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SUMMARY KEYWORDS

patient, surrogate, documents, called, talk, state, physician, client, capacity, provide, wishes, life, typically, terminal condition, dialysis, nutrition, palliative care, tube, attorney, living

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Hello,

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my name is Renee mallet. I'm here today to talk to you about advanced care planning. Just a little bit about myself, I am a nurse and an attorney. I've worked about 15 years in the hospital environment. So today's topic is about advanced care planning for when you're meeting with your elder clients, or just clients of any age, if they have questions about advanced care planning, that hopefully this presentation will allow you to help guide them. Some of the discussion points that we're going to talk about today is what is advanced care planning. It doesn't hail what's called a living will a durable power of attorney for

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health care,

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we're going to talk about organ donation, we're going to talk about life sustaining measures. And also how do you determine if your patient is has the capacity to enter into these legal documents? With that being said, advanced care planning is really what it is is just for you to decide, as a patient or a client, how would you like your life to unfold? Should you become sick, have a serious medical and physical condition, find yourself in a terminal condition, find yourself in a situation in which perhaps you have less than a year to survive. So really, you're just drawing those advanced care planning, putting it in writing, documenting what your wishes are talking with your family,

talking with your best friends, whoever is going to help you through your transition of your end of life care? Why is it important? We know from the CDC, about 70% of adult patients do not have these documents. So oftentimes what happens they find themselves in an emergency situation, perhaps in the walls of a hospital and emergency department. And without those documents or without any communication to their family, to their significant other to a friend, oftentimes, their family members are left trying to understand what they would determine as their quality of care how they would want to exit this world, what is the proper way to allow them to die naturally. So it's very important that we kind of capture those wishes. So you as a licensed attorney can provide comfort and support and peace to your clients. So when they're faced at the end of the life or some mortal condition, they can be fully prepared. There's a few key resources we'll kind of go through. There's tools on the website, one of them as conversations that light the way it was developed by the hyoe Palliative Care Association. And actually, it's like a toolkit, it's a document that your client can fill with their significant other, their spouse, and walks them through a couple scenarios that we'll walk through a little bit later in the presentation, start asking some of those questions. So when they come to see you, if they haven't started that conversation, I would personally give them that resource, have them go out, meet with their family, whether it's over the holidays, or having them come over for a Sunday evening dinner, but have the families start developing those conversations once those conversations are held, and they kind of work through this book. And it kind of gives them some things to think about, such as if they experienced a stroke, and it left them perhaps, you know, unable to speak or unable to walk if they have a new diagnosis of pancreatic cancer. So it's certain conditions like that, and it's certain healthcare scenarios that will help them kind of make those decisions. So it's just kind of triggering thoughts, opportunities for them to have those conversations with their family members, and actually what to talk about and what to outline. So once they completed that assignment, and they come back to your office now begins drafting those documents. But before we drop those, let's kind of go through some of the key medical terms and those documents. So as we know, advanced directives, it gives living documents and when I say living documents, once you kind of have those drafted and your client signs and dates, those you can always amend those, it can change. So say maybe you have a client that's 40 years old, and you have them enter in what's their advanced care planning documents, along with their estate documents, those medical documents, those living wills, and durable power of attorney for healthcare, they can be amended. Things might change once they reach 50, once they meet 60 once they meet seven days. So really, it's good measure for any adults to have those documents have their intentions captured and, and writing their wishes. But again, those are living breathing documents, they can change over time, you can actually revoke them so perhaps your client no longer wants those documents. They can tear them up, shred them. You can sign them, you can revoke them, maybe a couple years down the road, you enter into new documents, things change, they get married, they lose the child etc. They have different desires, etc. So let's talk about what's called a durable power of attorney for Healthcare that's common and most states, that's what it's called. But it's really you designate a Sarah kit. And what I mean by a surrogate is should that person lack the capacity

