Advanced Care Planning – Facilitating Rich End of Life Conversations

By: Michael Demoratz, PhD, LCSW, CCM

mdemoratz@gmail.com

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

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

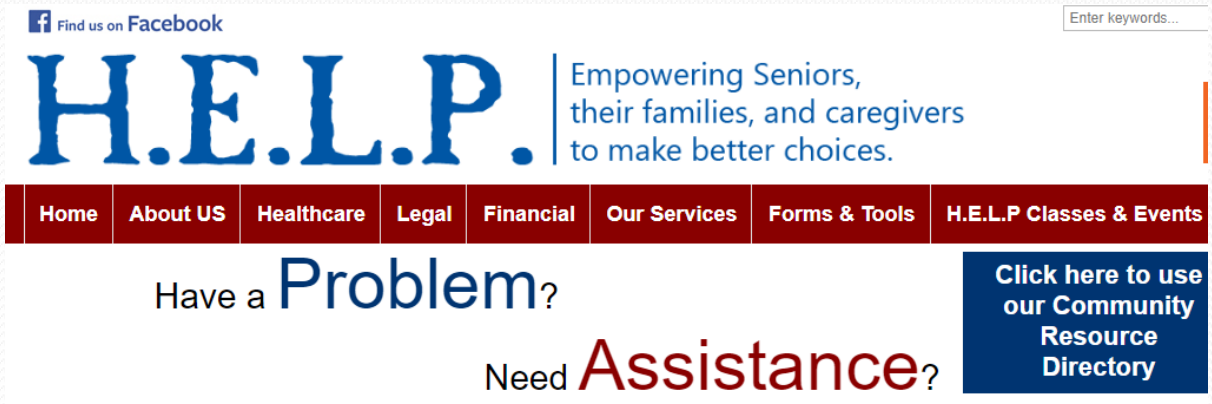
- • Provides custodial care for people with low income and limited ability to pay (includes aged, blind, disabled, young adults and children, pregnant women, persons in a skill nursing or intermediate care home)
- • Assets protected – home, vehicle, burial plan, $1,500

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



“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
• For anyone 18 and older	• For seriously ill or frail, at any age
• General instructions for ***future*** treatment	• Specific orders for ***current*** treatment
• Names medical decision maker	• 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

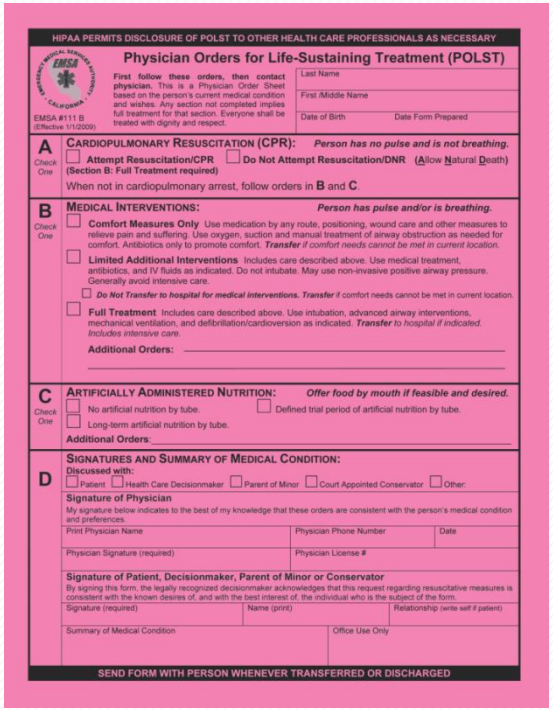
Advance Directives & the POLST Paradigm

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/



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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name | First /Middle Name | Date of Birth | Date Form Prepared

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse and is not breathing.*

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

(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B Check One — **MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name | Physician Phone Number | Date

Physician Signature (required) | Physician License #

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

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.

Signature (required) | Name (print) | Relationship (write self if patient)

Summary of Medical Condition | Office Use Only

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!

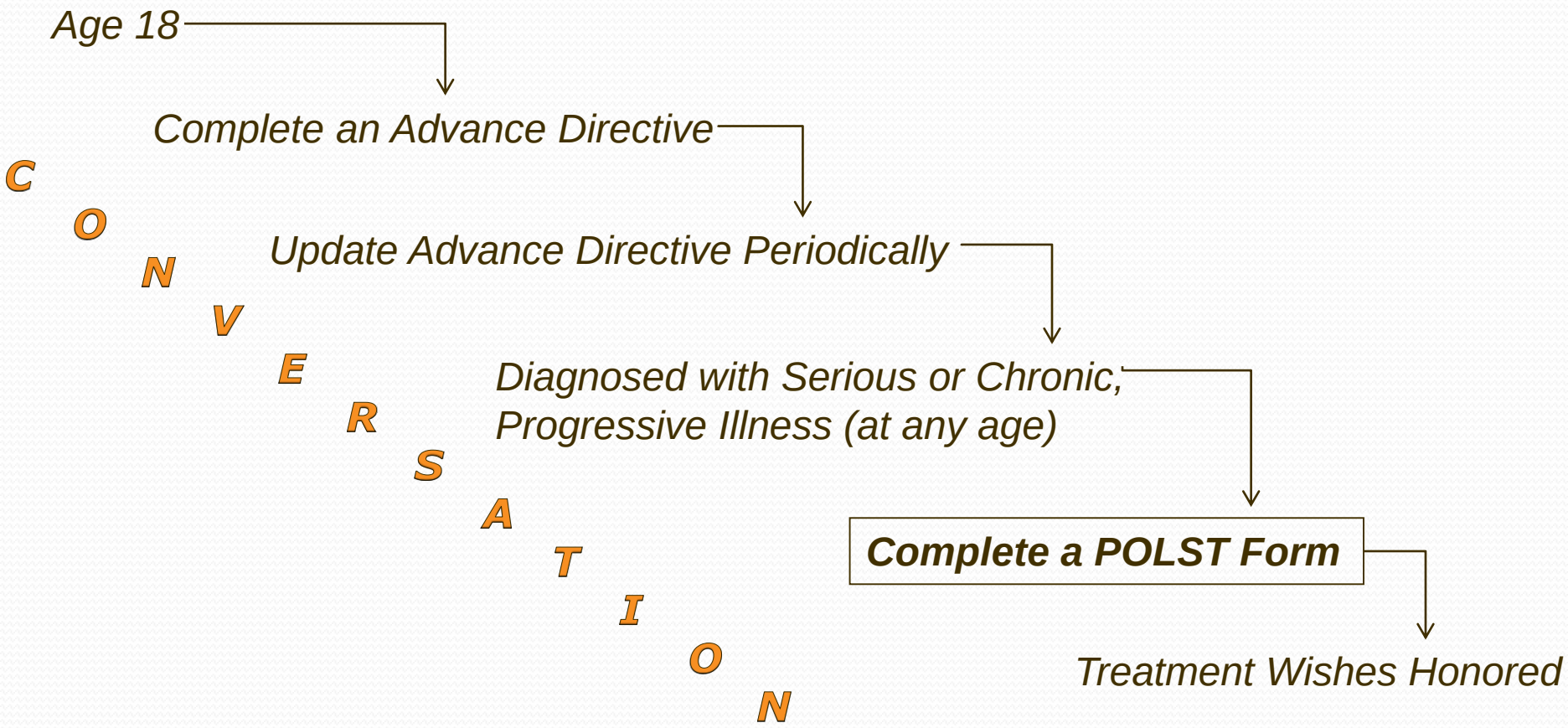
POLST continued

- 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