Help Your Clients Have
“THAT CONVERSATION”
About Advance Care Directives

CalCPA PFP Meeting
July 19, 2022

What People Say They Want

90% of people say it’s important to talk with family members about their care wishes and their family’s care wishes;
30% of folks have done so

60% of respondents said making sure family is not burdened by decisions about care was important,
56% have not talked with loved ones about the care they would want

82% said it was very important or somewhat important to put their wishes in writing,
23% of folks have done so

California Healthcare Foundation Survey

Most Important Factors at End of Life

67% Making sure my family is not burdened financially by my care

66% Being comfortable and without pain

61% Being at peace spiritually

60% Making sure my family is not burdened by tough decisions about my care

60% Having loved ones around me

58% Being able to pay for the care I need

57% Making sure my wishes for medical care are followed

55% Not feeling alone

44% Having medical practitioners who respect my cultural beliefs and values

36% Living as long as possible

33% Being at home

32% Close relationship with my medical practitioners

California Healthcare Foundation Survey

What Is Advance Care Planning

- Being prepared to make difficult decisions when the time comes
- Choices in care reflect ones goals, wishes, values and beliefs

Why is Advance Care Planning a CPAs responsibility?

60% of CPA practices offer advising services to their clients

According to Forbes, CPAs are one of the most trusted advisors with respect to a client's finances

65% of households do not have a will

CPAs are on the front line of their clients' financial and tax planning– critical to understand various elder care options of their clients

Succession Planning

Big Questions to Ask Your Clients

What happens if you live and get sick?

What happens if you have increased health care costs?

What if you need to rely on others for assistance for an extended period before you pass away?

The Advance Health Care Directive

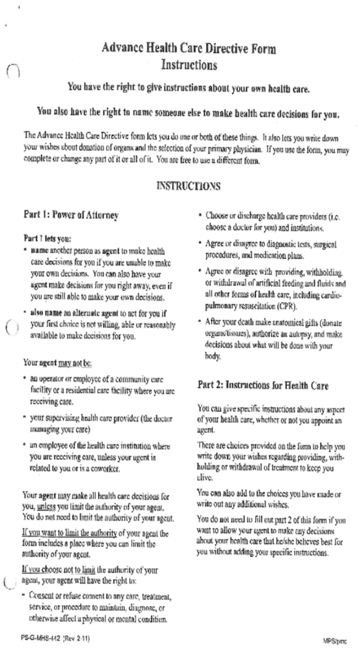
- A legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

Choosing a Health Care Agent

- A family member
- Not family member

- Proper Witness

Durable Power of Attorney for Healthcare



Advance Health Care Directive Form
Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardio-pulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

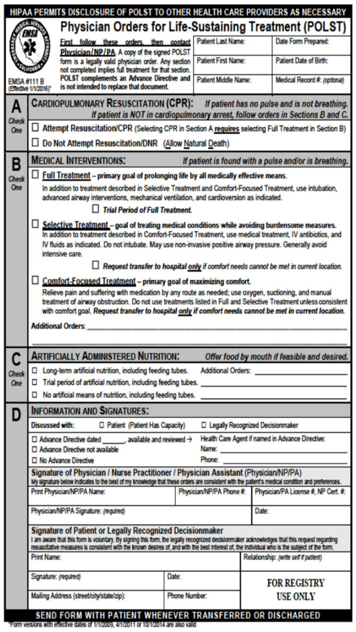
You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

PS-G-MHS-442 (Rev 2-11) MPS/pmc

POLST

Physician's Orders
for Life Sustaining
Treatment

- Must be signed by Physician, NP, or PA to be valid



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. 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. Additional Orders: ______
☐ Trial period of artificial nutrition, including feeding tubes. ______
☐ No artificial means of nutrition, including feeding tubes. ______

D — **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ______, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name: ______
☐ No Advance Directive Phone: ______

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
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/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA 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 individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

