LIFE CARE & ADVANCE CARE PLANNING FOR DEMENTIA

RULON & ADAMSHICK, ELDER LAW PRACTICE:

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KOKUA MAU:

KŌKUA MAU "Continuous Care" A Movement to Improve Care

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Let our advance worrying become advance thinking and planning.

Winston Churchill

People don’t plan on failing.
People fail to plan.

WHY PREPARE?

Once cognitive capacity is lost, a person's ability to validly sign a legal document communicating directions is lost:

- No will: State has a will for a person without one.
- No power of attorney or trust: Court must appoint a conservator to manage and protect assets and a guardian to protect the person (both time-consuming & expensive)
- No advance health care directive: Loved ones must appoint a surrogate (decision maker) to second guess what kind of care an elder would want.

MAJOR DECISIONS

- **Who will care for you?**
- **How will long term care be paid?**
- **Who will make financial and/or medical decisions if you can't make them?**

THE LIFE CARE PLANNING APPROACH:

A comprehensive, *medical/legal team approach* to Elder Law combining the skills of an elder law attorney and geriatric nurse to help older clients (and their families) prepare for, access and pay for good quality long-term care.

THE VALUE OF AN ELDER CARE COORDINATOR

The Life Care Planning team includes an Elder Care Coordinator who

- Conducts a current and prospective Quality of Life assessment of:
  - Health and capacity
  - Environment
  - Social stimulation
  - Family dynamics and support
- Recommends resources and improvements, if any, in all areas and steps for health promotion
- Understands your baseline state of health

- Advocates at hospital in the event of a crisis
  - Admission, not observation
  - 3-day minimum for Medicare coverage of rehab
  - Assists with discharge planning to quality rehab program
- Beyond rehab, educates as to best options for
  - Living arrangements depending upon care needs
  - Caregiver sources
  - Other resources to enhance life
- Monitors care going forward and assists with problem solving and good decision making

THE ROLE OF THE ELDER LAW ATTORNEY

I. Evaluates and recommends proactive solutions to paying for possible long-term care, including

- Cash reserve
- Reverse Mortgage or Equity Line of Credit (RELOC or HELOC)
- Long Term Care Insurance
- Parental Protection Trust

II. Creates or updates Legal Documents

III. Assists with ensuring a revocable trust is properly funded

IV. Performs a pre-Medicaid qualification analysis (and may develop an eligibility plan)

V. Maintains an annual list of financial accounts, including the client’s long-term care fund

Legal Documents may include

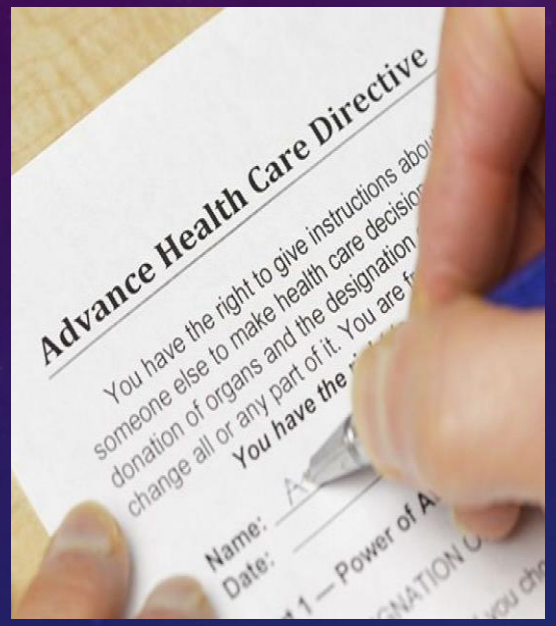
Directions as to your property:

- Will (for all property not in a trust)
- Revocable Trust
- Power of Attorney
- Medicaid Asset Protection Trust

Directions as to your care:

- Advance Health-Care Directive
- POLST (directions to EMS for emergency care)
- Your Way booklet & Letter to Doctor
- Caregiver Agreement

WHAT IS AN ADVANCE HEALTH-CARE DIRECTIVE (AHCD)?



A document under which you give another person the authority to manage your health care if you are unable to manage it yourself.

IT ALSO CONTAINS YOUR END-OF-LIFE DECISIONS, SUCH AS

- Removal of life support systems
- Pain management
- Feeding and hydration
- Organ donations

WHY DO YOU NEED AN AHCD?

- An AHCD is one of the most effective means to ensure your wishes for medical care are known if you cannot otherwise communicate.

- Doctors will use it as a guide to manage your care, and your Health Care Agent will use it to make sure you are getting what you want.

ADDITIONAL TOOLS TO EXPRESS YOUR WISHES

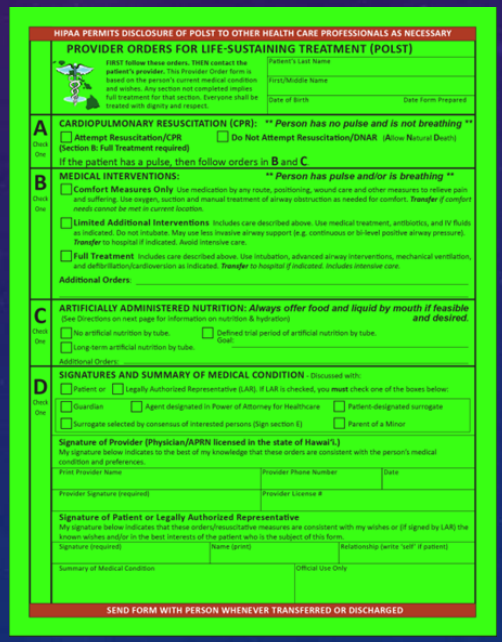
- Health decisions workbooks like
  - The Conversation Project
  - Your Way
  - Five Wishes

- Letter to your doctor or family

POLST FORM

- Portable Medical Order – signed by MD or APRN
- Documents a person's Care Plan
- Honored by EMS
- Appropriate for people with:
  - serious, chronic illness
  - frailty

Would you be surprised if this person died in the next year?


