If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.

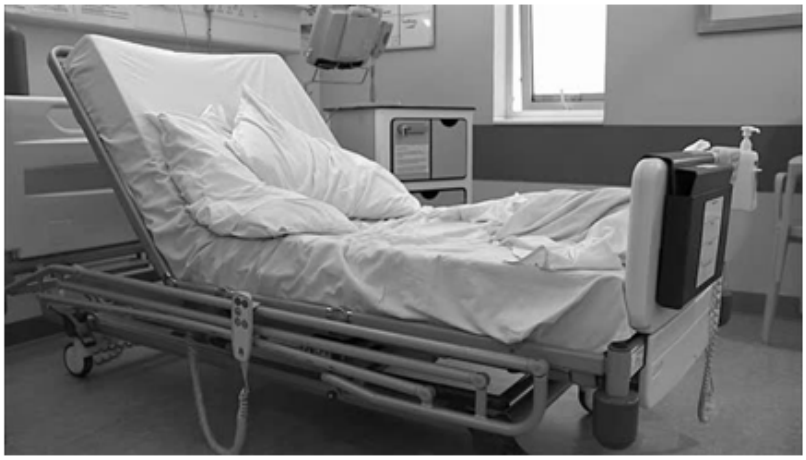
This handout is for reference only. It may not include content identical to the powerpoint. Any links included in the handout are current at the time of the live webinar, but are subject to change and may not be current at a later date.

Sharon Gorman, PT, DPTSc, GCS, FNP
Professor, Samuel Merritt University
Oakland, CA

Death & Dying: Things You Need to Know But Were Afraid To Ask

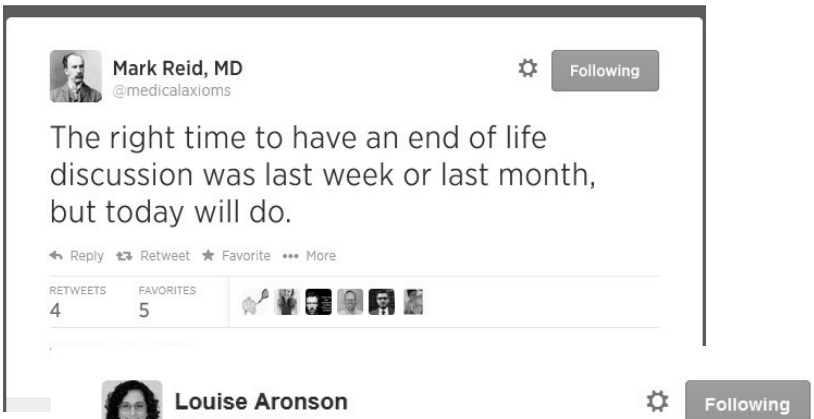
Objectives

* Compare and contrast current statistics related to end of life care in the US and information about patient values and wishes.
* Apply physical therapy interventions to the concept of "rehabilitation in reverse" as it relates to end of life patient care.
* Describe how using The Five Questions can open discussions with patients and their caregivers about concerns and values surrounding end of life care.
* Explore your perspectives on end of life care as the related to the death of a patient.




Elliot, have you been
in the supply closet crying?
Carla, I don't do that any more.

CONTINUED™



"If medicine takes aim at death prevention, rather than at health and relief of suffering, if it regards every death as premature, as a failure of today's medicine - but avoidable by tomorrow's - then it is tacitly asserting that its true goal is bodily immortality... Physicians should try to keep their eyes on the main business, restoring and correcting what can be corrected and restored, always acknowledging that death will and must come, that health is a mortal good, and that as embodied beings we are fragile beings that must stop sooner or later, medicine or no medicine."

(Kass LR. JAMA 1980;244:1947)

- "…almost everyone in medicine knows how to start CPR, when to start CPR, really what to do in CPR under even complex situations, but the one thing that almost no one really teaches us, and there are no guidelines for, is when to stop CPR. I think in some ways that is one of the biggest challenges that we in medicine face all the time."

-- Haider Warraich

5 Questions

What is your understanding of where you are and of your illness?

What are your fears or worries for the future?

What outcomes are unacceptable to you? What are you willing to sacrifice and not?

What are your goals & priorities?

What would a good day look like?

There are no boundaries on the ways we can creatively serve to optimize the human experience.

Ubiquity of death

- Not all of us get married…
- Not all of us get diabetes…
- Not all of us have children…
- But all of us will die – and we usually have no idea when.

Fantasy Death Exercise…

* Consider for a moment the most wonderful death you can imagine for yourself. As though you were in a play: it doesn't have to be realistic; it can be quite fantastic. You might not have thought about this before. Give it your best shot.
  * Where are you?
  * Who is with you?
  * What are you doing?
  * Any physical or emotional symptoms?
  * How long have you known?

