



### Caring. Giving. Together.

## **Advance Health Care Planning**

**Confidence and Peace of Mind for You and Your Family** 

# **Tips for using the zoom Q&A Feature**

- In your controls at the bottom of the window, click Q&A. If you are on a mobile device, tap Participants, then Q&A,
- The Q&A window will open on the right side or at the bottom of your screen.
- You can ask me questions and answer my questions in the Q&A window.
- Type your message into the Q&A window and press 'enter' to send me your message.





Why is advance health care planning important?

- Life is unpredictable
- Without clear direction, medical teams do everything possible to sustain life
- Best to not make hard decisions during a crisis
- Planning = Empowerment and Confidence
- Preparedness = Peace of Mind



Why is advance health care planning important?

In the midst of the COVID-19 pandemic, people are realizing they are unprepared. It is especially important to think about the care you, or someone you love, would want if faced with serious illness.

# Having the 'Conversation'

A few tips on having your conversation:

- Decide on a good time to talk.
- Decide who you want to be part of the conversation.
- Let the person(s) know in advance what you are going to talk about.
- Have the conversation in comfortable place, usually in your home.
- Pour yourself a nice cup of tea or something stronger ;)
- Have your talking points in mind or written down before you have your conversation.



# What do healthcare providers look for?

#### **California Advance Health Care Directive**

This form lets you have a say about how you want to be cared for If you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker. Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself. This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

#### Part 2 Make your own health care choices, Page 7

The form must be signed before it can be used.

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 Sign the form, Page 13



PREPARE University of California, 2018

You can fill out Part 1, Part 2, or both

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notary on Page 15.

Your Name



# capolst.org



### **Advance Health Care Directive**

### prepareforyourcare.org

Patient Information				
Name (last, first, middle):		Date	of Birth:	Gender:
NP/PA's Supervising Physician		Preparer Name	if other than signir	g Physician/NP/PA)
Name:		Name/Title:		Phone#:
	None	1		
Name:	Relation	ship to Patient:	Phone #:	
	Directions for H	ealth Care Provid	ler	
Completing POLST     Completing a POLST form is vol				
and provide immunity to those with or a muse paraticitione (MP) or any appropriate orders that are consist PRLST does not explain that which PRLST those not explain that which PRLST those not explain that which PRLST those the completed by a line PRLST thus to completed by a line PRLST thus to completed device matching the patient's priva- person whom the patient's priva- person whom the patient's priva- tion and order are acceptable with follow- t based be returned in patient's mark housed be returned in patient's mark	rysician assistant (PA) as tent with the patient's pref vance Directive. When a must appropriately to reaso path care provider based in may include a count-app pate. spouse, registered d innNPPA belowse best 1 kpressed wishes and value many taxetue the POLS1 we immediately. I within the scope of pract isigned by (1) a physician within the scope of pract poing a physician ient or decisionmaker, at oursed. Photocopies an	ting under the super- ferences. available, review the A live any conflicts. on patient preference nointed conservator or iomestic partner, pare crows what is in the p es to the extent know I form only if the patient to be a tubhorized by law thorized by law ANPPA in accordance tach it to the signed P of FAVes of a Signed PM	ission of the physic dvance Directive s and medical indi guardian, agent d nf of a minor, clos within's best intere m, int lacks capacity tioner or a physicic and (2) the patien e with facility/com inglish POLST form are less LST forms are less	cian, who will issue and POLST form to ications. lesignated in an Advan est available relative, o stand will make decis or has designated that t or decisionmaker. Ve munity policy. m.
Using POLST				
<ul> <li>Any incomplete section of POLST is Section A:</li> </ul>	implies full treatment for th	hat section.		
<ul> <li>If found pulseless and not breathing should be used on a patient who has a strength of the strengt of the strength of the strength of the strength of the strengt</li></ul>	g, no defibrillator (includin as chosen "Do Not Attern	ig automated externa ipt Resuscitation."	l defibrillators) or c	hest compressions
Section B:				
<ul> <li>When comfort cannot be achieved i should be transferred to a setting a</li> <li>Non-invasive positive ainway press. (BiPAP), and bag valve mask (BVI)</li> </ul>	able to provide comfort (e. ure includes continuous p	.g., treatment of a hip	fracture).	
IV antibiotics and hydration general Treatment of dehydration prolongs I Depending on local EMS protocol,	Ily are not "Comfort-Focu life. If a patient desires IV	fluids, indicate "Sele		
Reviewing POLST				
It is recommended that POLST be rev • The patient is transferred from one			/hen:	
There is a substantial change in the     The patient's treatment preferences	e patient's health status, o			
Modifying and Voiding POLST				
<ul> <li>A patient with capacity can, at any to revoke. It is recommended that i in large letters, and signing and da</li> <li>A legally recognized decisionmake the known desires of the patient or</li> </ul>	revocation be documente ating this line. er may request to modify t	d by drawing a line th the orders, in collabor	rough Sections A	through D, writing "VO
This form is approved by the Californi				

