HOLDING YOUR HAND THROUGH HEALTH CARE

AIACPA Annual Education Seminar 2015

Care of a loved one near the close of life: Hospice Care

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Visit: www.aiacpa.org

Objectives

- EOL (End Of Life) care
- Differences between **Palliative** and **Hospice** care
- When to involve palliative care
- Resources

Plan:

Do you have a written plan stating

"what health care treatments you would or would not want if you could not speak for yourself?"

VICTOR

VICTOR – Continued…

- Victor is a married business executive whose best friend was in a coma from a critical car accident. After his friend was in the intensive care unit for 4 weeks, he was diagnosed as “brain dead.”

- Victor witnessed

- agonizing and difficult decisions his friend’s family had to make. about whether to continue life-sustaining treatments or not.

VICTOR – Continued…

- Victor's friend had never talked about his end-of-life care wishes and had not completed his advance directives which left his family in a major crisis about what decisions to make.

- Victor knew that if he were in the same situation, he would not want to be kept alive on a ventilator and feeding tubes.

VICTOR – Continued…

- Victor talked to his **wife** about what he would want if he were ever in a similar situation and completed his **advance directives.**

- Victor also discussed his advance directives with his **primary doctor** and gave him **a copy to include in his medical records**.

VICTOR – Continued…

- Since Victor has talked about what health care he wants and does not want with his wife and doctor, he can now trust that his end-of-life care wishes will be honored.

- Victor's example is one of many that highlights the need for all of us to think through and make a plan about our care at the end of life.

Why you need Advanced Directives

- Your wishes will be known.
- Only used if you are **unable** to express your decisions.
- This can happen to anyone – at any age.
- Give your loved ones the gift of peace of mind – **write down your wishes!**

Interesting to Note…

- Most Americans – 88 % – feel comfortable discussing issues relating to death and dying.

- Yet only 42% have a living will.

  (Robert Wood Johnson Foundation)

What are Advance Directives

- A **written statement** of your wishes, preferences and choices regarding end-of-life health care decisions.

- A tool to help you think through and communicate your choices.

Advance Directives

- Written instructions about future medical care
- Only used:
  - If you are seriously ill or injured, and
  - Unable to speak for yourself
- Should include:
  - Living will
  - Medical (health care) power of attorney (POA).

What is a Living Will?

- A **legal document** with your wishes about medical treatment
- You choose:
  - What you **do want ?**
  - What you **don't want ?**

Medical Power of Attorney (POA)

- A **legal form** that states who you want to make decisions about medical care .

- The person is authorized to speak for you **ONLY** if you are unable to make your own medical decisions.

- May also be called:
  - **“Health care proxy or agent"**
  - **“Health care surrogate”**
  - **“Durable power of attorney for health care"**

Advantages of Advance Directives

- You are in charge of making your own decisions.
- Documents can be changed anytime.
- You DO NOT need an attorney.
- Documents can help you express your wishes.
- Individual forms are available to download for **FREE** at **www.caringinfo.org**

Disadvantages of Advance Directives

- Advance Directives (AD) may not be available when needed.
- Not readily available in patient charts.
- Living wills:
  - may not be specific enough
  - may be **overridden** by a treating Physician
  - **does not immediately** translate into Physician order

Medical Terms for End-of-Life Care Decision Making

- Life-Sustaining Treatment
- Artificial Nutrition and Hydration **(Tube feeding)**
- Cardiopulmonary Resuscitation **(CPR)**
- Do-Not-Resuscitate Order **(DNR)**
- Palliative Care
- Hospice

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

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. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

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

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing.*

When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

- ☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*
- ☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*
- ☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

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

Check One

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

Additional Orders: _____

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

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:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

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:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