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to make their own healthcare decisions. a surrogate is somebody that steps into their shoes. So when they step into their shoes, it's very important that they understand what the wishes of the patient are or your client. Typically, a surrogate has to be somebody 18 and older. It doesn't have to be somebody that's necessarily related to the client, whether it's a marriage in relation, or a blood relative, it could be their next door neighbor, it could be their best friend from childhood, it could be a co worker, it really just has to be somebody who understands what their wishes are, and at the time, if they're called to act on behalf of the patient, because the patient no longer can express their wishes or does not have that capacity. They know how to act and answer some key questions around medical decision making. If the surrogate, perhaps they're designated and they decide at a certain point that they're uncomfortable, or they no longer understand what the patient's wishes are, or your client's wishes, perhaps it was a surrogate that was named 10 years ago, that is no longer in contact with that patient, maybe they're no longer talking, and they don't understand perhaps what is best for that patient, it's always great to have a designate an alternative, so always have a primary surrogate, and then an alternative, just for a couple backups or, you know, again, if those documents were completed 10 to 15 years ago, a lot can happen between those those age, that that time span. So basically, it's always good practice to understand that that surrogate once that surrogates appointed, they specifically understand when you're completing those documents, usually all standard documents have you put the surrogates name, address, phone number, how to get ahold of them, how to contact them, etc, etc. And we talked about why it's important to have a secondary surrogate. So basically, some laws have what provisions or prohibitions on what surrogates cannot be. So for example, in the state of Ohio, the patients or clients attending physician cannot be their health care surrogate, a nurse or other other health care provider that's providing direct care, should they find themselves in a nursing home, it cannot be the nursing home administrator cannot be any health care professionals, a nurse in the long term care facility, or any of those real relatives. So there are some just check your local state, there are some prohibitions on who and cannot serve as a surrogate. Again, that surrogate is going to step into the role not only make health care decisions about life sustaining treatment, but all other health care decisions. So it's very important that surrogate and your client have that good relationship, perhaps that toolkit that you have given them is shared with that surrogate, so they specifically understand all the different healthcare scenarios and how they should act on behalf of the patient. So let's talk about the living wills. So we talked about the durable power of attorney for health care. So just to summarize, that's when you name somebody to step into your shoes, that surrogate somebody to make health care decisions. Living Well is a little bit more technical and a little bit more directive. So oftentimes, in and many states such as the state of Ohio, that living world will take effect when the patient kind of meets a couple health care decisions. So basically, it takes effect if the patient is in a terminal condition or a permanent, unconscious state with no chance to recover. So that's when that living will take effect. The patient at that time could be confident they could your client could be giving and providing direction. And really, they're looking at their physician to say if I reach these two

conditions, this is when I want my living will to take effect. Now if your patient is unable to express those wishes, of course, you have this living document that gives some guidance, and if they no longer can provide consent or don't have the capacity than the surrogate takes effect. So just to kind of understand the differences. So the living rule is really to when the patient reaches certain criteria, and it spells out kind of what their wishes would be.

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So let's just kind of review some states have what's called the terminal condition criteria. And typically that means any error reversible, incurable and treatable conditions caused by a disease, illness or injury, in which there can be no recovery and death is likely to occur within a short period of time. So that's the definition of a terminal condition. Many states have the exact same definitions are similar. A permanent unconscious state means a permanent unconscious state characterized by both of the following Many states have these definitions. So it's an irreversible awareness of one's being to their environment, and total loss of cerebral or high brain functioning. So basically, your patient has no capacity to make a healthcare decision, your client cannot decide on themselves. So let's review a living will, would take effect if your client meets that terminal condition, and then also would have that permanent unconscious state. So let's just kind of walk through the first scenario, if they have that terminal condition. And as we review that, that's an irreversible, incurable, untreatable condition, they're going to pass away within a matter of maybe a couple months, within a year, they're in a terminal state. So we can kind of play out the diagnosis of pancreatic cancer that maybe has metastasized throughout the body. And the physician is saying your survival rate is probably less than a year. So they're in a terminal condition so that living well takes effect. In your living well, you have a couple key things that you can make decisions on. Those key things are life sustaining treatment. So let's kind of review what that means. So it could be you decide when and how you want CPR, you decide if you want the use of a ventilator or an artificial respirator? If you want nutrition? How do you want that nutrition to be delivered? Do you want hydration along with your nutrition? And we'll further talk about that. Do you want dialysis? Do you want? Do you want to be an organ donor? And then do you want comfort care, so you can kind of shape that living? Well. So let's just take an example. You're in a terminal condition that Living Will takes effect. And at that time, the patient is saying, here's what I'd like to have, here's what I'd not like to have, I no longer want to receive dialysis. I don't want to be placed on a ventilator. I don't want life sustaining treatment, etc. So we'll kind of walk through some of those key terms. Let's kind of go back and say what if your patient is in a permanently unconscious state. So again, that's unable to have that higher brain functionality. Typically, we see automobile accidents that come in through the emergency department, it's a head severe head injury, and at the end of the day, you have typically you have two physicians confirming that that patient has brain death has irreversible brain capacity. So they're in a terminal kind of a vegetative state, that living world takes effect. In order to determine that, of course, they're going to do brain studies, they're going to do monitors, they might do a period of