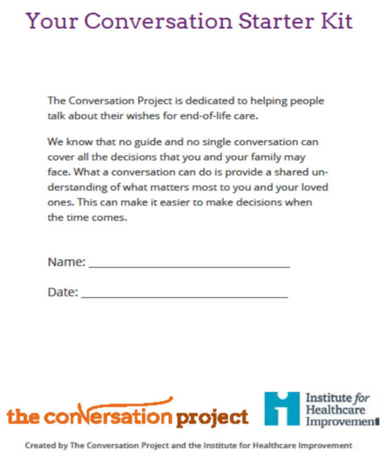
*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

Why is it so difficult to talk about Advance Care Plans ?

The Conversation Starter Kit

A tool to

- Gather thoughts
- Open conversation
- Share with others



Your Conversation Starter Kit

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

We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

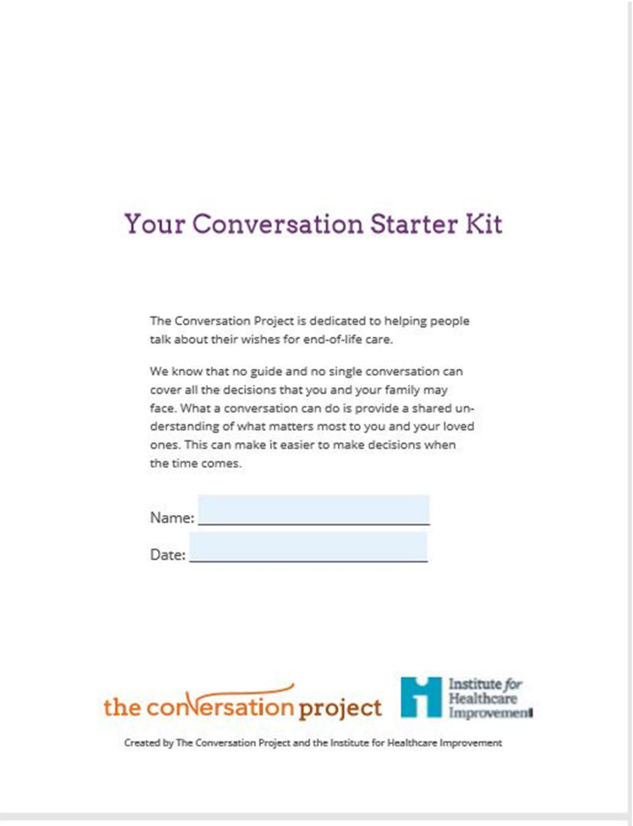
Name: ______________________________

Date: ______________________________

the conversation project

Institute *for* Healthcare Improvement

Created by The Conversation Project and the Institute for Healthcare Improvement



Your Conversation Starter Kit

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

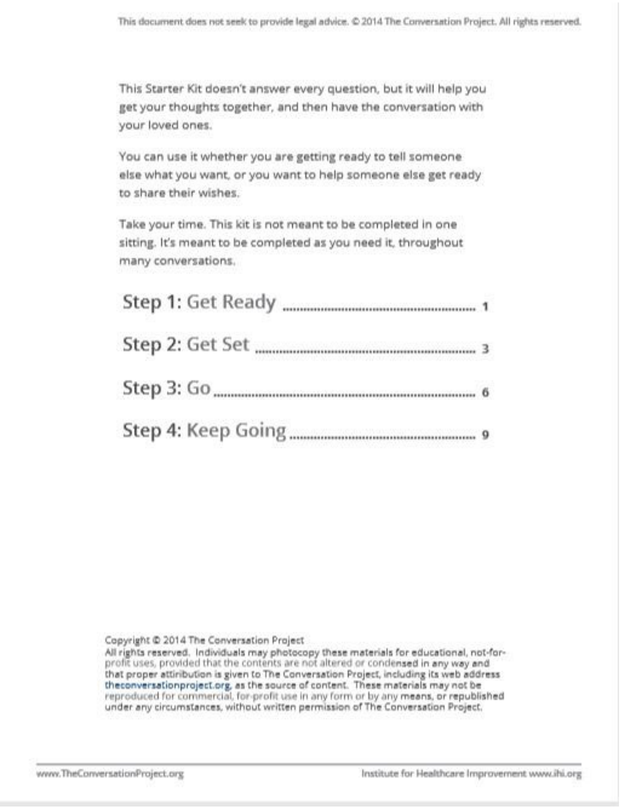
We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

