End of Life Decisions

Participant Manual

The Supreme Court *of* Ohio
Judicial College

THE SUPREME COURT *of* OHIO

END OF LIFE DECISIONS

PARTICIPANT MANUAL

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END OF LIFE DECISIONS

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SUPREME COURT OF OHIO JUDICIAL COLLEGE
Adult Guardianship Continuing Education: End of Life Decisions

Session Agenda

Welcome & Introductions	Judicial College Staff
Guardian Responsibilities at the End of Life	**Derek Graham** *Resch, Root, Philipps & Graham, LLC*
Medical Considerations Involving End of Life and Hospice Care	**Annette K. Collier, MD** *Sincera Supportive Care and Symptom Relief*
Break	
Selecting and Working with Long-Term Care and Hospice Providers	**Christopher Stieben** **Megan Benner Senecal** *Advocates for Basic Legal Equality, Inc.*
Preparing for Loss, Memorial Services, and End of Life	**Julie Olds, CT** **Kevin Schoedinger** *Schoedinger Funeral and Cremation Service*
Adjourn	

FACULTY BIOGRAPHIES

ANNETTE K. COLLIER, MD is board certified in Internal Medicine and Hospice and Palliative Care. She is currently medical director of Sincera, the palliative care program at Hospice of Northwest Ohio and serves as an inpatient palliative care consultant at University of Toledo Medical Center and St. Luke's Hospital. Dr. Collier is a graduate of Miami University and the Medical College of Ohio.

DEREK GRAHAM is a partner with the law firm Resch, Root, Philipps & Graham LLC. Derek's practice areas are disability law, guardianship and estate planning. Derek serves as legal counsel to Advocacy & Protective Services, Inc., commonly known as APSI, and in that capacity he practices in guardianship cases statewide. Derek attended law school at the Moritz College of Law at The Ohio State University and has a Bachelors in Business Administration from the University of Kentucky. Derek is active in many non-profit organizations and is on the Board of Directors of the Down Syndrome Association of Central Ohio.

JULIE OLDS, Certified Thanatologist, has been serving as the Director of Community Relations and Education at Schoedinger Funeral and Cremation Service since January 2012. Prior to her current position, she served the senior housing and healthcare community for over 10 years. She received her Bachelor of Science Degree in Allied Medicine from The Ohio State University and her Master's Degree in Marketing and Communication from Franklin University.

KEVIN SCHOEDINGER is executive vice president, secretary, treasurer, and a sixth-generation owner at Schoedinger Funeral and Cremation Service in Columbus, Ohio. He received a degree in Human Resources Management from the University of Colorado, Leeds School of Business. Schoedinger Funeral Service was founded in 1855 and now operates 15 locations, a pet cremation service, and a monument company in the central Ohio area.

MEGAN BENNER SENECAL has been serving as the Ombudsman at Advocates for Basic Legal Equality, Inc. (ABLE) since October 2017. She received her Bachelor of Arts Degree from Tiffin University. She graduated from the University of Toledo with a PhD in Philosophy.

CHRISTOPHER STIEBEN has worked at ABLE for 9 years, gaining experience as a Certified Ombudsman Specialist and as a Certified Program Director. As a seasoned Ombudsman, he is passionate about advancing Advocacy and Information for elders across the ageing network. Before joining ABLE, Chris worked at Promedica as a Financial Advocate for almost 10 years. Chris attended the University of Toledo and Spring Arbor University. In addition to his responsibilities at ABLE, he is involved in the Coalition of Organizations Protecting Elders, serving on several committees, he is the Current Chairman of TRIAD. He is a Disabled Veteran of the USMC.

Guardian Responsibilities at the End of Life

Derek Graham. Esq.
Resch, Root, Philipps & Graham, LLC

Guardianship End of Life Situations

Derek L. Graham, Resch Root Philipps & Graham, LLC

DECISION-MAKING

- Guardianship is about decision-making
- Best Interest standard
- End of life situations require complicated and critical decisions

GUARDIANSHIP DUTIES

- Rule 66.08

  (D) Promptly notify the probate court upon ward's death.

  (L) Filing of Ward's Legal Papers. Guardian must file a list, including location of all important legal papers including but not limited to estate planning documents, advance directives and powers of attorney.

- Rule 66.09

  (B) Due Diligence. "communicating with the ward and being fully informed about the implications."

