PALLIATIVE CARE

in Estate Planning

ABOUT US

- Dorothy Lippman NP, MSN retired after 40 years in nursing, founded the Palliative Care Service at Providence St Jude Medical Center in 2003

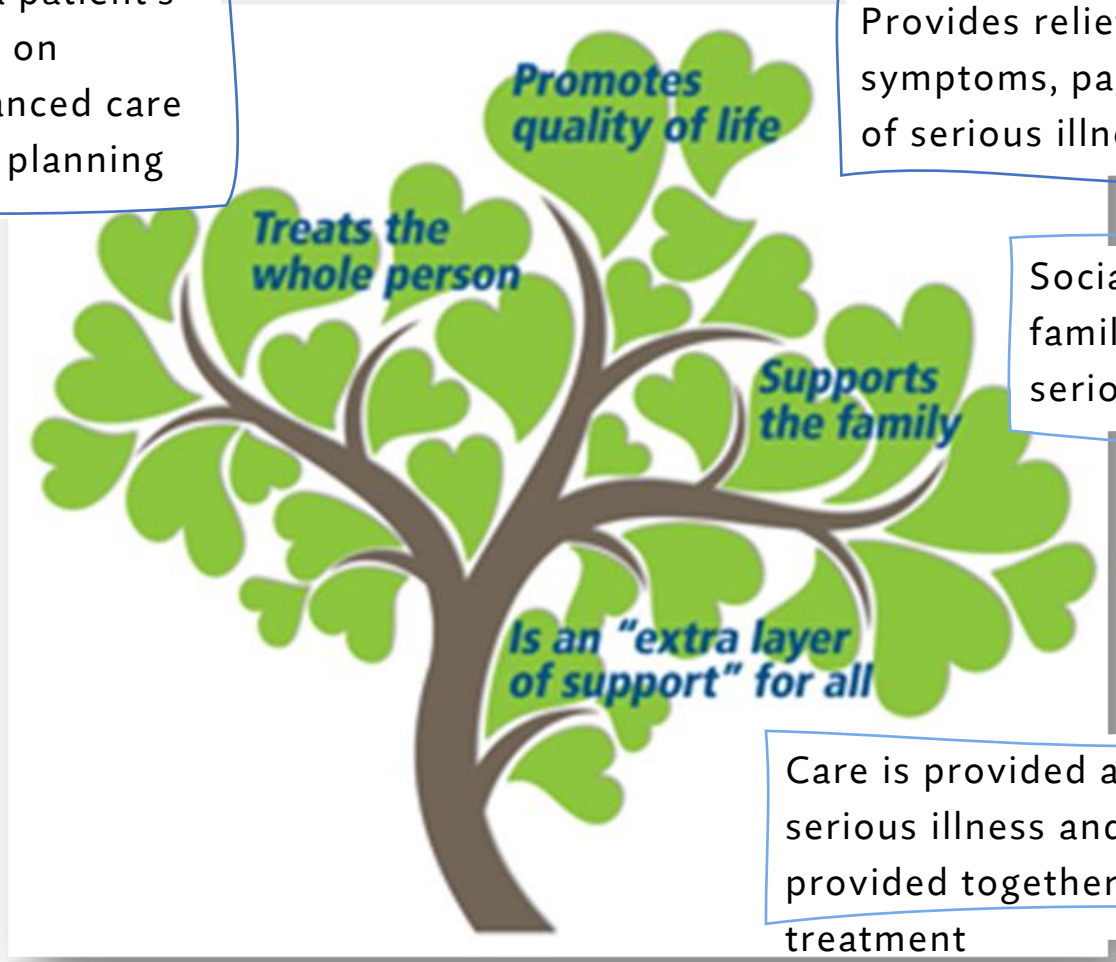
- Gloria Franklin, NP, MSN is a Nurse Practitioner and the manager of Palliative care at Providence St. Jude Medical Center. She has worked in Pain and Palliative care for the past 21 years.