Name: ____________________________

Date: ____________________________

the conversation project Institute for Healthcare Improvement

Created by The Conversation Project and the Institute for Healthcare Improvement



This Starter Kit doesn't answer every question, but it will help you get your thoughts together, and then have the conversation with your loved ones.

You can use it whether you are getting ready to tell someone else what you want, or you want to help someone else get ready to share their wishes.

Take your time. This kit is not meant to be completed in one sitting. It's meant to be completed as you need it, throughout many conversations.

Step 1: Get Ready

There are a million reasons to avoid having the conversation. But it's critically important. And you can do it.

Consider the facts.

More than **90%** of the people think it's important to talk about their loved ones' and their own wishes for end-of-life care.

Less than **30%** of people have discussed what they or their family wants when it comes to end-of-life care. Source: National Survey by The Conversation Project 2013.

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

56% have not communicated their end-of-life wishes

Source: Survey of Californians by the California HealthCare Foundation (2012)

70% of people say they prefer to die at home

70% die in a hospital, nursing home, or long-term-care facility

Source: Centers for Disease Control (2005)

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care

7% report having had an end-of-life conversation with their doctor

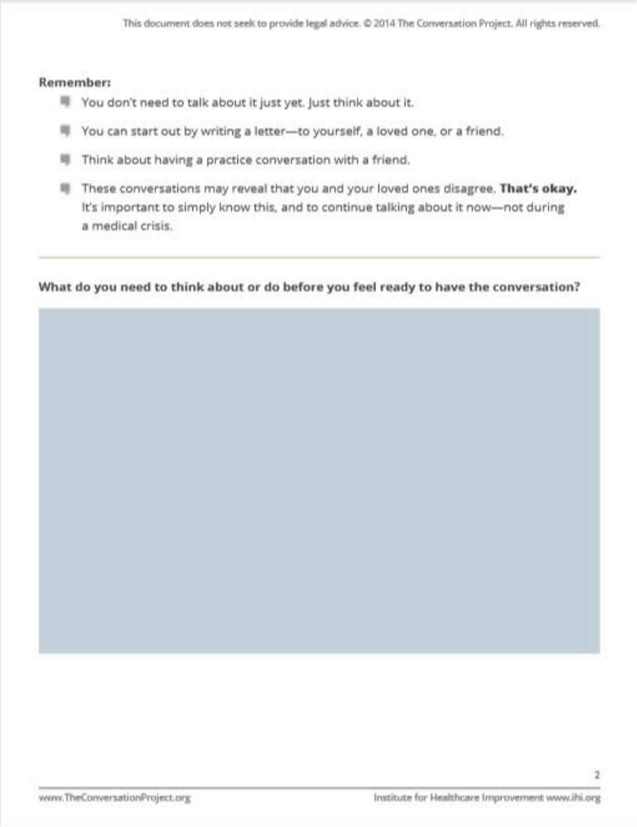
Source: Survey of Californians by the California HealthCare Foundation (2012)

82% of people say it's important to put their wishes in writing

23% have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012)