…Fantasy Death Exercise

* Only caveat: as in life, you must die. There is no way out.
* What does your death look like?

… Fantasy Death: There are Common Themes

* Feeling at home, or being at home
* Comfort
* Sense of completion (task accomplished)
* Saying goodbyes
* Life review
* Love
* No pain
* Make it quick

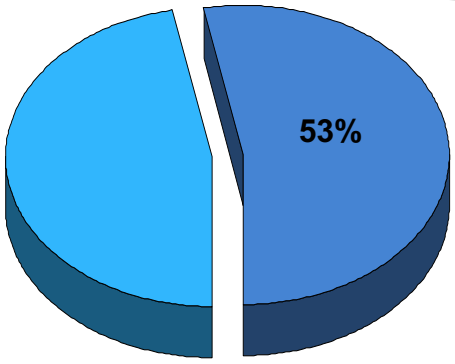
Consideration…

* Where's the disconnect?
* Does research have anything to add? Clarify?

SUPPORT: Background

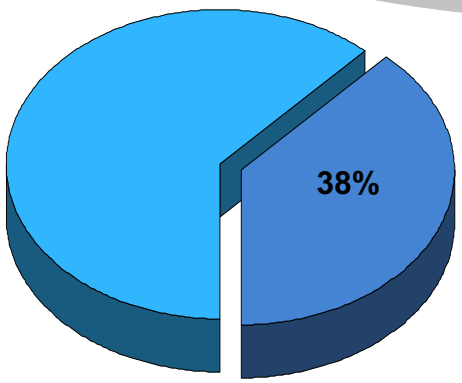
* Controlled trial to improve care of seriously ill hospitalized patients
* Multicenter study funded by RWJ
* 9000 patients with life threatening illness

Physician Did Not Understand That a Patient Wanted to Avoid CPR



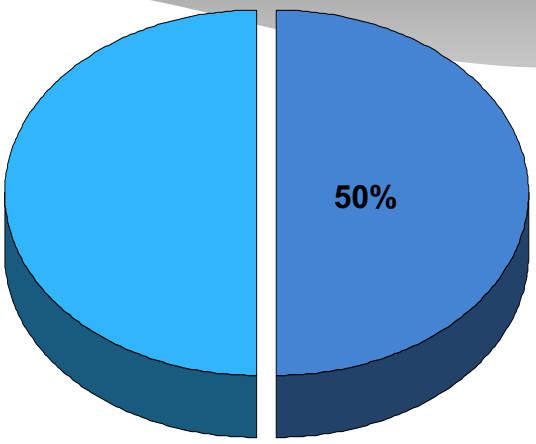
The study to understand prognoses and preferences for outcomes and risks of treatment (SUPPORT): phase II. *JAMA*. 1995;274(20):1591-1598.

Prolonged Suffering: 10 or More Days in ICU, in Coma, or on Ventilator



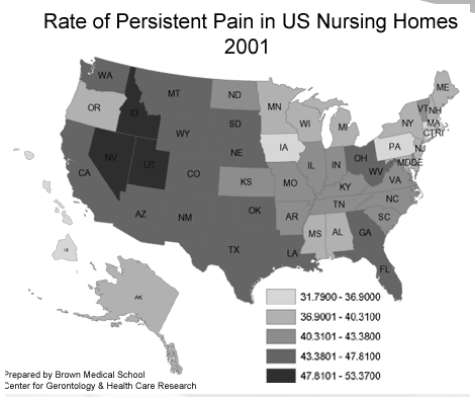
The study to understand prognoses and preferences for outcomes and risks of treatment (SUPPORT): phase II. *JAMA*. 1995;274(20):1591-1598.

Experienced Moderate or Severe Pain at Least Half of the Time Within Their Last Few Days



The study to understand prognoses and preferences for outcomes and risks of treatment (SUPPORT): phase II. *JAMA*. 1995;274(20):1591-1598.

2001 CA SNF PAIN DATA



* 44.4% had worsening pain or their pain remained at a severe level.
  * Nationally, the rate is 41.4%.
* Specific Conditions
  * CA: 51.1% were noted as having persistent severe pain.
    * Nationally, the rate is 46.7%.
  * Terminally ill: 46.3% experienced this level of pain.
    * Nationally, the rate is 44.3%.
* Persistent pain was 53.4%.
  * Nationally, the rate is 48.3%.