  (C) Least Restrictive Alternative. To the extent possible, let the individual make the decisions.

  (D) Person Centered Planning. "Advocate for services focused on a ward's wishes and needs."

  (I) Extraordinary Medical Issues. "A guardian shall strive to honor the ward's preferences and belief system concerning extraordinary medical issues."

  (J) End of life decisions

  A guardian shall make every effort to be informed about the ward's preferences and belief system in making end of life decisions on behalf of the ward.

The redundancy is intentional!

DECISION-MAKING

Decision-Making Progression

(1) Did they sign formal documents indicating their wishes?
(2) Have you discussed their wishes with them?
(3) Have they discussed their wishes with a third party?
(4) Based on information available, what do you think is in their best interest?

Formal Documents Used to Communicate

- Estate Planning
- Advanced Directives
    - Powers of Attorney
    - Living Will
    - Financial Powers of Attorney
- Appointment of Representative
- Written Directives

Informal Ways of Communication

- Conversation
- Family traditions
- Religious beliefs/practices
- Countless ways to communicate
- ALL COMMUNICATION SHOULD BE CONSIDERED

POWER OF ATTORNEY (POA) AND GUARDIANSHIP?

Healthcare POA and General (financial) POA

- ORC § 1337
- Confusion
- Not automatically terminated by Guardianship
- If disagreement exists between guardian and POA agent—report to court immediately
- Only probate court can terminate power of attorney for good cause shown after notice given to agent in POA

Living Will

- ORC § 2133.03
- Specifies health care person wants to receive if they become terminally ill or permanently unconscious

  Permanent Unconscious State OR Terminal Illness
- Can be revoked at any time (including verbally)
  *Do not confuse with a DNR

Permanently Unconscious State

- Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Terminal Illness

- Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

NOTHING WRITTEN DOWN—WHAT DOES A GUARDIAN DO?

- Communication (verbal and otherwise) becomes critical
- Guardian makes decisions concerning continuation of life-prolonging treatment
- Decisions should be supported by medical experts

DO NOT RESUSCITATE

DNR order addresses the various methods used to revive people whose hearts have stopped functioning or who have stopped breathing.

- A medical order—completed by physician
- Standardized form—completed by physician
- Guardian's consent necessary
- Check local rules—Court consent may be required

HOSPICE CARE

- Guardians can consent to hospice care
- Care is no longer focused on cure
- More to come from other presenters!

WHAT TO TELL THE COURT?

- Check Local Rules
- Address in Guardian's Report or Annual Plan
- Majority of Counties do not Require Court notice in advance for DNR or Hospice Care
- When in doubt—tell the court!

GUARDIAN DUTIES AFTER DEATH

- Notify court timely
- Some Courts require Application to Terminate Guardianship
- File Death Certificate
- Organ Donation
- Right of Disposition
- Funeral / Burial

COURT REQUIREMENTS - DEATH

- Application to Terminate Guardianship
    - Several counties use standardized form
    - Make sure to inform court
    - File a copy of death certificate
- Understand ongoing duties vis-à-vis disposing of body/autopsy/etc.
- Guardian of Estate
    - Do not expend funds after death
    - Prepare final account & hand off funds to estate

ORGAN DONATION

- ORC § 2108.04
- An anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education ….by any of the following:

  (1) The donor → (2) Agent of the Donor (i.e. POA) → (3) Parent of the donor → (4) Guardian

RIGHT OF DISPOSITION – ASSIGNMENT OF RIGHTS

- ORC § 2108.70 to 2108.73
- An adult who is of sound mind may execute at any time a written declaration assigning to a representative one or more of the following rights:

(1) Right to direct the disposition, after death, of the declarant's body;
(2) Right to make arrangements and purchase goods and services for the declarant's funeral;
(3) Right to make arrangements and purchase goods and services for the declarant's burial, cremation, or other manner of final disposition

WRITTEN DECLARATION

- ORC § 2108.72
- The written declaration must include:
    - Declarant's legal name and address;
    - Declarant, being of sound mind, appoints a representative to have the declarant's right of disposition for the body upon death;
    - Decisions made are binding;
    - Name, address, phone number of representative;
    - Successor Agent

RIGHT OF DISPOSITION – NO DECLARATION

- ORC § 2108.81
- The Right of Disposition is assigned to the following persons, if mentally competent adults who can be located with reasonable effort, in the order of priority stated:

(1) Spouse → (2) surviving child(ren) → (3) surviving parent(s) → (4) surviving siblings → (5) surviving grandparent(s) → (6) surviving grandkid(s) → (7) lineal descendants of deceased person's grandparents → (8) guardian at the time of death

AUTOPSY

- ORC § 2018.50
- Authority to Consent follows same succession plan as Right of Disposition statute.