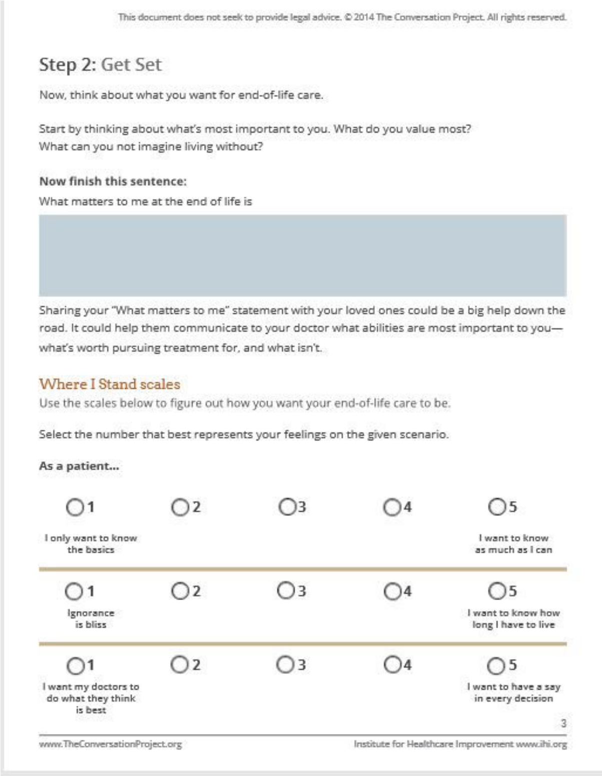
One conversation can make all the difference.



Remember:

- You don't need to talk about it just yet. Just think about it.
- You can start out by writing a letter—to yourself, a loved one, or a friend.
- Think about having a practice conversation with a friend.
- These conversations may reveal that you and your loved ones disagree. **That's okay.** It's important to simply know this, and to continue talking about it now—not during a medical crisis.

What do you need to think about or do before you feel ready to have the conversation?



Step 2: Get Set

Now, think about what you want for end-of-life care.

Start by thinking about what's most important to you. What do you value most?
What can you not imagine living without?

Now finish this sentence:
What matters to me at the end of life is

Sharing your "What matters to me" statement with your loved ones could be a big help down the road. It could help them communicate to your doctor what abilities are most important to you—what's worth pursuing treatment for, and what isn't.

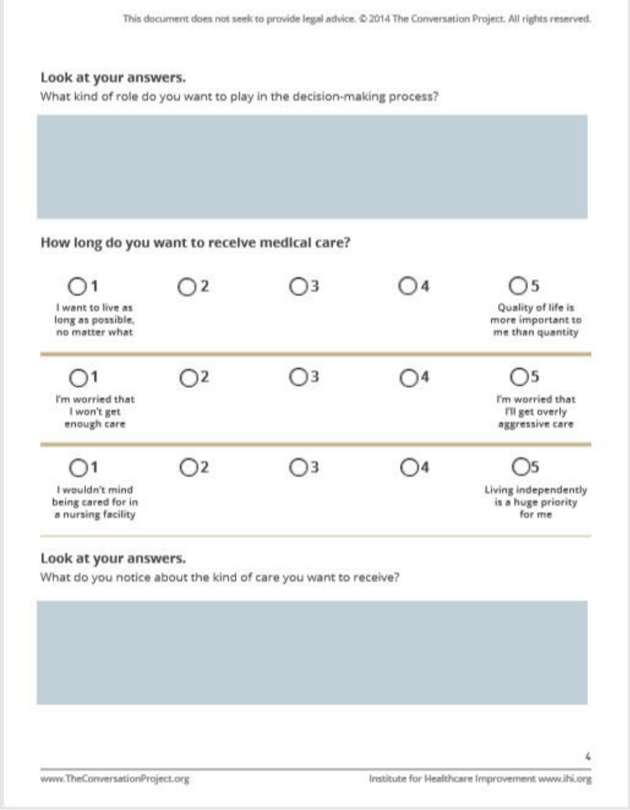
Where I Stand scales

Use the scales below to figure out how you want your end-of-life care to be.

Select the number that best represents your feelings on the given scenario.

As a patient...

