

FAMILY TAKE-HOME PACKET

PLANNING AHEAD FOR FUTURE CARE

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What This Packet Is

This packet is designed to help residents and families think through important health care decisions before a crisis happens. It provides simple explanations, conversation starters, and practical next steps for planning ahead.

These decisions can feel overwhelming, but you do not need to complete everything at once.

Who This Is For

- Residents planning for future care
- Family members helping make health care decisions
- Health care proxies or patient advocates
- Loved ones supporting someone living with serious illness or dementia

How to Use This in 10 Minutes

□ Read the “If You Only Read One Page” section
□ Review the Palliative Care vs. Hospice comparison table
□ Identify who would make decisions if you could not
□ Complete the “What Matters Most” checklist
□ Bring your questions to your next care conference

Bring Back / Discuss With

- Care conference
- Social worker
- Nurse
- Provider
- Family meeting

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Section 1

If You Only Read One Page



Why These Conversations Matter

When someone becomes seriously ill, they may not be able to speak for themselves.

Planning ahead helps ensure care decisions reflect what matters most to the individual—not just what happens by default in a medical crisis.

Talking early can:

- reduce stress for loved ones
- help avoid unwanted treatments
- support comfort and dignity
- make care decisions clearer for everyone

Next Step

Talk with your care team about:

- who should make decisions for you
- what treatments you would or would not want
- whether palliative care or hospice may be appropriate

If You Only Do One Thing

Choose and talk with someone you trust to make medical decisions for you.

Section 2

Palliative Care vs. Hospice

What Is Palliative Care?

Palliative care focuses on comfort, symptom relief, emotional support, and quality of life for people living with serious illness.

It can:

- begin at any stage of illness
- be provided alongside treatment
- involve a team of providers working together
- support both the individual and their family

Palliative care often includes help with:

- pain and symptom management
- understanding treatment options
- coordinating care
- emotional and spiritual support

What Is Hospice Care?

Hospice care is a type of palliative care for people nearing the end of life.

When treatment is no longer helping to cure or slow illness, hospice focuses fully on comfort, dignity, and quality of life.

Hospice care includes:

- comfort-focused care
- support for family members
- guidance through end-of-life decisions

Important to know:
Choosing hospice does not mean stopping all care. Supportive treatments such as pain management, wound care, and medications for comfort can still continue.

Section 2

Palliative Care vs. Hospice

Quick Comparison

QUESTION	PALLIATIVE CARE	HOSPICE
Who can receive it?	Anyone with serious illness	Usually when life expectancy is about 6 months or less
Can treatment continue?	Yes	Comfort-focused care only
Where is care provided?	Home, assisted living, nursing home, hospital, clinic	Home, assisted living, nursing home, hospice home, hospital
Is family support included?	Yes	Yes

When to Start the Conversation

Don’t wait too long to talk about these options.

Starting early allows more time to:

- understand choices
- plan ahead
- make decisions with confidence

Section 3

Planning Ahead

What is Advance Care Planning?

Advance care planning means thinking about and sharing your wishes for future medical care.

It helps guide decisions if you are unable to speak for yourself. This is not a one-time decision. It is an ongoing conversation.

Simple Steps

- □ Reflect on what matters most to you
- □ Talk with your provider
- □ Choose a health care proxy
- □ Complete advance directive forms
- □ Share your wishes with family
- □ Review your decisions yearly



Practical Tips to Get Started

- Start small. You do not need to decide everything at once
- Talk about general preferences if specific decisions feel overwhelming
- Ask your provider about situations you may face based on your health
- Write down your thoughts or share them in a letter
- Review your wishes after major life or health changes

Section 3

Planning Ahead

Advance Directives

Advance directives are legal documents that help communicate your wishes if you cannot speak for yourself.

Living Will

Describes what types of treatments you would or would not want.

Note: Living wills are not recognized in all states.

Health Care Power of Attorney

Names someone you trust to make decisions for you.

This person should understand your values and preferences.

Dementia and Planning Early

Dementia is progressive.

Planning early allows people to participate in decisions about future care while they are still able.

These conversations are especially important when memory, judgment, or communication may change over time.

Section 4
What Matters Most

Fillable Conversation Checklist

My Priorities

- □ Staying comfortable
- □ Staying at home if possible
- □ Avoiding hospitalization
- □ Living as long as possible
- □ Being able to recognize family
- □ Maintaining independence
- □ Spiritual or religious support
- □ Pain control
- □ Family present at the end of life
- □ Other: _____

My Worries

- □ Being in pain
- □ Being a burden to family
- □ Losing independence
- □ Feeding tubes
- □ Breathing machines
- □ CPR or resuscitation
- □ Hospital transfers
- □ Other: _____

My Decision Maker

The person I trust to make medical decisions for me is:

_____

Questions I Want to Discuss

_____

_____

_____

Section 5

Helpful Terms and Resources

Common Terms

ADVANCE DIRECTIVES

Legal documents that share your wishes for future health care.

