



# The CARES Toolkit

## End-of-Life Cases and Resources:

An Interprofessional Toolkit for Health Science Students

Case Study

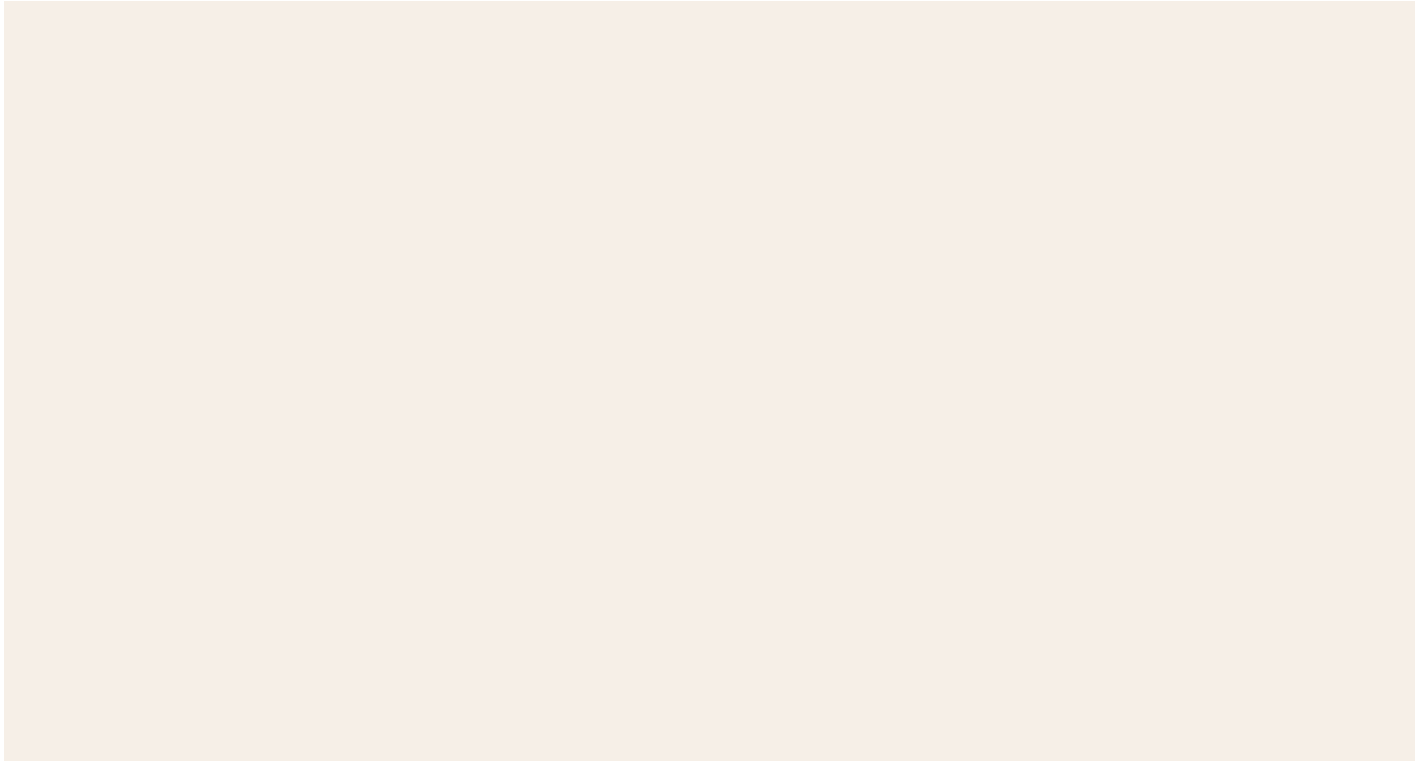


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*Case Title*

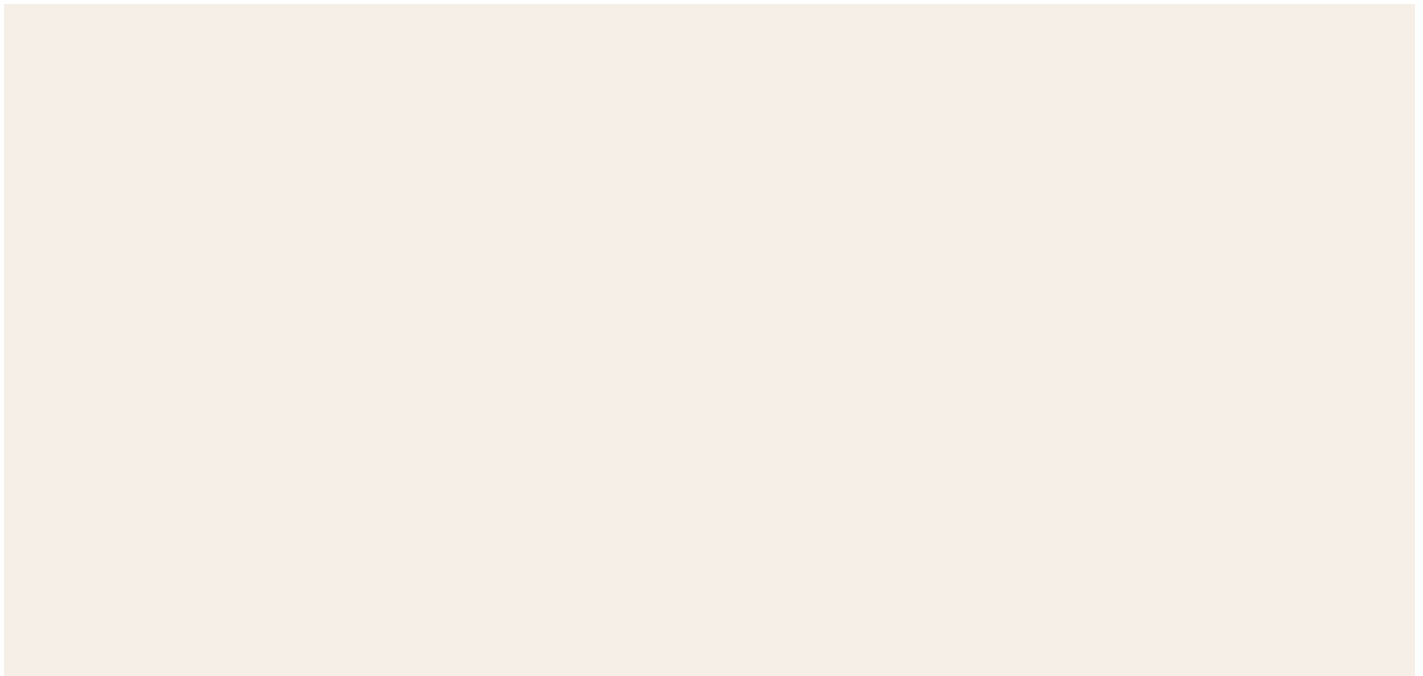
## Case Summary

### Encounter #1 Setting



*Ex. Community site, home, clinic, ED, hospital, assisted living, long-term care nursing home*