Spouse → surviving child(ren) → surviving parent(s) → surviving siblings → surviving grandparent(s) → surviving grandkid(s) → lineal descendants of deceased person's grandparents → **guardian** at the time of death

QUESTIONS?

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Medical Considerations Involving End of Life and Hospice Care

Annette K. Collier, MD
Sincera Supportive Care and Symptom Relief

Medical Considerations
Involving End of Life and Hospice Care

Annette Collier, MD, Hospice of Northwest Ohio and University of Toledo

WHAT IF?

"*It is harder to be seriously ill – and much harder to die - than ever before*."

Ira Byock The Best Care Possible, 2012

INSTITUTE OF MEDICINE REPORT 2014

Dying in America

- Most patients at the end of life choose care focused on comfort
- Many patients nearing EOL are not able to make their own decisions
- Advance care planning is essential "upstream"
- Many patients do not initiate advance care planning discussions

Why don't the conversations happen earlier?

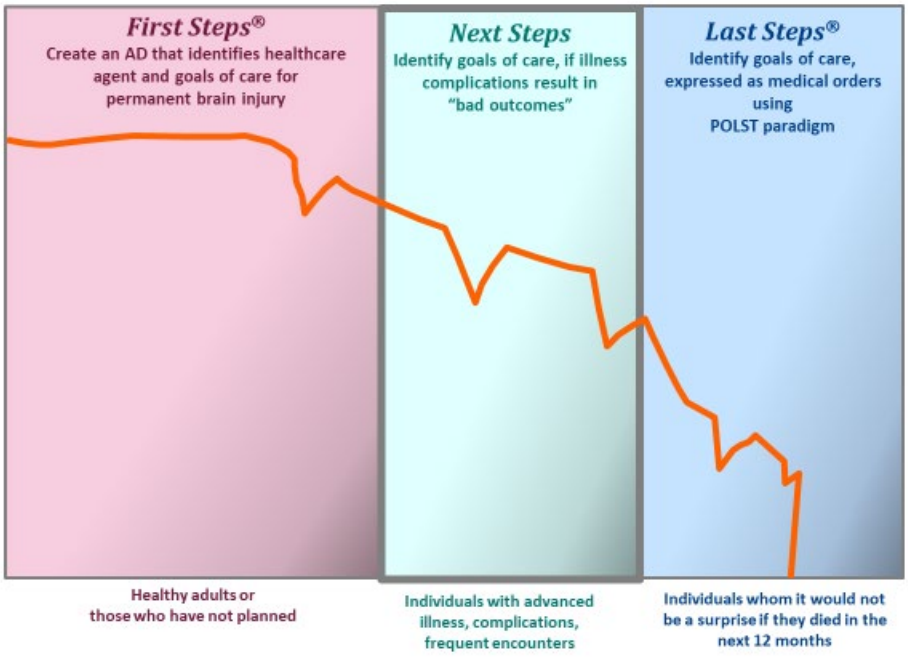
- lack of training
- it makes us uncomfortable

PREPARING FOR DECISION MAKING

The Conversation(s)

- Has the person had experiences with family members at end of life or serious illness?
    - Have them talk about that experience
    - Did they learn anything about how they would want to be treated?
- Has the patient been hospitalized or been critically ill in the past?
    - Have them talk about that experience
    - Are there things you would never want to go through again?
- Has the patient executed a Living Will before losing capacity?
    - Patient's wishes should be honored
- Speak with caregivers and family members
    - What gives the patient joy?
    - Are there treatments, situations, interventions that are especially difficult for patient?
    - How has the patient's overall condition changed over recent months to years?
- "What does a good day look like?"