Impact of Serious Illness on Patients' Families

Needed large amount of family caregiving	34%	
Lost most family savings		31%
Lost major source of income	29%	
Major life change for family member	20%	
Other family illness from stress		12%
At least one of the above	**55%**	

(SUPPORT: phase I. JAMA. 1994;272:1839-1844).

SUPPORT: Site of Death

* Site of death predicted by :
  * number of hospital beds
  * hospice spending
  * % patients in nursing home
  * expenditures on long term care
  * diagnostic category
* Patient preferences irrelevant

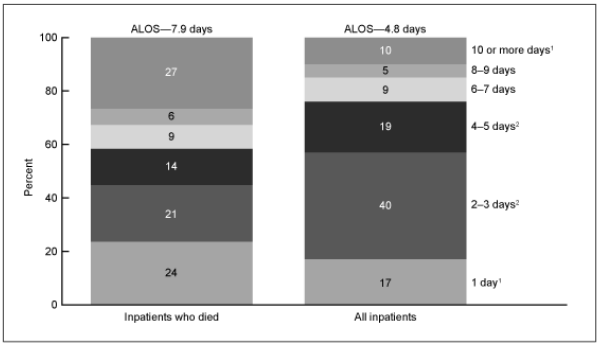
Site of Death—US adjusted rate

Site	1989	1997	2001
Home	15.9%	22.5%	23.4%
Hospital	62.3%	51.7%	49.5%
SNF	19.2%	23.0%	23.2%

Center on Gerontology and Health Care Research. Facts on dying Web Site. Available at: http://www.chcr.brown.edu/dying/usastatistics.htm. Accessed on May 22, 2017.

2010 LOS Differences

Figure 3. Hospitalizations ending in death and all hospitalizations, by length of stay: United States, 2010



[1]Percentage of those who died in the hospital was higher than percentage of all inpatients.

[2]Percentage of those who died in the hospital was lower than percentage of all inpatients.

NOTES: Percentages may not add to totals due to rounding. ALOS is average length of stay.

SOURCE: CDC/NCHS, National Hospital Discharge Survey, 2000–2010.

https://www.cdc.gov/nchs/products/databriefs/db118.htm

Are these data consistent with your fantasy death scene?

What is POLST?

Physician
Orders for
Life
Sustaining
Treatment

POLST
CALIFORNIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

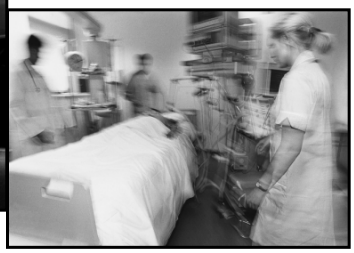
Why POLST?

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
CALIFORNIA

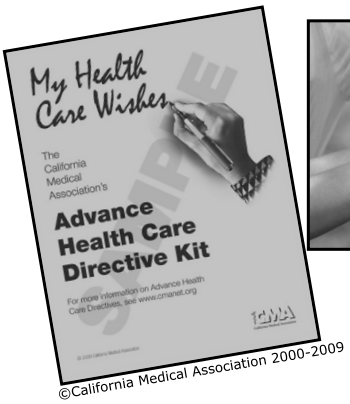
CONTINUED™

Case Study: What We Know



POLST CALIFORNIA

Case Study: What We Didn't Know



©California Medical Association 2000-2009

POLST CALIFORNIA

CONTINUED™

Case Study: What Happened

- AHCD not transferred with patient.
- DNR wishes not documented.
- Over-treatment against patient wishes.
- Unnecessary pain and suffering.

What is POLST?

- A physician order recognized throughout the medical system.
- Portable document that transfers with the patient.
- Brightly colored, standardized form for entire state of CA.

What is POLST?

- Allows individuals to choose medical treatments they want to receive, and identify those they do not want.
- Provides direction for healthcare providers during serious illness.