# **Discuss what matters most to you?**

### **Consider these questions:**

- What and who are most important in your life?
- What experiences have you had with serious illness or death?
- If you were very sick, what would be most important to you?
- Would you want to live as long as possible even if that means accepting serious physical and social limitations?

# Putting your healthcare wishes in writing

#### **California Advance Health Care Directive**

This form lets you have a say about how you want to be cared for If you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker. Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself. This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

#### Part 2 Make your own health care choices, Page 7

The form must be signed before it can be used.

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 Sign the form, Page 13



PREPARE

weatry of California, 2018

You can fill out Part 1, Part 2, or both

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notary on Page 15.

Your Name



### **Advance Health Care Directive**

### prepareforyourcare.org

			I Part of the second second		Gender
Name:         Name/Tile         Phone #           Additional Contact         None         Phone #           Additional Contact         None         Phone #           Name:         Restorable to Point:         Phone #           Completing POLST         Directions for Health Care Provider           Completing POLST         Point is voluntary. California hav requires that a POLST form be followed by healthcare pro and provides immunkly to those who comply in good faith. In the hospital setting, a patient will be assessed by a pi or a muse provides immunkly to those who comply in good faith. In the hospital setting, a patient will be assessed by a pi or a muse provides the Advance Directive. When smallable.           - POLST must be completed by a health care provider based on patient preferences and medical indications.         - Aloggity recognition of the patient is approximately to resolve any conficts.           - Aloggity recognition devices and which mass approached based on patient preferences and medical indications.         - Aloggity recognition of the patient is nepressed whethe and values to the extent known.           - Aloggity recognition devices and which me scopes of practice adviced by law and (1) the patient takes capacity or has designate decisionmalist and which the scope of practice adviced by law and (2) the patient of adviced and which a storad the extent who have a bigned by (1) a physician. To by a nurse practiciant scored applet and wall. A should be retrained in patient is medical accord, on UNE PRA patient possible.           - A transited form is sub out patient of decisionmala and care as eacciptable with the locore of pracic	ame (last, first, middle):		Date of Birth		Gender.
Additional Contact None Name: Readonship to Patient Provide Name: Readonship to Patient Provide Patient Provide Patient Provide Patient Provide Patient Provide Patient Patient Provide Patient Patie	P/PA's Supervising Physician			han signing	Physician/NP/P/
Reationship to Patient     Prove #	ame:	Name	/Title:		Phone#:
Completing POLST on its voluntary California law requires that a POLST form be followed by healthcare pro and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by api 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 ensure consistency, and update forms appropriately to resolve any conflict. POLST does not replace the Advance Directive will be assessed by api 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 ensure consistency, and update forms appropriately to resolve any conflict. POLST does not replace the Advance Directive will be approximately to resolve any conflict. Advance Directive confly designated surrogate. spouse, registered domaskic, preview the Advance Directive and POLST form ensure consistency and update forms appropriately to resolve any conflict. POLST does not replace the Advance Directive the POLST form only of the patient approximately and will make in accordance with the patient's preview may exact the POLST form only of the patient or decisionmaker decisionmaker's actionary is effective immediately. POLST form only on a physician and within the scope of practice authorized by twan and (2) the patient or decisionmaker and order are acceptable with follow up signature by physican/PIPA in accordance with facility community policy. PAD is the supervision of a physician and within the scope of practice authorized by twan and (2) the patient or decisionmaker and order are acceptable with follow up signature by physican/PIPA in accordance with facility community policy. PAD is the supervision of the score and practice authorized by twan and (2) the patient or decisionmaker and and the supervision of the active transmitter of a signate policy. PAD is the supervision of the score and prace po					
