The University of Arizona Health Sciences

The CARES Toolkit

End-of-Life **Ca**ses and **Res**ources:

An Interprofessional Toolkit for Health Science Students

Facilitator Notes

Pharmacy: 88-Year-Old Hispanic Woman Living with Dementia — Scenario 2

Case Title

Directions

1. Develop a series of questions and answers that address specific discussion points.

2. Develop 1-2 different scenarios (with questions and answers) that change or add discussion points.

3. Develop a list of needed community/healthcare resources and support services.

Possible Discussion Points (See Pages 9-11 for Example Questions):

- Difficult Conversations
- Ethical / Legal Considerations
- Patient Goals, Preferences and Values
- Medical Decision-Making Capacity
- Social Determinants of Health
- Advance Care Planning
- Community Resources/Access to Care
- Cognitive Impairment
- Health Literacy
- Sensory Deficits
- Ageism, Gender or Other Bias
- Cultural Humility / Diversity / Spiritual Considerations
- Family / Caregiver Concerns
- Limited English Proficiency
- Public Policy

Questions

Develop a series of questions and answers that address specific discussion points.

1. How can pharmacist promote Advance Care Planning?

- Meet the patient's immediate needs (working the patient's provider to diagnose dementia and provide home-based support)
- Acquire knowledge about Advance Care Planning
- Gauge an opportunity to talk about end-of-life care and planning
- Emphasize and educate about What Matters Most with the patient and family

· Advance Directives for Medical Decisions
Zagaria MAE. US Pharm. 2012;37(7):20-22.
https://www.uspharmacist.com/article/advance-directives-for-medical-decisions

Table 1. Common Terms and Definitions in Advance Care Planning

Advance directives: Oral or written statements made by patients when they are competent that are intended to guide care should they become incompetent. While *oral* statements are ethically binding, they are not legally binding in all states. Living wills and durable powers of attorney for health care are *written* advance directives and follow state law; some states combine both in one document (see **Resources for the Patient** for state-specific advance directive forms).

- **Living will:** A document in which an individual stipulates the type of medical care—including life-prolonging medical care—that is and is not desired in the event of conditions such as a terminal illness, permanent unconsciousness, end-stage of a chronic illness, or vegetative state
- **Durable power of attorney for health care:** A document that allows an individual to designate someone (called a *proxy* or *agent*) to speak for him or her in making medical decisions

End-of-life medical interventions: Measures such as cardiopulmonary resuscitation (CPR), including vasopressor medication; mechanical ventilation; hospitalization and intensive care; dialysis; and nutrition and hydration assistance.

Do Not Attempt Resuscitation Order: Also referred to as the Do Not Resuscitate order (DNR), a request by the patient that the clinician write an order that CPR not be attempted on them.

Organ donation: A patient can specify in advance any wishes about donating organs, eyes, and tissues for transplantation, or the body for scientific study.

Source: References 1, 5, 6, 8, 9.

Questions

Develop a series of questions and answers that address specific discussion points.

· Pharmacist care planning services: What matters most
Breault et al. 2021 https://doi.org/10.1177/17151635211004631

TABLE 1 Care planning: What matters most

Develop your expertise	Participate in professional development to further develop expertise. Recognizing an area of expertise supported pharmacists in gaining confidence and a sense of contributing more to patient care.
Optimize roles and workflow	Optimize roles, workflow and space for pharmacists and pharmacy technicians to support implementation of the care planning service.
Customize the documentation	Develop a care plan template that supports the care planning process and facilitates sharing information that is clear, concise and consistent.
Schedule time for care planning	Schedule time for care planning with consideration to the time needed to prepare before seeing the patient, time with the patient, time to document/share information and time for follow-up.
Promote the service	Develop a standard description of the service, verbal and written, and share it with patients, members of the pharmacy team and others involved in the patient's care to promote the service.
Involve the patient in the care planning process	Involve patients in every step of the care planning process and provide education and information in plain language to support engagement.
Outline responsibilities	Document and communicate specific responsibilities and actions in the care planning process.
Share information in a timely manner	Share care plan documentation with patients. Include a current medication list, concise action plan outlining patient's goals, any health behaviour changes to implement and instructions for monitoring and follow up.
Monitor progress and revise the care plan as needed	Revisit the care plan regularly to determine if specific goals are being achieved and goals revised based on new information, new drug therapy problems identified and new action plans to be implemented.
Explore possibilities for shared care plans	Strive to develop and implement shared care plans with other members of the health care team.

· Exploring the Expanded Role of Pharmacists in Advance Care Planning
Ma JD, et al. JCO Oncol Pract 2021;17:102-106.
https://ascopubs.org/doi/full/10.1200/OP.20.00684

Questions

Develop a series of questions and answers that address specific discussion points.

1. What are some ways to approach utilizing an interprofessional team for the advance care planning and who should be involved?

- Providing information, such as the Arizona PREPARE Advance Directive document for patient and family to read and think about when they are ready.
- Patient, daughter, other children, primary care provider or geriatrician, social worker, home health nurse, physical therapist, occupational therapists, priest, etc.

Arizona PREPARE Advance Directive: PREPAREforYourCare.org

2. What resources are available that focus on assisted living, dementia care, and fall prevention for this patient with dementia?