time 24 to 48 hours to determine if that patient regains any sort of mental capacity, they're going to give you those diagnostic test. So that surrogate if they do that, again, if that surrogate is stepping into the shoes of the patient, in order to make their health care decisions, they're going to have all that diagnostic test, there's usually good criteria, standard practices of care, what meets brain death brain criteria. Maybe your patient is dementia or has Alzheimer's. So let's kind of talk about that they're slowly losing their brain functionality they become Do they have the mental capacity. So incapacity is defined as the physical or mental ability to manage your own affairs. So do they have capacity to make everyday decisions. And if we talk about healthcare decision, that's usually a more technical, higher level decision making. It's not every day where I'm going to have lunch, what I'm going to have for dinner, where I'm going to buy my groceries, this is determining, you know, your health care. And, you know, the higher the level of decision making, the more you want that patient to have that capacity. So though fully understanding the risks, benefits and alternatives to medical treatment.

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So when you're determining capacity, the physician is probably going to look at the patient and see if they have the ability to reason or deliberate on a decision. It's risk benefits, alternatives. Do they understand is this in conjunction with their values and their goals? Can they appreciate the circumstances can they appreciate the options of what they're being asked? And are they fully being able to understand that information? A lot of times we'll have the patient speak it back, recite it back to us. And that gives us an idea that that client is understanding the risk benefits, their options, they're understanding maybe what this invasive procedure does for them, what's going to happen and if they can't really recite that back, that's just an opportunity for us to kind of help us determine whether they're having that capacity. Now, it's interesting capacity can waive over time. So perhaps the patient comes into the hospital. They're in a situation where they're dehydrated, they're malnourished, they haven't been eating for days. You know, their electrolytes are all off so they're having a little bit of a electrolyte imbalance. So sometimes they they are sluggish in their thought process, right? It's like us waking up without the proper amount of sleep where we need our coffee we need to get going, etc. So imagine a patient, if they're at the end of their life or they're an elderly patient. Once they begin receiving treatment, sometimes their capacity comes back, they become alert because they're receiving nutrition because they're being hydrated. So capacity can wax and wane. So you just kind of have to figure out whether they have the capacity. And again, the physicians, health care providers are going to help you determine if that patient has the capacity. And when they feel that perhaps that patient doesn't have that mental capacity to make a big decision, they're going to look to the surrogate. There are some exceptions for when we'll just talk about exception if that living wheel kicks in, and the patient happens to be a pregnant mom. So most states the the surrogate may not refuse to withdraw, care for a patient when they're pregnant. Because again, we want to make sure that we're looking at that Bible fetus, we're looking at the mother at the same time. So hence, you

know, if the, perhaps the the the woman completed her living well, at the time she wanted, if this happens to me, this is what I'd like to have done. Sure I'm in these circumstances, she finds herself pregnant, she finds herself in an auto accident. So again, basically, at that point, the surrogate obviously cannot refuse to withdraw, treatment that would terminate the pregnancy, at that point, we have to look at the the fetus, also, some states do require you to look at the health of the mother. So perhaps, we are providing an aggressive treatment, because we want to keep that fetus, we want to be able to have that fetus, you know, mature for its nine months period. But however, some of the treatment we're providing to the mother, perhaps it starts affecting her life and her her state and her health. So there's has to be a balance there. Basically, sometimes we find because of that, that automobile accident, the fetus probably would not make it to maturity, the fetus, maybe at that point has has passed on the fetus would not be born alive. So therefore you can decide at that