AIA of Central Pennsylvania

NNACLEHEALTH

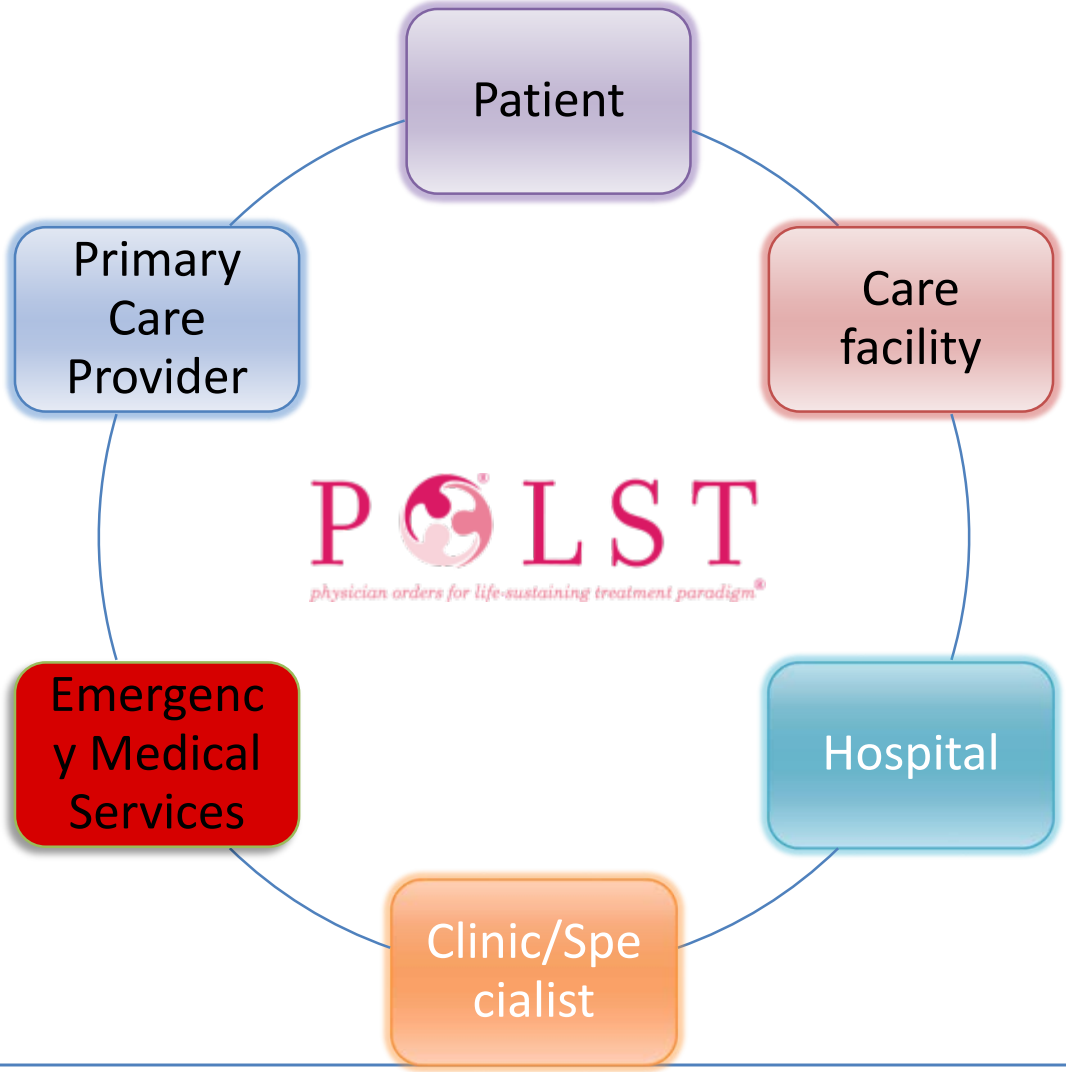
What is POLST?

- **P**hysician
- **O**rders for
- **L**ife
- **S**ustaining
- **T**reatment

- Portable document that transfers with the patient.
- Brightly colored, standardized form for entire state of PA.

Purpose of POLST

To provide a mechanism to communicate patient preferences for end-of-life treatment across treatment settings



Why POLST?

1. Patient wishes often are not known.
   - The Advance Healthcare Directive (AHCD) may not be accessible.
   - Wishes may not be clearly defined in AHCD.