○1	○2	○3	○4	○5
I only want to know the basics				I want to know as much as I can
○1	○2	○3	○4	○5
Ignorance is bliss				I want to know how long I have to live
○1	○2	○3	○4	○5
I want my doctors to do what they think is best				I want to have a say in every decision

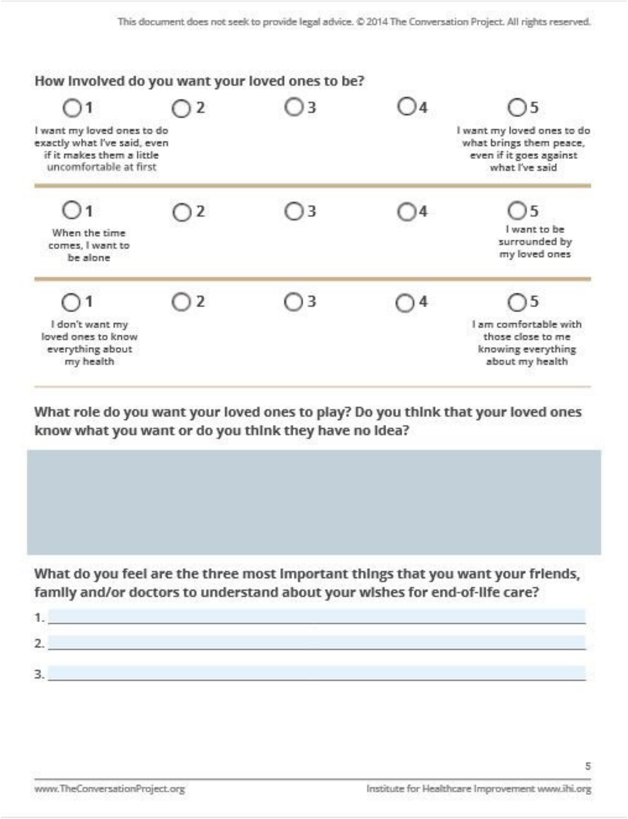


Look at your answers.
What kind of role do you want to play in the decision-making process?

How long do you want to receive medical care?

○1	○2	○3	○4	○5
I want to live as long as possible, no matter what				Quality of life is more important to me than quantity
○1	○2	○3	○4	○5
I'm worried that I won't get enough care				I'm worried that I'll get overly aggressive care
○1	○2	○3	○4	○5
I wouldn't mind being cared for in a nursing facility				Living independently is a huge priority for me

Look at your answers.
What do you notice about the kind of care you want to receive?



How involved do you want your loved ones to be?

○ 1	○ 2	○ 3	○ 4	○ 5
I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable at first				I want my loved ones to do what brings them peace, even if it goes against what I've said
○ 1	○ 2	○ 3	○ 4	○ 5
When the time comes, I want to be alone				I want to be surrounded by my loved ones
○ 1	○ 2	○ 3	○ 4	○ 5
I don't want my loved ones to know everything about my health				I am comfortable with those close to me knowing everything about my health

What role do you want your loved ones to play? Do you think that your loved ones know what you want or do you think they have no idea?

What do you feel are the three most important things that you want your friends, family and/or doctors to understand about your wishes for end-of-life care?

1. ______
2. ______
3. ______

Step 3: Go

When you're ready to have the conversation, think about the basics.

Mark all that apply:

Who do you want to talk to? Who do you trust to speak for you?

☐ Mom
☐ Dad
☐ Sibling
☐ Child/Children
☐ Partner/Spouse
☐ Minister/Priest/Rabbi
☐ Friend
☐ Doctor/Caregiver
☐ Other: ______

When would be a good time to talk?

☐ The next big holiday
☐ At Sunday dinner
☐ Before my kid goes to college
☐ Before my next big trip
☐ Before I get sick again
☐ Before the baby arrives
☐ Other: ______

Where would you feel comfortable talking?