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point,

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let's start withdrawing life sustaining treatment, let's honor the wishes of the mom, she no longer has a viable fetus. Therefore, we're going to start withdrawing, withdrawing life sustaining treatment. So let's go back. Exactly what is those life sustaining treatment? And what are those choices. So let's just talk about CPR, we often see it on our TV, whether we watch Chicago Med, whether we watch Grey's Anatomy, we see CPR being provided. So we know CPR. It's actually a guideline developed by the American Heart Association, and it's a life saving procedure. It basically is an opportunity when the patient experienced cardiac arrest, meaning their heart stops, you provide CPR resuscitative measures to bring that to get their heart to start beating again. So I could administer chest compressions, I can insert an artificial airway to make sure oxygen is going into the patient. Therefore, we want to make sure we're re oxygenating the heart, the organs, the brain, providing other forms, maybe I don't have to intubate the patient, but maybe I put a respiratory mask over them to help them breed, breathe on giving and resuscitative drugs, and I might have to cardiovert them defibrillate them because oftentimes a cardiac arrest can be because of a electrical discharge that has malfunction within the art and the heart. So you need to like recalibrate the heart. Sometimes patients have said, You know what, I want all components of CPR. But I don't want you to intubate me, because at the end of the day, I don't want to be on that ventilator. So you can provide these other forms of resuscitation to me, you can, you know, give me chest compressions, you can maybe start an IV Give me those resuscitative drugs, whether it's epinephrine, light, a cane, whatever else, administrative resuscitative drugs might help me, I just don't want to be placed on the ventilator.

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So let's just kind of

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determine what is respiratory arrest, a respiratory arrest is when the patient just stops breathing. Oftentimes, when they experienced respiratory arrest, they're experiencing cardiac arrest, but sometimes you can have cardiac arrest, and then it leads into respiratory arrest, they stop breathing. So just kind of just a little bit differences between cardiac and respiratory arrest. Typically, with respiratory arrest, you're going to provide resuscitation back to that patient, you might not have to do chest compressions. But you might have to intubate them turn up there, they might kind of start going into respiratory distress and then arrest. So during that respiratory distress period, we might decide that oxygen needs to be turned up a little bit or perhaps we have to force a little bit more air so we're going to put a mask on them or other sort of respiratory devices to assist them. Talk about let's talk about the ventilator as emergency support. So we all know that it's really a tube that passes through the patient's trachea and then helps get air oxygen into the lungs. So it's interesting. Typically, once the patient's intubated, if they're intubated for longer than two weeks that throats, that tube in the back of their throat will start irritating. Depending on what the patient's ages, usually, a younger patient can be intubated a little bit longer, but an older patient that erosions going to start sooner just because they're older, their skin is not as firm and thick as a younger patient. So after a determination after they're intubated, if they still need to have that forced air in them, the doctor might come and say, our next step would be to place a trake. And a trick is just a surgical opening and their trachea. And it just again, it's all for a long term placement, sometimes you'll hear that the patient has been on the vent for six months, for a year. Typically, at that point, they're put on a train tracks are reversible. So for happens, you might have to put them on a trade for three or four months. And then actually, the patient might start improving, they'll just have a scar tissue there once you reverse the trade take out the tube. So they are reversible. But it is also a long term measure. I think we talked about the trake. Typically the trade is done as a bedside procedure. And typically if the patient does have to be on long term ventilation support, and they are transferred to a long term care facility, a nursing home, typically they're provided, they're given a trake the nursing homes don't have the capacity to worry about the intubation of the tube because you kind of it's more maintenance, you have to monitor the tube, you have to make sure it's in the right position, there's a cuff at the very end of the tube. And that's what keeps it from coming out from the patient. A trake is kind of low maintenance. It's you know, it's an invasive procedure. But once invasive procedure and the tray heals, it's it's it's kind of self sufficient.

