Interprofessional Geriatrics Training Program

End of Life: Hospice and Advanced Directives

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Introduction

Learning Objectives

Upon completion of this module, learners will be able to:

1. Differentiate between key elements and services of hospice and palliative care
2. Discuss the effective management of common end of life symptoms
3. Identify criteria that qualify a patient for hospice care
4. Use effective communication skills to deliver bad news
5. Discuss advanced directives, end of life decisions, and the use of the shared decision-making process

History of Hospice Care

History

- **1963:** Dr. Cicely Saunders first proposes the idea of specialized care for the dying in a speech at Yale
- **1967:** Dr. Saunders establishes the first hospice, St. Christopher's Hospice, in the UK
- **1969:** Dr. Elisabeth Kübler-Ross identifies the 5 stages of death progression and pleads for home care in her international bestseller *Death and Dying* (1969)

(National Hospice and Palliative Care Organization, 2016)

History, Continued

- **1972:** Dr. Kübler-Ross testifies at the first national hearings on death and dignity: "…we should not institutionalize people. We can give families more help and home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home" (Special Committee on Aging, 1972)
- **1974:** Connecticut Hospice in Branford, Connecticut, is founded
- **1978:** U.S. Department of Health, Education and Welfare task force reports that the "hospice movement as a concept for the care of the terminally ill and their families is a viable concept"
- **1979:** The Health Care Financing Administration pilots 26 hospice programs across the country

(National Hospice and Palliative Care Organization, 2016)

History, Continued

- **1980:** Hospice accreditation standards are developed by the Joint Commission on Accreditation (JCAHO), now known as The Joint Commission
- **1982:** Medicare begins funding for hospice care
- **1984:** JCAHO initiates hospice accreditation
- **1988:** The American Academy of Hospice and Palliative Physicians is formed
- **1997:** The American Board of Hospice and Palliative Care is incorporated to provide certification for hospice and palliative care

(National Hospice and Palliative Care Organization, 2016)

Differences Between Hospice Care and Palliative Care

What are Hospice and Palliative Care?

- Hospice is a focus of palliative care providing comprehensive comfort care to dying patients
- Palliative care is the management of symptoms and quality of life in patients facing life-limiting illnesses

Pre-Hospice Palliative Care and Hospice Palliative Care

Pre-Hospice Palliative Care	Hospice Palliative Care
Meticulous attention to symptom management	Meticulous attention to symptom management
Psychological and spiritual support to patients and families	Psychological and spiritual support to patients and families
Team-based approach	Team-based approach
For patients facing serious illness and receiving life-prolonging therapies	Life expectancy < 6 months
Usually initiated in the hospital but can be provided at home, in a skilled nursing facility (SNF), or an assisted living facility (ALF)	Usually provided at home, but can also be provided at an SNF or inpatient hospice unit

Hospice Care

- 60-80% of patients state that they prefer to die at home, but only 20% of people died at home as of 2004 (50% died in hospitals) (Gruneir et al., 2007; Hall et al., 2013)
- Mortality benefit with hospice care was demonstrated in a retrospective study of 4,493 patients with congestive heart failure (CHF) and end-stage cancer (Connor et al., 2007)
- Early palliative care has also shown similar mortality benefits (Rocque & Cleary, 2013)

What are Hospice Care Qualifications?

- To qualify for hospice care, a patient must have a prognosis of less than 6 months and be willing to forgo curative therapies
  - Note that this does not mean that health care providers forgo all therapies, only those exclusively designed to extend life
- There are some cases in which curative intent can be pursued, such as within the Veterans Administration Healthcare System
- Oncologists statistically overestimate prognosis, while intensivists statistically underestimate prognosis

(Hall et al., 2013)

Pain Management

Pain Management in Palliative Care

- Pain is often under-treated in older adults
- Important to assess pain in all patients
- Older adult patients have less visceral pain than younger patients due to decreased ability to mount an inflammatory response
  - This means an older adult patient may have a heart attack without any chest discomfort, or an acute abdomen without guarding or rebound tenderness on exam, so a high index of suspicion must be maintained in these patients
- Important to begin with non-pharmacologic and behavioral approaches
- Medications are often required; opioids are often the best option in hospice patients
  - Concerns regarding addiction and hastening death are less relevant in the hospice population

Assessment Question 1

Which of the following patients is most appropriate for palliative care?

