



**Re-Imagining Life Care Planning:
The Meaning of Living**

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Objectives

- Address and demystify common misunderstandings about Life Care Planning and its role in the long view of care
- Become familiar with strategies on how to approach this topic with patients and their families
- Identify 1-2 action items to encourage or promote Life Care Planning for your patients, loved ones, or for yourself

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**Broadening our Thinking
around Life Care Planning**

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Imagine

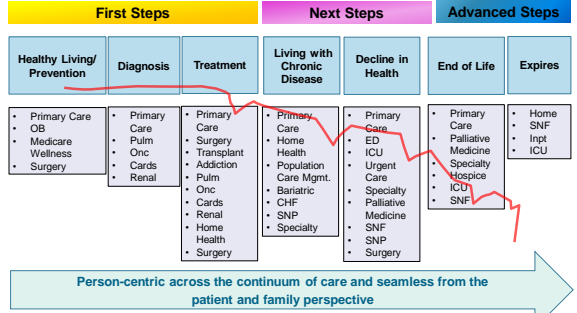
- A 28 year old looking forward to having her first baby
- 53 year old who is hospitalized for CHF complications
- 95 year old with a hip fracture

Who needs Life Care Planning?

Myth #1: This is only for people who are frail and elderly.

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Journey Map



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Credit: South Bay Medical Center

**Myth #2:
I thought the palliative care
team has these
conversations.**

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**Myth #3:
Everyone needs a POLST.**

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Advance Directive

A legal document that allows a person to express autonomy in the selection of:

1. Identification of a health care decision-maker should they become incapacitated
2. Direction for the kind of care one wants in the event of serious medical illness
 - Recommended for everyone over 18 years of age
 - Never expires and can be changed at anytime



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Advance Directive vs. POLST

| Advance Directive | POLST |
|---|--|
| Patient completes - indicating treatment preferences and a surrogate, typically for future decisions | Physician completes with patient-exploring values and indicating treatment choices for right now |
| Signed by patient and notary OR 2 witnesses, And patient signs name/MRN on every page | Patient and physician both sign the form Any blank areas imply full treatment for that section |
| A copy of the form is mailed to The original stays with the patient. 1011 South East St. Anaheim, CA 92805 | The form is scanned into the electronic health record. The original stays with the patient. A copy is provided to the health care agent. |

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Your Role

- Initiating the Conversations
 - Relationships matter
 - Normalize the process
 - Understanding of LCP
- Connecting Members to Resources
 - Life Care Planning class
 - Kp.org/lifecareplan



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REFLECT: What is important to you?

- What makes your life **meaningful**? What activities or abilities are **most important** to you?
- What **personal experiences** have you had that have influenced your beliefs about life sustaining treatments?
- What spiritual, cultural or personal **beliefs** are important to you in making decisions?



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SELECT: Your health care decision maker

A Well Chosen and Informed Decision Maker

- Accepts this role,
- Knows your wishes well,
- Agrees to honor your wishes (your health care decisions) even if they are different from their own, and
- Someone who is able to make decisions during a difficult or emotional situation.



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Life Changes, Updating Your Life Care Plan

Remember the 5 Ds:

- **D**ecade
- **D**eath
- **D**ivorce
- **D**iagnosis
- **D**ecline in health



Document your wishes as they stand today. Life changes over time and we recommend that you review your plan and make modifications as your wishes and health status change.

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A Paradigm Shift

Life Care Planning is Transformational Work

- Leadership
- Compassion
- Engagement
- Empowerment
- Advocacy







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An opportunity...



Taking Action

-  Begin your planning
-  Enculturate into the organization
-  Encourage conversations
-  Share stories

Q&A Session