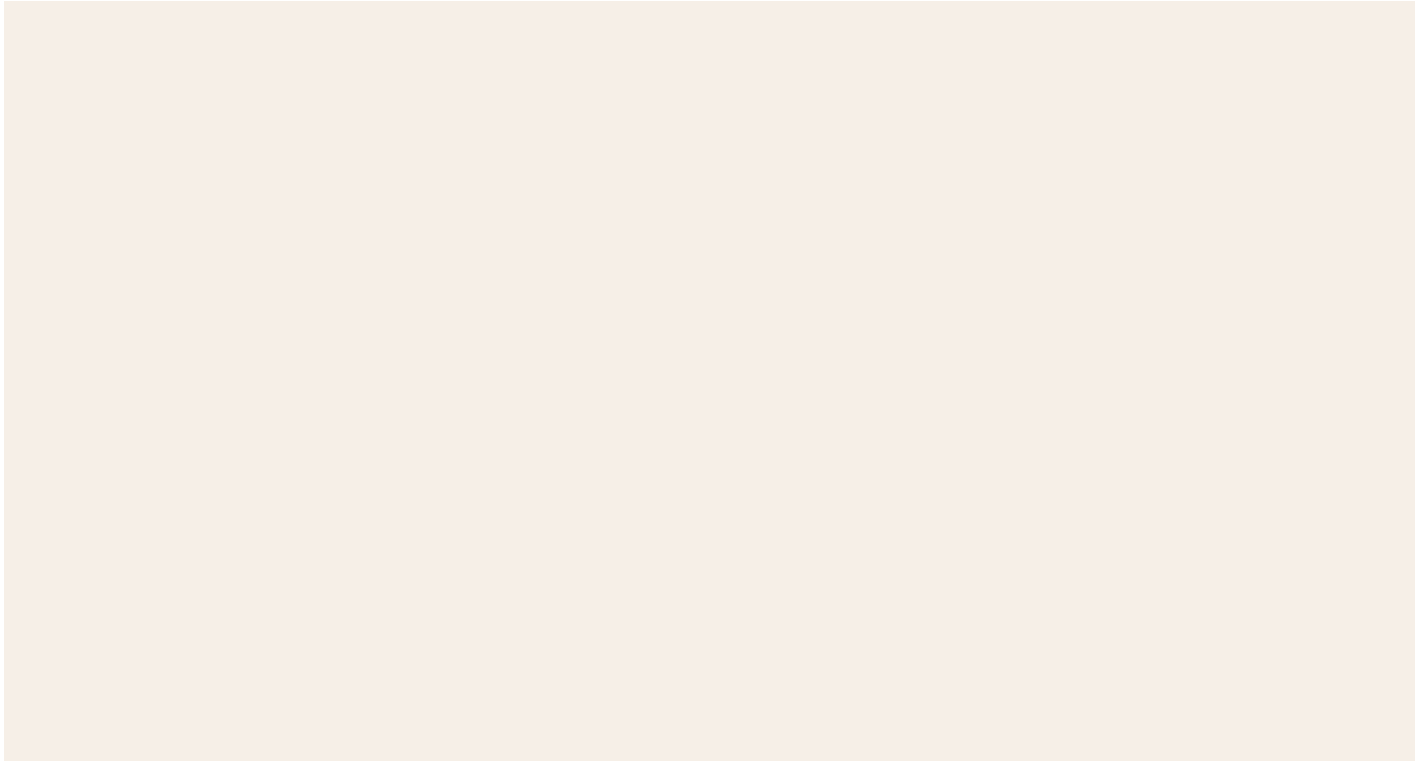
### Context / Reason for Encounter #1



*Ex. Background/sets the stage; include cultural beliefs/perspectives, ADLs/IADLs, suicide ideation or risk of*

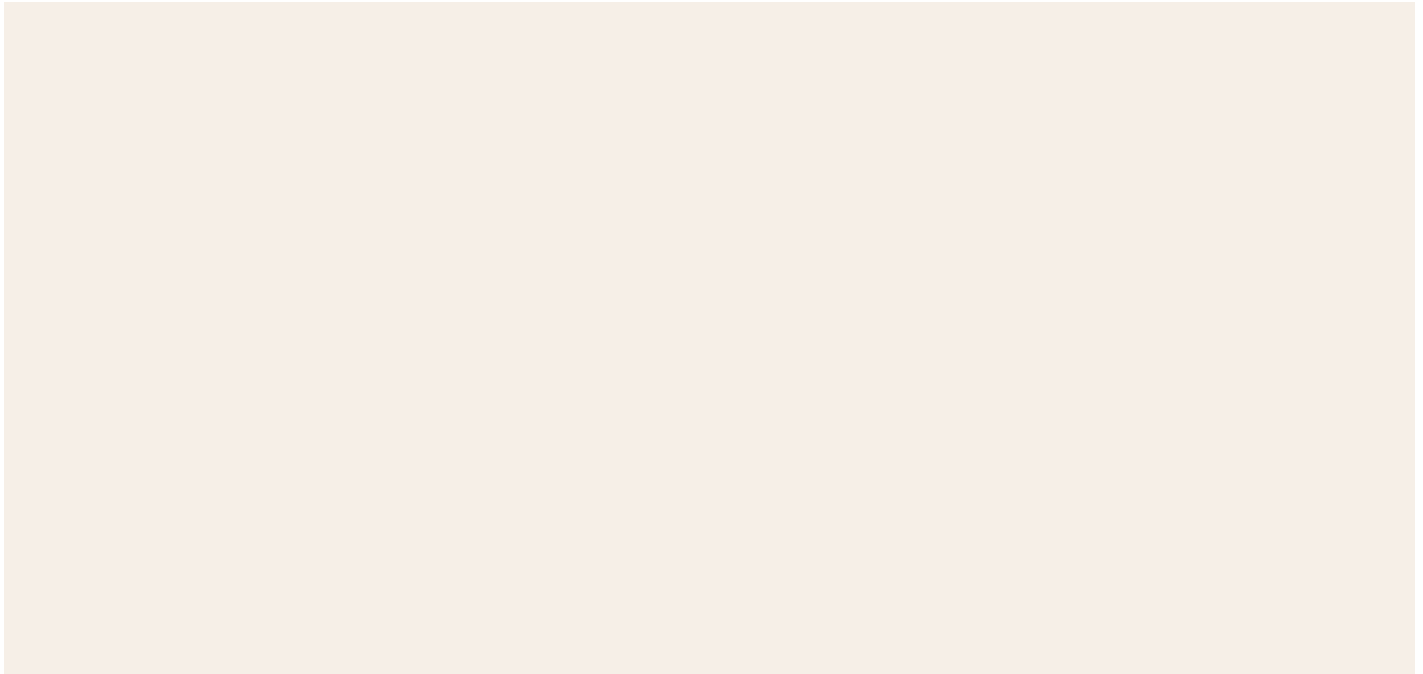
## Case Summary

### Encounter #2 Setting



*Ex. Community site, home, clinic, ED, hospital, assisted living, long-term care nursing home*