- Refer to Medicare resources for selecting an assisted living that has memory care in place.
- Provide caregiver resources for dementia support and fall prevention
- Educate patient and family about environmental screening and other strategies for fall prevention

· Arizona Center on Aging Care Partner Information Sheets:
Dementia - https://www.uofazcenteronaging.com/care-partners?title=dementia
Falls - https://www.uofazcenteronaging.com/care-partners?title=falls

· CDC STEADI Older Adults Fall Prevention:
Pharmacy Care (STEADI-Rx) - https://www.cdc.gov/steadi/steadi-rx.html

Scenario 1 and Questions

Develop 1-2 different scenarios (with questions and answers) that change or add discussion points.

Encounter 1: 82-year-old woman with multiple issues, including well-controlled diabetes, high blood pressure, osteoarthritis of both knees and hips, and some difficulty hearing. The patient only speaks Spanish. She complains of difficulty walking because of her arthritis, but otherwise doesn't have any other concerns. The daughter says that her mother moved in with her a few years ago because she thought her mother needed "help" with her medications- and she has noticed that her mother has needed more help over the years. Daughter manages the medications and all finances. The patient is somewhat independent in ADLs (except bathing) and dependent in IADLs, though likes to assist with cooking. MMSE = 15. The patient does not drink or smoke.

Past Medical History (PMH): Type 2 Diabetes, Hypertension, Osteoarthritis, and some difficulty hearing. The patient is taking metformin XR 1000mg BID, chlorthalidone 25mg Qday, lisinopril 10mg Qday, acetaminophen 650mg TID, hydroxyzine 50mg Qday, omeprazole 20mg Qday.

· What are the goals for today's visit and how can you initiate end-of-life discussion?
· How can pharmacist encourage end-of-life conversation between the patient and family?
· Does the current medication regimen appropriate for the patient?
· What tests/physical exams do we need before the next visit?

Scenario 2 and Questions

Develop 1-2 different scenarios (with questions and answers) that change or add discussion points.

Encounter 2: Patient needs assistance with ADLs, including bathing, toileting, feeding. Can still use the restroom for stool, but mostly incontinent of urine (uses pads). Feeds self slowly and needs assistance. Lost 12 lbs in past 6 months. She can walk around the house with her cane but does not want to walk outside since her last fall. Family reports that she becomes agitated at times and depressed at other times. She has an erratic sleep schedule and insomnia; she loves watching TV in her bed. Came into clinic in a wheelchair today. On exam, MMSE = 5.

· What are possible evaluation and management strategies for the patient/family's concerns? Cognitive decline, weight loss, and fear of fall.
· What resources are available to help the family think about assisted living and memory care for the patient?
· What resources for fall prevention for pharmacists?

Resources and Support Services for the Patient / Family

Develop a list of needed community/healthcare resources and support services.

Arizona Advance Health Care Directive - PREPAREforYourCare.org

Arizona Advance Directive (Medical POA & Living Will) - https://eforms.com/advance-directive/az/

El Rio Health - Monthly Advance Care Planning Workshops
- What is Advance Care Planning?
- Why should we plan for our future healthcare?
- Who will speak for me when I cannot speak?
https://www.elrio.org/advancecareplanning/

Medicare plan that help with assisted living
https://www.nia.nih.gov/health/paying-care

National Institute on Aging
https://www.nia.nih.gov/health/getting-help-alzheimers-caregiving

CDC guidelines on fall prevention
https://www.cdc.gov/falls/index.html

End-of-Life Support
https://www.mayoclinic.org/healthy-lifestyle/end-of-life/in-depth/cancer/art-20047600

Example Questions for Discussion Points

Difficult Conversations

- What is the specific communication/conversation skill(s) that is needed for this case? (e.g., Best Case/Worse Case framework; Serious Illness Conversation)
- How would you begin the conversation?

Ethical / Legal Considerations

- Are there any ethical/legal considerations that need our attention?
- Do they have a medical power of attorney?

Patient Goals, Preferences and Values

- How do you ensure you know/understand the patient's care preferences and values?
- What strategies would you use to assess the patient's goals, preferences, and values?

Medical Decision-Making Capacity

- Decision-Making capacity is always related to a specific medical decision. Capable patients have the legal and ethical right to make their own treatment decisions.
- Does the patient have decisional capacity? What more would you need to know?

Community Resources / Access to Care

- What community or healthcare resources or services would help the patient and/or family?

Social Determinants of Health (SDH)

- How would you address any known SDH issues? (food, housing or transportation insecurities; childcare, utility, legal, or education needs; financial resources; employment instability).

Advance Care Planning

- What do you see as the important decisions that the patient/family are facing?
- What specific knowledge is needed to provide the best of care? (e.g., definition of palliative care vs. hospice benefits).

Cognitive Impairment

- Does the patient have any cognitive impairment?

Health Literacy

- Can the patient understand and navigate health-related issues? Note: health literacy is different from general literacy.

Sensory Deficits

- Does the patient have any sensory impairment (hearing, vision)?

Ageism, Gender or Other Bias

- Can you identify any overarching bias?
- Can you identify any possible assumptions one might make about this patient? Note: Ageism occurs for people of ALL ages.

Cultural Humility / Diversity / Spiritual Considerations

- How does the patient's culture influence our approach to care?
- What terms may be misunderstood because of cultural definitions?

Family / Caregiver Concerns

- Does the patient have a caregiver?
- What is their relationship?
- Does the patient live with the caregiver?
- If not, does the caregiver live close-by or are they a long-distance caregiver?
- How is caregiver handling the stress of being a caregiver?
- Do they need support/resources?

Limited English Proficiency

- How do you identify if someone has limited English proficiency?
- When do you know you should bring a translator into the conversation?
- How do you access a translator?

Public Policy

- What information about this patient might inform public policy or regulatory action?

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