



# The CARES Toolkit

## End-of-Life Cases and Resources:

An Interprofessional Toolkit for Health Science Students

Facilitator Notes



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*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 11-13 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.

| Acronym       | Meaning   | Order/Form      | What It Is   |
|---------------|---|-----------------|--|
| DNR           | Do Not Resuscitate                                      | physician order | No CPR and typically no intubation                         |
| DNI           | Do Not Intubate   | physician order | No intubation; may include no CPR at some facilities       |
| AND           | Allow Natural Death                                     | physician order | Usually no CPR or intubation                               |
| POLST (MOLST) | Physician (Medical) Order for Life-Sustaining Treatment | physician order | Varies depending on the contents from full CPR to full DNR |
| ACP           | Advance Care Plan                                       | varies          | Varies depending on the contents                           |
| AD            | Advance Directive                                       | legal form      | Varies depending on content; 18 and up only                |

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# Scenario 1 and Questions

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



# Scenario 2 and Questions

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

# Resources and Support Services for the Patient / Family

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

# 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?