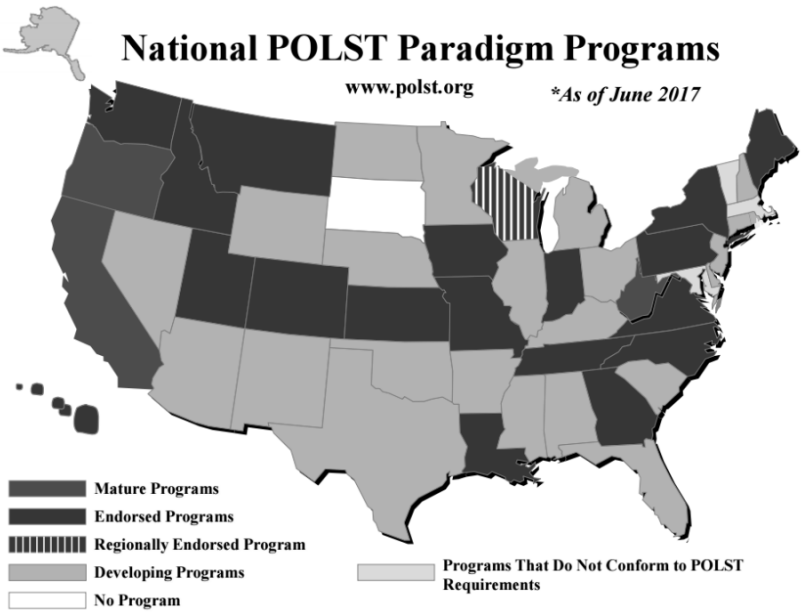
POLST CALIFORNIA

Who Would Benefit from Having a POLST Form?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- Tool for determination
  - "You wouldn't be surprised if this patient died within the next year."

POLST CALIFORNIA

CONTINUED™



POLST Success

- Oregon study of 180 Skilled Nursing Facility (SNF) patients:
  - POLST stated No CPR and Comfort Measures Only.
  - Patient wishes were honored.
- More research available at www.polst.org.

POLST CALIFORNIA

CONTINUED™

POLST in individual states

- One form for entire state.
- Use not mandated.
- **Honoring form is mandated**.
- Provides immunity from civil or criminal liability.

POLST CALIFORNIA

POLST vs. Advance Healthcare Directive

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

POLST CALIFORNIA

POLST vs. Advance Healthcare 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 decisionmaker	• Appoints decisionmaker

POLST CALIFORNIA

Where Does POLST Fit In?

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

C O N V E R S A T I O N

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness *(at any age)*

Complete a POLST Form

End-of-Life Wishes Honored

POLST CALIFORNIA

CONTINUED™

POLST vs. Pre-Hospital DNR *(Do Not Resuscitate)*

- Similarities:
  - Physician orders.
  - Address Do Not Resuscitate.
  - Intended for medically frail or those with chronic or serious illness.

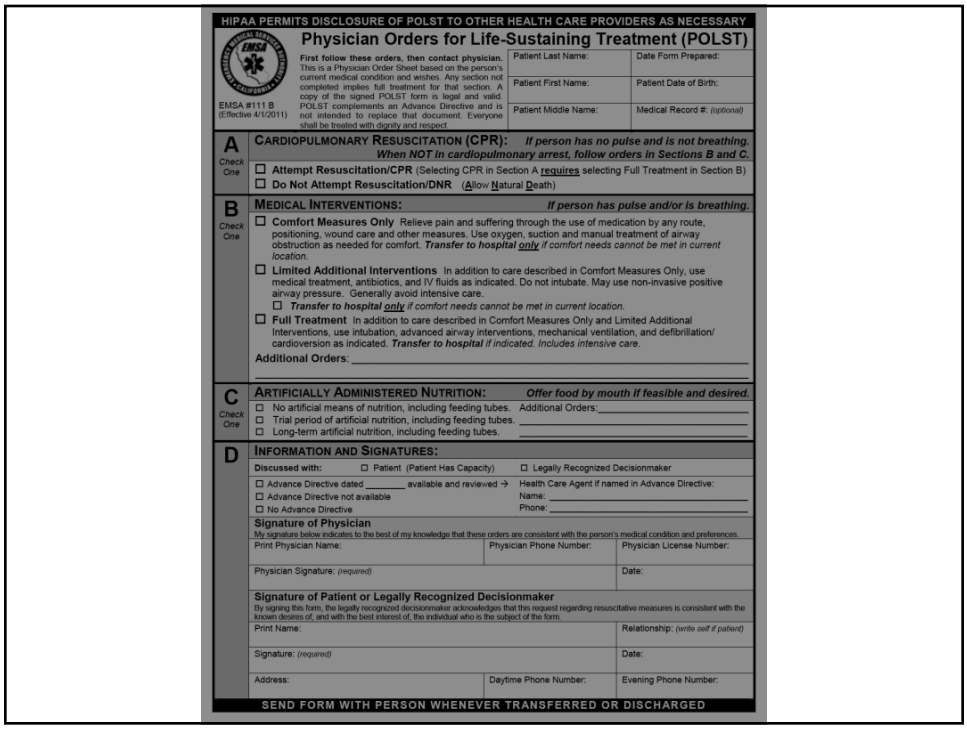
POLST CALIFORNIA

POLST vs. Pre-Hospital DNR *(Do Not Resuscitate)*

POLST	Pre-Hospital DNR
• Allows for choosing resuscitation	• Can only use if choosing DNR
• Allows for other medical treatments	• Only applies to resuscitation
• Honored across all healthcare settings	• Only honored outside the hospital

POLST CALIFORNIA

CONTINUED™



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. 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.

