Learn and apply Leadership & Quality Improvement principles from experts!
Share and get practical tips from colleagues!

✓ Community of Learning
✓ Confidential Case Sharing
✓ Practical

✓ Interdisciplinary
✓ On-line Learning
✓ Free CME and CE

Project ECHO University of Hawaii
Long-Term Care Learning Action Network
A Collaborative Partnership to Provide Education from Quality Improvement and Leadership and Implementation Experts with Case Discussion to build a Community of Learning

Long-Term Care Learning Action Network

This series is made possible through GWEP funding to the University of Hawaii Department of Geriatric Medicine from the Health Resources and Services Administration (HRSA): Grant Nos. U1QHP28729 and T1MHP39046 and the support from generous our donors- AlohaCare and UnitedHealthcare
Confidential & Safe

We commit to maintain and safeguard the confidentiality of information shared. All case presentations are required to be de-identified and HIPAA compliant. In order to create a safe learning environment, we will foster a culture of mutual learning and encouragement, rather than negativity, shame and blame.

ECHO case consultations do not create or otherwise establish provider-patient relationships between any ECHO specialists and patients whose cases are being presented in an ECHO setting.
Learning Objectives

• Explore strategies for well-being during the Pandemic and recovery
• Practice Age Friendly Health Systems strategies
• Identify QI strategies to improve nursing home care.
• Increased knowledge for regulatory guidance for COVID and QMs
The Hawaii Consortium for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This program is approved by the National Association of Social Workers - Hawai‘i Chapter (Approval HI62792021-190) for up to 1 Social Work continuing education contact hour(s).

In order to receive CMEs please:

1. Register:
   https://echo.zoom.us/meeting/register/tJUqcuysrjsvGtE2kdnnVk9kl4iAu9cPoOGB
2. Complete an Evaluation
   https://geriatrics.jabsom.hawaii.edu/nh-echo-lan/

** Some systems do not allow access to google forms. Fillable PDFs can be found on our website. Please send to Jon at Nakasone@hawaii.edu
If you would like to get AFHS Recognition from IHI for providing comprehensive geriatric care at your Nursing Facility, we can help you.

Stay tuned...
What Matters Series - 4 Parts

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb</td>
<td>Who Knows What Matters?</td>
</tr>
<tr>
<td>Mar</td>
<td>Understanding What Matters</td>
</tr>
<tr>
<td>Apr</td>
<td>Addressing What Matters</td>
</tr>
<tr>
<td>May</td>
<td>Care Plans that Matter</td>
</tr>
</tbody>
</table>

** Session Topics subject to change

LTC ECHO LAN

Schedule 2\textsuperscript{nd} Tuesday of each month
2:00 - 3:00 pm
Introducing: The Hub Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aida Wen, MD, CMD</td>
<td>UH Dept of Geriatric Medicine</td>
<td>Course Director</td>
</tr>
<tr>
<td>Hope Young Kokua Mau</td>
<td>Kokua Mau</td>
<td>Speaker</td>
</tr>
<tr>
<td>Gayle Rodrigues, MSN, RN</td>
<td>Director of Nursing, Oahu Care Facility</td>
<td>Facilitator</td>
</tr>
<tr>
<td>Dana Mitchell, RN</td>
<td>Mountain Pacific Quality Health</td>
<td>QI Coach</td>
</tr>
<tr>
<td>Lori Henning, LNHA</td>
<td>HAH-Quality &amp; Education Program</td>
<td>COVID and Regulatory updates</td>
</tr>
</tbody>
</table>
Wellness

1. Rest
2. Restore
3. Create
4. Connect

These are important to put back into your life – DO IT THIS WEEK!
Regulatory & COVID-19 Updates

Healthcare Association of Hawaii
What Matters Series – Part 3

Addressing What Matters Most

Documenting the Conversation
Let’s Talk Story!!

Kokua Mau’s Let’s Talk Story Program

Advance Directives and POLST

Hope Young
Advance Care Planning Coordinator
Advance Care Planning
Why is it important?

- No one knows when they may become “Very ill”
- Helps companions to find their voice
- Helps prepare them and their family for what’s coming
- Ease the burden for others having to make tough choices
- Helps assure their wishes are followed
- COVID 19 has changed the way health care is provided
“I’m not afraid of death; I just don’t want to be there when it happens.”

~Woody Allen
If the unexpected happened,

Who would speak for you?
Would they know what you would want?

Or possibly what you would not want?
Did you know…

- Everyone over the age of 18 should have an Advance Health Care Directive (AD or AHCD) which appoints a Health Care Agent.

- Without an AD, precious time could be spent trying to designate a Health Care Agent from “interested parties”, there is no next-of-kin hierarchy in the state of Hawaii. If the “interested parties” cannot come to an agreement, it could become a guardianship case, which could take 6 months to resolve.
Cover all your bases!