☐ At the kitchen table
☐ At a cozy café or restaurant
☐ On a long drive
☐ On a walk or hike
☐ Sitting in a garden or park
☐ At my place of worship
☐ Other: ______

What do you want to be sure to say?

If you wrote down your three most important things at the end of Step 2, you can use those here.

How to start

Here are some ways you could break the ice:

- "I need your help with something."
- Remember how someone in the family died—was it a "good" death or a "hard" death? How will yours be different?
- "I was thinking about what happened to (Uncle Joe), and it made me realize…"
- "Even though I'm okay right now, I'm worried that (I'll get sick), and I want to be prepared."
- "I need to think about the future. Will you help me?"
- "I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

What to talk about

☐ When you think about the last phase of your life, what's most important to you? How would you like this phase to be?

☐ Do you have any particular concerns about your health? About the last phase of your life?

☐ Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? *(This person is your health care proxy.)*

☐ Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?

☐ Are there any disagreements or family tensions that you're concerned about?

☐ Are there circumstances that you would consider worse than death? *(Long-term need of a breathing machine or feeding tube, not being able to recognize your loved ones)*

☐ Are there important milestones you'd like to meet if possible? *(The birth of your grandchild, your 80th birthday)*

☐ Where do you want (or not want) to receive care? *(Home, nursing facility, hospital)*

☐ What kinds of aggressive treatment would you want (or not want)? *(Resuscitation if your heart stops, breathing machine, feeding tube)*

☐ When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

☐ What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*

This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your doctor or nurse if you're looking for more end-of-life care questions.

Remember:

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances shift.
- Every attempt at the conversation is valuable.
- This is the first of many conversations—you don't have to cover everyone or everything right now.

Now, just go for it!

Each conversation will empower you and your loved ones. You are getting ready to help each other live and die in a way that you choose.

Step 4: Keep Going

Congratulations!

Now that you have had the conversation, here are some legal and medical documents you should know about. Use them to record your wishes so they can be honored when the time comes.

- **Advance Care Planning (ACP):** the process of thinking about your wishes—exactly what you have been working on here.
- **Advance Directive (AD):** a document that describes your wishes.
- **Health Care Proxy (HCP):** identifies your health care agent (often called a "proxy"), the person you trust to act on your behalf if you are unable to make health care decisions or communicate your wishes. In some states, this is called the Durable Power of Attorney for Health Care. This is probably the most important document. Make sure you have many conversations with your proxy.
- **Living Will:** specifies which medical treatments you want or don't want at the end of your life, or if you are no longer able to make decisions on your own (e.g. in a coma).

You can find more information about these documents from the link in the "Keep Going" section of the website Starter Kit at **www.TheConversationProject.org.**

Remember, this was the first of many conversations.

You can use the questions below to collect your thoughts about how your first talk went, and then look back to them when you prepare for future conversations.

Is there something you need to clarify that you feel was misunderstood or misinterpreted?

Who do you want to talk to next time? Are there people who should hear things at the same time (like siblings who disagree about everything)?

How did this conversation make you feel? What do you want to remember? What do you want your loved ones to remember?

What do you want to make sure to ask or talk about next time?

We hope you will share this Starter Kit with others. You have helped us get one conversation closer to our goal: that everyone's end-of-life wishes are expressed and respected.

“That Conversation”
Coaching & Training

Clients Co-workers Groups

Janet Thompson

Marketing Communications Group

janet06thompson@gmail.com

(925) 408-4096

Your Conversation Starter Kit

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

We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

Name: ___________________________________

Date: ____________________________________

the conversation project

Institute for Healthcare Improvement

Created by The Conversation Project and the Institute for Healthcare Improvement

This Starter Kit doesn't answer every question, but it will help you get your thoughts together, and then have the conversation with your loved ones.

You can use it whether you are getting ready to tell someone else what you want, or you want to help someone else get ready to share their wishes.