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

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

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** ***If person has no pulse and is not breathing. When 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** (**A**llow **N**atural **D**eath)

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

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

- ☐ 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: _____

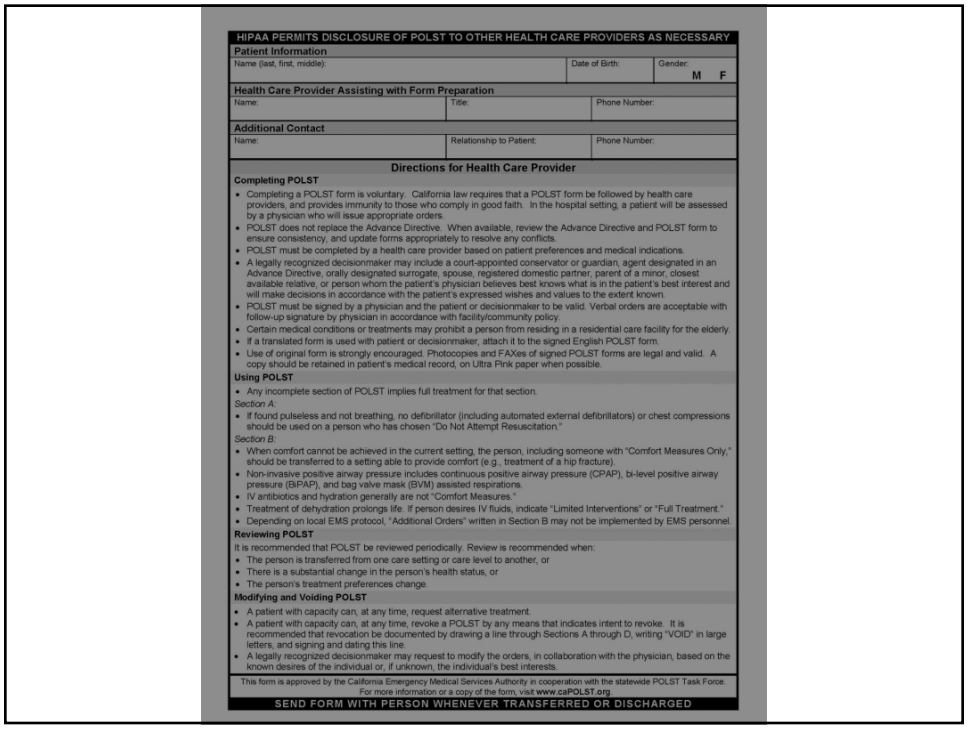
Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

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



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

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:

Additional Contact

Name:	Relationship to Patient:	Phone Number:

Directions for Health Care Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian; agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

CA POLST Form – Front Side

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)*

POLST CALIFORNIA

Section A: CPR

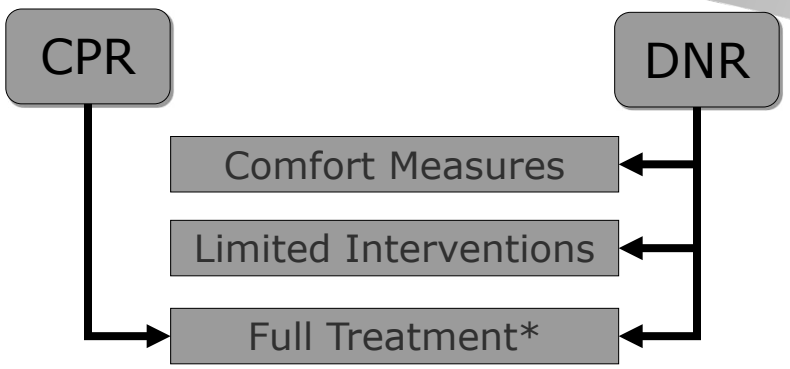
A *Check One*	CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.*
	☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
	☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

POLST CALIFORNIA

Section B: Medical Interventions

B Check One	MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*
	☐ **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: _____

Diagram of POLST Medical Interventions



*Consider time/prognosis factors under "Full Treatment"
"Defined trial period. Do not keep on prolonged life support."