Types of Planning

- Personal Planning for while you are alive
  - Advance Care Planning
  - Health
  - Personal
- Estate Planning for after death
  - Will
  - Legal
  - Financial

Source: Nidus Personal Planning Resource Centre and Registry
Advance Health Care Directive

Available to download on Kokua Mau Website  www.kokuamau.org
Advance Health Care Directive (AHCD)

- Legal document completed only when you are of **sound mind**
- Appoints a Health Care Power of Attorney (s)
- State instructions for future choices on your end of life decisions
AHCD – Part 1:
Health Care Power of Attorney (HCPOA)

- Who do you trust to make health care decisions for you when you cannot?
  - Familiar with your personal values
  - Willing and able to make decisions
- Doesn’t need to be a family member.
- Select alternate
AHCD – Part 2
Section A: End of Life Decisions

Becomes effective only when:

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.
Choice –
Prolong or Not to Prolong Life

- “I want to stop or hold medical treatment that would prolong my life”

  OR

- “I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards”
PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:
Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)
Artificial Nutrition and Hydration: Important considerations

- Individual and personal decision.
- In some illnesses (e.g. stroke, esophageal/throat cancer) artificial nutrition can prolong life.
- In others (Parkinson’s, dementia, terminal cancer) artificial nutrition may not prolong life.
Section C & D: Relief of Pain and Other Important considerations

- Pain medications to ensure comfort at the end of life can hasten death.
- This is considered ethically acceptable by most medical professionals to provide comfort.
- Again, this is a personal and individual decision.

C. RELIEF FROM PAIN:
   □ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER
   □ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)
AHCD Part 2 –
Section E: What is Important to Me?

- What makes life meaningful?
- What would make quality of life unacceptable?
- If a trial of support is wanted – how long would they want?

---

**E. WHAT IS IMPORTANT TO ME:** (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

---

My thoughts about when I would not want my life prolonged by medical treatment (Examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

---
Must be signed in the presence of:

A Notary Public

OR

Two Witnesses

Witnesses

- must be 18 years or older
- Cannot be your health care agent, a health care provider or an employee of a health care facility
- One witness cannot be a relative or have inheritance rights
What is POLST?

- Provider
- Orders for
- Life
- Sustaining
- Treatment
Who Would Benefit from Having a POLST Form?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- A person for whom you would issue an in-patient DNR order
- “Would you be surprised if this patient died within the next year?”
POLST in Hawaii

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

Effective 2009, Updated 2014
HI POLST Form – Information

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

**PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)**

<table>
<thead>
<tr>
<th>Patient’s Last Name</th>
<th>First/Middle Name</th>
<th>Date of Birth</th>
<th>Date Form Prepared</th>
</tr>
</thead>
</table>

**Patient’s Preferred Emergency Contact or Legally Authorized Representative**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Date Form Prepared</th>
</tr>
</thead>
</table>

**Health Care Professional Preparing Form**

<table>
<thead>
<tr>
<th>Preparer Title</th>
<th>Phone Number</th>
<th>Date Form Prepared</th>
</tr>
</thead>
</table>
Section A:
Cardiopulmonary Resuscitation (CPR)

**Person has no pulse and is not breathing**
Section B: Medical Interventions

**Person has pulse and/or is breathing**
Diagram of POLST Medical Interventions

CPR

Comfort Measures

Limited Interventions

Full Treatment*

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

DNAR
Always offer food and liquid by mouth if feasible and desired.
**POLST**

**Section D – Important Signatures!**

- Physician or Advance Practice Registered Nurse (APRN) and
- Patient or their Legally Authorized Representative (LAR)
- LAR - Agent designated for Health care Power of Attorney:
  - Parent of a Minor
  - Patient-designated Surrogate
  - Surrogate selected by consensus of interested persons
  - Guardian

![Signature Summary Form]

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**Kōkua Mau Continuous Care**

**A Movement to Improve Care**
Section E: Surrogate Information

- Section E **only** needs to be completed if the patient lacks capacity and has not designated a health care power of attorney.

- **Non-Designated Surrogate:** This individual is appointed in accordance with HRS 327E, and has limitations placed upon him or her with respect to decisions about withholding or withdrawing artificial hydration & nutrition.