INTRO

- What are your healthcare wishes?
- How to get started?
- Conversations with Family
- Easing Suffering

PALLIATIVE CARE

Looks at all aspects of a patient's life, provides education on disease processes, advanced care planning and safety net planning

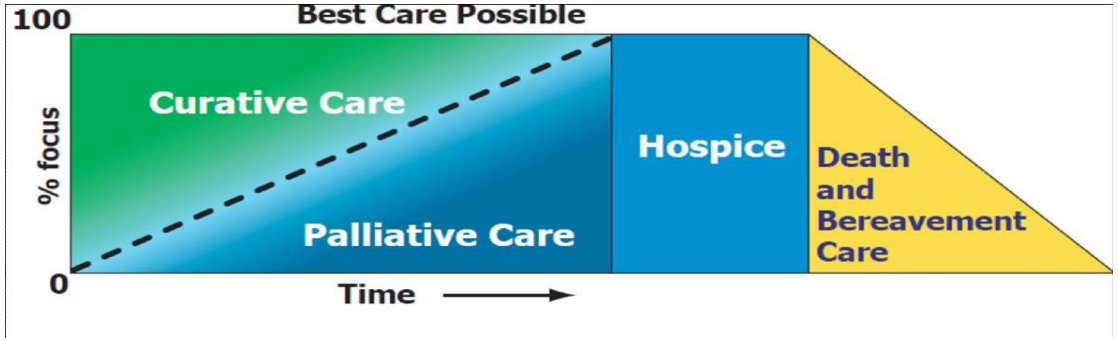


Provides relief of symptoms, pain and stress of serious illness

Social and Spiritual support for families of patients with serious illness.

Care is provided at any stage in a serious illness and can be provided together with curative treatment

WHAT IS THE DIFFERENCE?

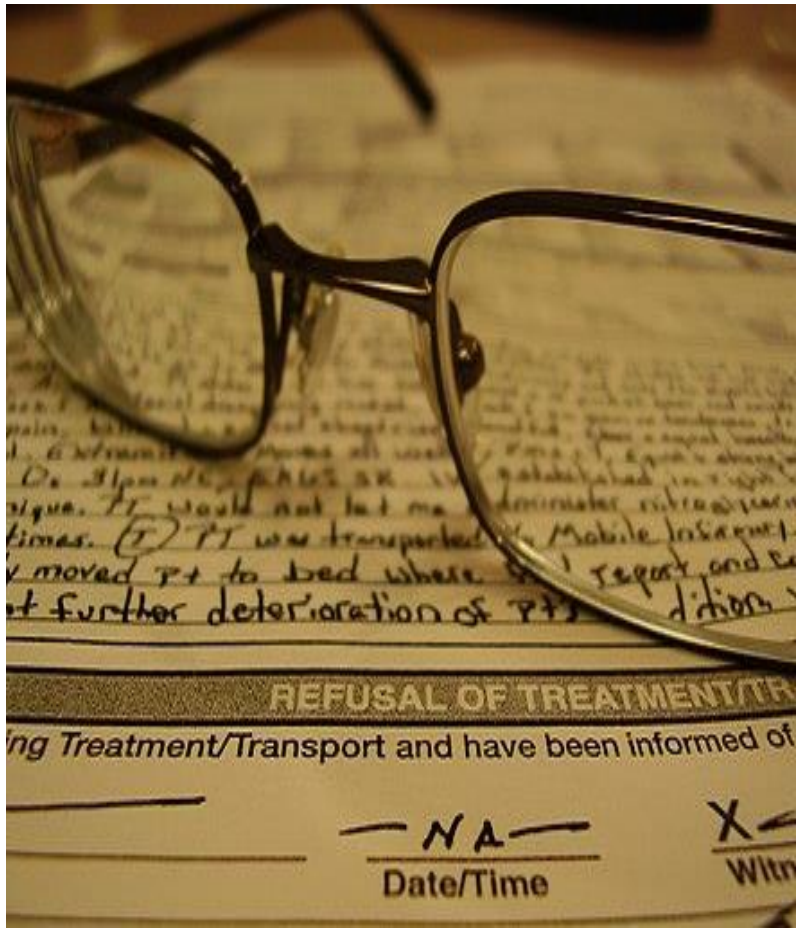


Palliative Care

- Improve quality of life for patients and families facing life-threatening illness
- Begins early, and continues while receiving curative treatment
- Manages pain and other symptoms, and psychological and spiritual distress.