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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider. This Provider Order form is 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.

Patient's 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 (Section B: Full Treatment required) ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)

If the patient has a pulse, then 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. *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 less invasive airway support (e.g. continuous or bi-level positive airway pressure). *Transfer* to hospital if indicated. Avoid intensive care.

☐ 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: *Always offer food and liquid by mouth if feasible and desired.*

(See Directions on next page for information on nutrition & hydration)

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

☐ Long-term artificial nutrition by tube.

Additional Orders:

D Check One — SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

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

Print Provider Name | Provider Phone Number | Date

Provider Signature (required) | Provider License #

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

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

Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADVANCE HEALTH CARE DIRECTIVE VS. POLST

Advance Directives	POLST
For anyone 18 years or older	Persons at any age with serious illness
Identifies wishes for **future** healthcare	Indicates decisions about **current** treatments
Appoints a health care representative	Legally authorized representative can be noted
Does not translate into orders for EMS personnel	Actionable orders
CPR/DNR not addressed	CPR/DNR order

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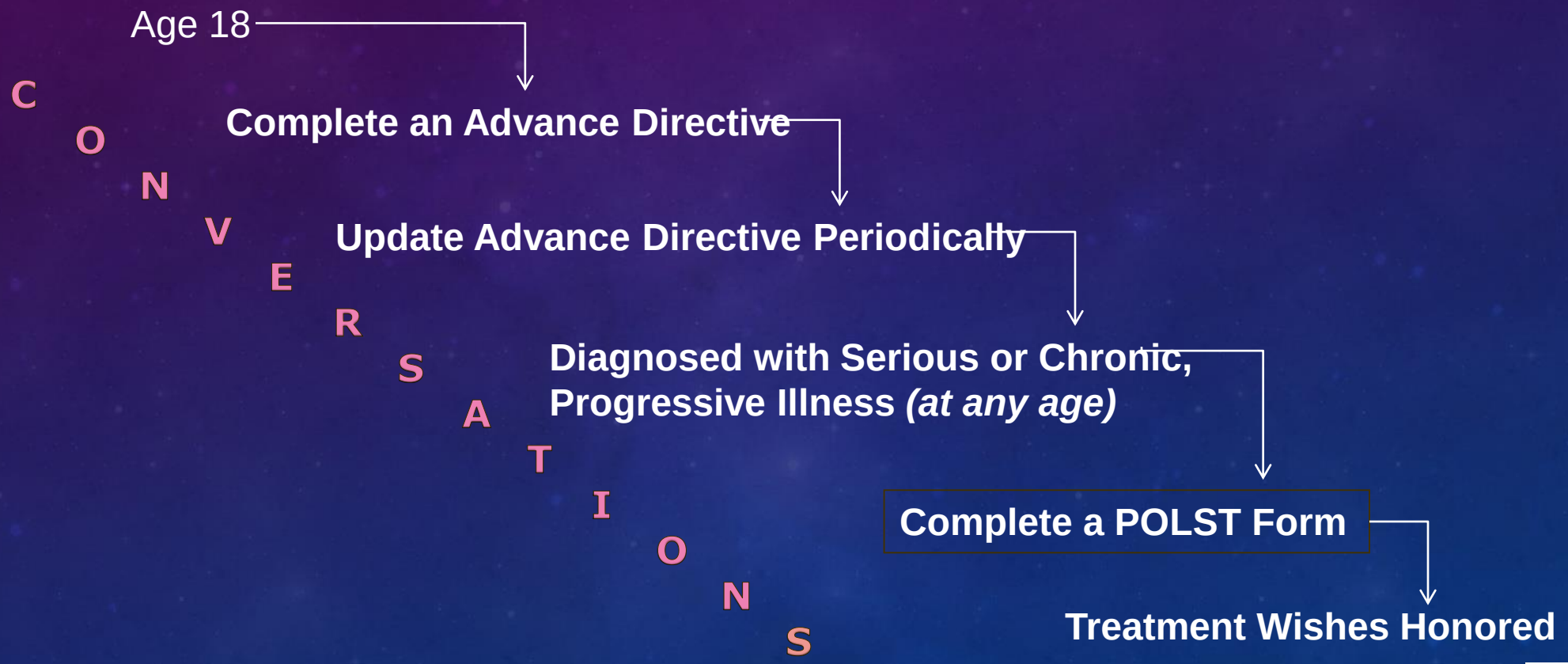
WHERE DOES POLST FIT IN?

Advance Care Planning Continuum



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RESOURCES:

Life Care Planning Law Firms Association:
https://lcplfa.org

Rulon & Adamshick LLC:
www.lifecareplanning-hawaii.com

Kokua Mau:
www.kokuamau.org

The Conversation Project:
https://theconversationproject.org/

Your Way:
www.help4srs.org

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