Take your time. This kit is not meant to be completed in one sitting. It's meant to be completed as you need it, throughout many conversations.

Step 1: Get Ready

There are a million reasons to avoid having the conversation. But it's critically important. And you can do it.

Consider the facts.

More than **90%** of the people think it's important to talk about their loved ones' and their own wishes for end-of-life care.

Less than **30%** of people have discussed what they or their family wants when it comes to end-of-life care. Source: National Survey by The Conversation Project 2013.

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

56% have not communicated their end-of-life wishes

Source: Survey of Californians by the California HealthCare Foundation (2012)

70% of people say they prefer to die at home

70% die in a hospital, nursing home, or long-term-care facility

Source: Centers for Disease Control (2005)

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care

7% report having had an end-of-life conversation with their doctor

Source: Survey of Californians by the California HealthCare Foundation (2012)

82% of people say it's important to put their wishes in writing

23% have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012)

One conversation can make all the difference.

Remember:

- You don't need to talk about it just yet. Just think about it.
- You can start out by writing a letter—to yourself, a loved one, or a friend.
- Think about having a practice conversation with a friend.
- These conversations may reveal that you and your loved ones disagree. **That's okay.** It's important to simply know this, and to continue talking about it now—not during a medical crisis.

What do you need to think about or do before you feel ready to have the conversation?

Step 2: Get Set

Now, think about what you want for end-of-life care.

Start by thinking about what's most important to you. What do you value most?
What can you not imagine living without?

Now finish this sentence:

What matters to me at the end of life is

Sharing your "What matters to me" statement with your loved ones could be a big help down the road. It could help them communicate to your doctor what abilities are most important to you—what's worth pursuing treatment for, and what isn't.

Where I Stand scales

Use the scales below to figure out how you want your end-of-life care to be.

Select the number that best represents your feelings on the given scenario.

As a patient...

○ 1	○ 2	○ 3	○ 4	○ 5
I only want to know the basics				I want to know as much as I can
○ 1	○ 2	○ 3	○ 4	○ 5
Ignorance is bliss				I want to know how long I have to live
○ 1	○ 2	○ 3	○ 4	○ 5
I want my doctors to do what they think is best				I want to have a say in every decision

Look at your answers.

What kind of role do you want to play in the decision-making process?

How long do you want to receive medical care?

○ 1	○ 2	○ 3	○ 4	○ 5
I want to live as long as possible, no matter what				Quality of life is more important to me than quantity

○ 1	○ 2	○ 3	○ 4	○ 5
I'm worried that I won't get enough care				I'm worried that I'll get overly aggressive care

○ 1	○ 2	○ 3	○ 4	○ 5
I wouldn't mind being cared for in a nursing facility				Living independently is a huge priority for me

Look at your answers.

What do you notice about the kind of care you want to receive?

How involved do you want your loved ones to be?

○ 1	○ 2	○ 3	○ 4	○ 5
I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable at first				I want my loved ones to do what brings them peace, even if it goes against what I've said

○ 1	○ 2	○ 3	○ 4	○ 5
When the time comes, I want to be alone				I want to be surrounded by my loved ones

○ 1	○ 2	○ 3	○ 4	○ 5
I don't want my loved ones to know everything about my health				I am comfortable with those close to me knowing everything about my health

What role do you want your loved ones to play? Do you think that your loved ones know what you want or do you think they have no idea?

What do you feel are the three most important things that you want your friends, family and/or doctors to understand about your wishes for end-of-life care?

1. ______________________________

2. ______________________________

3. ______________________________

Step 3: Go

When you’re ready to have the conversation, think about the basics.

Mark all that apply:

Who do you want to talk to? Who do you trust to speak for you?

☐ Mom
☐ Dad
☐ Sibling
☐ Child/Children
☐ Partner/Spouse
☐ Minister/Priest/Rabbi
☐ Friend
☐ Doctor/Caregiver
☐ Other: ____________________

When would be a good time to talk?