STAGES OF ADVANCE CARE PLANNING OVER AN INDIVIDUAL'S LIFETIME



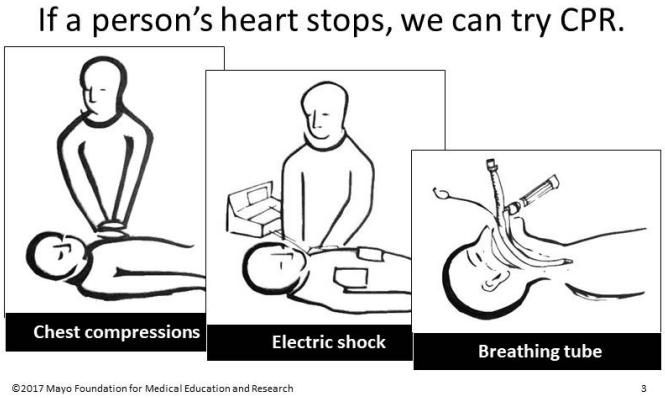
HOW DO PHYSICIANS ESTIMATE PROGNOSIS?

- Change in functional status
- Nutritional status/weight loss
- Rate of decline in medical condition
- Disease specific prognostic tools
- Recurrent hospitalizations for the same problem

WHAT DECISIONS MAY BE NECESSARY

Code Status/Do Not Resuscitate Orders

- CPR Decision Aid Cards
- On TV…about 75 out of 100 people do well after CPR.
- In real life… about 15 out of 100 people in the U.S. leave the hospital after CPR.
- Statistics are even worse for frail older people or people with chronic disease.



Mechanical ventilation

- What is the medically anticipated outcome?
- What is the best and worst case scenario?
- How will we know if it is helping?

Feeding tube

- Will it prevent aspiration pneumonia?
- Will it prolong patient's life?
- Will it enhance quality of life?

Feeding tubes to prevent aspiration pneumonia?

- Numerous studies have demonstrated a high incidence of pneumonia in patients receiving tube feeds

Feeding tube to prolong life?

- Best evidence for benefit
    - Bowel obstruction due to cancer
    - Patients receiving treatment for head and neck cancer
    - Some HIV patients
    - Patients with amyotrophic lateral sclerosis
    - During an acute illness
- No survival benefit in advanced dementia
    - May increase suffering by increasing confusion or causing abdominal pain
    - Does not eliminate risk of aspiration
- Little evidence that it helps patients with advanced cancer that are still able to eat but have no appetite
- May gain weight but no survival benefit

Tracheostomy

- Weeks to months when ventilator support is needed for recovery from an acute illness such as pneumonia.
- OR, permanent for conditions such as sleep apnea or brain injury.

Hemodialysis

- How would the patient tolerate ongoing treatments (usually 3 x week for 2-3 hours)?
- Can we do a time-limited trial?

WHAT DO YOU NEED TO TELL THE PHYSICIANS?

- Living Will declarations
- Baseline function
- What you know about the patient's values, fears, goals

WHAT IS THE DIFFERENCE BETWEEN DNRCCA AND DNRCC?

- **DNRCCA** – full medical support until cardiopulmonary arrest occurs
    - Patient will not have chest compressions
    - May be intubated for respiratory distress
    - Cardioversion ("shocking") for unstable rhythm with a pulse
- **DNRCC** – care focused on comfort
    - "no code" does not mean "no care"
    - decisions based on patient goals and medical condition

WHO CAN SUPPORT ME IN DECISION MAKING?

A palliative care clinician will:

- Communicate prognosis without the medical jargon
- Assist with decision making that is patient centered
- Support the decision maker
- Address patient's comfort and QOL regardless of decision for life-sustaining measures

PALLIATIVE CARE VS. HOSPICE CARE

Palliative Care

- Interdisciplinary care for patient and family focusing on symptom management and goals of care
- Any stage of advanced and life-threatening illness
- Simultaneously with other life-prolonging treatment
- Patients do not have to forgo curative care
- Fee for service

Hospice Care

- Interdisciplinary care for patient and family focusing on symptom management and goals of care
- Life expectancy of 6 months or less
- When curative treatment not wanted or effective
- Patients no longer pursuing curative treatments
- Comprehensive

The Relationship Between Hospice and Palliative Care

Hospice is a SUB-SET of Palliative Care which focuses on end-of-life care.