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So let's talk about artificial nutrition and hydration. This is really let's break it down nutrition. So

we often know sometimes a patient has difficulty eating, chewing, swallowing, they might have a stroke, they just don't have that capacity to chew food anymore to eat a meal. So sometimes their meals are more of a liquid form, it might be a thick, thick thickener placed in that liquid, but that might be the best opportunity for us to make sure they're not becoming malnourished once they become malnourished, it really leads to other things. So we want to make sure they have the proper nutrition so you can provide nutrition, it's called oral nutrition support. Other means are if they have an mg tube, and again, that's a tube that flows down the nasal passage and it floats down into your soft Agus and it resides in the stomach. That tube is typically sometimes you can give syringe boluses again, you're you're gonna maybe you could use ensure or you might use a commercially prepared nutritional supplement. There's a lot of nutrition companies such as Abbott nutrition, such as Nestle. So there's, it's called commercial to feeding that is provided to the patient. Sometimes you can bolus it by a syringe. Sometimes they're actually what's called a feeding pump that they have diabetes and other comorbidities we might the physician and working with a dietician may determine you know what this patient needs flow continues it needs, we need to make sure we're studying them. So they don't go into hyperglycemia I hope hypoglycemia. So depending on if the patient has other medical conditions, that might be the best mechanism to make sure they're getting feeding. Typically, if they need feeding more than 30 days, that energy tube greater than 30 days, you typically have to do more of an invasive procedure. So you're going to place the tube in the stomach and it's called a gastrostomy tube. Sometimes people call it a G tube. If it has to go into the intestines, it could be placed into the intestine. So again, that's just more for a longer period to make sure that nutrition along with these tubes, you can actually then provide hydration. So once you have a tube in the patient's nose, or if it's placed in the stomach, not only can you give that commercially prepared to feeding product, but you can also bolus in or some pumps are able to administer water. So they're getting both their nutrition and their hydration. If the patient's condition is a little bit more intense, sometimes we've seen because maybe there are there are a patient that comes in with an injury. So maybe there's injuries to their face, there's injuries to their abdomen, there's injuries to their chest, we cannot provide to feeding that way. So actually, it's called parental nutrition in which we provide nutrition support and we basically take a needle and place it in what's called a central vein a very large vein and the patient And it's called parental nutrition. So because of their, their disease state, perhaps they're recovering from a bowel procedure, perhaps they've had a motor vehicle, perhaps there's colon cancer, we just can't provide that nutrition towards our normal gi system. So then we'll use, there's the veins of the patient. And typically, we'll pick a central vein for that parental nutrition. Sometimes you've seen a patient just with a regular IV, and it's a saline solution, it might have a little bit sugar on there, depending on what the physician determines. And that's just IV support worse, we're hydrating, and with an IV, and that's the type of the way it's called like a, just, there's either salt sugar in there or water solution, other substance to keep them hydrated. So let's talk about dialysis. So at that time, sometimes the patient might have a

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renal disease renal failure, and if they're periodically being managed, and they're getting dialysis, but again, if they then go into a terminal condition, or having a permanent unconscious state, that you're, they're directing you, Hey, I no longer want my dialysis, I no longer need it, it's I'm going to die within a certain period of time, I want to withdraw that life sustaining support. So just a couple ways that we can provide dialysis as some patients are ambulatory, they actually have a tube in the stomach of their, in the walls of their abdominal cavity and called peritoneal dialysis. So they're fully functioning, they're walking around in the malls today, the grocery stores, we don't see those tubes that's typically tucked in. And then they just go and sometimes they self administer it, if they're if they're able to, or somebody comes to their home, or they go to an outpatient facility, maybe once or twice a week to have what's called peritoneal dialysis, or sometimes they have to have it daily, depending on the stage of their kidney disease, renal disease, etc. And then we also know the other form of dialysis, which we see it is them hooked up to a machine and it's hemo, dialysis. And really what the machine is stone is spinning out that way salt and fluid from the patient's blood, and then putting it back into taking it you know, removing those toxins, and then the blood is funneling back into the patient. So just a couple forms of dialysis. Oftentimes, on these living will, you can either have if they want to also provide any wishes. So perhaps it's very important for them that they want to be an organ donor, or they want to be a tissue donor, or they want to be an eye donor. So at that point, they might say, if I reach this, these conditions, before I pass away, I want you to be able to preserve any organs and donate them as much as possible and you know, donate my tissue, donate my eyes, etc. They don't have to put that in with their living well, some living wills, many living wills have that election on there, or they can do a separate eye and tissue donation informed consent, or perhaps they didn't have it on their living room. But the surrogate or the family members knew that they wanted to be an organ donor. So they might have it on their state license, or they might have it on other like a hand card or a pocket card in which they had consented to being a donor. Let's talk about what is a DNR order. So it's a Do Not Resuscitate order. So it's basically the patient saying I don't want to be resuscitated. Some states are progressive and they call it I want to die naturally, so it's kind of allow me to die naturally order. So basically, it has to be written by a physician. So we know as attorneys, we can, we can help prepare the Living Well, the durable power of attorney for health care, we can help prepare, prepare if there's a separate document for organ donation, but we as licensed attorneys cannot prepare prepare a DNR order that's written by a physician. Some states allow physician assistants, nurse practitioners, clinical nurse specialists to basically say this is when they would want a DNR order. Also some Living Will documents again, if those conditions are met terminal condition or permanent unconscious state. Those will when those conditions are met, the Living Will kicks in and part of that living will is provisions for a DNR order. So at any time a patient you know if they have the medical condition, the physician can always write a DNR so if the patient is say me, I'm 47 years old, I happened to find myself with a condition that I was unaware of I'm in the hospital. I have the ability to consent, maybe I don't have my livingwell completed at this time. But if I meet the medical condition, and