### Context / Reason for Encounter #2



*Ex. Background/sets the stage; include cultural beliefs/perspectives, ADLs/IADLs, suicide ideation or risk of*

## Demographics

Gender

Age or Date of Birth

Ethnicity

Living Situation

*Ex. Living in house/apartment/mobile home/homeless (unhoused), number of people in home, do they feel safe at home or in neighborhood, primary language/languages spoken at home*

Patient Occupation

Insurance Coverage Status

*Eligible for the following benefits/services*

## Family / Caregiver Issues

*One or more caregivers, family caregivers, paid caregiver, etc.*

## Social History

### Social Economic Status

### Social Determinants of Health

*Ex. Food or housing or transportation insecurity; utility need; financial resources; childcare; education; employment instability; legal resources; social isolation; health literacy*

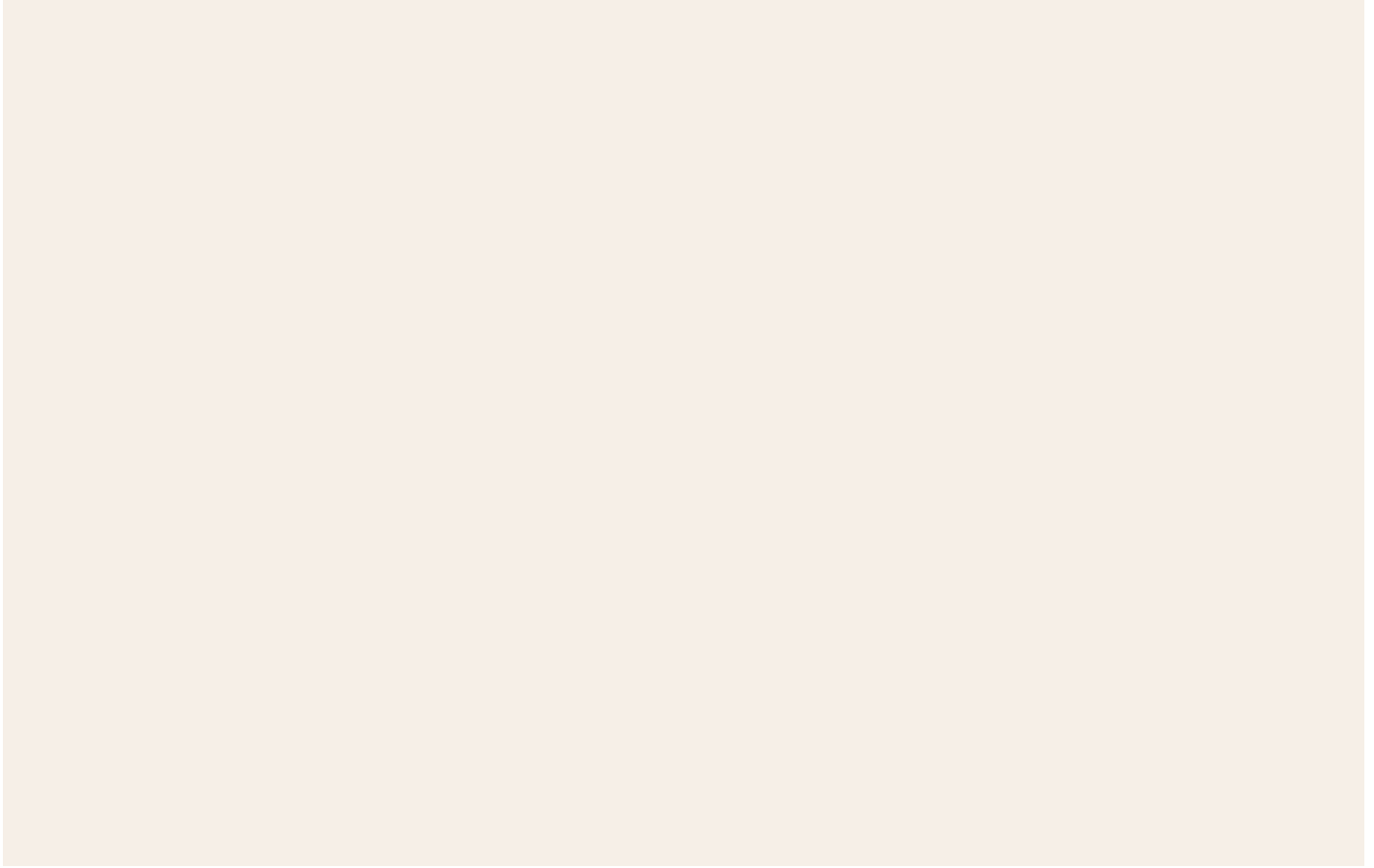
### Social / Mental Health Wellbeing

### Religious / Spiritual Considerations

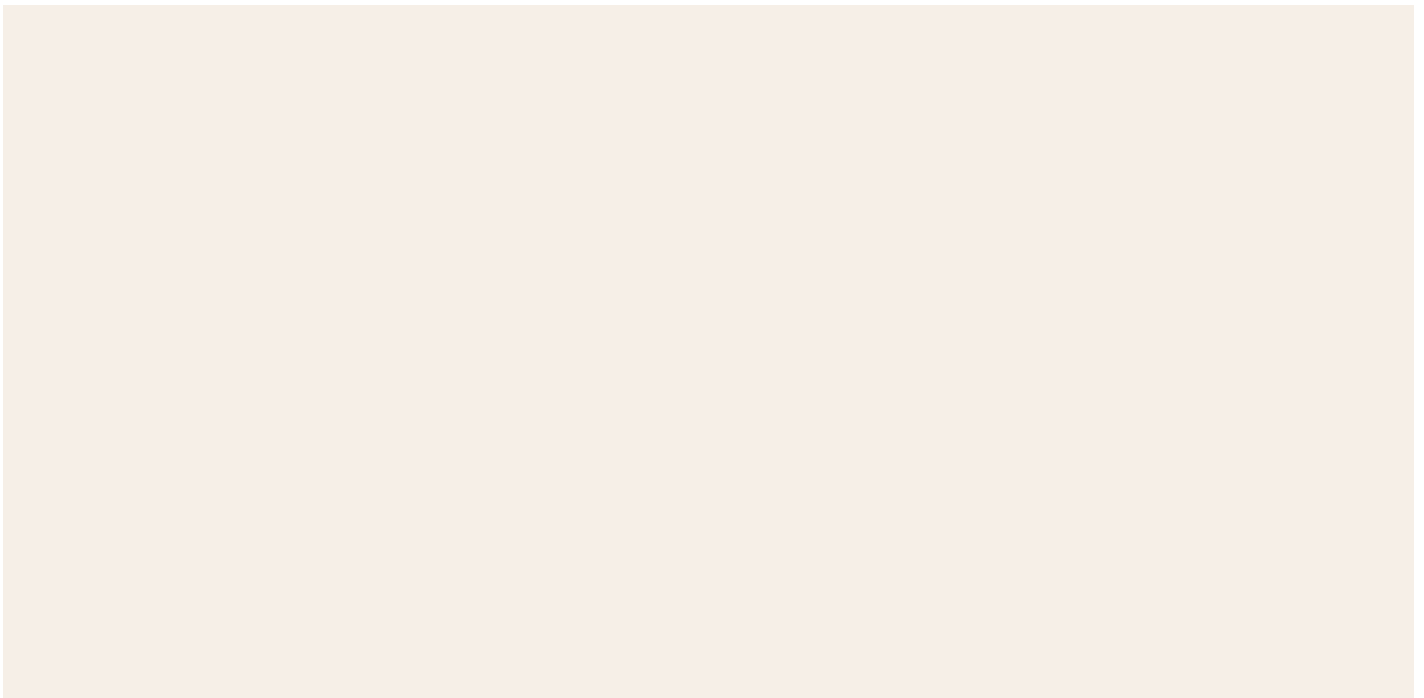
### Cultural Beliefs / Perspectives

# Patient Health Information

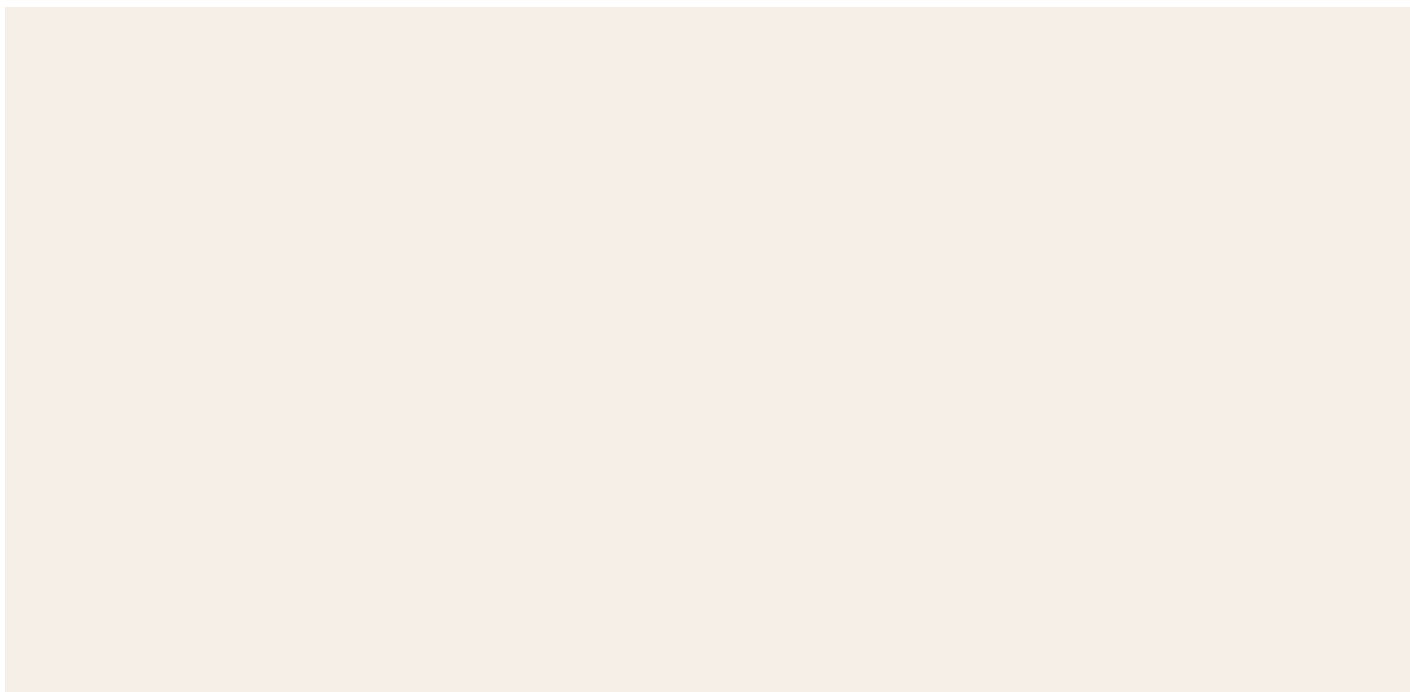
## History of Present Illness

A large, empty, light beige rectangular area intended for the patient's history of present illness.

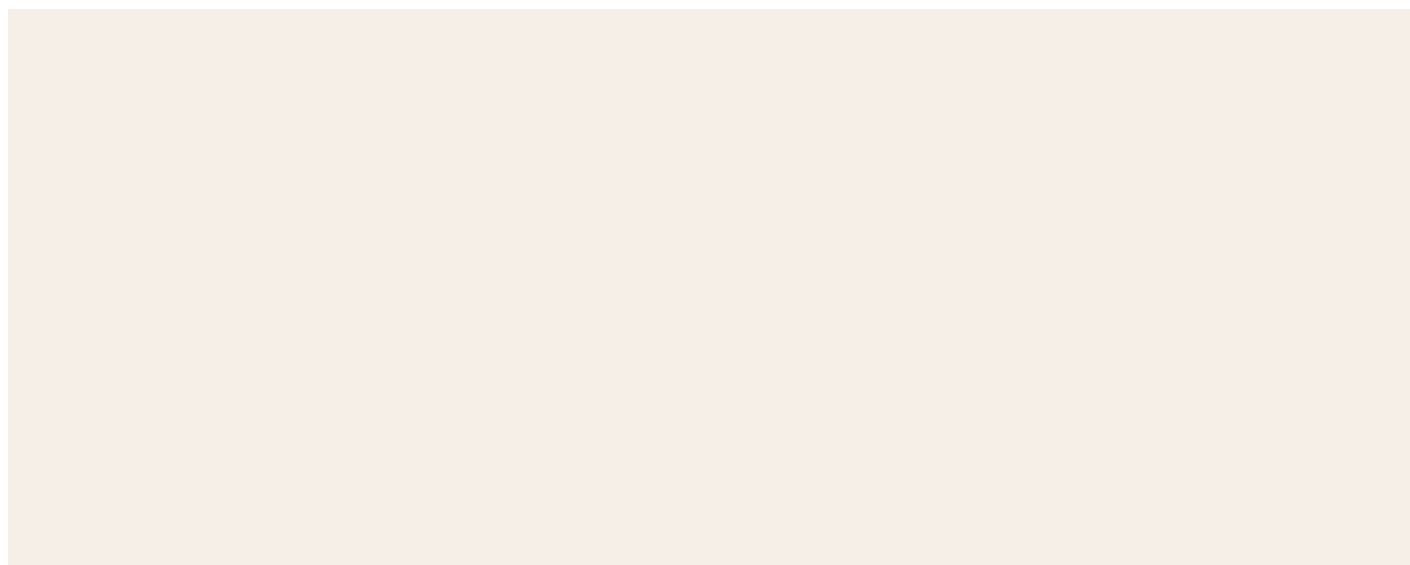
## Illness Course / Treatment Information

A large, empty, light beige rectangular area intended for the patient's illness course and treatment information.