LIVING WILL

A document stating which treatments you would or would not want.

HEALTH CARE POWER OF ATTORNEY

Names someone to make decisions for you.

DNR / DNI

Medical orders about CPR and breathing machines.

POLST / MOLST

Medical orders used during serious illness or emergencies.

Helpful Resources

- **National Institute on Aging:** nia.nih.gov
- **The Conversation Project:** theconversationproject.org
- **CaringInfo:** caringinfo.org
- **Center to Advance Palliative Care:** capc.org
- **Hospice Foundation of America:** hospicefoundation.org
- **Alzheimer's.gov:** alzheimers.gov

Final Reminder

You are not alone in these decisions. These conversations can feel difficult, but they can also bring clarity and peace of mind. Your care team is here to support you and your family with compassion and guidance.

About the Authors

Manda Ayoub, NHA

Manda has over 30 years of healthcare experience. As the Chief Operating Officer at Pomeroy Living, she oversees facility operations, clinical outcomes, and regulatory compliance. Since joining in 2011, she has helped open Pomeroy's assisted living communities and implemented initiatives that improved patient outcomes and care quality. Manda is a licensed nurse and nursing home administrator in Michigan, with diverse roles in the post-acute healthcare industry, including Infection Control Nurse and Risk Manager.

Beth Carroll, BSN, RN

With a nursing career spanning more than a decade, Beth has been a registered nurse since 2015 with extensive experience across long-term care, acute care, and palliative and hospice settings. The majority of her professional journey has been rooted in skilled nursing, where she has held progressive leadership roles including Director of Nursing and Regional Nurse Consultant. In these positions, she has provided clinical oversight, operational leadership, regulatory guidance, and mentorship to interdisciplinary teams across multiple facilities. Beth is known for her strong clinical judgment, commitment to quality outcomes, and passion for guiding teams through complex patient care and compliance environments, while maintaining a patient-centered and compassionate approach to care delivery.

Melanie Flachs, RN

Melanie L. Flachs is a nurse leader with 41 years of experience, including over 30 years in long-term care. She has served as Director of Nursing, MDS Coordinator, and Clinical Consultant. Currently, she is the Chief Clinical Officer at The Peplinski Group, overseeing 10 skilled nursing communities. Her expertise includes clinical operations, regulatory compliance, and reimbursement. Melanie's consulting work covers survey compliance, plans of correction, facility turnaround, and reimbursement optimization. She has hands-on experience with Interact III care pathways and has led various initiatives, including electronic medical record implementation and clinical education. A frequent speaker, she is committed to advancing clinical excellence in long-term care.

Anne Shelley, MBA, BSN, RN

With 27 years of experience in hospice and 16 in home health, Anne began her career as a staff nurse at Hospice of Memorial Hospital in 1988, later advancing to patient care coordinator and director by 1994. She expanded her responsibilities in 1997 to include the hospital's home health agency, forming Memorial Home Health and Hospice. In 2008, she transitioned to become the CEO of Hospice of North Central Ohio for two years, and later served as CEO of Universal Home Health and Hospice until March 2016. Actively involved with the Ohio Hospice and Palliative Care Organization (OHPCO), Anne served on its board for nine years, holding roles such as Chair and Public Policy Committee Chair, and she presented on legislative matters at various meetings. Following the merger of Midwest Care Alliance and LeadingAge Ohio in 2015, she became the Director of Professional Development and Home Health and Hospice Regulatory Relations for ten years and now works as a consultant. Anne holds a BSN from Bowling Green State University (1988) and an MBA from Tiffin University (2001).

Angie Szumlinski, LNHA, RN, GERO-BC, RAC-CT, BS

Ms. Szumlinski is a nationally-recognized leader in long-term care with experience as an Owner/Provider, Administrator, Director of Nursing, Corporate Quality Assurance Coordinator and independent consultant. Ms. Szumlinski conducts risk management visits at facilities across the country, touching every acuity level within the post-acute care spectrum. Ms. Szumlinski served as an Associate Board Member for NCAL, is a member of the AHCA/NCAL Survey/Regulatory committee, NCAL Quality committee, HCAM Legal/ Clinical Committee and served as a Senior Examiner/Team Leader for the AHCA/NCAL Quality Award Program for 7 years. Ms. Szumlinski is a Nurse Planner for the HealthCap® RMS ANCC accredited education program.

Marea Trotter, BSN, RN

Marea erves as Vice President of Clinical Services for The Peplinski Group, overseeing clinical operations and risk management initiatives across ten skilled nursing facilities in Michigan. With extensive experience in long-term care leadership, clinical compliance, infection prevention, and quality improvement, she has held roles including Director of Nursing, Regional Nurse Consultant, and Clinical Compliance Specialist. Marea's diverse healthcare background includes critical care nursing, nursing education, and military service as a decorated U.S. Army combat veteran. She brings a practical, systems-focused approach to risk management, patient safety, and regulatory compliance.