a) A 90-year-old man in perfect health
b) A 30-year-old woman with metastatic breast cancer not expected to survive the next three months
c) A 50-year-old male with symptomatic heart failure expected to survive at least six months
d) An 80-year-old woman with a debilitating stroke not expected to survive for six months whose family has refused hospice care after a prolonged discussion with the primary physician describing patient prognosis and benefits of hospice care

Assessment Question 1: Answer

Which of the following patients is most appropriate for palliative care?

a) A 90-year-old man in perfect health
b) A 30-year-old woman with metastatic breast cancer not expected to survive the next three months
c) A 50-year-old male with symptomatic heart failure expected to survive at least six months (Correct Answer)
d) An 80-year-old woman with a debilitating stroke not expected to survive for six months whose family has refused hospice care after a prolonged discussion with the primary physician describing patient prognosis and benefits of hospice care

Assessment Question 2

Which of the following patients is most appropriate for hospice care?

a) A 90-year-old man in perfect health
b) A 30-year-old woman with metastatic breast cancer not expected to survive the next three months
c) A 50-year-old male with symptomatic heart failure expected to survive at least six months
d) An 80-year-old woman with a debilitating stroke not expected to survive for six months whose family has refused hospice care after a prolonged discussion with the primary physician describing patient prognosis and benefits of hospice care

Assessment Question 2: Answer

Which of the following patients is most appropriate for <u>hospice</u> care?

a) A 90-year-old man in perfect health

b) A 30-year-old woman with metastatic breast cancer not expected to survive the next three months (Correct Answer)

c) A 50-year-old male with symptomatic heart failure expected to survive at least six months

d) An 80-year-old woman with a debilitating stroke not expected to survive for six months whose family has refused hospice care after a prolonged discussion with the primary physician describing patient prognosis and benefits of hospice care

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The Dying Process

The Dying Process

- The dying process is a social, cultural, and personal experience
- A comprehensive review of the dying process includes examining the four domains of comfort care at the end of life and identifying non-pharmacologic and pharmacologic approaches to managing symptoms of dying
  1. Physical
  2. Mental and emotional issues
  3. Spiritual issues
  4. Practical tasks

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(S. Lopez, 2007)

The Dying Process

For a comprehensive training module, see the ENGAGE-IL module "The Dying Process" at engageil.com

End of Life Symptoms

- Pain
- Constipation
- Nausea/Emesis
- Diarrhea
- Anorexia
- Delirium
- Depression
- Dyspnea

Pain and Symptom Management

Pain and Symptom Management

- Symptom management includes:
  - Prognostic estimates
  - Coping and spiritual support
  - Goals of care planning discussions

Interview with Expert: Tanjeev Kaur, MD

Goal of Symptom Management
Expert Interview: Tanjeev Kaur, MD

Listen to Our Expert Discuss:

- The goal of both pain and symptom management is to:
  - Alleviate suffering
  - Provide comfort
  - Help the family not see their loved ones in pain and agony

Constipation

- Constipation is a common end of life symptom
- May be caused by opioids, immobility, and poor fluid intake

Non-Pharmacologic Management

- Ensuring adequate fluid intake
- Ambulation, if possible
- *Referral Cue: There may be a role for palliative physical therapy*

Pharmacologic Treatment

- Start with stool softeners and bowel stimulants
- Then add osmotic laxative
- Enema if no bowel movement (BM) in 3-4 days
- If impacted, disimpact manually or with enema prior to starting laxatives

Nausea/Emesis
Expert Interview: Tanjeev Kaur, MD

- Management depends on the cause
- Medications cause nausea via the serotonergic/dopaminergic/histaminergic pathways in the brainstem
  - Nausea can be managed by dopamine antagonists, prokinetic agents, and serotonergic agents
  - The exact agent must be chosen based on the risk factors of the patient
- Emesis can originate in the gut from gastric irritation, opioids, liver capsule stretching, etc.
  - It can be treated with prokinetic agents and serotonergic agents, but avoid antihistamines in the elderly

Nausea/Emesis
Expert Interview: Tanjeev Kaur, MD

- Vestibular apparatus nausea can be managed with scopolamine and meclizine
- Cerebral cortex causes (usually secondary to increased intracranial pressure) are best managed with dexamethasone

Diarrhea
Expert Interview: Tanjeev Kaur, MD

- Affects 29% of radiation-treated cancer patients and 48% of patients receiving chemo or radiation therapy (Sonis et al., 2015)
- Ensure adequate fluid replacement
- Screen for overflow incontinence and fecal impaction
- Cut back on laxative therapy

