COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Advance Care Planning (ACP)

Kate O'Malley, RN, MS

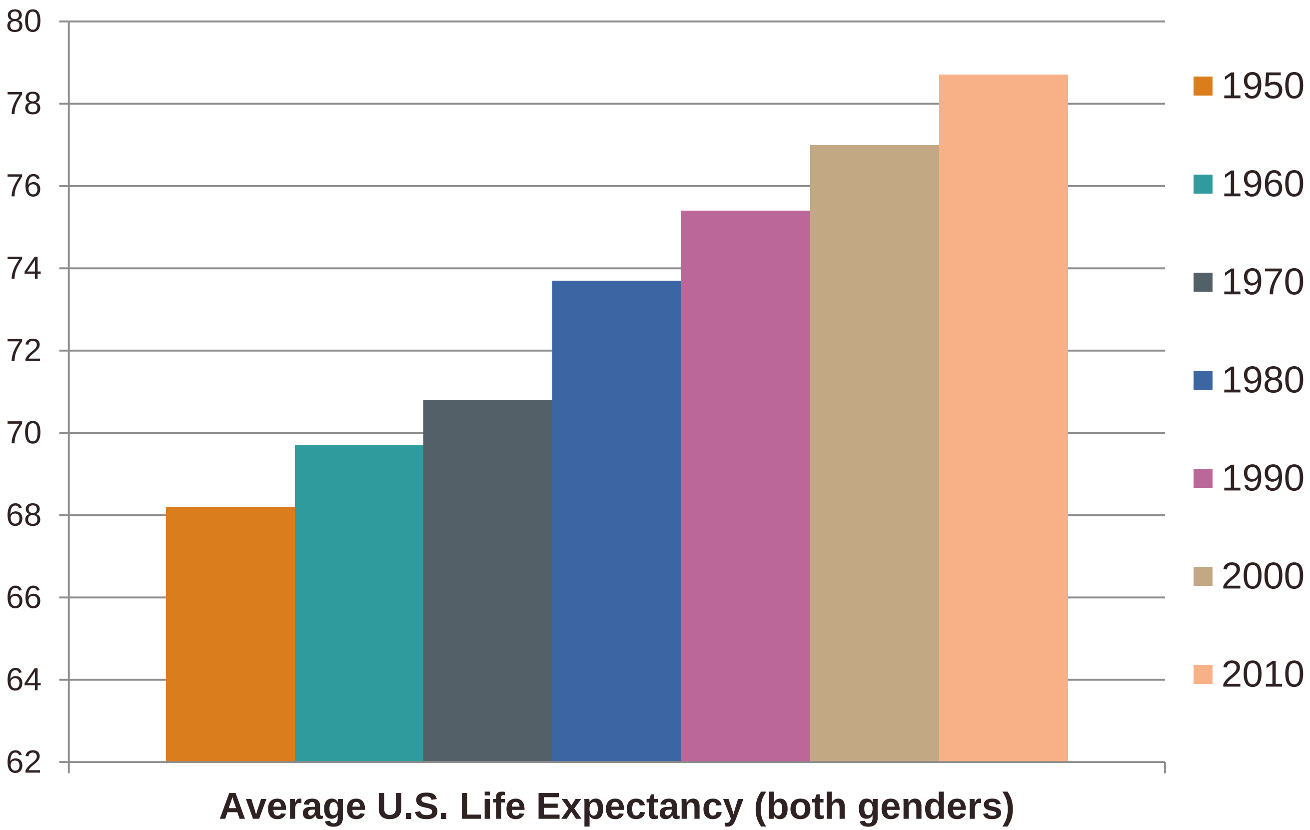
Judy Thomas, JD

Overview

- The need for and benefits of advance care planning
- Resources for advance care planning

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Life Expectancy



Centers for Disease Control, Atlanta, GA: National Centers for Health Statistics. Available from: http://www.cdc.gov/nchs/.

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

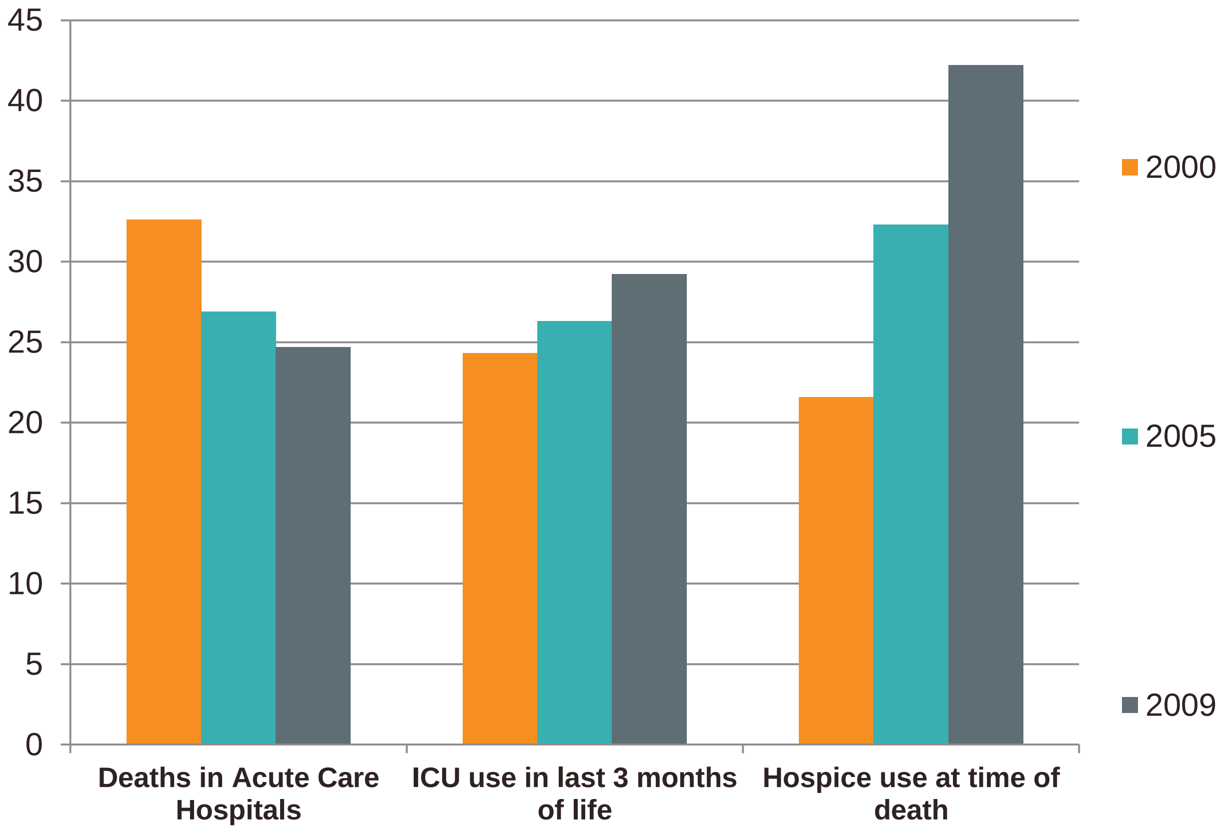
Changes in leading causes of death

Top Three Causes of Death	
1900	**2010**
Pneumonia & Influenza	Heart disease
Tuberculosis	Cancer
Diarrhea & Enteritis	Chronic Lower Respiratory Disease

Centers for Disease Control. Hyattsville, MD: Leading Causes of Death; 2010. Available from: http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.