2. Allows healthcare providers to know and honor wishes for end-of-life care

POLST vs. Advance Healthcare Directive

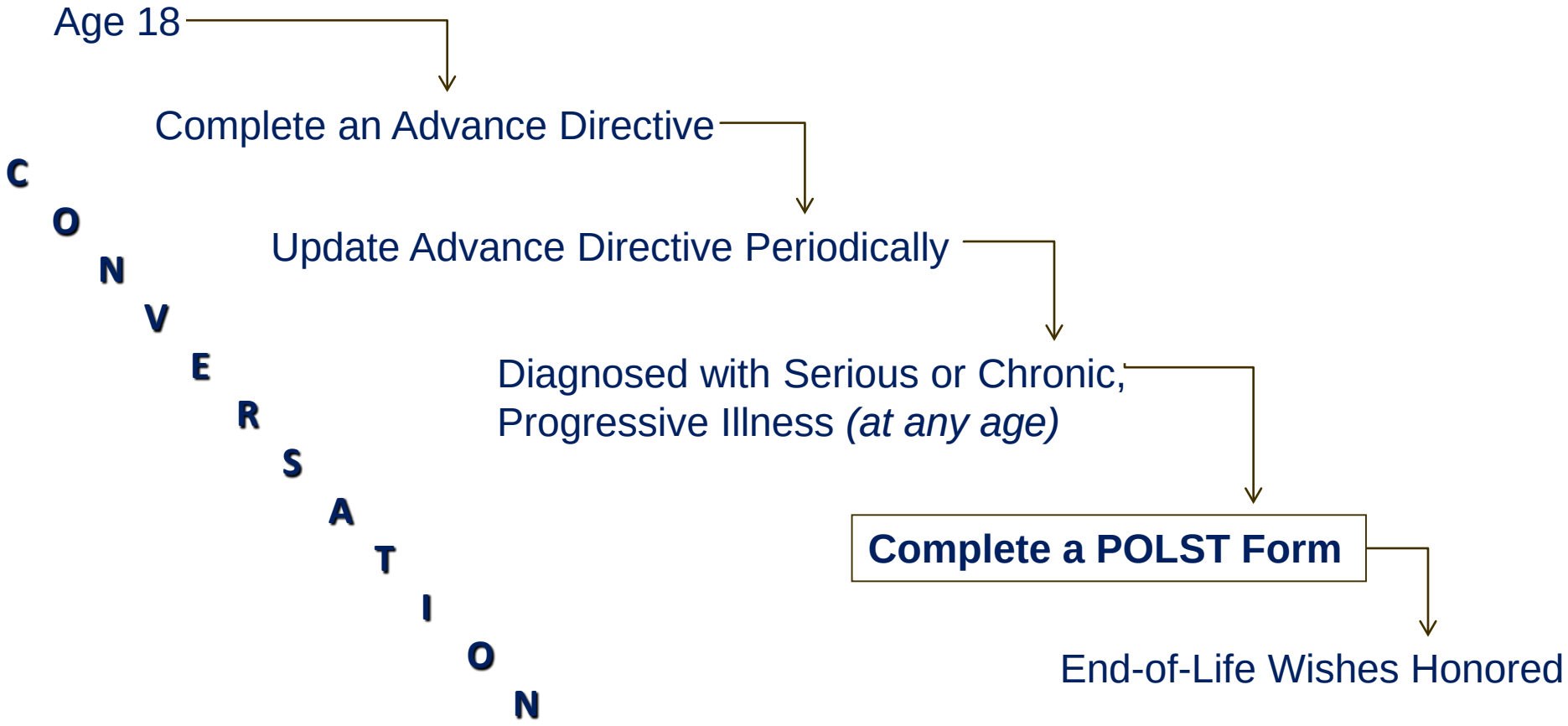
- POLST **complements** the Advance Healthcare Directive (AHCD).
- Both are legal documents.

POLST vs. Advance Medical Directive

POLST	AHCD
• For seriously ill/frail, at any age	• For anyone 18 and older
• Specific orders for current treatment	• General instructions for future treatment
• Can be signed by decision maker	• Appoints decision maker

Where does POLST fit in

Advance Care Planning Continuum



Who can help complete POLST?