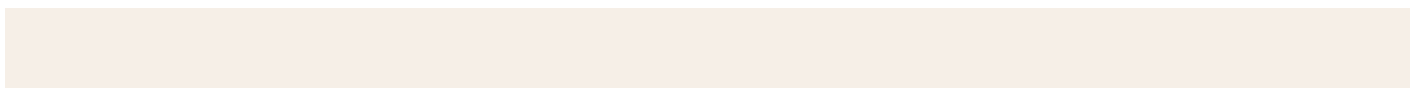
## Physical Exam



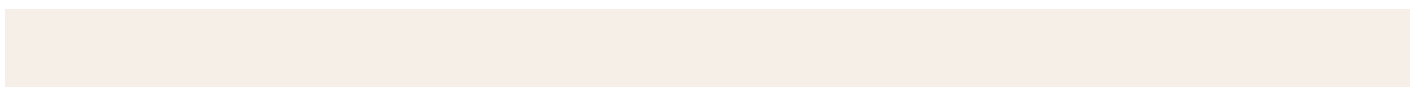
## Medications / Treatments



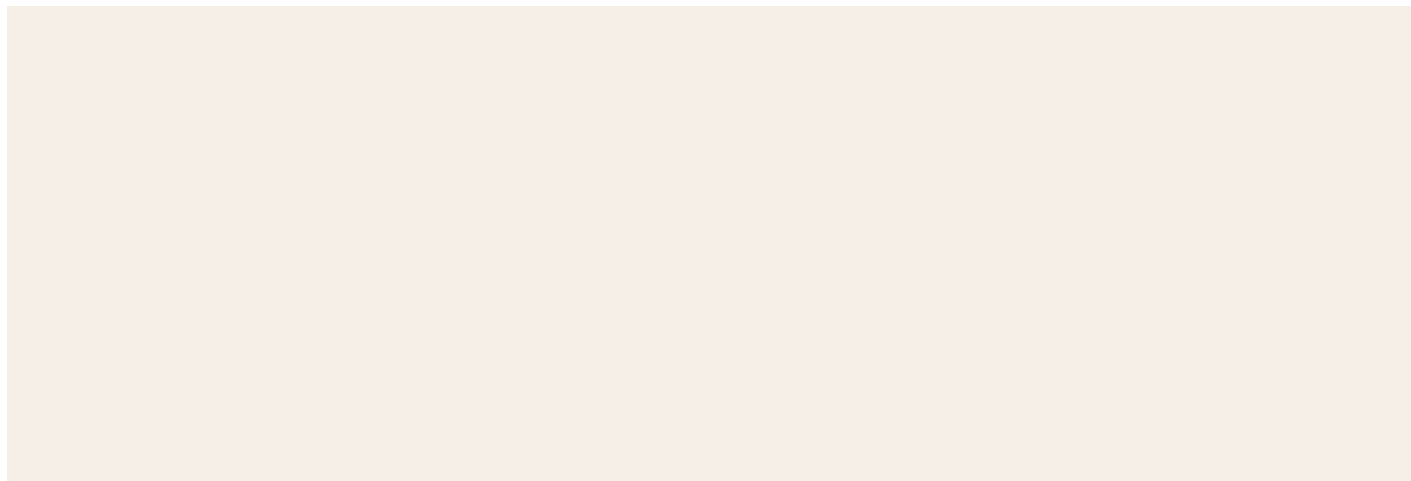
## Allergies / Intolerances



## Tobacco, Alcohol, or Substance Abuse

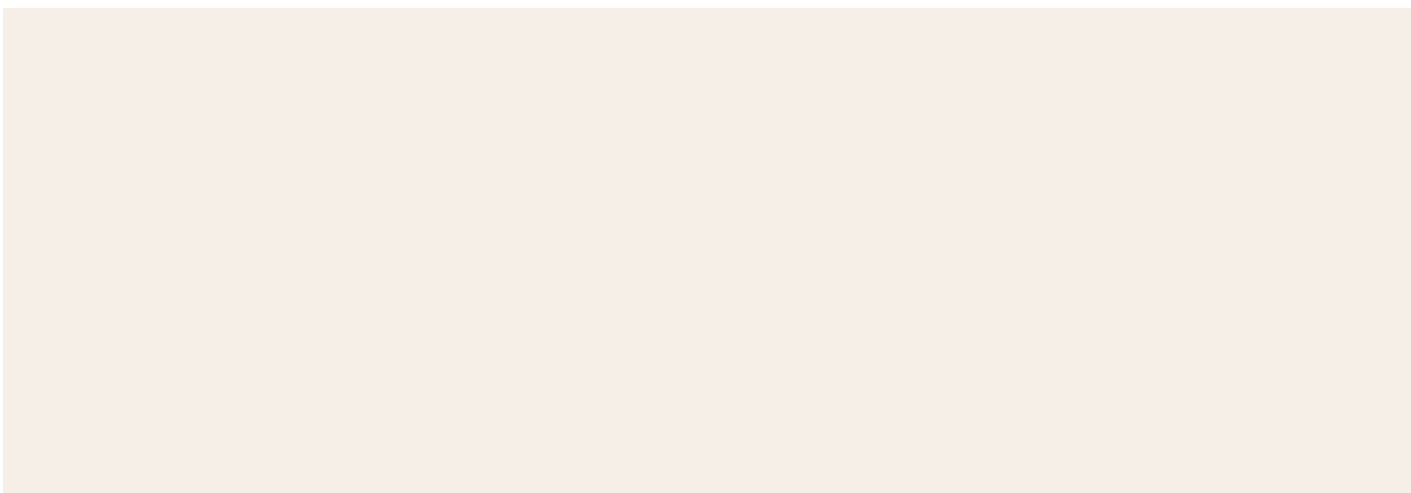


## Review of Systems



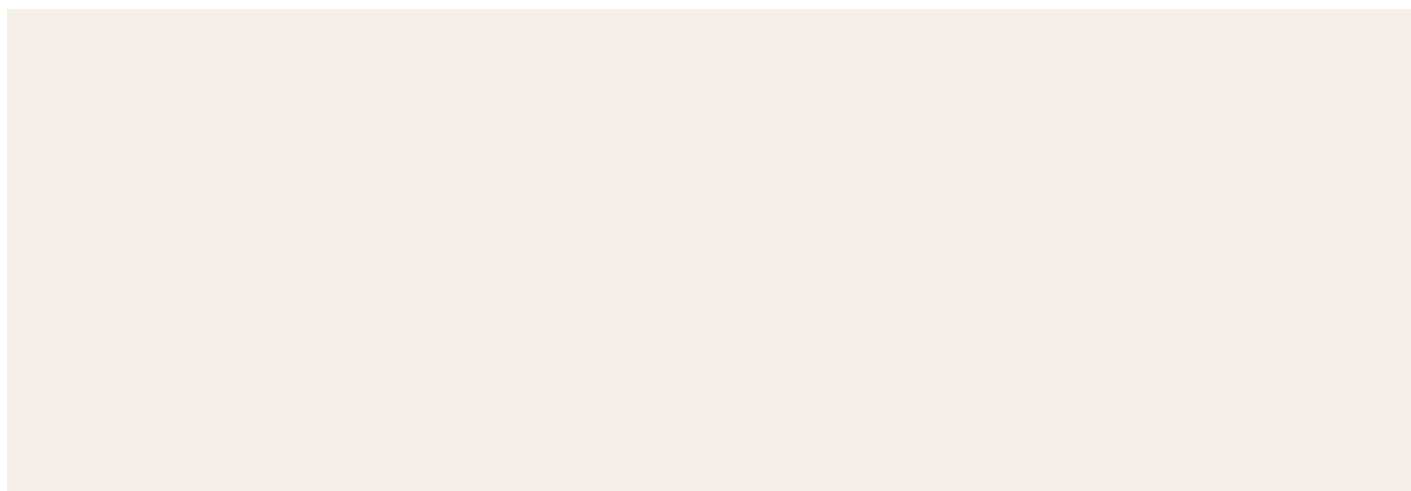
*Include mobility, cognition, mood; do they need assistive devices? Does living environment impact mobility?*