Section C: Artificial Nutrition

C Check One	ARTIFICIALLY ADMINISTERED NUTRITION:	*Offer food by mouth if feasible and desired.*
	☐ No artificial means of nutrition, including feeding tubes.	Additional Orders:_____
	☐ Trial period of artificial nutrition, including feeding tubes.	_____
	☐ Long-term artificial nutrition, including feeding tubes.	_____

POLST CALIFORNIA

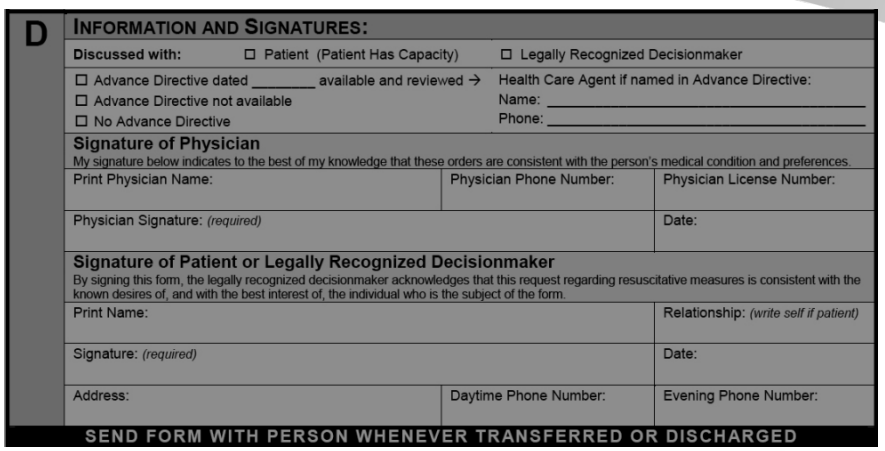
The POLST Conversation

- POLST is <u>not</u> just a check-box form.
- The POLST conversation provides context for patients/families to:
  - Make informed choices.
  - Identify goals of treatment.

POLST CALIFORNIA

CONTINUED™

Section D: Information and Signatures



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:
☐ Advance Directive not available Name: _____
☐ No Advance Directive 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

Who Can Speak for the Patient?

- Surrogate decisionmaker/agent
- Parent, guardian, conservator
- Closest available relative

CA POLST Form – Back Side

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
Patient Information			
Name (last, first, middle):		Date of Birth:	Gender: M F
Health Care Provider Assisting with Form Preparation			
Name:	Title:	Phone Number:	
Additional Contact			
Name:	Relationship to Patient:	Phone Number:	

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

When Should POLST be Reviewed?

- Transfer from one care setting to another.
- Change in patient's health condition.
- Patient's treatment preferences change.
- Patient Care Conference.

POLST CALIFORNIA

Can POLST be Changed?

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

POLST CALIFORNIA

CONTINUED™

Where Should We Keep POLST?

Original pink POLST stays with patient

- At SNF/Hospital:
  - File in medical chart (with AHCD).
  - Send original with patient upon return to home/SNF/hospital.
  - Keep copy if resident transferred; review POLST upon resident's return.

POLST CALIFORNIA

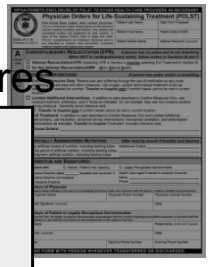
Where Should We Keep POLST?

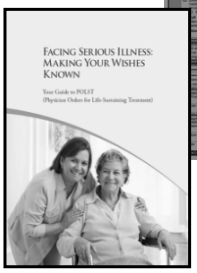
- At home:
  - Post in easy-to-find location (with AHCD).
  - Give to EMS to transport with patient.

POLST CALIFORNIA

POLST Form & Resources

- Available at **www.caPOLST.org**
  - Translations available
- Provider and Consumer Brochures
- FAQs
- Videos





POLST CALIFORNIA

"To cure sometimes,
To relieve often,
To comfort always."

- 15th C French saying

CONTINUED™

End of Life Care

* Technologically intense end of life care **less** likely…
  * In Whites
  * In North America and Northern Europe
  * If your physician shares your geo-ethnic background
  * If your physician has more clinical experience
  * If your physician routinely works in ICU

Frost et al. *Crit Care Med*. 2011;39(5):1174-1189.

End of Life Care

* Technologically intense end of life care **more** likely…
  * Younger
  * Less comorbid conditions
  * Good (not limited) functional status
  * Possibly male gender plays a role

Frost et al. *Crit Care Med*. 2011;39(5):1174-1189.

End of Life Discussions

* Patients and clinicians have different expectations & preferences
  * Religion
  * Race
  * Culture
  * Geography

Frost et al. *Crit Care Med*. 2011;39(5):1174-1189.

Palliative care & family (Gelfman, 2008)

* Palliative care integrates the family into the care of the patient at the end of life.