the physician talks to me about a DNR order, I can give consent and again, there's standards in which it's appropriate when a patient has that DNR order and it's really the physician working with the patient at that time to determine Tommy what you want. Do you want to be resuscitated? Do you want to To diet naturally, let us know what your wishes are.

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So again, your client can independently say that they want a DNR order. And oftentimes, if you've watched those TV shows Grey's Anatomy, they might have a patient with a tattoo or something written on permanent ink on his chest saying no code are Do Not Resuscitate me, that's their way of displaying that I'm a DNR and again, the physician depending on what the medical situations are, they're either going to abide by that or they're not going to abide by it, but a healthy walking, breathing patient that happens to come into the ER, if he has that tattoo, but he's not ready to die yet. Obviously, they're not going to honor that DNR, with having more of a conversation. So just keep in mind, that's a it's an opportunity for the patient to voice their wishes. So we understand you have this tattoo. We understand what your wishes are, but we want to make sure you're you're falling into that medical need that medical category for us to abide by your wishes. Also, oftentimes, when a patient is placed into long term care, it's typically it's it's it's state law, that as I'm admitting a patient, I'm going to ask Do you have an advanced directive? Do you have a living will? Do you have a healthcare surrogate somebody to make decisions should you not be able to, and also have you talked about DNR, again, they're going into a long term care facility. And if that is because they're, it's at that at the end of their life, they're no longer able to care for themselves. Those questions need to be asked now, if they're there. We know sometimes patients go to long term care, because they need a place to recoup after an extensive surgery, and it's they're not ready to live by themselves. They don't have care providers, they're using that long term care facility, just maybe as another 30 months of care and support. Again, those conversations may occur. But really typically, those conversations should always occur for a patient that they're there at the end of their life, and that's where they're going to reside. So let's just talk about palliative care. We hear the term palliative care, comfort care. There's a clinical practice guideline by the quality Palliative Care Association, it's in the presentation, you can read their exact definition. But basically, it's treating the patient holistic, I'm going to look not only at their physical needs, but I'm going to look at their psychological needs, there practical needs, their spiritual needs, their emotional needs, their experiences, serious illness, I want to make sure I'm comprehensive in my approach, and hospitals have that comprehensive, they'll typically have what's called palliative care teams, some other health care facilities, nursing homes have those palliative care processes approach in place. And basically, it's when the patient is experiencing a serious illness, I'm going to look at them holistically and make sure I'm meeting all their needs. CMS defines it as a patient and family centered care that optimizes their quality of life by anticipating preventing and treating suffering. So let's kind of talk about the components of palliative care. So it might be talking to the patient and saying, how would you want me to

manage your shortness of breath? So talk to me about that. Here's some opportunities that I have that I can assist you when you have those episodes of shortness of breath, maybe you're gasping for air, let's figure out how you want this to be managed. Also, do you want us to limit any diagnostic testing at this point, we don't want to send you for invasive procedures, we don't want to send you for complex testing. Perhaps we only need blood daily laboratory stick daily, we don't need to be providing laboratory four to five times a day drawing blood. So let's start limiting those diagnostic testing for you. Again, we're going to preserve your quality of care. And then obviously, let's provide spiritual and emotional counseling, what does that look like to you, and then we're going to give you medicine to treat your pain. Treat your anxiety, treat your depression. If you've all often experienced nausea, or any gi related symptoms because of your serious illness because of your cancer. We just want to be able to treat you make you comfortable, make you pain free, make you at peace, enhance the quality of life, what time you have life. So that's palliative care, comfort care.