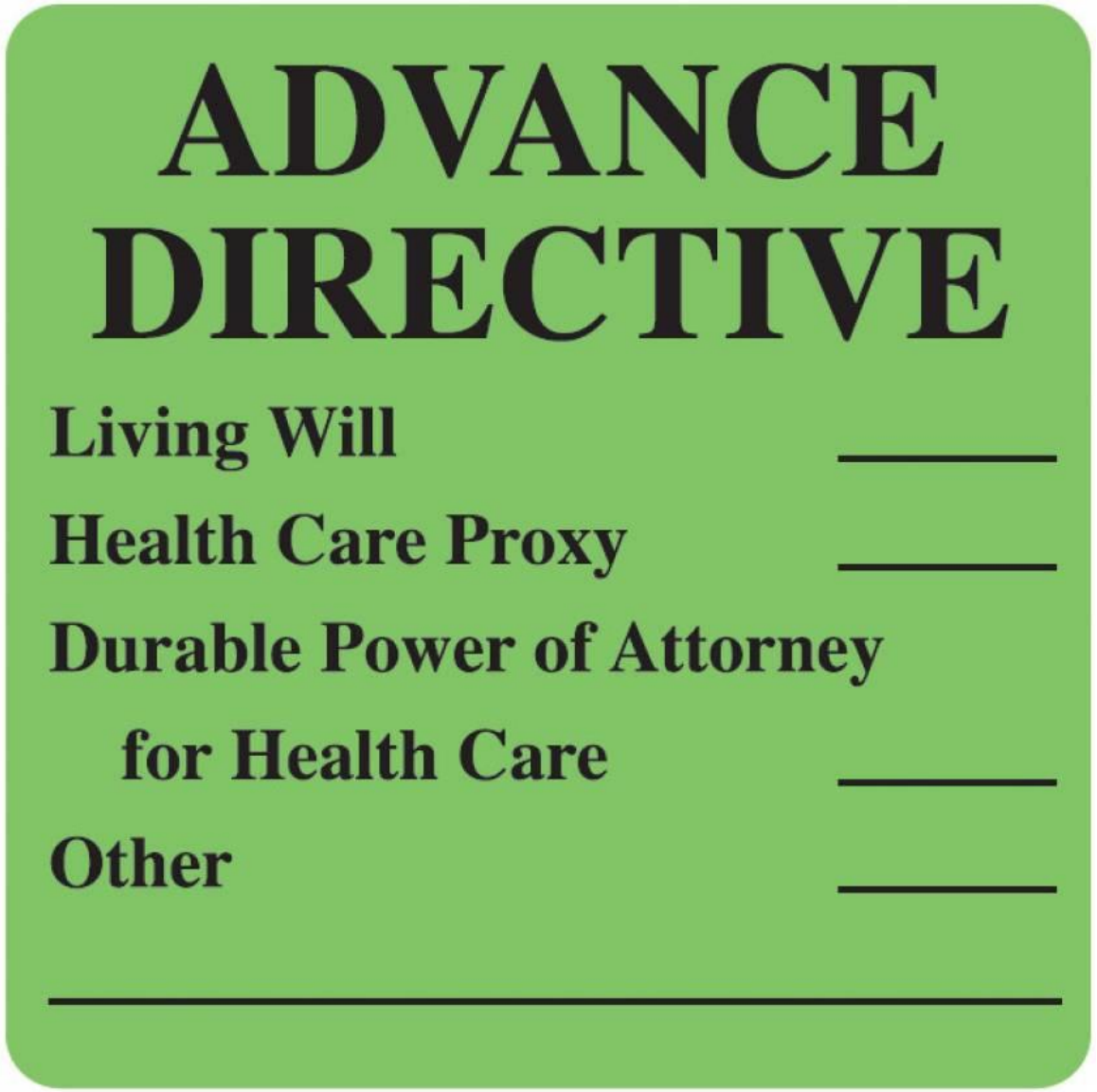
Hospice

- Care for patients that are no longer seeking curative treatment
- Last 6 months of life
- Manages pain and other symptoms
- Care brought to the home or care facility



ADVANCED HEALTH CARE DIRECTIVE

- A legal document that provides instructions for the type of medical care that you would, or would not, want for yourself if you are unable to speak for yourself
- Should be completed by any competent adult, who is at least 18 years old
- To become a legal document, it must be notarized OR signed by two qualifying witnesses
- Where do I get one? https://www.instituteforhumancaring.org/Advance-Care-Planning.aspx



CLARIFYING TERMINOLOGY…

LIVING WILL:

Document that outlines a patient's future wishes for medical care – particularly important when a person does not have capacity to make their own wishes known
(Also known as personal directive, advance directive, medical directive or advance decision)

DURABLE POWER OF ATTORNEY:

- An agent that has been appointed to make decisions on behalf of another person
- Also known as *healthcare proxy*

ADVANCE DIRECTIVE FOR HEALTHCARE:

In California, this legal document addresses the individual instructions for healthcare (living will portion), and DPOA section - appoints an agent(s).
(Differs from state to state)
Also includes a section regarding organ donation and PCP.