- Healthcare providers – “licensed, certified, or otherwise authorized to provide healthcare in the normal course of business.”

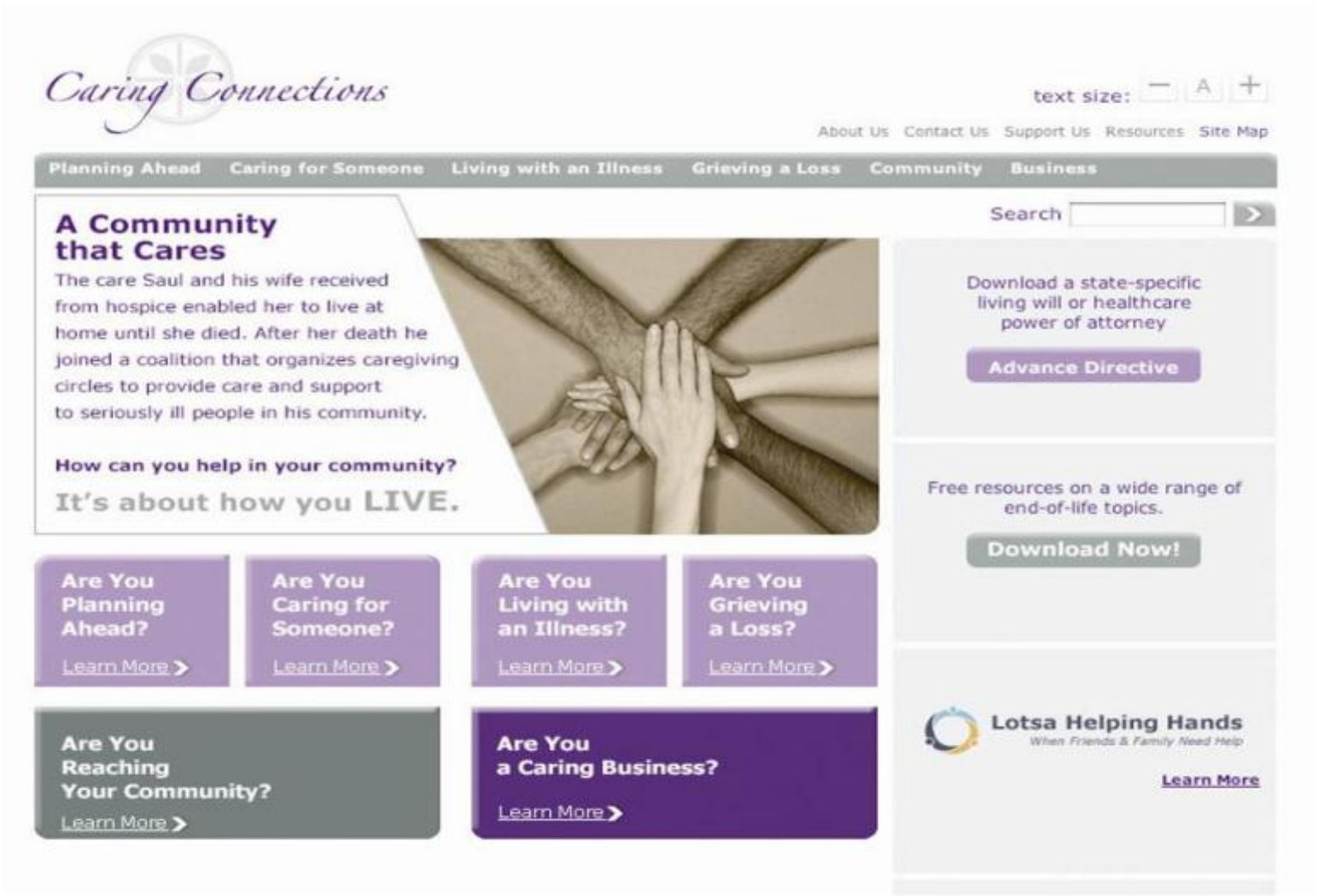
- Best practice suggests use of those trained in the POLST Conversation:
  - Physicians
  - Nurses
  - Social Workers
  - Chaplains
  - Social Service Designees

Can POLST be changed?

- Individual with capacity can request alternative treatment or revoke a POLST at anytime.
- Legally recognized decision maker may request change based on condition change or new information regarding patient wishes.

Key Message

Resources in our Community



FREE Resources Available from Caring Connections

- State-specific advance directives.
- Advance care planning Web resources.
- Brochures to download or order:
  - *Advance Directives and End-of-Life Decisions*
  - *Health Care Agents: Appointing One & Being One*
  - *Conversations Before the Crisis*
  - *You Have Filled Out Your Advance Directive… Now What?*
  - *Ask Tough Questions*

Its about how you “Live”

- **L**earn about your options, choices and decisions.
- **I**mplement your advance directive plans.
- **V**oice your decisions.
- **E**ngage others to complete their advance directives.

Palliative Care: PC

Interdisciplinary Care

Aims to

- relieve suffering
- improve quality of life

Combined with **ALL OTHER** appropriate medical treatment

What is Palliative Care

Palliative Care Is:

- ✓ Excellent, evidence-based medical treatment
- ✓ Vigorous care of pain and symptoms throughout illness
- ✓ Care that patients may want *at the same time* as Rx to cure or prolong life

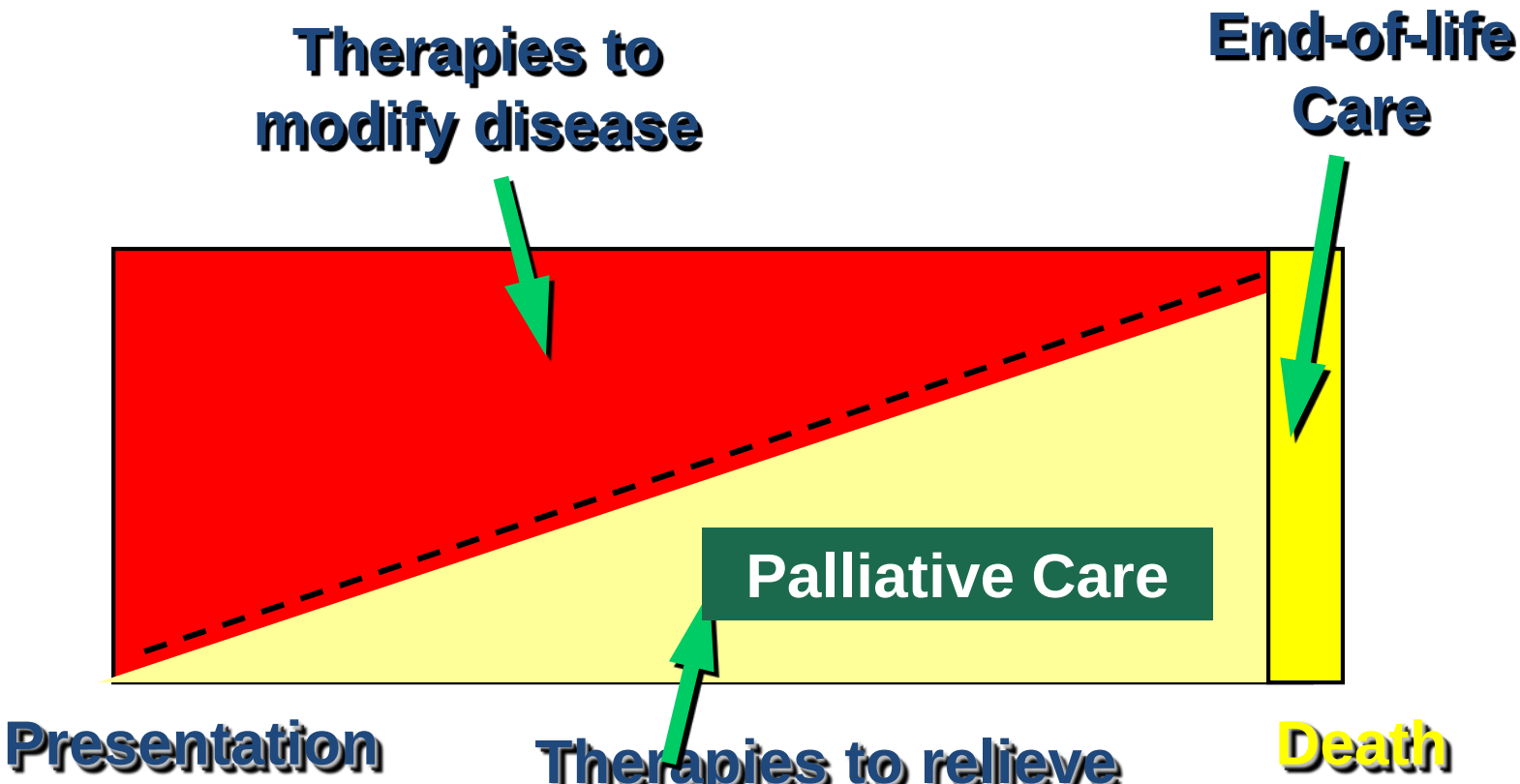
Palliative Care Is NOT:

- ✗ Not "giving up" on a patient
- ✗ Not in place of curative or life-prolonging care
- ✗ Not always the same as hospice

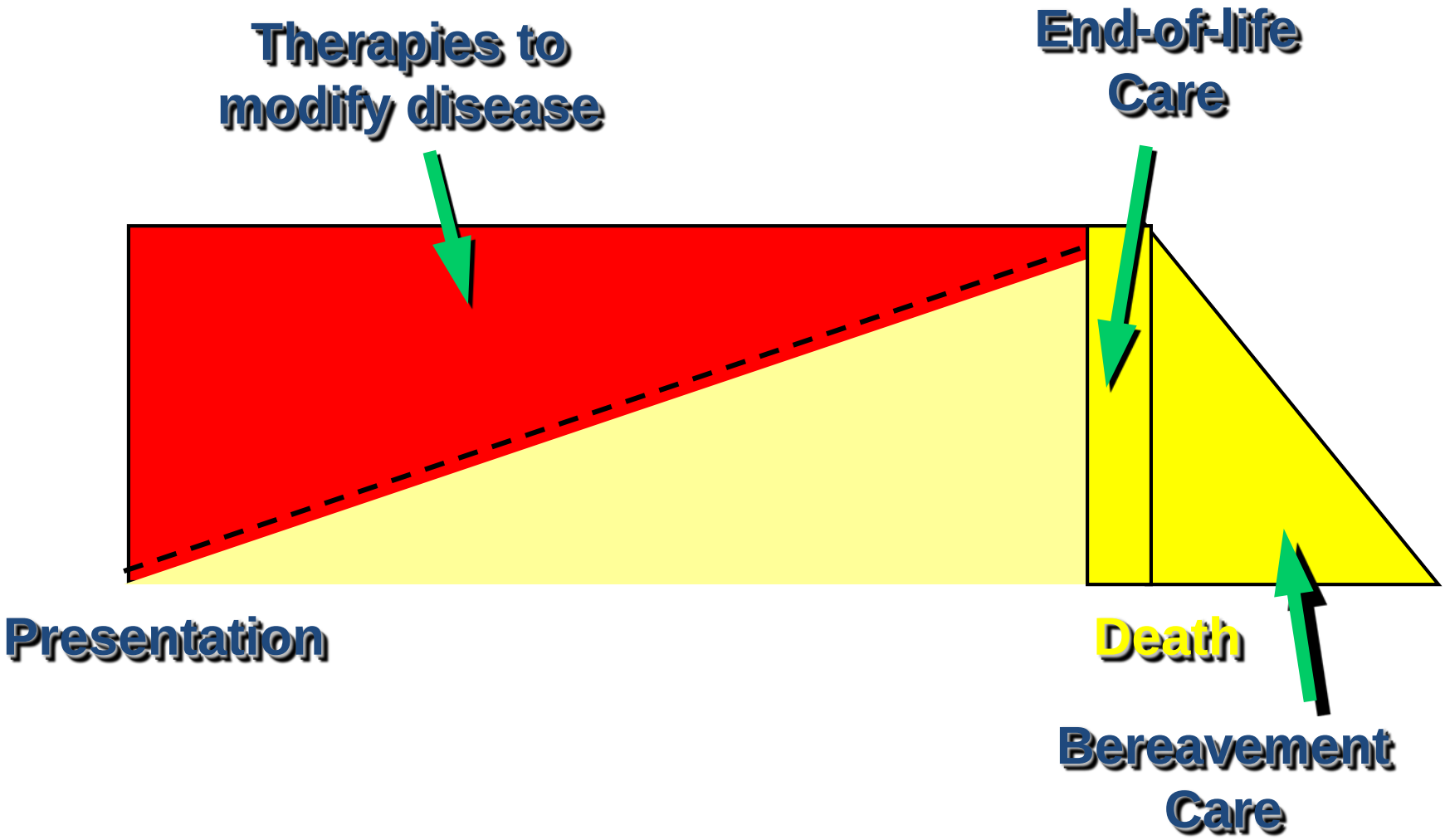
Palliative care is not about , whether to treat or not to treat, but about "**what is the best treatment**."