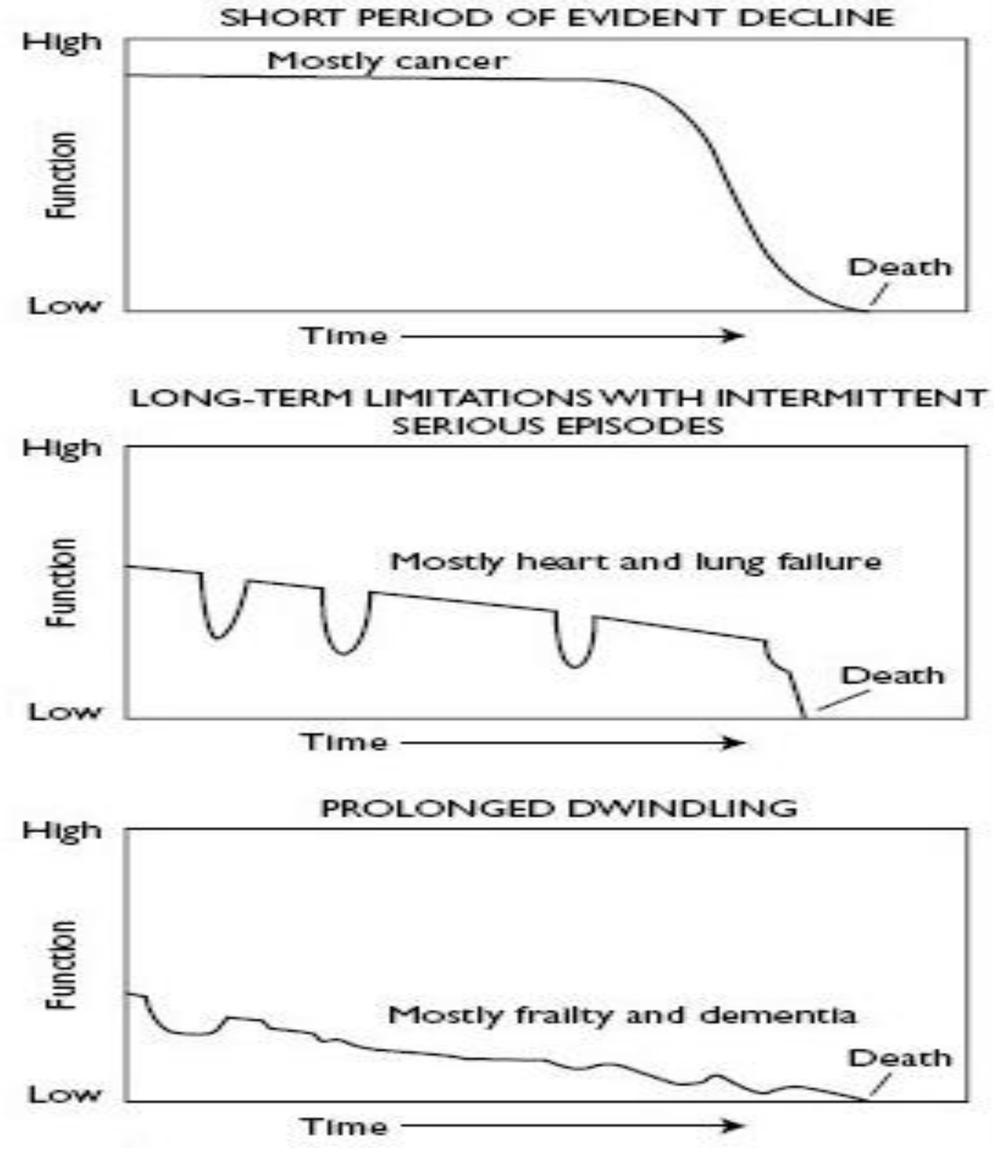
COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Deaths in Acute Care Settings are Down; Intensive Care at the End of Life is Increasing



Change in End-of-Life Care for Medicare Beneficiaries:
Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009
Teno JM JAMA. 2013 February 6.

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA



Trajectories of eventually fatal chronic illnesses. Source: Lynn & Adamson, 2003

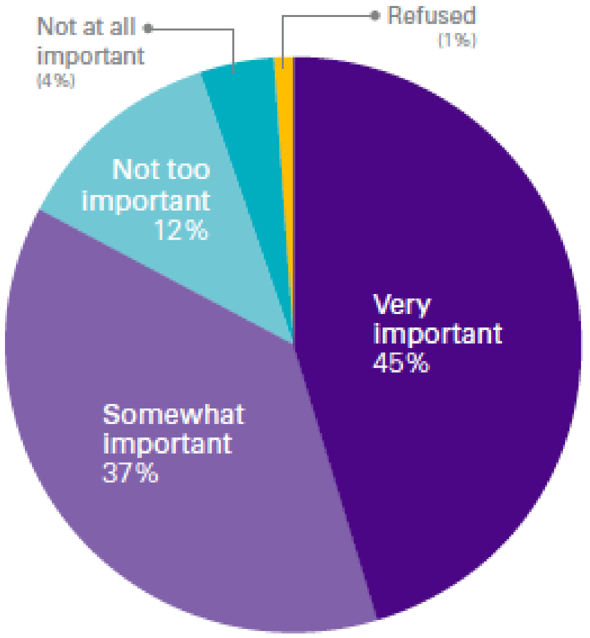
Why plan?

- 50% of people at the end of life won’t be able to make their own medical decisions

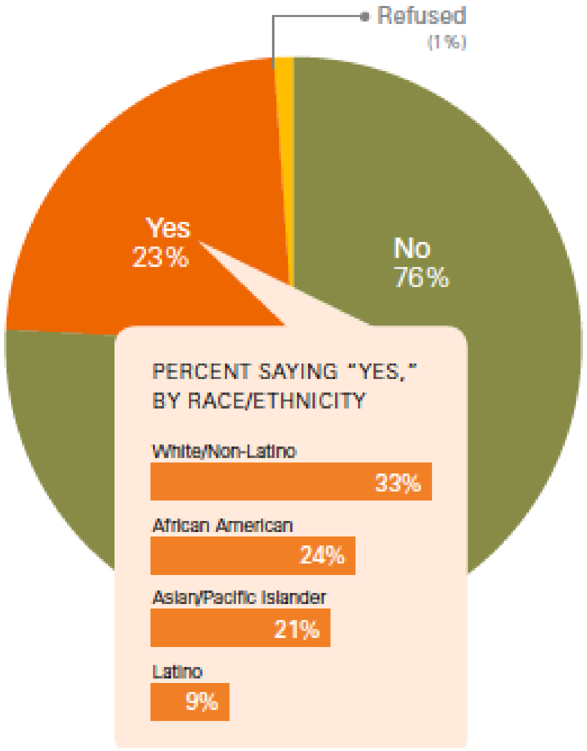
- Healthcare professionals and family are left with uncertainty, stress

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Californians Think Planning for Serious Illness and End of Life is Important



Think recording wishes
is important 82%



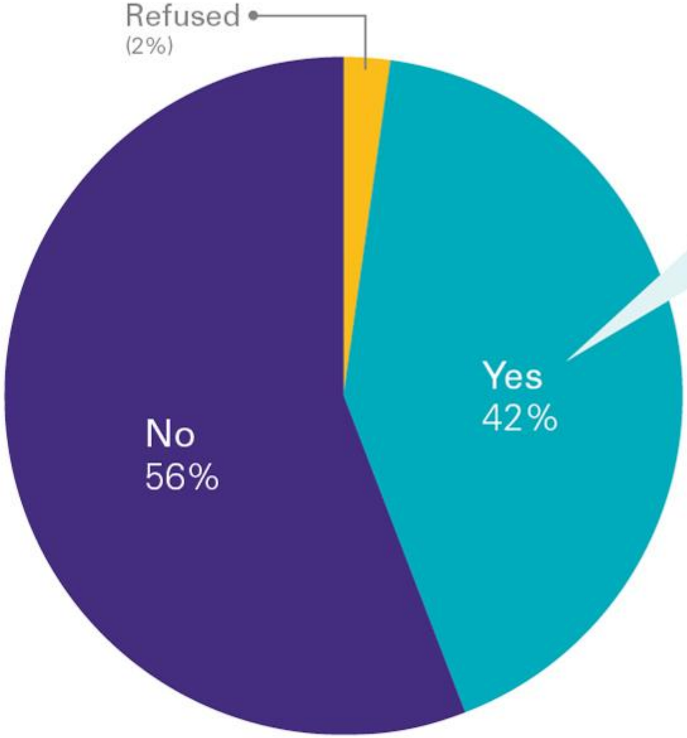
Wishes for care recorded
in some form 23%

CHCF 2012 data, The Final Chapter

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Most Patients Do Not Discuss End-of-Life Wishes with Family

Have you talked with (the loved one you would want to make decisions on your behalf) about the kind of medical treatment you would want?



Most likely to say "yes":

- Age 65+
  (71%)
- White
  (54% vs. 41% African Americans, 31% Latinos, and 33% Asians)
- Some college+
  (46% vs. 36% high school or less)
- Income $50K+
  (49% vs. 36% <$50K)
- Has chronic conditions
  (48% vs. 34%)

Source: Californians' Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide Survey of 1,669 adult Californians, including 393 respondents who have lost a loved one in the past 12 months. Copyright 2012, California HealthCare Foundation.

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Advance Care Planning: a conversation about…

What is **important** to the individual:

- Hopes, goals and concerns about the future

The **realities** facing the individual:

- Diagnoses, abilities, limitations, resources

Completing documents and arrangements

What is an Advance HealthCare Directive?

- Tool to make health care wishes known if unable to communicate

- Allows a person to do <u>either or both</u> of the following:
  - **Appoint a surrogate decision maker (Durable Power of Attorney for Health Care)**
  - **Give instructions for future health care decisions (Living Will)**

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

What goes into an AHCD?

- Healthcare Agent
- Goals
- Values
- Treatment Preferences
- Leeway

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Benefits of ACP Discussions: The Patient’s Perspective

- Increases likelihood that wishes will be respected at end of life
- Achieves a sense of control
- Strengthens relationships
- Relieves burdens on loved ones
- Eases sharing of medical information (HIPPA)
- Provides opportunities to address life closure

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

ACP: What patients need to hear from healthcare professionals

Current state

- Diagnoses
- Threats to wellbeing and function
- Expected trends and outcomes

Treatment options

- Benefits
- Burdens
- Likely results
- Alternatives

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Benefits of ACP Discussions: The health system perspective

- Individuals often choose care in the home and community, with lower overall costs
- Fewer hospitalizations
- Lower intensity of care
- Earlier hospice enrollment
- Better quality of life

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

What healthcare professionals need to hear from patients

Surrogate

- Who is to speak for the patient if incapacitated

Treatment wishes

- Such as resuscitation (CPR)

Values, Goals, Preferences

- What makes life worth living
- What needs to be completed before death
- What is unacceptable to the patient
    - “I’d rather die in comfort than _____ .”
- Special religious or cultural preferences

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Advance Care Planning Documents

California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

● **This form has 3 parts. It lets you:**

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

This form lets you choose the kind of health care you wan

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

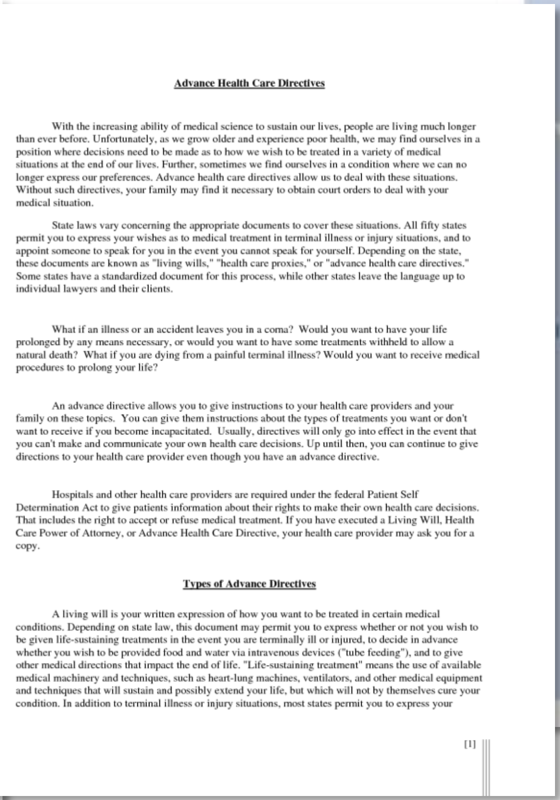
Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want.
Always sign the form in Part 3.

Go to the next page

1



Advance Health Care Directives

With the increasing ability of medical science to sustain our lives, people are living much longer than ever before. Unfortunately, as we grow older and experience poor health, we may find ourselves in a position where decisions need to be made as to how we wish to be treated in a variety of medical situations at the end of our lives. Further, sometimes we find ourselves in a condition where we can no longer express our preferences. Advance health care directives allow us to deal with these situations. Without such directives, your family may find it necessary to obtain court orders to deal with your medical situation.

State laws vary concerning the appropriate documents to cover these situations. All fifty states permit you to express your wishes as to medical treatment in terminal illness or injury situations, and to appoint someone to speak for you in the event you cannot speak for yourself. Depending on the state, these documents are known as "living wills," "health care proxies," or "advance health care directives." Some states have a standardized document for this process, while other states leave the language up to individual lawyers and their clients.

What if an illness or an accident leaves you in a coma? Would you want to have your life prolonged by any means necessary, or would you want to have some treatments withheld to allow a natural death? What if you are dying from a painful terminal illness? Would you want to receive medical procedures to prolong your life?

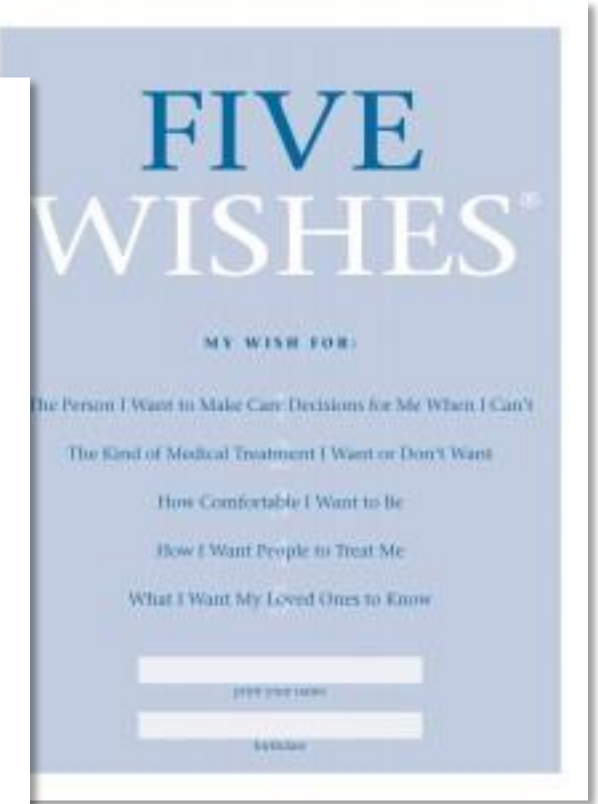
An advance directive allows you to give instructions to your health care providers and your family on these topics. You can give them instructions about the types of treatments you want or don't want to receive if you become incapacitated. Usually, directives will only go into effect in the event that you can't make and communicate your own health care decisions. Up until then, you can continue to give directions to your health care provider even though you have an advance directive.

Hospitals and other health care providers are required under the federal Patient Self Determination Act to give patients information about their rights to make their own health care decisions. That includes the right to accept or refuse medical treatment. If you have executed a Living Will, Health Care Power of Attorney, or Advance Health Care Directive, your health care provider may ask you for a copy.

Types of Advance Directives

A living will is your written expression of how you want to be treated in certain medical conditions. Depending on state law, this document may permit you to express whether or not you wish to be given life-sustaining treatments in the event you are terminally ill or injured, to decide in advance whether you wish to be provided food and water via intravenous devices ("tube feeding"), and to give other medical directions that impact the end of life. "Life-sustaining treatment" means the use of available medical machinery and techniques, such as heart-lung machines, ventilators, and other medical equipment and techniques that will sustain and possibly extend your life, but which will not by themselves cure your condition. In addition to terminal illness or injury situations, most states permit you to express your

[1]



FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care Decisions for Me When I Can't

The Kind of Medical Treatment I Want or Don't Want

How Comfortable I Want to Be

How I Want People to Treat Me

What I Want My Loved Ones to Know

ACP across the 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

CONVERSATIONS

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

POLST

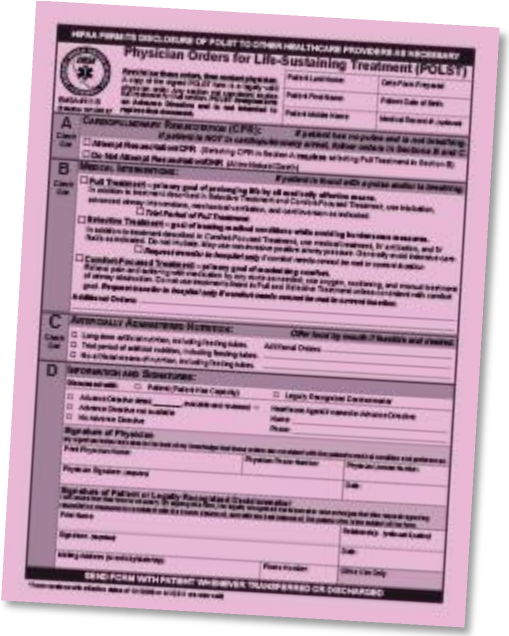
Physician Orders for Life-Sustaining Treatment

- Physician’s Medical Order
- Provides instructions regarding specific medical treatment
- Legally binding across healthcare sites in California
- Valid only if appropriately signed

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Indications for a POLST Form

- Serious illness
- Medically frail
- Chronic progressive condition



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Advance Directive & POLST

AHCD	POLST
• General instructions for **FUTURE CARE** • Requires interpretation	• Specific orders for **CURRENT CARE**
• Needs to be retrieved	• Stays with the patient
• Many different forms • Signed by patient, witnesses	• Single, standardized form • Signed by patient (or HC Agent) anc

What Is Our Goal?

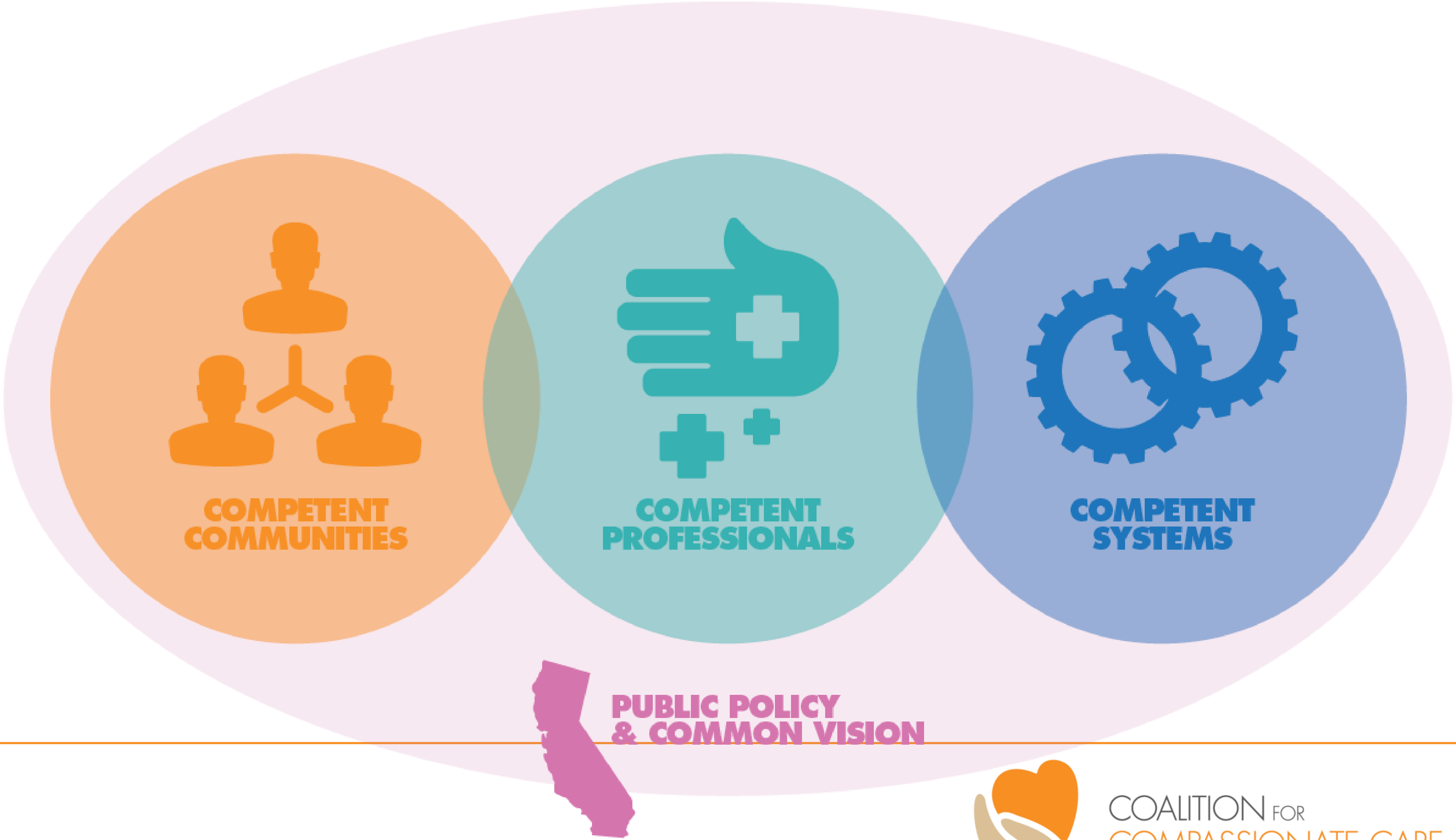
WISHES EXPLORED

WISHES EXPRESSED

WISHES HONORED

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

What We Need to Get There



COMPETENT COMMUNITIES

COMPETENT PROFESSIONALS

COMPETENT SYSTEMS

PUBLIC POLICY & COMMON VISION

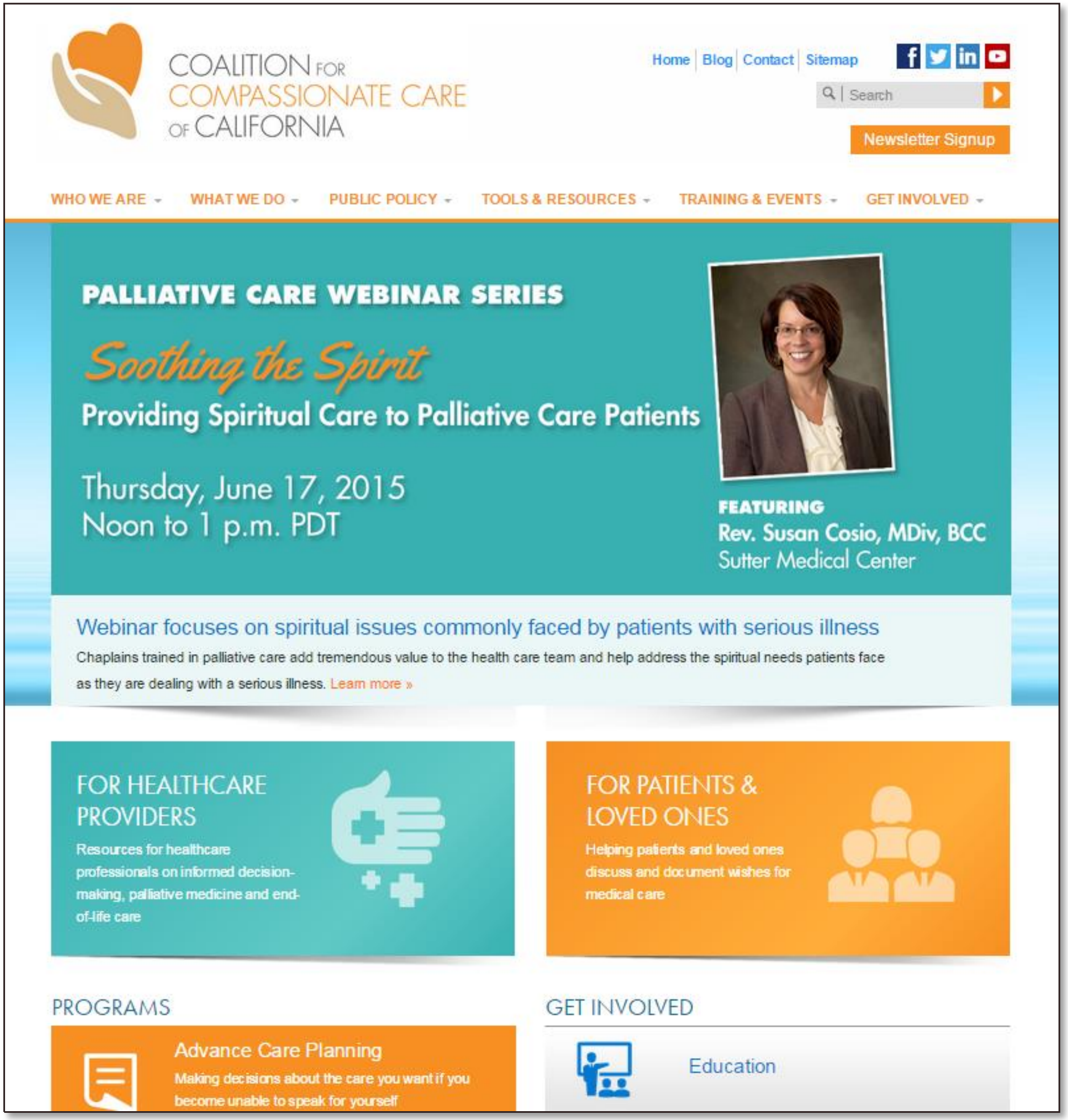
COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Effective Communities

Resources for Creating Effective Communities

- Local Coalitions
  - **POLST & Advance Care Planning**
  - **Training in advance care planning**
- Faith Leader Outreach
- Social Media

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA



PALLIATIVE CARE WEBINAR SERIES

Soothing the Spirit

Providing Spiritual Care to Palliative Care Patients

Thursday, June 17, 2015
Noon to 1 p.m. PDT

FEATURING
Rev. Susan Cosio, MDiv, BCC
Sutter Medical Center

Webinar focuses on spiritual issues commonly faced by patients with serious illness

Chaplains trained in palliative care add tremendous value to the health care team and help address the spiritual needs patients face as they are dealing with a serious illness. Learn more »

FOR HEALTHCARE PROVIDERS

Resources for healthcare professionals on informed decision-making, palliative medicine and end-of-life care

FOR PATIENTS & LOVED ONES

Helping patients and loved ones discuss and document wishes for medical care

PROGRAMS

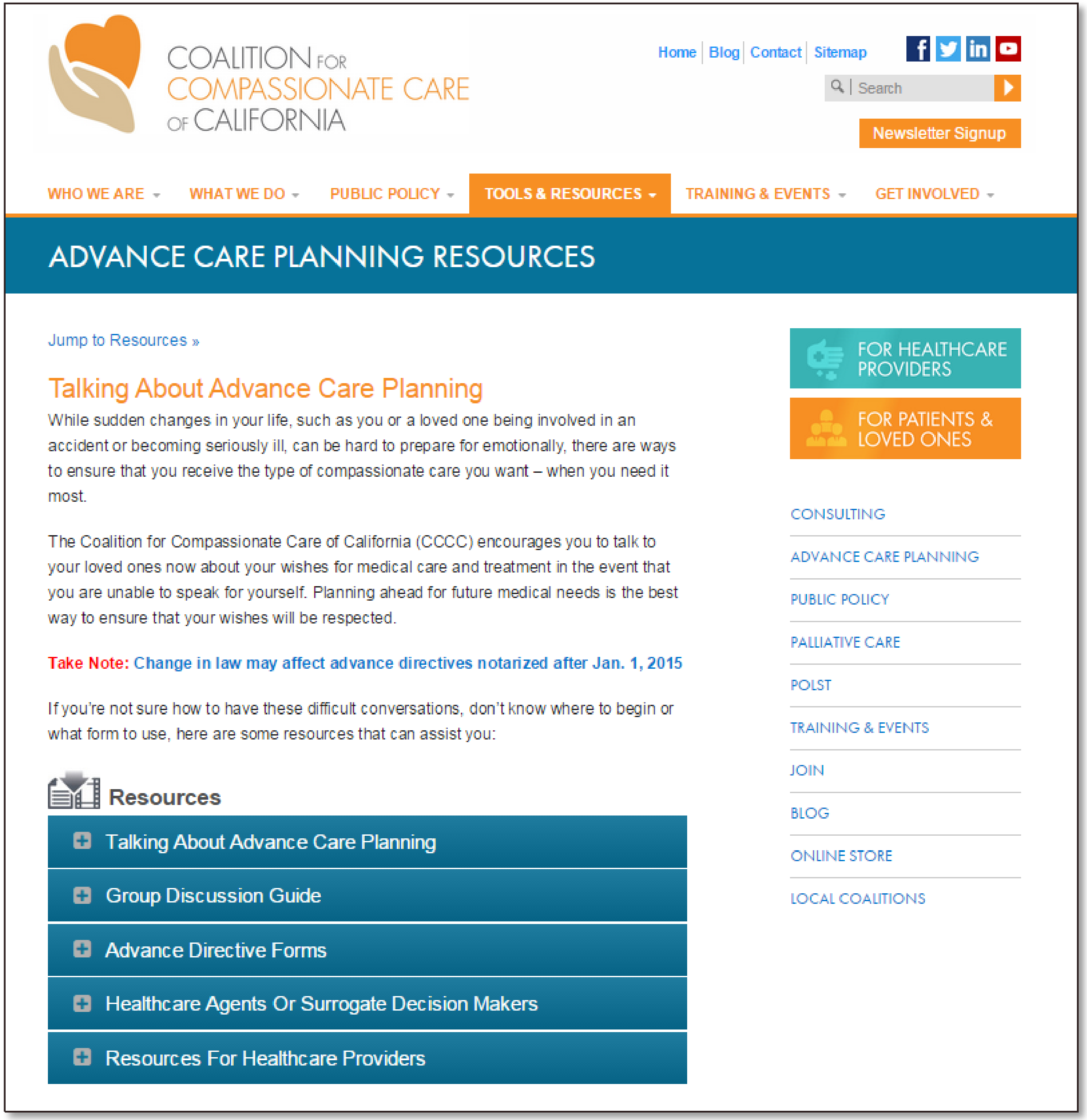
Advance Care Planning

Making decisions about the care you want if you become unable to speak for yourself

GET INVOLVED

Education

COALITIONCCC.ORG



ADVANCE CARE PLANNING RESOURCES

Jump to Resources »

Talking About Advance Care Planning

While sudden changes in your life, such as you or a loved one being involved in an accident or becoming seriously ill, can be hard to prepare for emotionally, there are ways to ensure that you receive the type of compassionate care you want – when you need it most.

The Coalition for Compassionate Care of California (CCCC) encourages you to talk to your loved ones now about your wishes for medical care and treatment in the event that you are unable to speak for yourself. Planning ahead for future medical needs is the best way to ensure that your wishes will be respected.

Take Note: Change in law may affect advance directives notarized after Jan. 1, 2015

If you're not sure how to have these difficult conversations, don't know where to begin or what form to use, here are some resources that can assist you:

Resources

- Talking About Advance Care Planning
- Group Discussion Guide
- Advance Directive Forms
- Healthcare Agents Or Surrogate Decision Makers
- Resources For Healthcare Providers

COALITIONCCC.ORG/tools-resources

Public Engagement Initiative

- One year pilot project
- 9 Local coalitions
- Ranging from 10 to nearly 100 members

CALIFORNIA HEALTHCARE FOUNDATION

- ✓ Alameda/Contra Costa
- ✓ Orange
- ✓ Riverside
- ✓ Santa Cruz
- ✓ Sonoma
- ✓ Journey Project/Sonoma
- ✓ Monterey
- ✓ CACCC
- ✓ West Los Angeles

Local coalition members represented:

- hospices
- hospital systems
- medical groups
- senior organizations
- county health agencies, and
- faith communities.

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

ACP Facilitator Trainings

- CCCC trained 21 coalition members as ACP facilitator trainers

- Coalition members in turn trained more than 400 community members as ACP champions and/or coaches

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

ACP Community Outreach

- Local coalitions hosted more than 160 events
- Attended by more than 3,100 people

Effective Professionals

Resources for "The Conversation"

FACING SERIOUS ILLNESS: MAKING YOUR WISHES KNOWN

Your Guide to POLST
(Physician Orders for Life-Sustaining Treatment)

What is Artificial Hydration?

¿Qué es la CPR?

什麼是管餵食？
What is Tube Feeding?

管餵食是專為因病而難以自行進食或吞嚥有困難的人，將流質食物藉由餵食管直接送進胃部。

- 若餵食管只需留置數天至數週，餵食管會經由鼻部放置到胃部。
  - 這類餵食管稱之為鼻胃管 (NG tube)。
- 若餵食管需留置超過數週，餵食管會藉手術經皮膚放入胃部或小腸。
  - 這類餵食管稱之為皮內視鏡胃造口管(PEG tube)。

餵食管有用嗎？
Does a feeding tube work?

這要看個人的疾病狀況與是否接近生命末期。
對於嘴部或喉部有損傷，但會很快恢復的病人，餵食管能幫助他們減輕因進食所造成的疼痛。
如果病人的腦部或神經有疾病，在他們生命末期的好幾年前，他們就可能有吞嚥問題。有些人因受傷或殘障而有吞嚥困難。餵食管可能會幫助這些人。

餵食管對於生命末期或末期失智症的病人有幫助嗎?
Does a feeding tube help people near the end of life or in the late stages of dementia?

對於生命末期的病人，餵食管有時不但無益於生命的延續，還會造成不必要的傷害。
對於生命末期和末期失智症的病人(嚴重的記憶力損失)，您的身體會減緩並停止消化，這是正常的。

- 在生命末期，停止進食是正常的。
- 身體無法再吸收和利用食物。
- 因為無法再吸收和利用食物，管餵食可能會導致：
  - 胃痛與腹瀉。
  - 腿部積水。
  - 肺部積水，造成呼吸困難。

FINDING YOUR WAY

MEDICAL DECISIONS WHEN THEY COUNT MOST

做好生命末期醫療決定
Medical Decisions Near the End of Life

李媽媽的故事
Mrs. Lee's Story

CoalitionCCC.org

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Resources for Creating Effective Professionals

Interactive training

- Skill development
- Communication

Education for Professionals

Regular Offerings

- **POLST**
- **Advance Care Planning**
- **Diversity and Cultural Sensitivity**

Monthly Webinars

- **Palliative Care, Public Policy, and More**

Online Course

Working with POLST for Professionals

CSU The California State University
Institute for Palliative Care
AT CALIFORNIA STATE UNIVERSITY SAN MARCOS

Bringing Training to You

Recent trainees:

IHA
INTEGRATED HEALTHCARE ASSOCIATION

PARTNERSHIP HEALTHPLAN of CALIFORNIA

KAISER PERMANENTE®

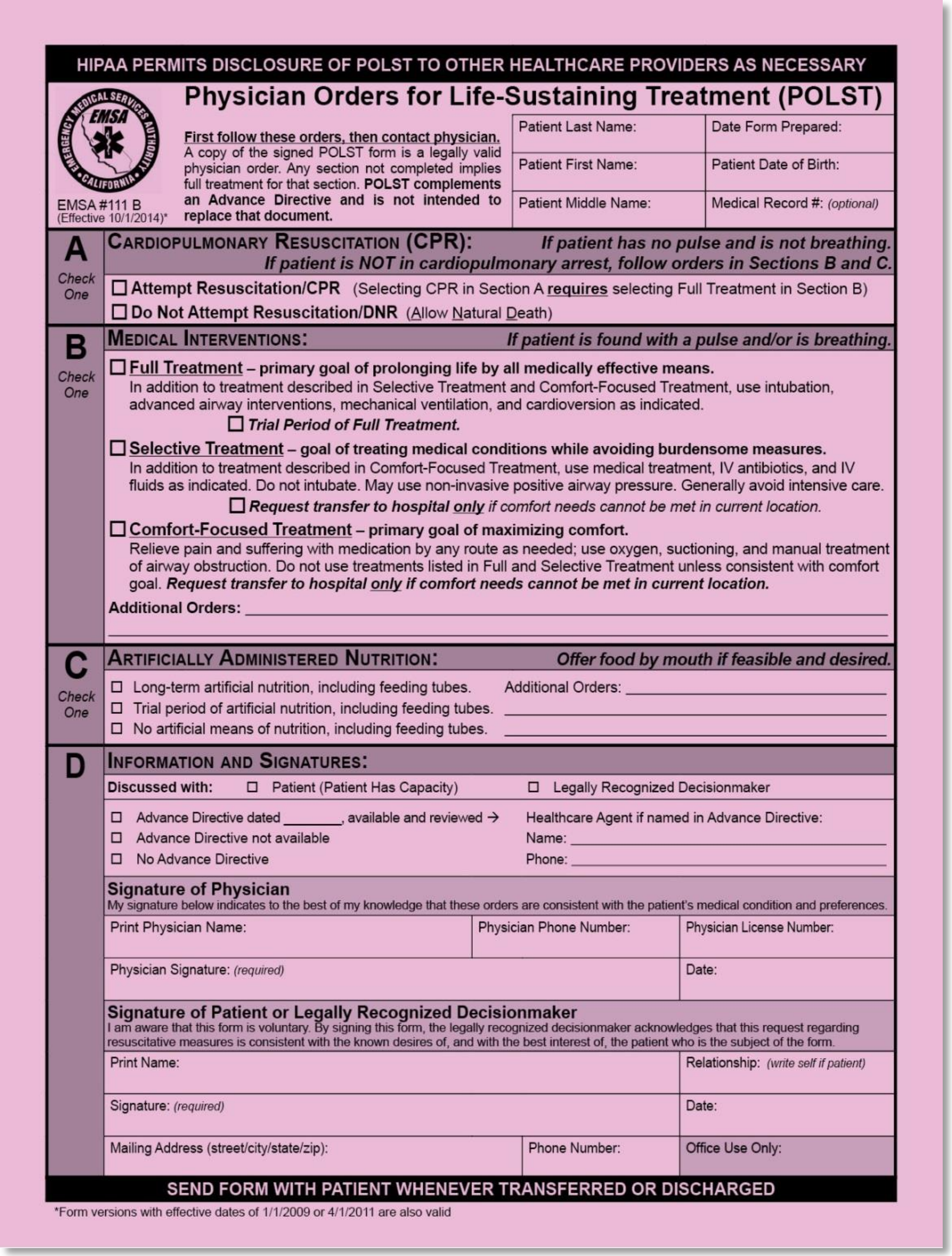
CALVET

Effective Systems

Resources for Creating Effective Systems

- POLST Form
- POLST Registry
- Resources
- Consultation Service

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

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 patient has no pulse and is not breathing.***
If patient is 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)

B

Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ____
____

C

Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of 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

Healthcare 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 patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

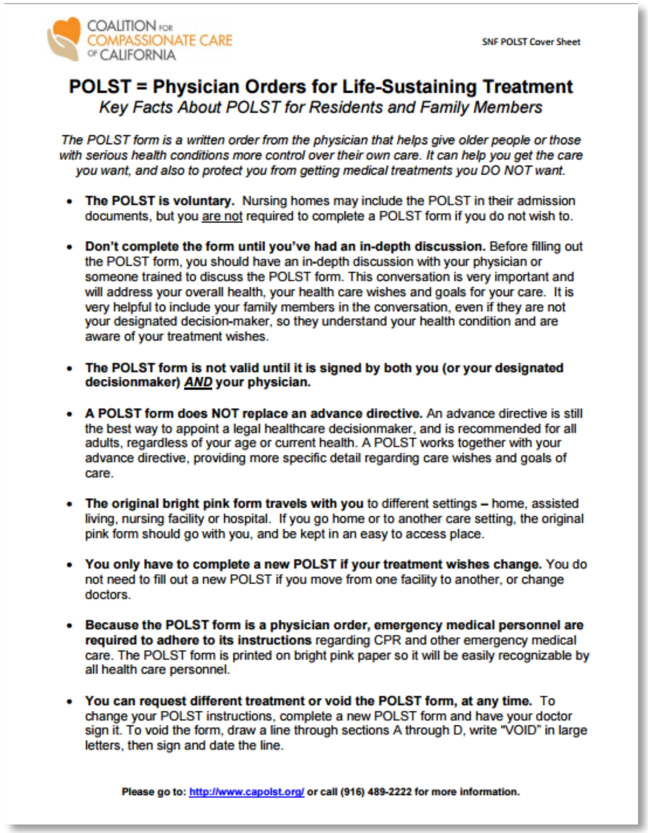
Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

POLST Cover Sheets



COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

SNF POLST Cover Sheet

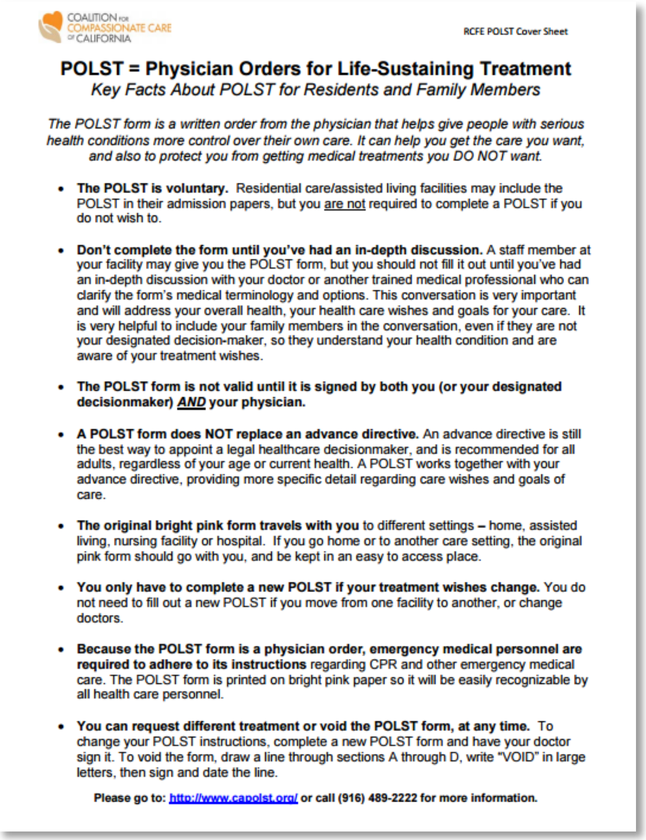
POLST = Physician Orders for Life-Sustaining Treatment

Key Facts About POLST for Residents and Family Members

The POLST form is a written order from the physician that helps give older people or those with serious health conditions more control over their own care. It can help you get the care you want, and also to protect you from getting medical treatments you DO NOT want.

- **The POLST is voluntary.** Nursing homes may include the POLST in their admission documents, but you are not required to complete a POLST form if you do not wish to.
- **Don't complete the form until you've had an in-depth discussion.** Before filling out the POLST form, you should have an in-depth discussion with your physician or someone trained to discuss the POLST form. This conversation is very important and will address your overall health, your health care wishes and goals for your care. It is very helpful to include your family members in the conversation, even if they are not your designated decision-maker, so they understand your health condition and are aware of your treatment wishes.
- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician.**
- **A POLST form does NOT replace an advance directive.** An advance directive is still the best way to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of your age or current health. A POLST works together with your advance directive, providing more specific detail regarding care wishes and goals of care.
- **The original bright pink form travels with you** to different settings – home, assisted living, nursing facility or hospital. If you go home or to another care setting, the original pink form should go with you, and be kept in an easy to access place.
- **You only have to complete a new POLST if your treatment wishes change.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors.
- **Because the POLST form is a physician order, emergency medical personnel are required to adhere to its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it will be easily recognizable by all health care personnel.
- **You can request different treatment or void the POLST form, at any time.** To change your POLST instructions, complete a new POLST form and have your doctor sign it. To void the form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.



COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

RCFE POLST Cover Sheet

POLST = Physician Orders for Life-Sustaining Treatment

Key Facts About POLST for Residents and Family Members

The POLST form is a written order from the physician that helps give people with serious health conditions more control over their own care. It can help you get the care you want, and also to protect you from getting medical treatments you DO NOT want.

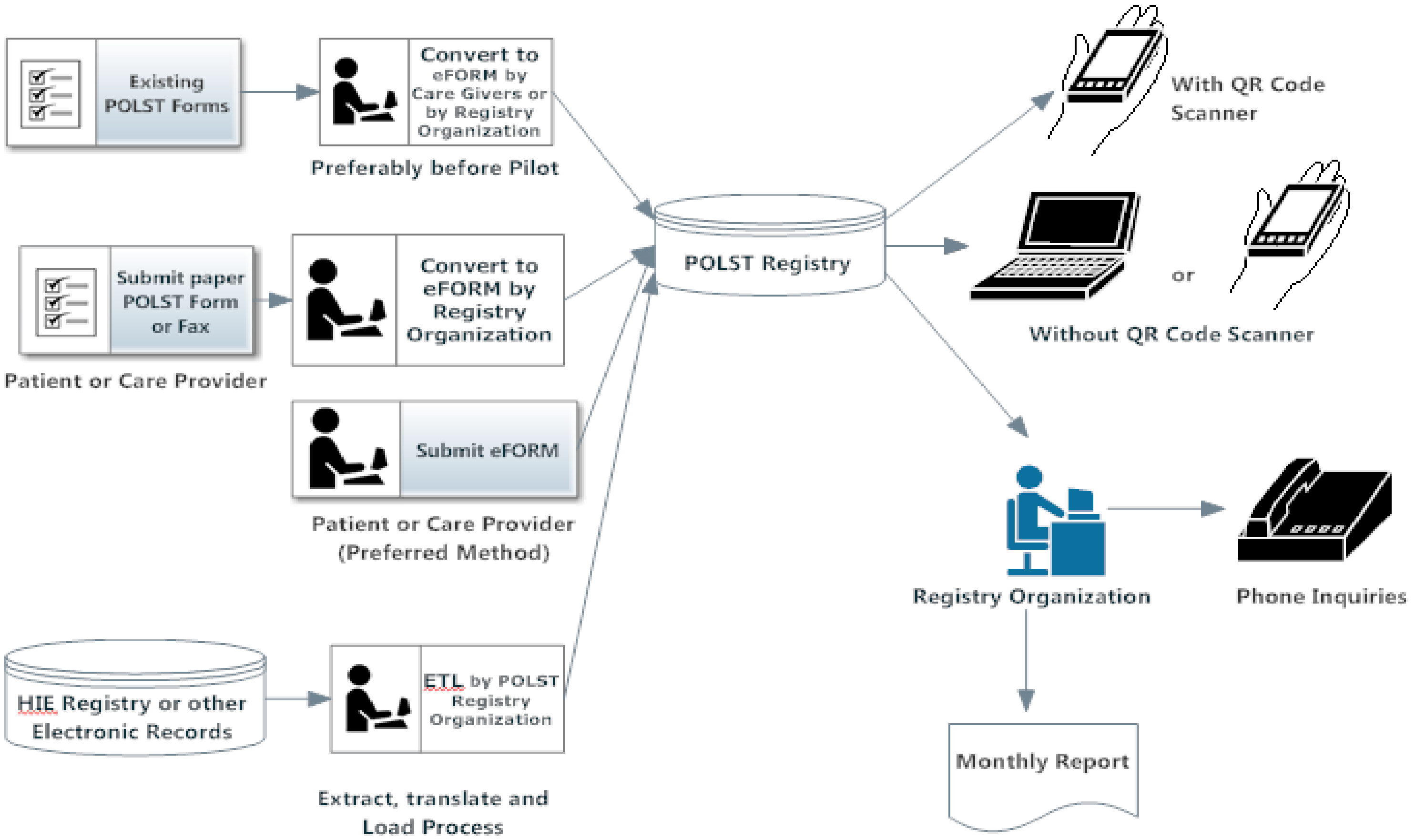
- **The POLST is voluntary.** Residential care/assisted living facilities may include the POLST in their admission papers, but you are not required to complete a POLST if you do not wish to.
- **Don't complete the form until you've had an in-depth discussion.** A staff member at your facility may give you the POLST form, but you should not fill it out until you've had an in-depth discussion with your doctor or another trained medical professional who can clarify the form's medical terminology and options. This conversation is very important and will address your overall health, your health care wishes and goals for your care. It is very helpful to include your family members in the conversation, even if they are not your designated decision-maker, so they understand your health condition and are aware of your treatment wishes.
- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician.**
- **A POLST form does NOT replace an advance directive.** An advance directive is still the best way to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of your age or current health. A POLST works together with your advance directive, providing more specific detail regarding care wishes and goals of care.
- **The original bright pink form travels with you** to different settings – home, assisted living, nursing facility or hospital. If you go home or to another care setting, the original pink form should go with you, and be kept in an easy to access place.
- **You only have to complete a new POLST if your treatment wishes change.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors.
- **Because the POLST form is a physician order, emergency medical personnel are required to adhere to its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it will be easily recognizable by all health care personnel.
- **You can request different treatment or void the POLST form, at any time.** To change your POLST instructions, complete a new POLST form and have your doctor sign it. To void the form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

CaPOLST.org/forms

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

POLST Registry



Existing POLST Forms

Convert to eFORM by Care Givers or by Registry Organization

Preferably before Pilot

Submit paper POLST Form or Fax

Patient or Care Provider

Convert to eFORM by Registry Organization

Submit eFORM

Patient or Care Provider (Preferred Method)

HIE Registry or other Electronic Records

ETL by POLST Registry Organization

Extract, translate and Load Process

POLST Registry

With QR Code Scanner

or

Without QR Code Scanner

Registry Organization

Phone Inquiries

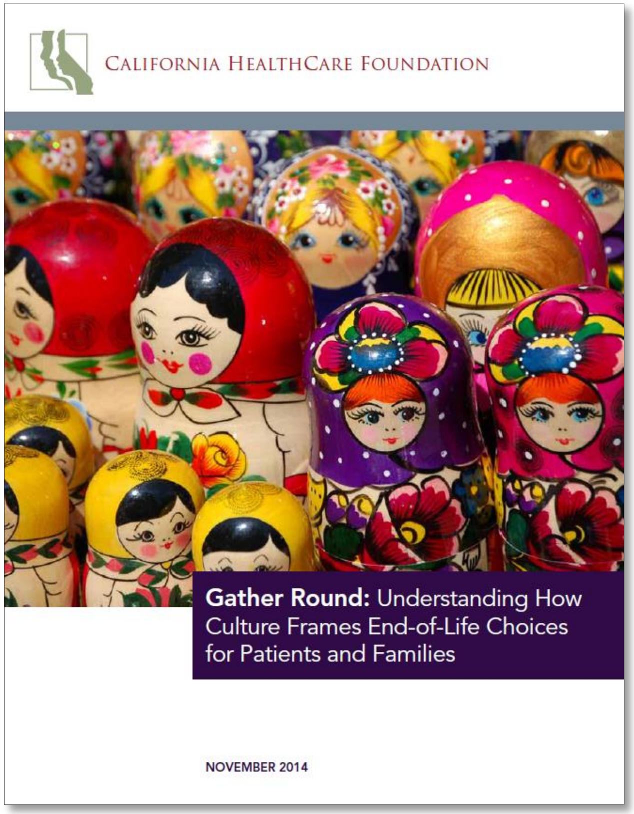
Monthly Report

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Ethnographic Research

Gather Round:

Understanding How Culture Frames End-of-Life Choices for Patient and Families



CALIFORNIA HEALTHCARE FOUNDATION

Gather Round: Understanding How Culture Frames End-of-Life Choices for Patients and Families

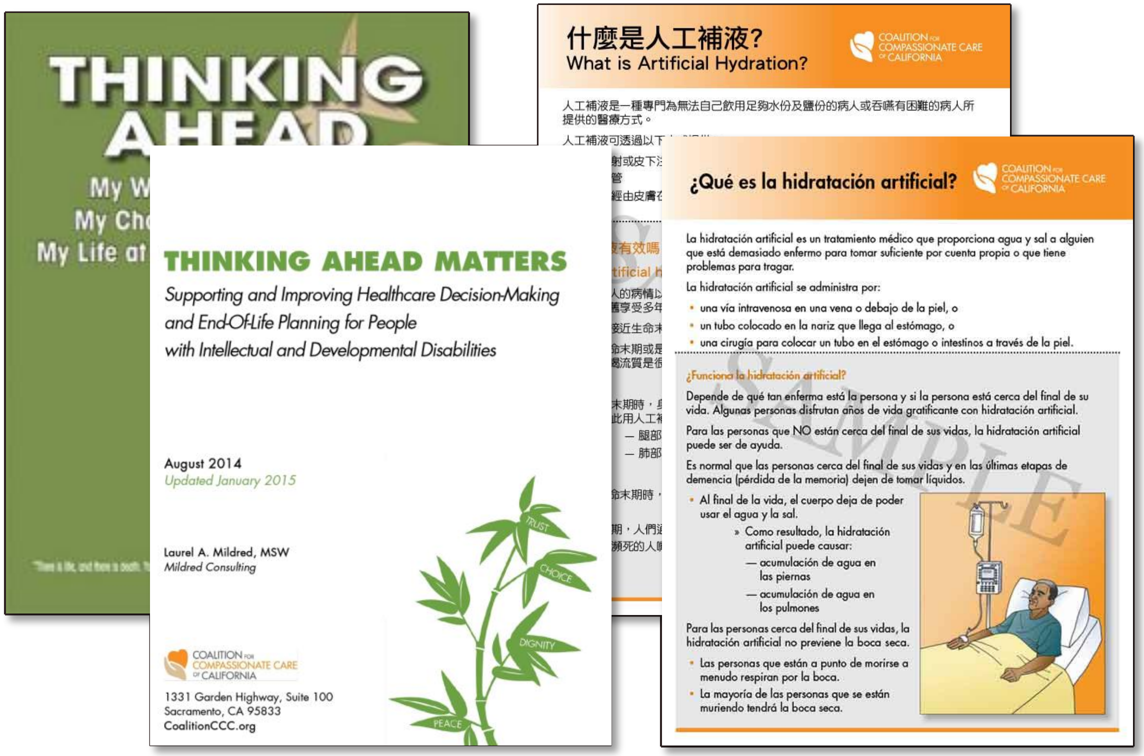
NOVEMBER 2014

CHCF.org/gatherround

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Diversity Training & Resources

- Shared decision-making
- Developmental disabilities
- Multilingual resources



THINKING AHEAD

THINKING AHEAD MATTERS

Supporting and Improving Healthcare Decision-Making and End-Of-Life Planning for People with Intellectual and Developmental Disabilities

August 2014
Updated January 2015

Laurel A. Mildred, MSW
Mildred Consulting

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA
1331 Garden Highway, Suite 100
Sacramento, CA 95833
CoalitionCCC.org

什麼是人工補液?
What is Artificial Hydration?

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

人工補液是一種專門為無法自己飲用足夠水份及鹽份的病人或吞嚥有困難的病人所提供的醫療方式。

¿Qué es la hidratación artificial?

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

La hidratación artificial es un tratamiento médico que proporciona agua y sal a alguien que está demasiado enfermo para tomar suficiente por cuenta propia o que tiene problemas para tragar.

La hidratación artificial se administra por:

- una vía intravenosa en una vena o debajo de la piel, o
- un tubo colocado en la nariz que llega al estómago, o
- una cirugía para colocar un tubo en el estómago o intestinos a través de la piel.

¿Funciona la hidratación artificial?

Depende de qué tan enferma está la persona y si la persona está cerca del final de su vida. Algunas personas disfrutan años de vida gratificante con hidratación artificial.

Para las personas que NO están cerca del final de sus vidas, la hidratación artificial puede ser de ayuda.

Es normal que las personas cerca del final de sus vidas y en las últimas etapas de demencia (pérdida de la memoria) dejen de tomar líquidos.

- Al final de la vida, el cuerpo deja de poder usar el agua y la sal.
  - » Como resultado, la hidratación artificial puede causar:
    - — acumulación de agua en las piernas
    - — acumulación de agua en los pulmones

Para las personas cerca del final de sus vidas, la hidratación artificial no previene la boca seca.

- Las personas que están a punto de morirse a menudo respiran por la boca.
- La mayoría de las personas que se están muriendo tendrá la boca seca.

Resources for Making the Case

VALUE SNAPSHOT | Advance Care Planning

Advance care planning promotes complia with patients' wishes and improves satisfactio

VALUE SNAPSHOT | Home-Based Palliative Care

Home-based palliative care increases satisfaction, reduces symptoms

VALUE SNAPSHOT | Hospice Care

Timely hospice care reduces pain and discomfort nd increases family satisfac

VALUE SNAPSHOT | Inpatient Palliative Care

Inpatient palliative care improves care quality and family satisfaction

VALUE SNAPSHOT | Palliative Care Clinics

Clinic-based palliative care decreases symptoms and ent satisfaction

Value Snapshots

CoalitionCCC.org/valuesnapshots

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Consultation Service

Recent clients:

UCLA Health

SONOMA COUNTY CALIFORNIA 1850

YOUR LOGO HERE

COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

CoalitionCCC.org