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So let's talk about forms and templates. Many states have come together. So the Hospital Association, the Ohio palliative care, the Ohio State Bar Association, the high Medical Association. Many years ago, these state associations came together and have what's called standardized form. So if a patient happens to come to their doctor, they're going to give those documents if they come to the hospital, the hospital social worker, nurse might be talking to them. If they happen to go see their estate planning attorney. He's going to have those documents or she is going to have those so maybe most states have kind of come up with standardized templates and documents. It was interesting why I was putting this presentation together or refreshing it, you can actually go to a RPS website, and you can click on each state and they actually are pulling up those standardized documents. So you as an attorney, just make sure you understand those many of those documents have a lot of places where you have to find where you have to initial where you have to date. So just make sure all those documents are properly signed and dated. So me if I was practicing in the ICU, and I picked up that form, and I saw it was incomplete, I want to make sure it's all complete. Typical what physicians or I'm sorry, what attorneys I've seen, sometimes I've seen them actually put their business address on it a stamp a phone number, so if there are any questions that the bedside nurses or the physicians have at that attorney still available, oftentimes he can, or she can recollect on that, sometimes we'll have patients come forward and give us kind of, it's all their living wills, their power of attorney, and also they have their financial power of attorney together. So keep in mind, if they're standardized forms, I would probably use those. And then if you want to put it together with that financial power of attorney, like who's controlling their money, you can certainly put all those documents together. If you do want to type everything out and customize it, just make sure you're following state law. Again, I would always advise using the standard templates and maybe adding to them if they're special needs that the patient has, but definitely and the durable power

of attorney for healthcare and the Living Well, there's usually a comment section. So you can add the special wishes of a patient I've seen when they're passing away, they want a type of music played or if they're in a nursing home they want. Here's what they want, they want, you know, certain things around them that provide them comfort, whether whether it's fresh fires every day, whether it's here's the type of food they want snack, so sometimes they're detailed in that capacity. And again, as we talk, sometimes they're detailed about other life sustaining treatments, what they really don't want, what they don't want. As far as sometimes I've seen CPR, I just want chest compression, I don't want any other of the components of the CPR, so you can kind of customize it, but still using those standard formats. Just make sure you're abiding by whether they need to be witnessed. And we all know that the witness has to be an independent witness. That can't be I can't as a nurse, witness it sign it. Physicians can't sign it. Those who are treating the patient cannot sign it now. If I'm an attorney, and my best friend wants me to help her witness it, and I'm not her healthcare surrogate can I serve as a witness? Absolutely. But just make sure your witnesses are impartial. Some of them require both witnesses and notarized. Some of them require you can notarize it. Some of it require just the two independent witnesses. So let's talk about I would always tell you client, you can have a copy to put in your

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file as their attorney, make sure they've given copies to their family members, definitely their surrogates, whoever their alternative surrogates are, they can actually provide a copy to their primary care physician, we're in the world of electronic health records. So oftentimes, hospitals and physicians, they're in sync with the same health system. So we've seen you know, health systems are able to directly employ physicians, so oftentimes that primary care might put it in their electronic medical record. And it's visible if that patient is admitted to the hospital. Or you can have the patient take it to the hospital. And again, they can integrate it into that patient's medical record. Or if that patient has never went to an hospital before they can actually go into a medical records of a hospital and have a record open and they can have a medical record opened and really could just be those two documents. So if maybe it's an elderly patient that moves and has a summer home, here in Michigan, but has a winter home in Florida, you want to make sure those two documents are in both of those states. And again, that you can go to a local hospital, they can open up a medical record. And basically it could just be those documents so it's ready for them should they use that hospital and have to have treatment at that particular, they also might want to give it to none of their primary care. But if they have a special physician specialized such as a cardiologist, nephrologist, pulmonologist, any other specialists that they see that they just want to provide those copies. And then we talked about they, if they would ever update those documents, they're in lies that they will always want to make sure they have the most updated version, you're going to sign it data, you're going to say it revokes the prior version. Perhaps if maybe it's 10 or 15 years and time has elapsed and the patient has really changed their mind. Rather than trying to amend it, you might just totally revoke their previous version and start

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again.