WHY DO I NEED AN ADVANCE DIRECTIVE?

Video

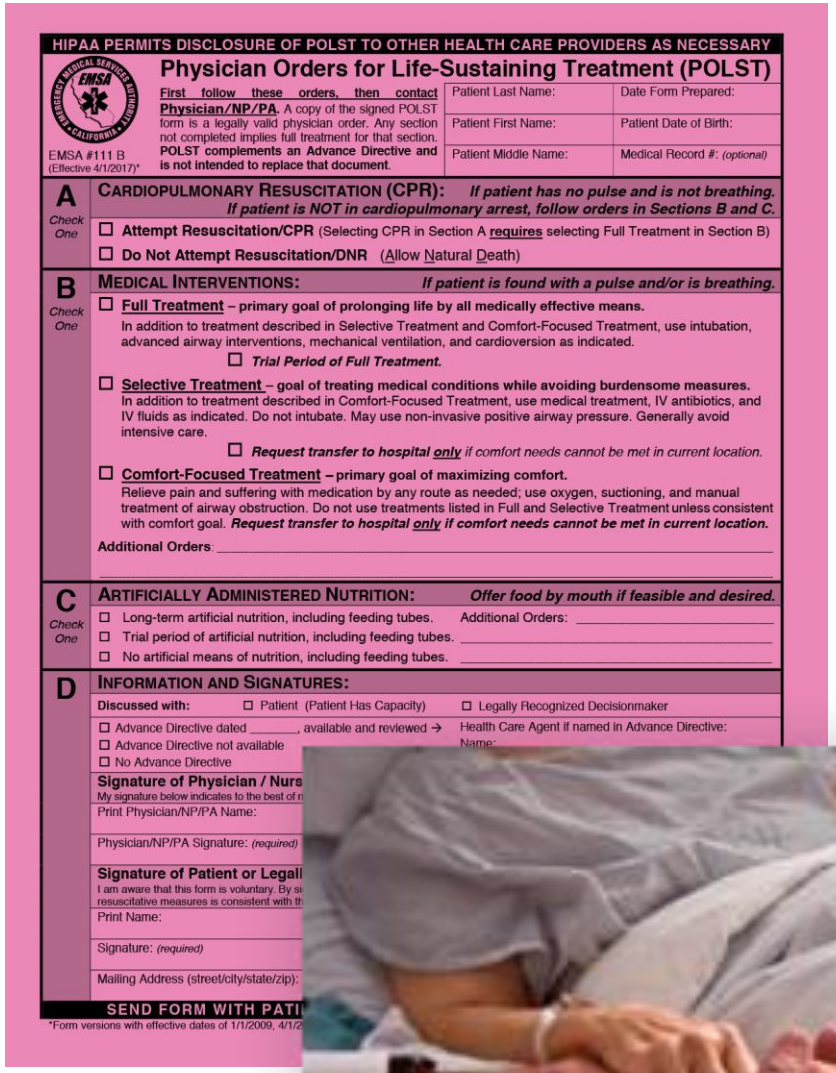
CHOOSING A HEALTHCARE SURROGATE

What happens if you can't make your own healthcare decisions?

Who would follow your wishes and advocate for you?

Who should speak for you? Video

ADVANCED CARE HEALTH DIRECTIVE VS POLST



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

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)

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

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 → Health Care Agent if named in Advance Directive: Name:
☐ Advance Directive not available
☐ No Advance Directive

Signature of Physician / Nurs
My signature below indicates to the best of
Print Physician/NP/PA Name:
Physician/NP/PA Signature: (required)

Signature of Patient or Legal
I am aware that this form is voluntary. By s
resuscitative measures is consistent with th
Print Name:
Signature: (required)
Mailing Address (street/city/state/zip):

SEND FORM WITH PATI

*Form versions with effective dates of 1/1/2009, 4/1/2

POLST

Physician Order for Life Sustaining Treatment

- Needed if you have a serious illness
- Used by EMS in the event of an emergency
- Specific orders for current treatment:
  - CPR
  - Medical Interventions
  - Artificial Nutrition

AHCD

Advanced Health Care Directive

For anyone 18 and older

General instructions for future treatment

Not effective in a medical emergency

Determines a decision maker

SAFETY NET PLANNING

WHY SAFETY NET PLANNING?

Recurrent medical events crises and progressive debility are **predictable** in patients with severe or progressive medical conditions.

The Question is not IF. The Question is WHEN.

When will I have a recurrent issue with a physical symptom or a flare up of my chronic disease?

When will I need assistance with:

- Self-care
- Household tasks
- Transportation

HOPE IS NOT A STRATEGY

WHAT IFS?

Planning for the **WHAT IFs** –

- Is this negative thinking?
- Inviting bad vibes or causing negative events to happen?
- Can't we just maintain a positive attitude and hope? for the best?

YES, WE CAN!

YES, we can continue to hope for the best –
No flare ups, No disease progression, No debility, and No disability
AND we also need to have a plan to prevent a crisis.

PLANNING MATTERS

Last minute management, dealing with things as they happen, leads to rushed decisions made under pressure and increase the risk for adverse outcomes.

SAFETY NET PLANNING QUESTIONS

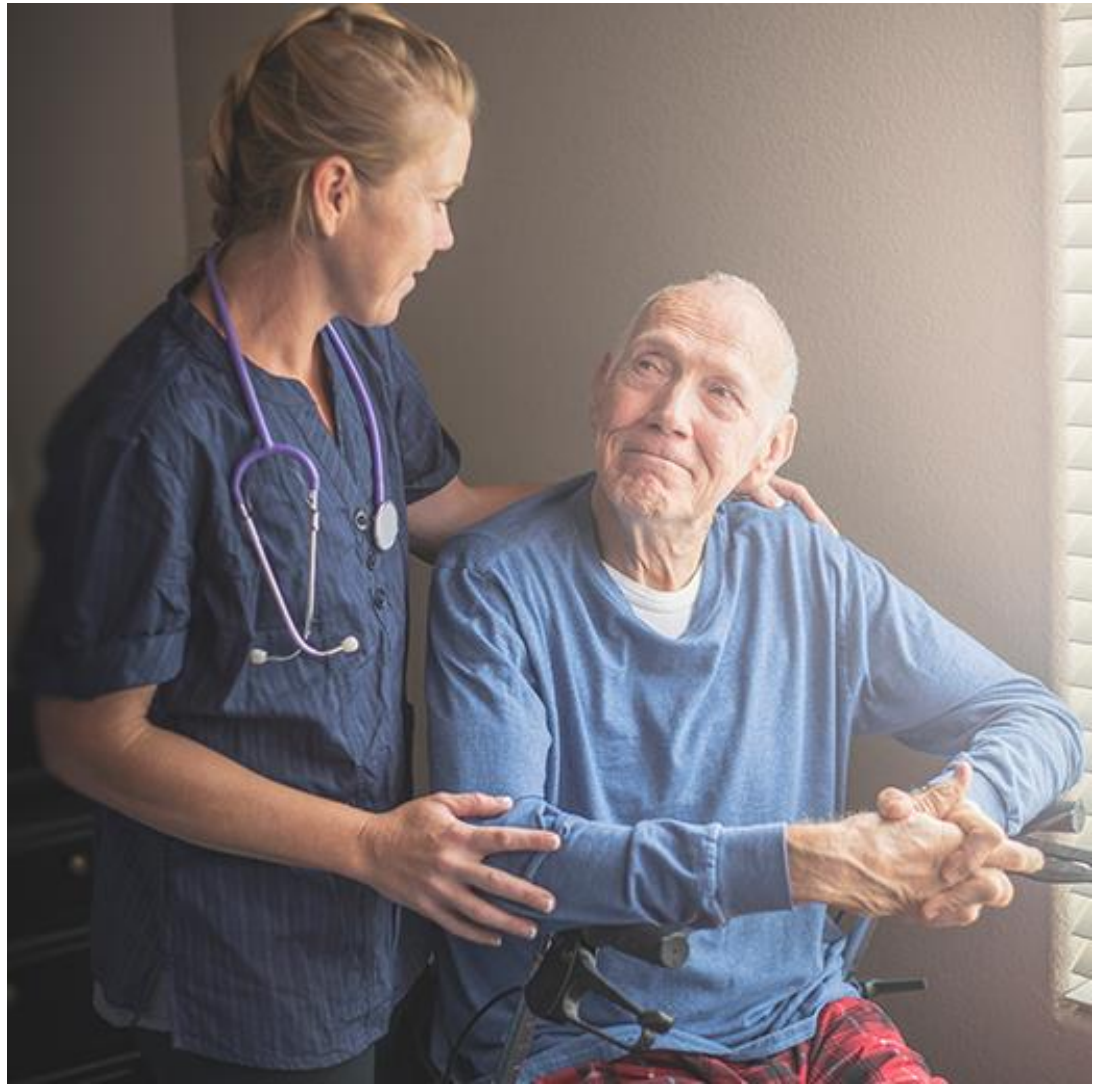
Medical Safety Net

- What will I do when symptoms escalate or when I get a flare up of a chronic condition?
- Do I have the medications I need readily at hand to deal with symptom exacerbation or disease flare up?
- Do I know WHEN and HOW to get medical assistance when I need it?

Caregiving Safety Net

- When I need temporary help, what will I do?
- If I am suddenly disabled or debilitated, what is my "rescue" or emergency plan?
- If I have a progressively debilitating condition, what do I need to do *now* while I am still able?

TRANSITIONS TO COMFORT FOCUSED CARE



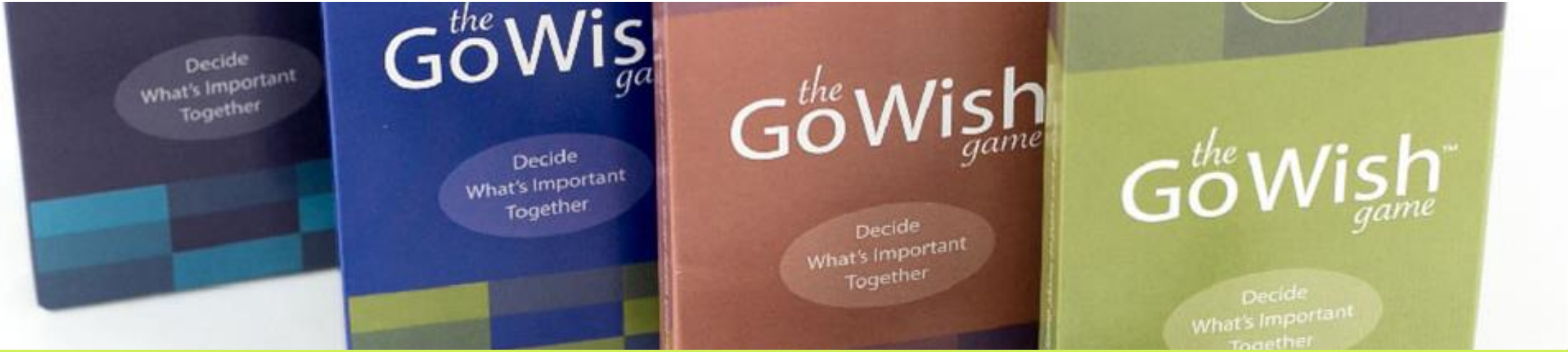
Providing a New Framework of care

No More Hospital Visits

Change in Goals

Symptom management

When to Start?


Decide
What's Important
Together
the GoWish game
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Decide
What's Important

GO WISH!


the GoWish™ game
Instructions
To have
my family
with me

SUMMARY

- Many of us will face serious illness in our lifetime.
- Early planning can help you have control over treatment decisions and reduce family conflicts.
- Advanced directives, empower individuals to have their wishes respected.
- Creating medical and caregiving safety net plans allows you to feel some control over your life when assistance is needed.
- Together, these elements promote a smooth transition, honoring individual preferences while providing comfort and support to you and your family.
- By embracing palliative care in these areas, we can ensure peace of mind and a compassionate journey for all involved.

THANK YOU

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