## Past Medical History



*Include alternative medicine preferences; cultural perspectives*

## Family History





## Health & Community Services

Is the Patient Currently Receiving or Will They Need Any New Home and/or Community-Based Services?

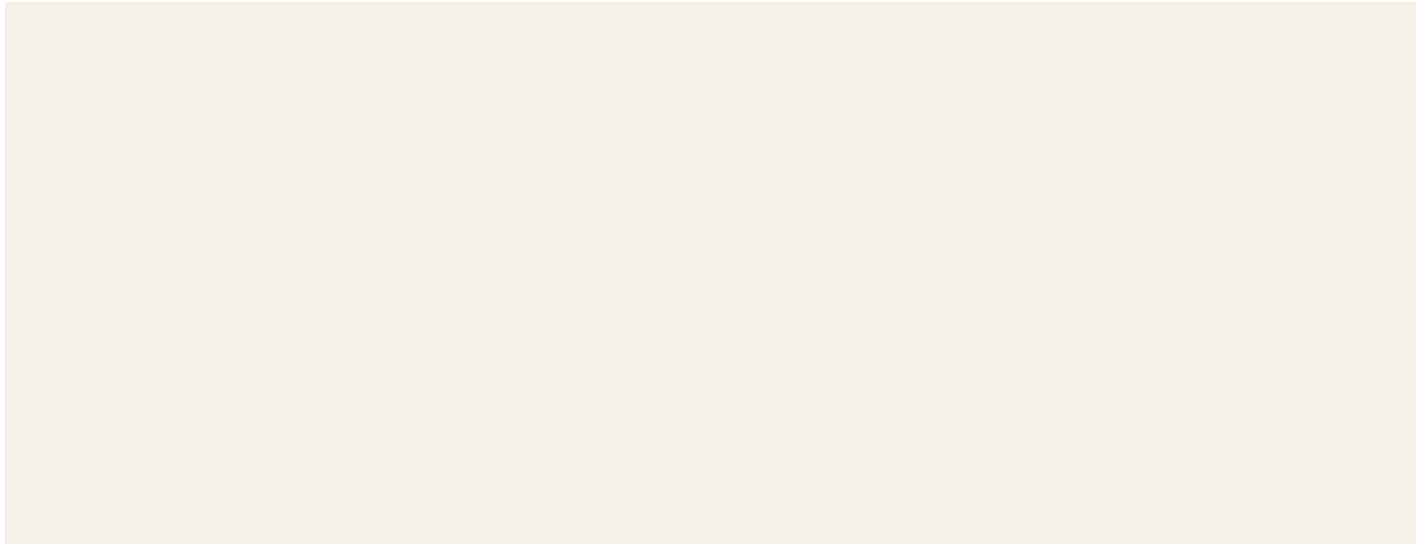
### Healthcare Services:

*Eligibility / Enrollment / Contact Information*

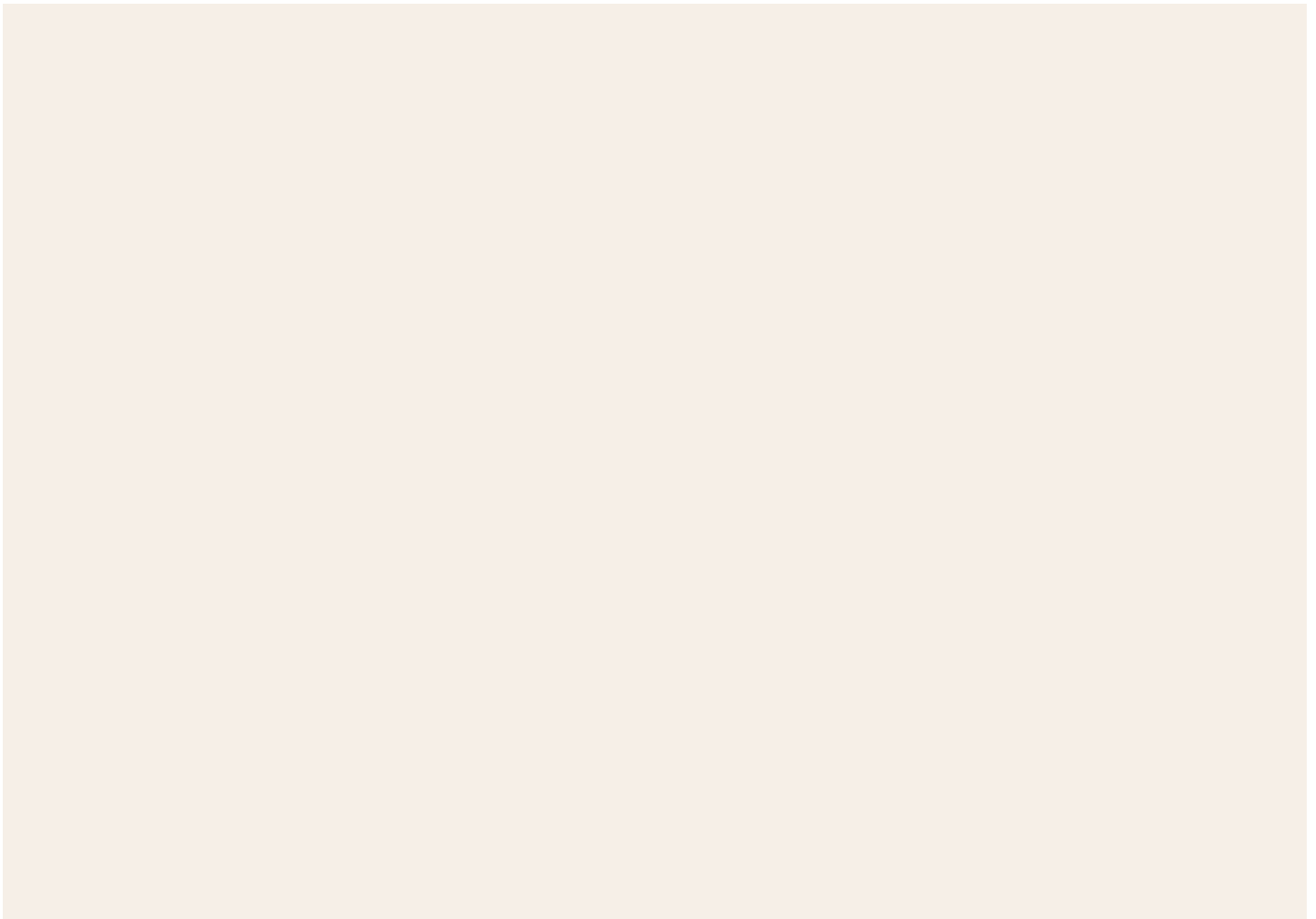
### Community Services:

*Eligibility / Enrollment / Contact Information*

## Overall Assessment

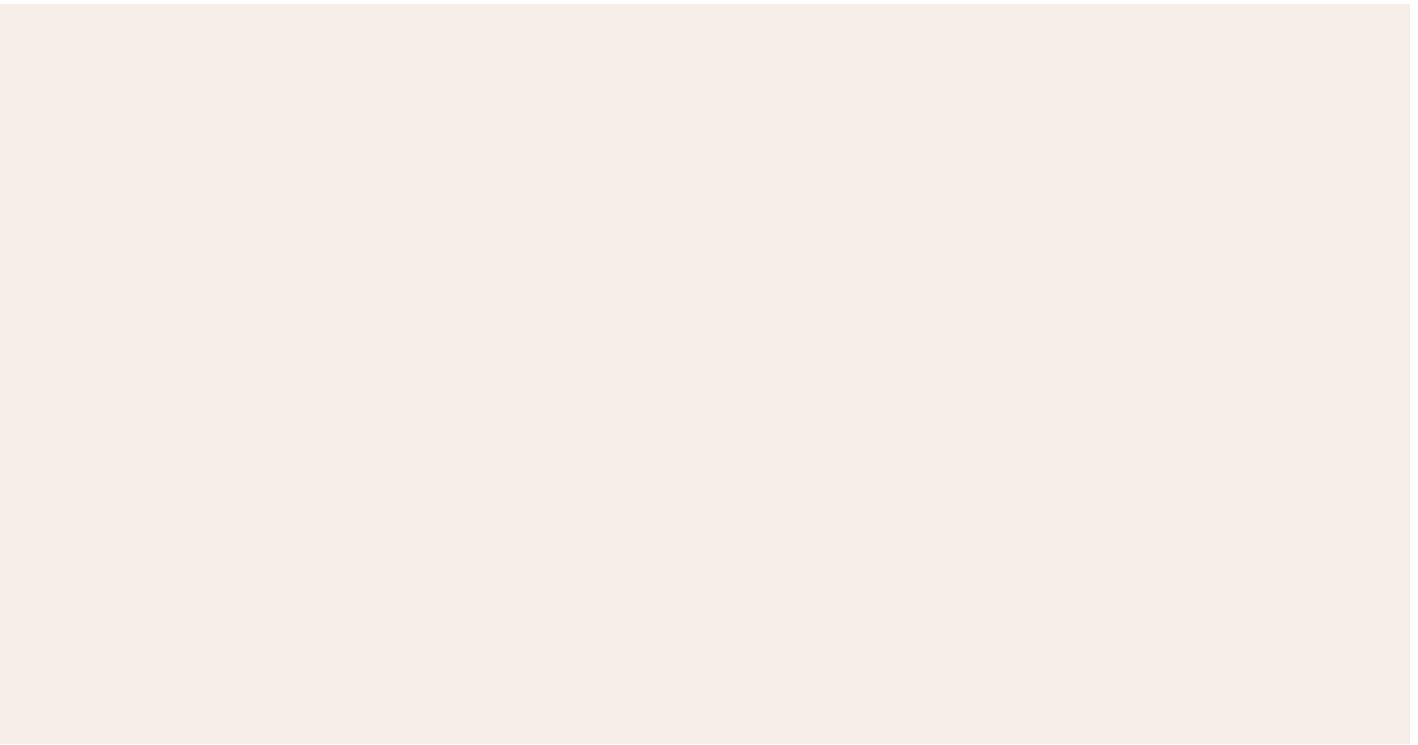


## Advance Care Planning



*Please provide details/scenario about serious illness or end-of-life conversations with the patient, family and/or providers; and indicate if the patient has any Advance Directives on file*

What Matters Most to the Patient Now?



What Do They Want Their Health For?



**What  
matters  
most?**

## Next Steps / Outcomes

What Happens Next?