* Palliative care showed a benefit for bereaved family members
* 65% reported spiritual or emotional needs met
  * Vs. 35% w/o palliative care
* 67% reported confidence in self-efficacy domains
  * Vs. 44% w/o palliative care

Palliative care not just for hospice

- 20% of all deaths in US are in ICUs
- Mortality rate of 50% if in ICU for > 2 wks
- Goals of palliative care in ICU
  - Improve communication to promote patient autonomy
  - Improve provision of cost-effective care through better informed decisions
    - Avoid futile and unnecessary interventions

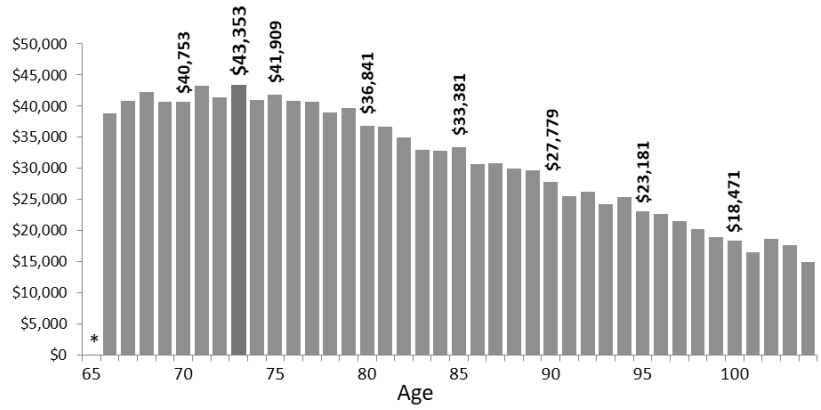
Morgan L et al. *Dimens Crit Care Nurs*. 2011;30(3):133-138.

Does Medicare Cover Palliative Care?

- Terminally ill, not pursuing curative treatment
  - Comprehensive, array of services
  - Physician must certify
  - Medicare Advantage plans not required to cover
    - Falls under Medicare A or B
- Can be provided in home or inpatient settings
- Hospice accounts for 10% of Medicare spending in last year of life
- Concerns about growth of for-profit hospice agencies

Figure 1

Among traditional Medicare beneficiaries over age 65 who die during the year, Medicare per capita spending decreases with age, 2014



Number of decedents	Ages 66-69: 0.1 million	Ages 70-74: 0.2 million	Ages 75-79: 0.2 million	Ages 80-84: 0.2 million	Ages 85-89: 0.3 million	Ages 90-94: 0.2 million	Ages 95-99: <0.1 million	Ages 100+: <0.1 million

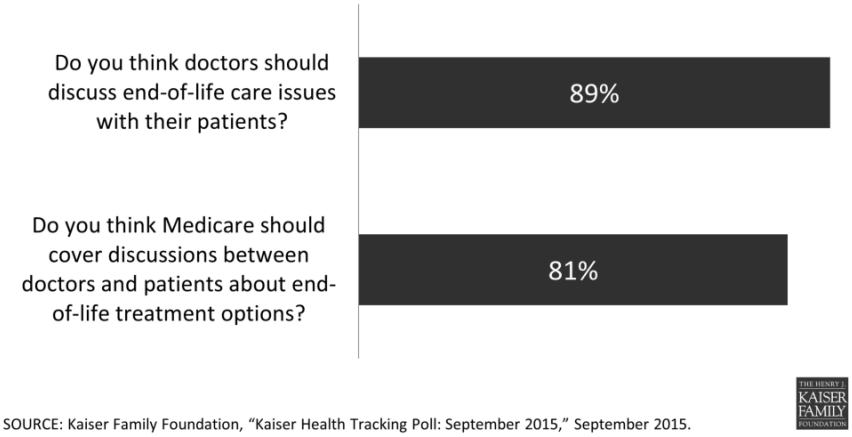
SOURCE: Kaiser Family Foundation, "Medicare Spending at the End of Life: A Snapshot of Beneficiaries Who Died in 2014 and the Cost of Their Care," July 2016.

Institute of Medicine Recommendations

- Coverage of comprehensive care Both advanced serious illnesses who are nearing the end of life
  - By both government and private health insurers
- Quality metrics/standards for clinician-patient communication and advanced care planning,
  - Insurance reimbursement tied to performance on these standards;
- Strengthening clinical training and licensing/credentialing requirements in palliative care
- Establish financial incentives for integrating medical and social
  - Including electronic health records that incorporate advanced care planning
- Provide information to the public on the benefits of advance care planning and the ability to for individuals to choose their own course of treatment.