PARTING WORDS

"The final disease that nature inflicts on us will determine the atmosphere in which we take our leave of life, but our own choices should be allowed, insofar as possible, to be the decisive factor in the manner of our going." Dr. Sherwin Nuland, 1993

"The capacity to give one's attention to a sufferer is a very rare and difficult thing; it is almost a miracle. It is a miracle." Simone Weil (1909-1934)

READING TO CONSIDER…

- Best Care Possible. A Physician's Quest to Transform Care Through the End of Life. Ira Byock, MD
- Extreme Measures. Jessica Zitter, MD
- Being Mortal. Atul Gawande, MD
- A Beginner's Guide to the End. BJ Miller, MD
- The Conversation. Angelo Volandes, MD
- www.getpalliativecare.org

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Medical Director, Sincera Palliative Care, Hospice of Northwest Ohio

Assistant Professor of Medicine, University of Toledo

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:	**Providers Will Not:**
• Conduct an initial assessment • Perform Basic Medical Care • Clear airway of obstruction or suction • If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP • If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death • If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)	• Perform CPR • Administer resuscitation medications with the intent of restarting the heart or breathing • Insert an airway adjunct • De-fibrillate, cardiovert or initiate pacing • Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

HEA 1930 Revised 09/01/2019

Selecting and Working with Long-Term Care and Hospice Providers

Christopher Stieben
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Selecting and Working with Long-Term Care and Hospice Providers

Chris Stieben and Meg Senecal, Long-Term Care Ombudsman Program, ABLE, Inc.

ABLE AND LAWO

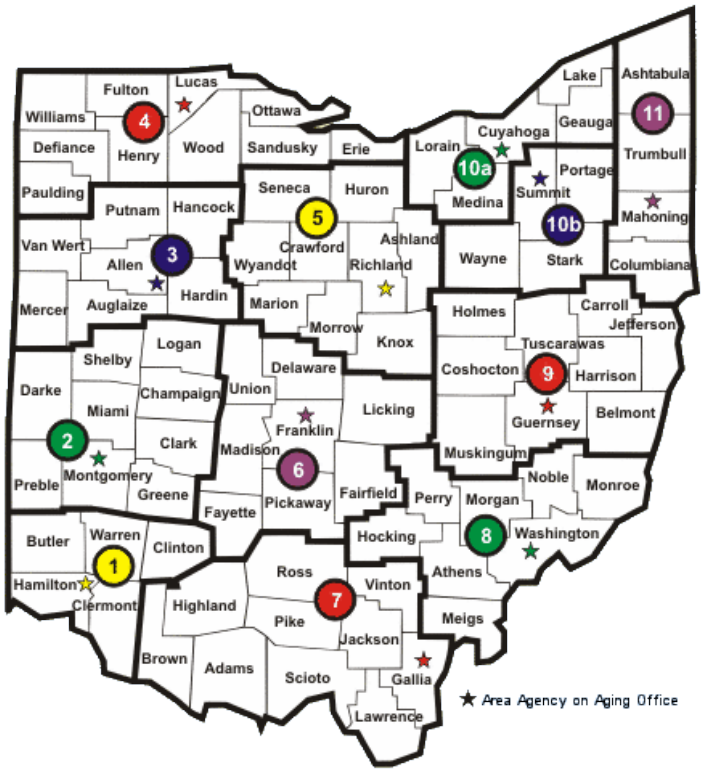
Advocates for Basic Legal Equality, Inc. (ABLE) Legal Aid of Western Ohio, Inc. (LAWO)	non-profit regional law firms that provide high quality legal assistance in civil matters to help eligible low-income individuals and groups in western Ohio achieve self reliance, and equal justice and economic opportunity.

MISSION AND GOAL OF OMBUDSMAN PROGRAM

- The mission of the Ombudsman Program is to improve the quality of life and quality of care for consumers of long-term care including institutional, residential, and community-based services.
- The goal of the Ombudsman Program is to provide a voice for the concerns of consumers of long-term care.

HOW DOES THE PROGRAM WORK?

- Help ensure that residents rights under the Ohio law are understood and upheld by the nursing home and residential care facility
- Assist if consumer threatened with transfer/discharge from facility;
- Ensure that consumer is involved in planning their care
- Assist resident and family councils
- Answer questions about Medicare and Medicaid benefits
- Assist in resolving concerns of all aspects of long-term care



SHORT-TERM REHAB STAY

- Occupational Therapy, Physical Therapy, and Speech Therapy
- Gain strength, recover from injury/surgery/procedure
- Identify desired facility early
- Research Facility
    - https://eldercare.acl.gov/Public/Index.aspxon OR @ 1-800-677-1116
    - "Nursing Home Compare" on www.medicare.gov
    - Call your state health department
    - Call your regional Long-Term Care Ombudsman office for selection assistance