PALLIATIVE CARE **IS NOT** HOSPICE

When to call palliative care

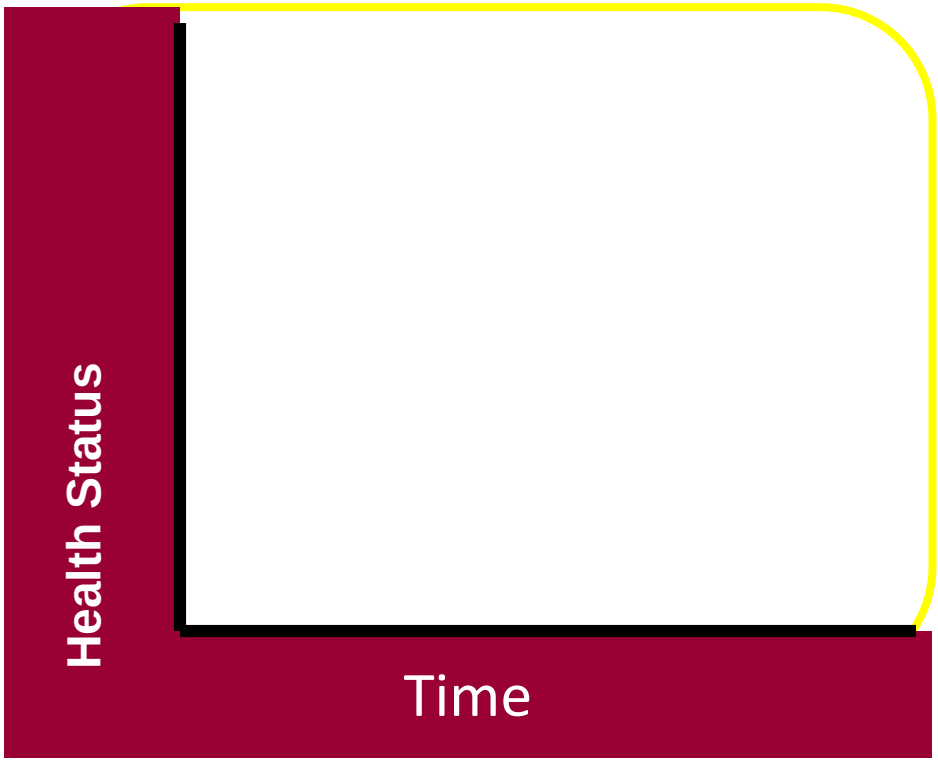


When to call Hospice care

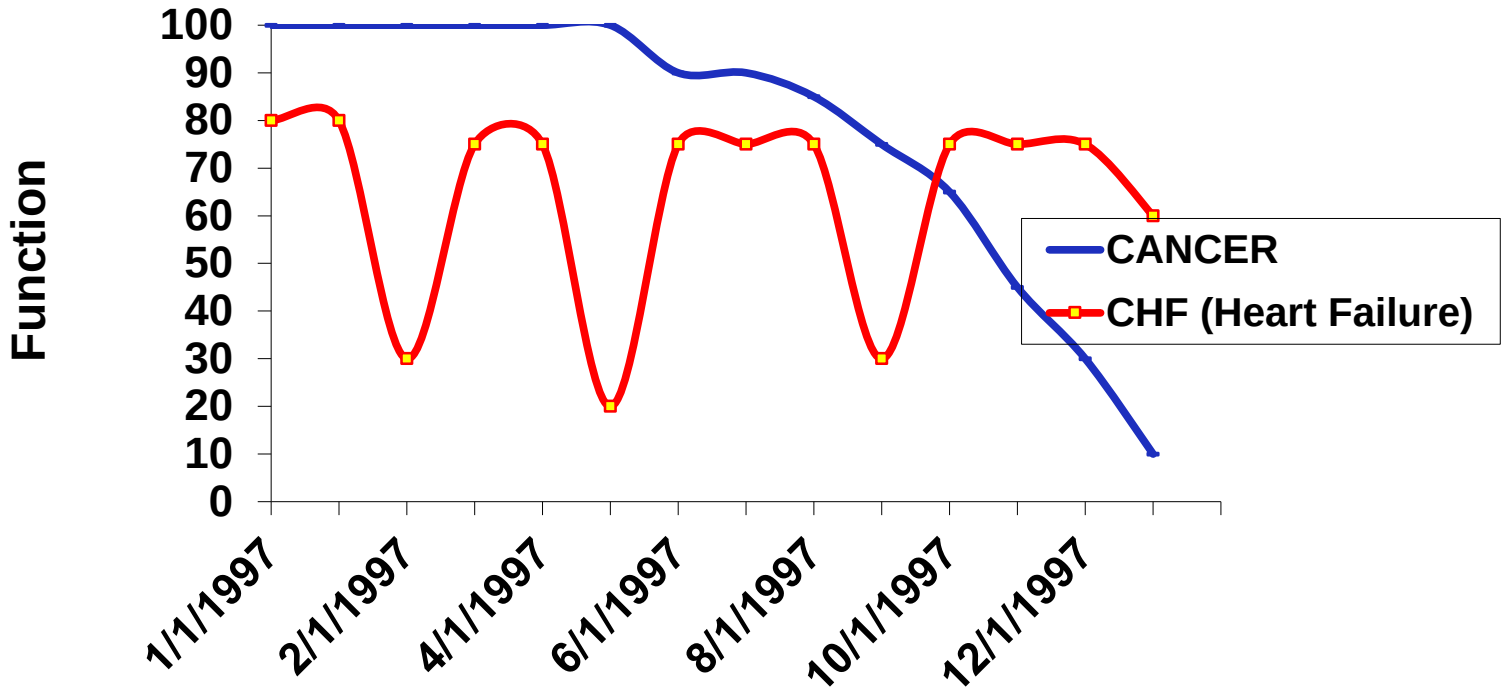


Sudden death, unexpected cause

< 10%, Heart attack, accident, etc.



Slow decline in Chronic diseases:



Hospice Care

Def:

- The comprehensive care system for Pts with limited remaining life expectancy at home or in institutional settings.

- Established as a Medicare health care benefit in 1982 by the Federal govt.

Hospice Care

- Provides **support and care** for those in the last phases of life-limiting illness.
- Recognizes dying as part of the normal process of living.
- Affirms life and **neither hastens nor postpones** death.
- Focuses on quality of life for **individuals** and their **family** caregivers.

Core Aspects of Hospice

- **Patient/family focused**
- **Interdisciplinary**
- **Provides a range of services:**
  - Interdisciplinary case management
  - Pharmaceuticals
  - Durable medical equipment
  - Supplies
  - Volunteers
  - Grief support

Who Pays

- Medicare
- Medicaid
- Insurance
- Private pay
- Sometimes a combination of these…

Summary

- EOL Care
- Advance Directives
- Living Will
- Medical Power of Attorney
- POLST
- Differences between hospice and palliative care
- When to involve palliative care