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We kind of talked about proper notification. So let's talk about those types of patients who should be entering These documents, I actually have advanced directives, just because of my nursing background and what I've seen. And of course, I would want my sisters and my parents to know what my wishes are. I haven't had to update those, I probably should update it with the the most available version, but it's still intact. It's available. It's a living, breathing document at any age, can any person say, here's what your wishes are. But typically, you want to if you have clients coming in, and they maybe have a family history of Alzheimer's, they're concerned about dementia. because keep in mind, once the patient loses their capacity, they can't then try to enter into a living will or does determine who should make healthcare decisions for him, they no longer have that capacity to provide a decision. So they can't really execute a living will at that time. And say they don't have a health care durable power of attorney or agent, typically, we're going to look to the next of kin. So is that spouse married? Do they have any adult children, typically, there's statutes that talk about informed consent, who's next in line to provide that proper consent. So that's sometimes why you want these documents if they don't want to use that informed consent, who's next in line to provide guidance. And again, if it's maybe your best friend, maybe a person that you work with that knows you a little bit more, or you're you don't want to put your spouse or children in that position to make healthcare decisions. That's why those documents are useful. So definitely somebody who's prior to Alzheimer's or dementia, maybe early onset of a diagnosis of cancer. They have heart disease, maybe chronic heart failure CHF, they have a respiratory type disease, maybe black lung, chronic obstructive pulmonary disease called COPD, perhaps they have renal disease, perhaps they have kidney failure. They basically have complex medical conditions, they're on top of it, maybe they're a diabetic, so that adds a level of complexity to their current medical condition. So I would definitely encourage them to if they don't complete the documents, start having conversations how they want their end of life care to, to look like. So this next slide here is from that document, convert calm cons are conversations that lead the way, excuse me about that. So here's just a couple of scenarios we talked about. If they're firstly diagnosed with dementia, or Alzheimer's, start having those conversations, perhaps they had a heart attack. And if they would have another heart attack, what will that look like? If they have a stroke, and it leaves them completely paralyzed? Whether it's paralyzed on one side of their body, maybe partial parallelisation, unable to speak, unable to eat unable to really enjoy life? What do they want done at that point? And or if they've been diagnosed with some form of cancer, so that is just some some opportunities and that toolkit, I really can't say enough about it. It just really starts those conversations and those what ifs. So what are the benefits and risk of my treatment? What do I want? What's the worst possible outcome? What's my bottom line? What does the big picture look like for me? What treatment

makes my life better? What happens if you refuse treatment? Are there other treatment decisions is that again, those are just goals to their end of life. resources. So here is wonderful resources. And like I said, I would have you go to the AARP website, I was really impressed with it. They have everything. They have those financial directives, they have end of life care directives, they have links to those standardized documents. And along also with this resource is just other. Some of these are federal agencies. And some of them are just national that we know from a healthcare perspective, such as the National Hospice and Palliative Care Organization, the National Alliance for Caregiving care connection, so American Academy of Hospice and Palliative Care Medicine. So you'll see those resources, you'll see the website, it's a wonderful opportunity, if the family there's a Family Caregiver Alliance, that they need a little bit more information to break some of these life sustaining treatments. They're, they're complex. So that is the end of my presentation. Again, it's just for you as whether your attorney just to be acclimated with these terms. There might be you know, a client that comes to you might not practice elder care. This not might not be your specialty, but you might know of another attorney that practices that your client, you can refer them to Oregon, you could just have them meet with their local hospital, usually social workers, advanced care nurses. The medical profession understands these documents. Oftentimes they can complete a note on their own. But again, if you're an attorney and you're dealing

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with eldercare, this is an opportunity for you to learn a little bit more about what what advanced care planning is