LONG-TERM CARE

- Order from MD
- Home with In-home care no longer appropriate/safe
- Research facilities
- Use same resources to research facilities for LTC placement
- Insurance
- Options for payment, coverage, and facility rep-payee
- Meet ward's needs
- Quality of life

IN EITHER SITUATION…

- Make a visit to the facility and observe the following:
    - **Quality of life**: Is the staff respectful? Do residents have choices? Privacy?
    - **Quality of care**: Is there enough staff? Can residents still see their personal doctor? Does the inspection report show care deficiencies?
    - **Location**: Is the nursing home close to family/friends?
    - **Availability**: Is a bed available now or can you add your name to a waiting list?
- Make another visit

ONCE YOU DECIDE, MAKE SURE YOU HAVE…

- Insurance information
- Medical history
- Current health status
- A list of current medicines-doses and how often you take it
- Health care providers- names, numbers, addresses
- A list of family members to call in case of emergency
- Any relevant decision making paperwork (e.g. Guardianship papers, POA, Living Will) **Stay involved via **Care Plan meetings** and **Resident (or Family) Councils** to ensure ward's preferences and best interests are reflected

PALLIATIVE CARE

- Palliative care teams are made up of doctors, nurses, and other professional medical caregivers, often at the facility where a patient will first receive treatment
- There are no time restrictions. Palliative care can be received by patients at any time, at any stage of illness whether it be terminal or not
- It acts to fill the gap for patients who want and need comfort at any stage of any disease, whether terminal or chronic. In a palliative care program, there is no expectation that life-prolonging therapies will be avoided.

HOSPICE

- No further care to cure any terminal illness and/or a doctor has determined that efforts to cure your ward's illness aren't working
- Must generally be considered to be terminal or within six months of death to be eligible for most hospice programs or to receive hospice benefits from your insurance.
- It is important to check on policy limits for payment. While hospice can be considered an all-inclusive treatment in terms of payment (hospice programs cover almost all expenses) insurance coverage for hospice can vary.

DECIDING TO USE HOSPICE

- Is the hospice program certified and licensed by the state or federal government?
- How many other patients are assigned to each member of the hospice care staff?
- Will the hospice staff meet regularly with you to discuss care?
- How does the hospice staff respond to after-hour emergencies?
- What measures are in place to ensure hospice care quality?

NON-COVERED WHEN ON HOSPICE

- Treatment intended to cure your terminal illness and/or related conditions.
- Prescription drugs to cure your illness (rather than for symptom control or pain relief).
- Care from any hospice provider that wasn't set up by the hospice medical team
- Care in an emergency room, inpatient facility care, or ambulance transportation, unless your hospice team arranged it or it's unrelated to your terminal illness.

****You can decide to terminate hospice services at any time**

HOME CARE

- How to choose
    - Ltc.ohio.gov
    - Regulatory enforcement
- Payment source
    - Medicare, Medicaid, Private-duty

- Available programs for in-home care
    - PASSPORT

CONTACT INFORMATION

- Long-Term Care Ombudsman Program
    - (800) 282-1206.
- Ohio Department of Health
    - (800) 342-0553
- Ohio Department of Aging
    - (800) 282-1206
- Department of Job and Family Services
    - (800) 324-8680

Preparing for Loss, Memorial Services, and End of Life

Julie Olds
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Schoedinger Funeral and Cremation Service

Preparing for Loss, Funeral and Memorial Services, and End of Life

By Julie Olds, CT and Kevin Schoedinger, VP,
Schoedinger Funeral and Cremation Service

OBJECTIVES

- Identify two ways guardians can be proactive in advance care planning.
- Identify at least two options for funeral and/or memorial services.
- Identify three benefits of preplanning and prepaying for funeral or cremation services.

The most important thing…

Have those conversations!

Knowing what a person wants or prefers for end-of-life care and funeral services in advance of having to make those decisions reduces stress and emotional turmoil.

WHAT TO TALK ABOUT

Advance Care Planning Questions

- How do you want to be cared for as you age and require more health services?
- What are your preferences regarding life-sustaining measures/treatments?
- Who do you want involved in the decisions about your care?

HEALTHCARE DOCUMENTS

Ohio Advance Directives

- Healthcare Power of Attorney
- Living Will
- DNR
- Anatomical Donation

WHAT TO TALK ABOUT

Advance Care Planning Questions

- What is most important to you regarding your funeral or memorial preferences?
- Have you considered prearranging funeral services?
- How can you ensure that your funeral wishes will be carried out?

FORMS OF DISPOSITION

- Burial
- Cremation
- Entombment
- Body Donation – must be planned in advance if considering a university.
- For profit body donation.
- *Alkaline Hydrolysis* – not a recognized form in Ohio.

ADVANCE FUNERAL PLANNING

- Advance Funeral Plans document a person's final wishes.
- Pre-paying funeral arrangements takes the burden off family (or others) at the time of death.
- Prepaid funerals can be changed at any time.
- Prepaid funeral arrangements can be transferred to another funeral home.

WHY DO PEOPLE PREPLAN?

- Together versus Alone
- Medicaid Spend Down
- Personalized Selection
- Reduce Impact of Inflation
- Affordable Payment Options
- Prevents Emotional Spending
- Peace of Mind

ADVANCE FUNERAL PLANNING OPTIONS

- Irrevocable Trusts
- Annuities
- Whole Life Insurance
- Payable on Death CD's

APPOINTMENT OF REPRESENTATIVE FOR DISPOSITION

- A preplanned and prepaid funeral is not enforceable if the next of kin decides to make changes to it.
- This Ohio document allows a person to designate another person to be solely responsible for funeral decisions.
- Supersedes next-of-kin rules
- Supports couples who are not married
- Allows for someone other than family to be responsible

APPOINTMENT OF REPRESENTATIVE FOR DISPOSITION

- There are 4 adult children who cannot agree on funeral services for their parent.
- I'm on my third marriage and it is likely my spouse will NOT honor my funeral wishes, but my son from my first marriage will.
- I have lived with my partner for over 30 years but we are not married.
- I have no living relatives but my best friend knows what I want for funeral services.

WHY DO WE NEED FUNERALS?

"A good funeral gets the dead where they need to go and the living where they need to be."

-Thomas Lynch

THE IMPORTANCE OF FUNERAL SERVICES

Funerals…

- Help us acknowledge that someone we love has died,
- Allow us to say goodbye,
- Offer continuity and hope for the living,
- Provide a support system for us, friends, family members and the community,
- Allow us to reflect on the meaning of life and death.

THE FIVE ANCHORS OF FUNERAL RITUALS

From Dr. William Hoy

- Symbols
- Gathered Community
- Ritual Action
- Cultural Heritage
- Presence of the Body

WHAT ABOUT COST-SENSITIVE FAMILIES

Resources

- Cities
- Veterans
- Charitable Foundations (Children's charities)
- For-profit Body Donation
- Life Insurance Policies
- Crowd Funding

WHAT NOT TO SAY

It is normal to feel uncomfortable and not know what to say.

- I know just how you feel
- It's probably for the best
- Everything happens for a reason
- You can always have another baby / You can always remarry
- God needed another angel
- If there is anything you need, just call me
- God never gives us more than we can handle

WHAT TO SAY

People intuitively want to say something helpful.

- I am so sorry for your loss
- This must be very hard for you
- I remember the time when…
- I wish I had the right words, just know that I care
- I am here for you
- It's okay to cry if you need to

SUPPORTING OTHERS

- Accept the grieving person and provide reassurance that their grief is valid and that the life of the person who died meant something.
- Allow them to shed tears in your presence and express their grief without judgment or without trying to change their behavior.
- Express your own sadness and loss.

SUPPORTING OTHERS

- Sometimes the only thing you need to do is be there.
- Listen to what they have to say.
- Don't try to "fix" their pain.
- Mention the person who died by name.

YOUR GRIEF JOURNEY

- Acknowledge the reality of the death.
- Experience and work through the pain of loss.
- Develop a new self-identity. Adjust to a new life without the person.
- Continue the relationship with the deceased through treasured memories.

RESOURCES FOR YOU

- https://www.thecaregivingtree.com/advance-care-planning
- Ohio's Advance Directives
- Appointment of Representative for Disposition
- Pre-Planning FAQ's
- Meaningful Funerals Brochure
- Advance Funeral Planning Checklist

Checklist and Resources

Guardianship Checklist for End of Life

HEALTHCARE DECISIONS AT THE END OF LIFE

Does the person have a living will?

☐ **Yes** If the person signed a Living Will, retain a copy and be familiar with their wishes.

☐ **No** If the person does not have a Living Will, you as the guardian will likely make decisions.