Anorexia
Expert Interview: Tanjeev Kaur, MD

- Almost universal in terminal patients
- Not a source of significant discomfort
- Important to reassure the families
- Make sure to wet lips, but feeding tube is rarely indicated
- Tube feeds specifically are not indicated in advanced dementia, terminal cancers (with the exception of some GI cancers)

Delirium
Expert Interview: Tanjeev Kaur, MD

- Identify and treat underlying causes
- Attempt to reorient patient
- All the medication treatments for delirium are off-label use
- Can consider a minimal dose of antipsychotics, but all antipsychotics are sedating
- Benzodiazepines should be avoided

Depression
Expert Interview: Tanjeev Kaur, MD

- Very under-recognized and under-treated in terminal patients
- Be aware of cognitive changes, memory deficits, loss of appetite or sleep
- Treat aggressively with antidepressants and arrange psychiatric consult if needed

Depression
Expert Interview: Tanjeev Kaur, MD

For a comprehensive training module on managing depression, see the ENGAGE-IL module "Depression and Delirium of the Older Adult" at engageil.com

Dyspnea
Expert Interview: Tanjeev Kaur, MD

- Can be a very significant discomfort to the patient
- Only way to measure is patient report
- Consider supplemental oxygen if oxygen saturation is less than 90%, but use with caution in carbon dioxide retainers
- Benzodiazepines *do not* control dyspnea
- Opioids *do* control dyspnea
- Opioids really help in end of life dyspnea management

Assessment Question 3

End of life symptom management includes:

a) Prognostic estimates
b) Coping and spiritual support
c) Goals of care discussions
d) Disposition planning
e) All of the above

Assessment Question 3: Answer

End of life symptom management includes:

a) Prognostic estimates
b) Coping and spiritual support
c) Goals of care discussions
d) Disposition planning
e) All of the above (Correct Answer)

Conversations About Death

Where Do Americans Die?

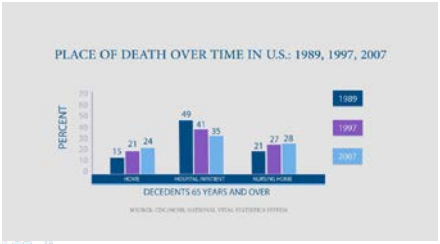
Where People *Prefer* to Die

- Home (60-80%) (Gruneir et al., 2007)

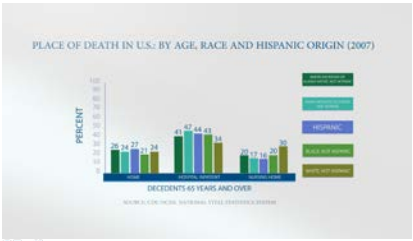
Where Americans Die

- Hospitals: 35%
- Nursing Homes: 28%
- Home: 24% (CDC, 2011)

Where Do Americans Die?



Place of Death in U.S.: By Age, Race and Hispanic Origin (2007)



Delivering Bad News

Delivering Bad News

- Prepare
- Establish the patient's understanding
- Determine how much the patient wants to know
- Deliver the information
- Respond to the patient's feelings
- Develop a plan and follow-up procedure

End of Life Decisions: *The Conversation*

What Do People Want at End of Life?

- 90% of respondents said it was important to discuss end of life care with loved ones, but only 27% have actually done so (Conversation Project National Survey, 2013)
- 82% of respondents said it was important to put their wishes in writing, but only 23% have actually done so (California Healthcare Foundation, 2012)

End of Life Decisions: *The Conversation*

***The Conversation* Must Include**

- Understanding of context
- Illness trajectory
- Anticipation of events
- Final outcomes in death

Health Care Provider Responsibilities

- Discuss illness
- Discuss future issues
- Discuss risks and benefits of treatment
- Write orders consistent with patients' preferences

(Conversation Project National Survey, 2013)

End of Life Decisions: *The Conversation*

The Conversation Project from the Institute for Healthcare Improvement (IHI)

- http://theconversationproject.org/
- The goal of The Conversation Project is to ensure that everyone's end of life wishes are expressed and respected
- Includes step-by-step instructions on how to consider and discuss end of life care issues

(Conversation Project National Survey, 2013)

End of Life Decisions: *The Conversation*

- The shared decision-making process integrates clinical facts and prognostication with the goal of achieving an informed decision

Ask Open-Ended Questions

- What concerns you most right now?
- Thinking about your future, what is most important to you?

(Scherer & Swidler, 2014)

Assessment Question 4

A 79-year-old woman comes to the office because she has had decreased appetite, weight loss, and abdominal distension for the past month. History includes hypertension and osteoporosis, and 5 years ago she had rectal cancer that was treated with surgery, chemotherapy, and radiation. On examination, there is scleral icterus and moderate abdominal distension with tenderness to palpation in the right upper quadrant and associated hepatomegaly. Laboratory studies show moderate anemia and liver dysfunction. CT of the chest and abdomen demonstrates two liver masses suggestive of metastatic disease and ascites. CT-guided biopsy of the liver is positive for adenocarcinoma consistent with recurrent, metastatic colorectal cancer with liver involvement. The patient's oncologist determines that she is not a candidate for further treatment and recommends hospice.

Assessment Question 4

Which of the following is the most appropriate first step in initiating the discussion about hospice?

a) Ask the patient to describe her current medical condition
b) Discuss code resuscitation status
c) Explain hospice and its services
d) Outline prognosis and life expectancy
e) Review the pathology and radiology results

Assessment Question 4: Answer

Which of the following is the most appropriate first step in initiating the discussion about hospice?

a) Ask the patient to describe her current medical condition (Correct Answer)
b) Discuss code resuscitation status
c) Explain hospice and its services
d) Outline prognosis and life expectancy
e) Review the pathology and radiology results

Legal Preparations: Overview

Advanced Directives

Advanced Health Care Directives

- Instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity
- Legal documents that allow the patient to spell out their wishes or decisions about end of life care ahead of time (MedlinePlus, 2016)
- It is important that these documents are shared with family, friends, and health care providers and placed in their medical records

Advanced Directives

Three Types of Advanced Directives

1. Living Will
   - Instructions for treatment
2. Power of Attorney (POA)
   - Durable power of attorney for health care decisions
   - Durable power of attorney for property
3. Provider Order for Life-Sustaining Treatment (POLST)

- People may have only one or a combination of advanced directives

Assessment Question 5

Which of the following statements about advanced directives is FALSE?

a) A power of attorney is an advanced directive indicating which individual is responsible for making medical decisions
b) A living will is one form of advanced directive, leaving instructions for treatment
c) People can only have one type of advanced directive
d) People may have a combination of advanced directives

Assessment Question 5: Answer

Which of the following statements about advanced directives is FALSE?

a) A power of attorney is an advanced directive indicating which individual is responsible for making medical decisions

b) A living will is one form of advanced directive, leaving instructions for treatment

c) People can only have one type of advanced directive (Correct Answer)

d) People may have a combination of advanced directives

Legal Preparations: In Detail

Living Will

- Oldest form of advanced directive
- A legal document that describes what the patient desires if they are unable to make decisions for themselves, usually with regard to resuscitation and advanced life support
- In many states, the living will is superseded by the power of attorney (POA)

Living Will

- The *Five Wishes* document is a form of living will that meets legal requirements in 42 states
- Usually provides specific directives about the course of treatment that is to be followed by health care providers
- In some cases, it may forbid the use of various kinds of burdensome medical treatment
- Only used if the individual has become unable to give informed consent or refusal (i.e., "individual health care instruction") due to incapacity
- Can be very specific or very general

Power of Attorney

- Powers of attorney are authorized by the state
- In **Illinois**, all powers of attorney are durable (by law) unless the document specifically states that the power of attorney is not meant to be durable
  - Non-durable powers of attorney are usually prepared for a specific transaction, like a real estate closing, and do not need to be durable
  - Durable powers of attorney continue to be valid even after the patient, who is called the "principal" in the power of attorney document, is incapacitated

Power of Attorney

- A durable power of attorney allows a competent person (the "principal") to appoint an agent to make decisions for themselves when they become incapacitated and unable to make decisions
  - This period of incapacity may be caused by a medical situation, such as a coma, or a period of mental incapacity, such as mental illness
- If the patient has capacity and can make decisions, then the agent (the person designated as the POA) cannot make decisions for the patient

Two Types of Power of Attorney (POA)

- These two separate documents are powerful tools that can be used to assist and protect an older or disabled person, or be misused to exploit that person

1. **Power of Attorney for Health Care**
   - The "principal" delegates power to an "agent" (trusted friend or family member) for health care and personal care decisions
   - This is a document indicating which individual is responsible for making medical decisions and is a legal document
   - Must be distinguished from a durable POA, which handles financial matters

Two Types of Power of Attorney (POA)

1. **Power of Attorney for Health Care (Continued)**
   - Patients should be encouraged to name someone who understands their wishes and lives in the same state as they do

Two Types of Power of Attorney (POA)

2. **Power of Attorney for Property (Continued)**
   - The patient/"principal" delegates power to an "agent" to issue decisions on finances and property management
   - The person whom the patient/"principal" designates as the "agent" must be aged 18 or over and cannot be his/her doctor or someone who is paid to provide health care services to the patient
   - The same person may serve as both the health care agent and the financial agent, or different individuals may be appointed

Power of Attorney: Agents

- The extent of the powers which the "principal" delegates to the "agent" may be very broad, or narrow and specific
  - These are matters at the discretion of the patient
- The powers the "principal" gives to the "agent," his/her right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, 4-9. and 4-10(b) of the **Illinois** "Powers of Attorney for Health Care Law"
- All states:
  - http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011_aging_hcdec_univhcpaform.authcheckdam.pdf

Decision-Maker if No POA Is Named

1. Court-appointed guardian
2. Spouse
3. Adult children
4. Parent
5. Adult siblings
6. Adult grandchildren
7. Close friend

Assessment Question 6

Ms. C is a 65-year-old female who was recently admitted to the hospital with the complaints of severe abdominal pain and worsening distention for 4 months. She underwent imaging tests which raised the suspicion of a malignant process and was subsequently diagnosed to have a metastatic ovarian cancer. You have been taking care of her in the hospital, and her pain has been well controlled with use of morphine. She does not know her diagnosis yet, and you are the one who has to deliver this news to her. How would you approach her?

Assessment Question 6

a) Determine if the patient would like any family to be present with her at the time of this discussion; also assess if she has religious faith and would like a chaplain to be present during the discussion
b) Determine what the patient and family know, but make no assumptions; you may ask, "What is your understanding of the reasons we did the CT scan" OR "What have you been told about your medical situation so far?"
c) Determine how much the patient would like to know about her current condition, and if she does not want to know, ask the patient whom she thinks would be the best person to discuss the same
d) Provide information slowly and assess for patient's comprehension and invite questions
e) Address the patient's emotions and provide support
f) All of the above

Assessment Question 6: Answer

a) Determine if the patient would like any family to be present with her at the time of this discussion; also assess if she has religious faith and would like a chaplain to be present during the discussion
b) Determine what the patient and family know, but make no assumptions; you may ask, "What is your understanding of the reasons we did the CT scan" OR "What have you been told about your medical situation so far?"
c) Determine how much the patient would like to know about her current condition, and if she does not want to know, ask the patient whom she thinks would be the best person to discuss the same
d) Provide information slowly and assess for patient's comprehension and invite questions
e) Address the patient's emotions and provide support
f) All of the above (Correct Answer)

Advanced Directive: POLST

Advanced Directive: POLST

Provider Order for Life-Sustaining Treatment (POLST)

- Medical order that MUST be followed
- Initial version was added to the statutory "do not resuscitate" order in March 2013
- The bill passed on May 30, 2015 makes several alterations to the state's first POLST form
  - The new form provides the opportunity to discuss other options, such as:
    - IV solutions
    - Feeding tubes
    - Pain medications
    - Hospice treatment
    - In addition to MDs, gives PAs, APNs, and senior medical residents the power to sign the directives

Advanced Directive: POLST

- 43 states have some kind of POLST
  - 2 states (Oregon, West Virginia) have "mature" programs
  - Illinois legislation was recently passed (SB3076) and is among 28 states whose program is "developing"
  - Similar to a living will, it must be signed by a physician or licensed provider
  - Find your state program: http://www.polst.org/programs-in-your-state/
  - Whether the above supersedes a designated POA varies from state to state
- Is binding to emergency medical personnel if kept somewhere readily accessible, such as on a refrigerator or front door
- Was initially designed for patients with terminal illnesses, but may be completed by any patient

Advanced Directive: POLST

- POLST gives patients three options:
  1. Comfort measures, avoiding transfer to hospital
  2. Limited interventions of basic medical treatments and transfers to hospitals but avoiding ICU
  3. Full treatment including transfer to hospital and ICU
     - www.polstil.org

Assessment

Checklist to Identify Patients for End of Life Care

Assessment Tool: CriSTAL

- Developed by researchers at The University of South Wales
- **Cri**teria for **S**creening and **T**riaging to **A**ppropriate **Al**ternative Care Checklist
- Assesses most likely predictors of death in the short term (30 days) to medium term (12 weeks)
- 29-item screening list