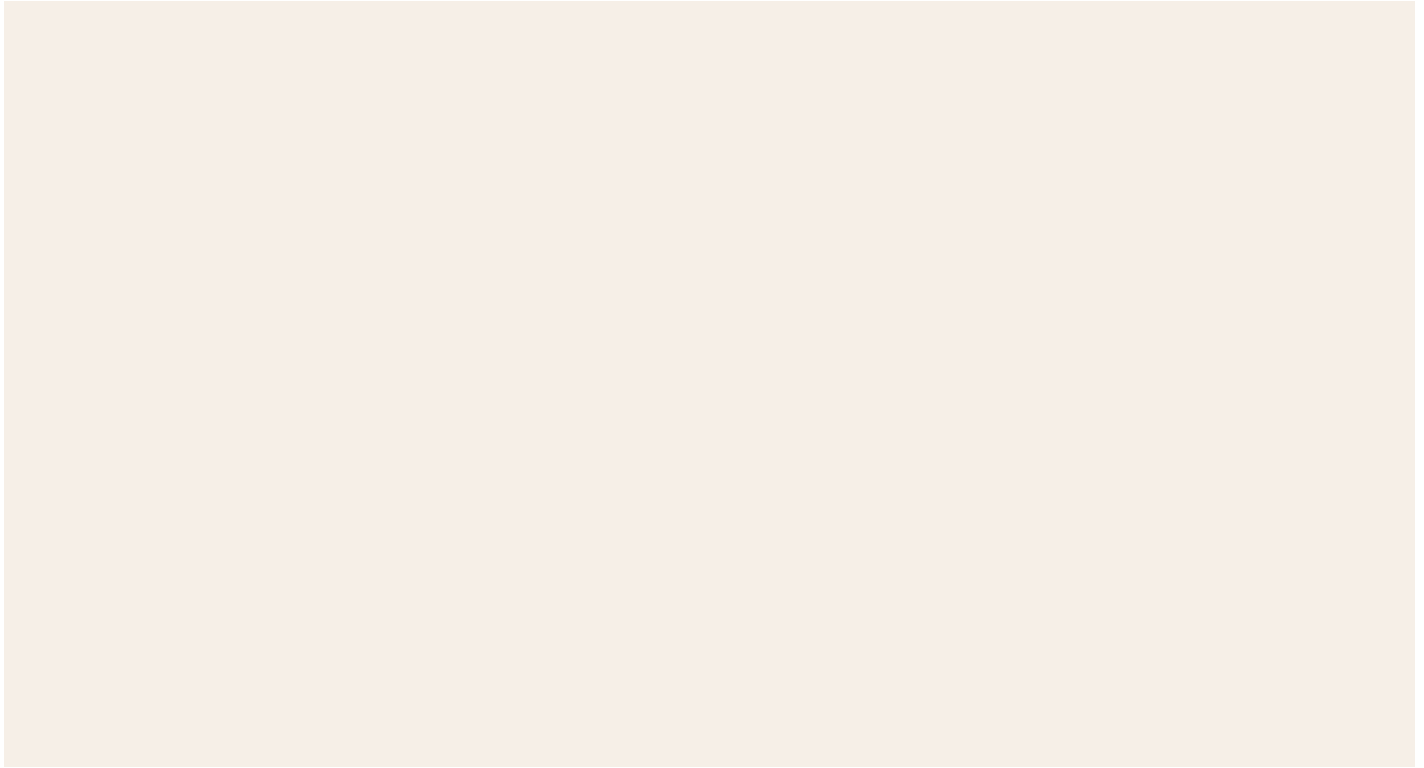
Details About Family Conversations

What Happens at, or Near, Death of Patient?

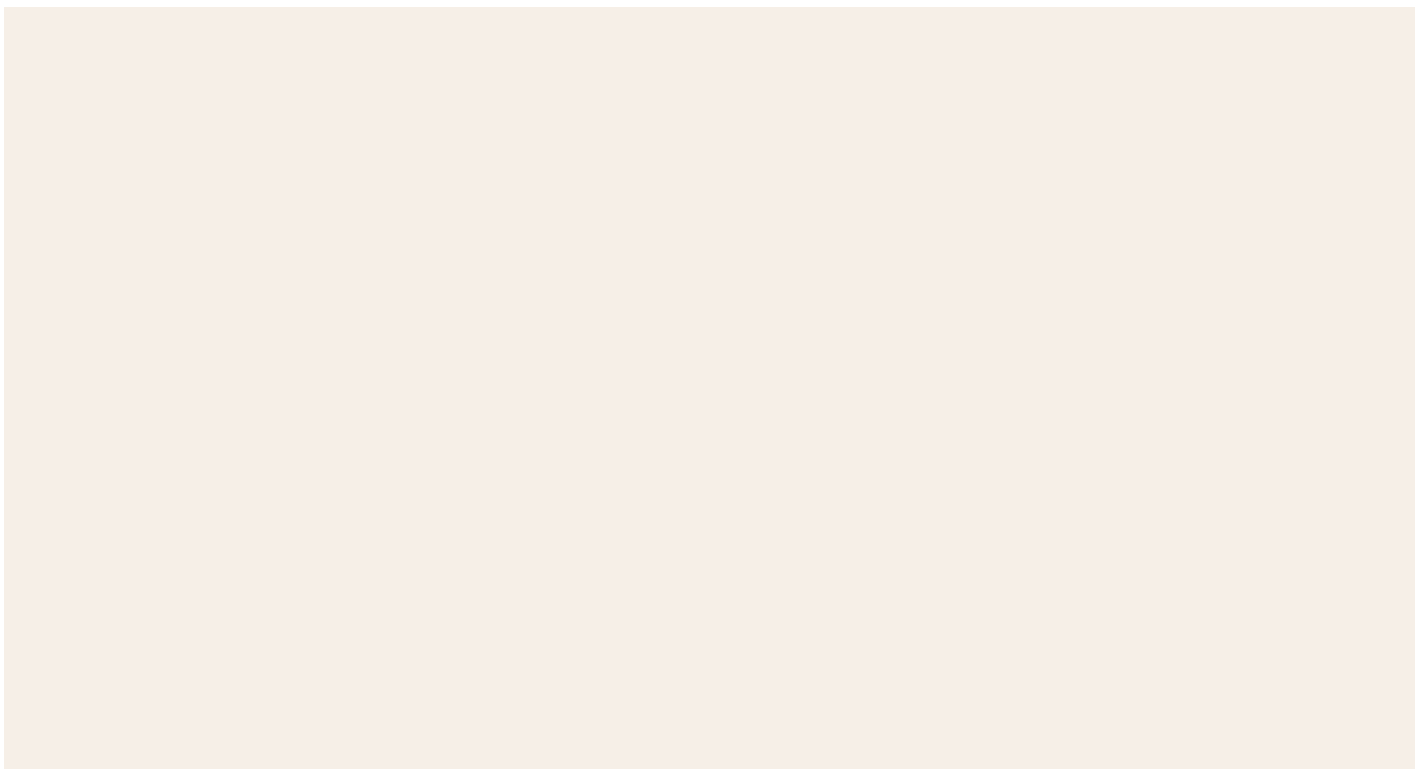
What Support Does Family Need Before and After Death of Patient?

# Challenging Conversations

Best / Worst Case



Risk / Benefit of Intervention



## **Interprofessional Focus**

**What Role Do Other Disciplines Play in This Patient's End-of-Life Care?**

**Who Can Help You Provide the Best Care and Honor the Patient's Wishes?**

**How Will You Approach Utilizing a Team Approach to Providing Care?**

**Beyond Referrals, How Will You Become Comfortable with Going Outside Your Comfort Zone?**

**Are there any Integrative, Traditional, or Complementary Therapies that will Help the Patient at this Stage or Later?**

## Questions to Consider

Can You Identify Any Overarching Bias?

Can You Identify Any Possible Assumptions One Might Make About This Patient?

What Information About This Patient Might Inform Public Policy or Regulatory Action?

### ADVANCE CARE DIRECTIVE

Teaching point: Each health science student should be

- knowledgeable about advance care directives; and
- be able to communicate and engage patients/families in advance care planning across settings and across the lifespan.

### PALLIATIVE CARE AND HOSPICE

Teaching point: Each health science student should be

- knowledgeable about palliative care and hospice and
- be able to effectively communicate this information to patients/families.

### CULTURAL HUMILITY

Teaching point: Each health science student should be

- knowledgeable about knowledgeable about cultural considerations in the care of patients and families, and
- be able to effectively communicate with humility, curiosity, care, respect, & dignity.

### COMMUNITY RESOURCES

Teaching point: Each health science student should be

- knowledgeable about community resources to support serious illness and end of life care, and
- be able to effectively connect patients/families with these resources.

### CHALLENGING CONVERSATIONS

Teaching point: Each health science student should be

- knowledgeable about how to deliver “best case/worse case” and
- be able to effectively conduct challenging conversations with patients/families (including how to discuss risk/benefits of interventions).

### INTERPROFESSIONAL CARE

Teaching point: Each health science student should be

- knowledgeable about the role of team members & benefits of team-based care and
- be able to effectively work with team members in the care of patients/families with serious illness or at the end of life.