Questions to Consider:

- If they become terminally ill or enter into a permanently unconscious state, do they want life-sustaining treatment?
- If they have challenges communicating their wishes, talk to other people who may know what they want.
- Has the person had experiences with family members at end of life or serious illness?
- Has the patient been hospitalized or been critically ill in the past?

Notes: _____

_____

_____

_____

Is there a valid power of attorney in place?

☐ **Yes** Alert the court about any Powers of Attorney if you have not done so already.

☐ **No**

Has the person executed a do not resuccitate order? (DNR, DNRCC, DNRCC Arrest)

☐ **Yes** If the person signed a DNR, retain a copy and be familiar with their wishes.

☐ **No** If the person does not have a DNR, you as the guardian will likely make decisions.

ISSUES RELATING TO COMFORT AND SATISFACTION

1. **Have you spoken with the person, caregivers, and family members about the following?**
   - What gives the person joy?
   - Are there treatments, situations, interventions that are especially difficult for patient?
   - How has the patient's overall condition changed over recent months to years?
   - What does a good day look like?

Provide details: _____

_____

_____

_____

2. **Thinking of the person under your care, what are important to them or their favorite:**

   Sight _____

   Smell _____

   Sound _____

   Touch _____

   Taste _____

   How can you ensure the person under your care has access to the things they enjoy?

   _____

3. **What ombudsman service region does the person under your care live in? _____**

   See tab 3, page 1 of manual for map and https://aging.ohio.gov/ for contact information.

4. **Is the person under your care currently in a nursing home or residential care facility?**

   ☐ **Yes** – Have you participated in a care plan meeting?

   ☐ **Yes** –Great job! Continue to attend every meeting you can, even if by telephone. Remember, you can also attend resident council meetings!

   ☐ **No** –Call the facility to ask when the next meeting is and place it on your calendar.

   ☐ **No** – If and when it is time to research long term care facilities, consult the following resources:

   - Inspection information for nursing homes or other residential care facilities: ltc.ohio.gov
   - Nursing Home Compare: https://www.medicare.gov/nursinghomecompare/search.html?

FUNERAL AND OTHER ISSUES AFTER DEATH

1. **Are there plans in place for funeral/burial?**

_____

_____

2. **What are the person's wishes after death? Consider religious, cultural, and spiritual beliefs.**

_____

_____

3. **Are there resources for the funeral or memorial service?**

_____

_____

Resources

Miscellaneous End of Life Resources

www.proseniors.org – Legal rights organization in Cincinnati--great fact sheets on about various benefits (Medicare, Medicaid, Social Security, SSI, DNR, Advance Directives)

- Financial Powers of Attorney, including form: https://www.proseniors.org/824-2/

www.disabilityrightsohio.org – a Has many links and helpful fact sheets for both children and adults living with disabilities

www.ohiobar.org – OSBA Law Facts Pamphlets for Laypersons: Listed alphabetically. Use the search box for topics, including Power of Attorney, Guardianship, and others.

- Law Facts: Financial Powers of Attorney: https://www.ohiobar.org/public-resources/commonly-asked-law-questions-results/law-facts/law-facts-financial-powers-of-attorney/

www.attorneygeneral.ohio.gov – Ohio Guardianship Guide from the Ohio Attorney General.

www.leadingageohio.org – Leading Age Ohio, a nonprofit trade association that represents Ohio long-term care associations and hospices.

- Conversations That Light the Way A Document to Guide Advance Care Planning and Make Your Wishes Known: www.leadingageohio.org/aws/LAO/asset_manager/get_file/116108?ver=40373
- Choices – Living Well at the End of Life (includes forms and guidance): www.leadingageohio.org/aws/LAO/asset_manager/get_file/314696?ver=8897

www.aging.ohio.gov/Ombudsman – Ohio Department of Aging Office of the State Long-Term Care Ombudsman.

www.ltc.ohio.gov – Ratings and inspection information for nursing homes or other residential care facilities.

www.medicare.gov/nursinghomecompare/search.html? – Nursing Home Compare has detailed information about every Medicare- Opens in a new window and Medicaid- Opens in a new window-certified nursing home in the country.

www.theconversationproject.org – The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

www.thecaregivingtree.com – The Caregiving Tree is designed to be a one-stop resource for caregivers throughout Central Ohio regarding end-of-life care, death, and aftercare.

The Supreme Court *of* Ohio
Judicial College