Figure 2

Most adults say doctors should discuss end-of-life care issues with their patients and that Medicare should cover these conversations



SOURCE: Kaiser Family Foundation, "Kaiser Health Tracking Poll: September 2015," September 2015.

Physical therapy's place regarding palliative care

* Does PT have a place in palliative care?
* How can PT play a role in palliative care?
* What interventions can PT offer patient's in palliative care?

The patient comes first

* Patients and families at this stage are having significant interior dialogue, adjustments, and loss
* This is an ending, it will be tied to the life the patient had, the world they lived in
* A clinician who is intuitive will grab the moment for dialogue, which will pave the way for meaningful intervention

Dealing with death

* Grief
  * Interior, personal, adjustment
* Mourning
  * Community, cultural ritual observances at the time of loss
* Bereavement
  * Individual integration of loss through grief and mourning

Cultural Humility

* Predicated on the notion that you must have a good grasp on your own cultural background
* Suspension of all preconceived and educated ideas related to your patient/client
* Engage the patient/client in dialogue

In practice…

* Study to achieve competency and familiarly with rudimentary cultural generalizations
* Practice engaging in this type of dialogue
* Remain humble, be curious about the dialogue you do have
* Don't be scared to ask about something you don't understand
* Confess ignorance; rarely as offensive as the arrogance of assuming knowledge

The person on the healthcare team with the most power is the patient.

Take Home Lessons…

- Dying is part of living.
  - Need to approach it openly despite its difficulty
- Advance directives empower patients to reflect on their values, meaning of life, and illness experiences
- They help clarify patient's wishes as to plan of care, and foster the patient-physician relationship

… Take Home Lessons

* When illness is incurable and death is inevitable, goals may shift from cure to palliation
  * This shift is usually gradual as disease progresses and curative options are exhausted
  * Needs to be recognized early
* Setting clear goals helps guide direction & plan of care, & avoids confusion and conflict

Resources

* CA POLST
  www.caPOLST.org
* Partnership for Caring
  www.partnershipforcaring.org
* American Academy of Hospice and Palliative Medicine: http://www.aahpm.org
* National Hospice and Palliative Care Organization
  http://www.nhpco.org/directory/
* Death Over Dinner
  http://deathoverdinner.org/
* The Conversation Project
  http://theconversationproject.org
* Order of the Good Death (Ask a Mortician videos)
  https://www.youtube.com/user/OrderoftheGoodDeath

Questions?

* Sharon Gorman
* Email: sgorman@samuelmerritt.edu

References

* The study to understand prognoses and preferences for outcomes and risks of treatment (SUPPORT): phase II. *JAMA*. 1995;274(20):1591-1598.
* SUPPORT: phase I. *JAMA*. 1994;272(23):1839-1844.
* Teno JM, Gruneir A, Schwartz Z, Nanda A, Welte T. Association between advanced directives and quality of end-of-life care: a national study. *J Am Geri Soc*. 2007;55(2):189-194.
* Tilden VP, Tolle SW, Drach LL, Perrin NA. Out-of-hospital death: advance care planning, decendent symptoms, and caregiver burden. *J Am Geri Soc*. 2004:52(4):532-539.
* Clements JM. Patient perceptions on the use of advance directives and life prolonging technology. *Am J Hospice Palliative Care*. 2009;26(4):270-276.
* Center on Gerontology and Health Care Research. Facts on dying Web Site. Available at: http://www.chcr.brown.edu/dying/usastatistics.htm. Accessed on June 21, 2014.

References (con't)

* Johnston SC, Pfeifer MP, McNutt R. The discussion about advance directives. Patient and physician opinions about when it should occur. End of life study group. *Arch Intern Med*. 1995;155(10):1025.1030.
* Gelfman LP, Meier DE, Morrison RS. Does palliative care improve quality? A survey of bereaved family members. *J Pain Symptom Manage*. 2008;36(1):22-28.
* Kass LR. Ethical dilemmas in the care of the ill: what is the patient's good? *JAMA*. 1980;244(14):1947.
* Frost DW, Cook D, Heyland DK, Fowler RA. Patient and healthcare professional factors influencing end-of-life decision-making during critical illness: a systematic review. *Crit Care Med*. 2011;39(5):1174-1189.
* Morgan L, Howe L, Whitcomb J, Smith K. Improving communication and cost-effectiveness in the intensive care unit through palliative care. *Dimens Crit Care Nurs*. 2011;30(3):133-138.

References (con't)

* POLST California. Coalition for Compassionate Care website. http://capolst.org/. Accessed June 21, 2017.
* 10 FAQs: Medicare's Role in End of Life. Kaiser Family Foundation website. http://www.kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/. Accessed June 20, 2017.