![Surrogate Selection Form](image-url)
Practical considerations

- Recommended to be printed on lime green paper (but any color, including black and white is acceptable)
- A copy of the POLST form is legal
- Recommended to be kept in a visible place at home:
  - Refrigerator
  - Bedroom door
  - Bedside table
  - Medicine cabinet
- A copy should be given to EMS personnel
- POLST is not transferable from state to state
## Advance Health care Directive vs. POLST

<table>
<thead>
<tr>
<th>Advance Directives</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>For anyone 18 years or older</td>
<td>Persons at any age with serious illness</td>
</tr>
<tr>
<td>Identifies wishes for <strong>future</strong> healthcare</td>
<td>Indicates decisions about <strong>current</strong> treatments</td>
</tr>
<tr>
<td>Appoints a health care representative</td>
<td>Legally authorized representative can be noted</td>
</tr>
<tr>
<td>Does not translate into orders for EMS personnel</td>
<td><strong>Actionable orders</strong></td>
</tr>
<tr>
<td>CPR/DNR not addressed</td>
<td>CPR/DNR order</td>
</tr>
</tbody>
</table>
Where Does POLST Fit In?

**Advance Care Planning Continuum**

- Age 18
  - Complete an Advance Directive
  - Update Advance Directive Periodically
    - Diagnosed with Serious or Chronic, Progressive Illness *(at any age)*
      - Complete a POLST Form
        - Treatment Wishes Honored
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.
POLST Conversations

- Opportunity to increase awareness of different courses of action possible

- Introduce concept of Palliative Care and Hospice

- Change the question:
  “What’s the matter with me?”
  to
  “What matters TO me?”
Kokua Mau Contact

Jeannette Koijane, Executive Director
jkoijane@kokuamau.org
808-585-9977
Hope Young, ACP Coordinator
hope@kokuamau.org
808-221-2970

www.theconversationproject.org
ACP Strategies
Talking about what matters

April 12, 2022
“The whole process of discussion of end-of-life care, clarification of related values and goals, and embodiment of preferences through written documents and medical orders. This process can start at any time and be revisited periodically, but it becomes more focused as health status changes.”

_Dying in America: Improving Quality and Honoring individual Preferences Near the End of Life_, National Academy of Sciences, 2014
“A resident who is at the end of life or in terminal stages of an illness or who has multiple organ system failures may have written directions for his or her treatment goals (or a decision has been made by the resident’s surrogate or representative, in accordance with State law). Although a facility’s care must reflect a resident’s wishes as expressed in the Directive, in accordance with State law, the presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advance Directive*”
Facility Requirements

• Provide written information about the right to formulate an advance directive
• Document in record
• Can’t provision care or discriminate due to an advance directive
• Educate staff on policies and procedures
Important Caveat-DNR

The presence of a "Do Not Resuscitate" (DNR) order is not sufficient to indicate the resident is declining other appropriate treatment and services. It only indicates that the resident should not be resuscitated if respirations and/or cardiac function cease.
Avoid Citations

- Ensure the care plan is resident-centered, individualized and consistent with their wishes
- Implement appropriate interventions or document why you cannot/should not implement
- Provide care based on the resident's needs
QI Efforts

• Periodically assess the number of residents who have advance directives in place
• Educate on strategies for having compassionate end of life conversations
• Consider adjusting efforts to boost completion: host an event, develop an awareness or education campaign for residents and families
• Ensure you have the appropriate staff members on your palliative team
Resources/References

SOM - Appendix PP (cms.gov)

How to Talk to Your Patients about End-of-Life Care (ihi.org)

Coffee and Conversation: How to Encourage Advance Care Planning (ihi.org)

The Conversation Project - Have You Had The Conversation?
OPEN FOR DISCUSSION

THANKS FOR CARING!
LOOK FOR 3 THINGS:

#1

GENERAL POWER OF ATTORNEY
OF
Jane Doe

I, ______________________, the Principal, of ______________________ [street address], City of ______________________, State of ______________________, hereby designate ______________________, [attorney-in-fact’s name], of ______________________ [street address], City of ______________________, State of ______________________, my attorney-in-fact (hereinafter referred to as “the Attorney-in-fact”) to act as set forth below, in my name, in my stead and for my benefit under this instrument and to exercise all powers of attorney I may have executed in the past.

#2

Advance Health Care Directive

You have the right to give instructions about your medical care

If you are unable to communicate, your designated person may make decisions about your medical care. It is understood that you have decided who that person will be. If you do not have a person designated, the person you have designated will be the person chosen for you.

#3

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Your health care professional(s) or any other health care professional(s) that you see during your treatment may use this information in making decisions about your medical care. If you do not have a person designated, this form will be used to determine your medical care decisions.

Signature of the Principal:

Date:

Signature of the Designated Person:

Date:
You will receive a link to fill out an online survey form to share how many of your residents have these 3 documents.

Please try have someone screen all your residents before our next session.

Please try to complete this, it helps us demonstrate that you are doing a good job helping residents achieve their wishes!

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>HOW MANY HAVE?</th>
<th>TOTAL# RESIDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power of Attorney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Care Planning (e.g. DPOA HC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLST form</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NEED HELP?

• MONDAY, 4/18/22
  • 2pm

Mibrao@hawaii.edu