(Cardona-Morrell & Hillman, 2015)

Checklist to Identify Patients for End of Life Care

Tool: CriSTAL (Continued)

- Completed by a nurse or doctor before hospital admission
- Intended for adults age 65 and older
- Assessment tool predictors include:
  - Vital signs
  - Cognitive impairment
  - Recent hospital stays
  - Signs of frailty
  - Presence of active or chronic diseases

(Cardona-Morrell & Hillman, 2015)

Checklist to Identify Patients for End of Life Care

Tool: CriSTAL (Continued)

- Does not intend to preclude access to health care for the terminal elderly, but to provide an objective assessment and definition of the dying patient as a starting point for honest communication with patients and families
  - About recognizing that dying is part of the life cycle
- CriSTAL is an effective and objective way of identifying patients near end of life and preventing inappropriate hospital admission and unnecessary treatment
  - http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full

(Cardona-Morrell & Hillman, 2015)

Prognostication

- Prognosis is more than life expectancy
- It is a composite of several clinical predictors
- Enables patients to gain perspective on the severity of their disease and its progression
- Should be communicated to the patient
- Covers the course of an illness (curable, stable, or progressive) and possible or expected symptoms and possible complications
- Should include effects of the treatment and potential side effects, the probable time course, and typical time range of trajectory of the illness
- Other topics to be discussed include: feeding tubes when swallowing becomes impaired, hospitalizations for infections, and intubation

Prognostication Assessment Tools

Assessment Tool	Link
Karnofsky Performance Scale (Crooks & Waller, 1991)	http://www.hospicepatients.org/karnofsky.html
Palliative Performance Scale (PPSv2) (Anderson et al., 1996)	http://www.npcrc.org/files/news/palliative_performance_scale_PPSv2.pdf
Functional Assessment Scale (FAST) (Reisberg, 1988)	http://geriatrics.uthscsa.edu/tools/FAST.pdf
Advanced Dementia Prognostic Tool (ADEPT) (Mitchell et al., 2010)	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2981683/

Resources

Illinois Resources

- The Illinois Department of Aging provides complementary copies of the following forms:
  - Power of Attorney for Health Care
  - Power of Attorney for Property
  - Living will
- For copies, contact the Senior Helpline:
  - 1-800-252-8966 • 1-888-206-1327 (TTY)
  - Email: ilsenior@aging.state.il.us

Resources

Type	Hospice and Palliative Care Organizations
National	National Hospice and Palliative Care Organization http://www.nhpco.org/ American Academy of Hospice and Palliative Care http://aahpm.org/

Resources

Type	Hospice and Palliative Care Organizations
Rural	*PACE in Rural Areas: A Curriculum Development Guide for Training Health Professionals in Interdisciplinary Geriatric Care* (free guide) https://www.ruralhealthinfo.org/pdf/pace_in_rural_areas.pdf *Providing Hospice and Palliative Care in Rural and Frontier Areas*, the rural toolkit: a project of the National Hospice and Palliative Care Organization, the Center to Advance Palliative Care, and the National Rural Health Association; $19.95 online publication http://palliativecare.issuelab.org/resource/providing_hospice_and_palliative_care_in_rural_and_frontier_areas

Resources

Type	Hospice and Palliative Care Organizations
Veterans	Veterans can receive hospice care through the VA; the VA can purchase hospice services from community practitioners, including hospice care provided at home or in an institution http://www.nhpco.org/billing-and-reimbursement/department-veterans-affairs-va

Resources

Type	Link
CriSTAL Tool (Cardona-Morrell & Hillman, 2015)	http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full
The Conversation Project Starter Kit	http://theconversationproject.org/starter-kit/get-ready/
POLST	www.polstil.org http://www.polst.org/programs-in-your-state/

Resources

http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011_aging_holoc_univhrpaform_authchecklam.pdf Accessed February 21, 2017
http://aahpm.org/ Accessed October 10, 2016
http://www.nhpco.org/billing-and-reimbursement/department-veterans-affairs-va Accessed October 10, 2016
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http://palliativecare.issuelab.org/resource/providing_hospice_and_palliative_care_in_rural_and_frontier_areas Accessed October 10, 2016
http://www.polstil.org Accessed October 10, 2016
http://www.polst.org/programs-in-your-state/ Accessed October 8, 2016
http://theconversationproject.org/ Accessed October 10, 2016
http://theconversationproject.org/starter-kit/get-ready/ Accessed October 10, 2016
http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full Accessed October 10, 2016
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