☐ The next big holiday
☐ At Sunday dinner
☐ Before my kid goes to college
☐ Before my next big trip
☐ Before I get sick again
☐ Before the baby arrives
☐ Other: ____________________

Where would you feel comfortable talking?

☐ At the kitchen table
☐ At a cozy café or restaurant
☐ On a long drive
☐ On a walk or hike
☐ Sitting in a garden or park
☐ At my place of worship
☐ Other: ____________________

What do you want to be sure to say?
If you wrote down your three most important things at the end of Step 2, you can use those here.

How to start

Here are some ways you could break the ice:

- "I need your help with something."
- Remember how someone in the family died—was it a "good" death or a "hard" death? How will yours be different?
- "I was thinking about what happened to (Uncle Joe), and it made me realize…"
- "Even though I'm okay right now, I'm worried that (I'll get sick), and I want to be prepared."
- "I need to think about the future. Will you help me?"
- "I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

What to talk about

☐ When you think about the last phase of your life, what's most important to you? How would you like this phase to be?

☐ Do you have any particular concerns about your health? About the last phase of your life?

☐ Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? *(This person is your health care proxy.)*

☐ Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?

☐ Are there any disagreements or family tensions that you're concerned about?

☐ Are there circumstances that you would consider worse than death? *(Long-term need of a breathing machine or feeding tube, not being able to recognize your loved ones)*

☐ Are there important milestones you'd like to meet if possible? *(The birth of your grandchild, your 80th birthday)*

☐ Where do you want (or not want) to receive care? *(Home, nursing facility, hospital)*

☐ What kinds of aggressive treatment would you want (or not want)? *(Resuscitation if your heart stops, breathing machine, feeding tube)*

☐ When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

☐ What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*

This list doesn't cover everything you may need to think about, but it's a good place to start.
Talk to your doctor or nurse if you're looking for more end-of-life care questions.

Remember:

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances shift.
- Every attempt at the conversation is valuable.
- This is the first of many conversations—you don't have to cover everyone or everything right now.

Now, just go for it!

Each conversation will empower you and your loved ones. You are getting ready to help each other live and die in a way that you choose.

Step 4: Keep Going

Congratulations!

Now that you have had the conversation, here are some legal and medical documents you should know about. Use them to record your wishes so they can be honored when the time comes.

- **Advance Care Planning (ACP):** the process of thinking about your wishes—exactly what you have been working on here.
- **Advance Directive (AD):** a document that describes your wishes.
- **Health Care Proxy (HCP):** identifies your health care agent (often called a “proxy”), the person you trust to act on your behalf if you are unable to make health care decisions or communicate your wishes. In some states, this is called the Durable Power of Attorney for Health Care. This is probably the most important document. Make sure you have many conversations with your proxy.
- **Living Will:** specifies which medical treatments you want or don’t want at the end of your life, or if you are no longer able to make decisions on your own (e.g. in a coma).

You can find more information about these documents from the link in the “Keep Going” section of the website Starter Kit at **www.TheConversationProject.org.**

Remember, this was the first of many conversations.

You can use the questions below to collect your thoughts about how your first talk went, and then look back to them when you prepare for future conversations.

Is there something you need to clarify that you feel was misunderstood or misinterpreted?

Who do you want to talk to next time? Are there people who should hear things at the same time (like siblings who disagree about everything)?

How did this conversation make you feel? What do you want to remember? What do you want your loved ones to remember?

What do you want to make sure to ask or talk about next time?

We hope you will share this Starter Kit with others. You have helped us get one conversation closer to our goal: that everyone's end-of-life wishes are expressed and respected.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. 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 — 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.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

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

Check One

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

Check One

☐ 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

Health Care Agent if named in Advance Directive:
Name: ______________________________
Phone: ______________________________

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

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/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA 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 individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name (if other than signing Physician/NP/PA)**	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED