with an end-stage disease and within a life expectancy of six months or less.
- Resource:
  - National Hospice and Palliative Care Organization www.nhpco.org

How To Find Your Personal Certified Care Manager?

AGING (ife CARE®
ASSOCIATION
The experts in aging well.

https://www.aginglifecare.org

Ask a Certified Care Manager

Tara Ackley, CMC, LVN, CDP

Nurse Care Manager

Age Well Care Consultants

Cell: 949.878.5466

Email: Tara@AgeWellCC.com