Completing POLST Completing POLST Completing POLSTorm is voluntary. California law requires that a POLST form be followed by healthcare por and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by api or a more paratory patient of the provides in the provide of the supervision of the physican, who will as appropriate orders that are consistent with the publicity preferences. POLST form to try part of the Advance Directive and POLST form POLST must be completed by a health care provider based on patient preferences and medical indications. POLST must be completed by a health care provider based on patient preferences and medical indications. POLST must be completed sup and the provident specification of the patient preferences and medical indications. POLST must be completed sup and the provident based on patient preferences and medical indications. POLST must be completed sup and the provident based on patient preferences and medical indications. POLST must be completed sup and the provident based on patient preferences and medical indications. POLST must be completed sup and the provident based on patient preferences and medical indications. POLST we and the patient's provident may exaculable the POLST form only if the patient Indica's capacity or has designated in a concretance with the patient's provident may exaculable the POLST form only the patient or decisionmal orders are acceptable with follow up signature by physican. To by a nurse practitioner or a physician assistent addition is advised than decisian conditioned by law and (2) POLST form only the patient or decisionmal orders are acceptable with follow up signature by physican PDPA in accordance with facility community policy. I at translated form is used with patient or decisionmal automated advised additional of advised and andical accord, on UIII and PDPA and exact possible. Section B: View of originate is and the provide acromoting (2), treatment of a high facture). Non-inva	ame:	Relationship to Pat	ient:	Phone #:	
<ul> <li>Completing a PQL ST form is voluntary. California taw requires that a POLST form be followed by healthcare point and provides immunity to have show comply in good fails. In the hospital setting, a platent will be assessed by a play and provides intervent to the physician, who will as appropriate orders that are consistent with the platent provides in the physician and provides intervent and the physician assubant (PA) acting under the supersion of the physician, who will as appropriate orders that are consistent with the platent provides that are consistent with the platent provides that are consistent with the platent or provides that are consistent.</li> <li>POLST from the completed by a health care provide thated on patient preferences and modical indications.</li> <li>POLST from the platent is physician. Platent provides thated on patient preferences and modical indications.</li> <li>POLST must be completed by a health care provider based on patient preferences and modical indications.</li> <li>A legally recognized decisionmaker may exacute the POLST form only if the platent lacks capacity or has designated in an accordance with the platent is playesican.</li> <li>A legally recognized decisionmaker may exacute the POLST form only if the platent lacks capacity or has designated decisionmaker analysis of a playesican and when the two species of playesican and when the supersition of a physician within the supersition of playesican within the supersition of a playesican and supersition of a playesican and supersition of a playesican and supersition of a supersition and when the supersition of a playesican and supersition and supersition and supersition and supersition and supersition andite supersition and supersitient and within the scope of playe</li></ul>		tions for Health Ca	are Provider		
and provide's immunity to those who configuring odd faith. In the hospital setting, a patient will be sissessed by given or a muse parcial controller (MP) or a hypical and assister (MP) acting under the supervision of the Physician. Now will as appropriate orders that are consistent with the patient's preferences. POLST does not replace the Advance Directive. When available, review he Advance Directive and POLST form POLST must be completed by a health care provider based on patient preferences and medical indications. A heaply recognized decisionmaker may include a court-appointed consentator or guardian. Appendix the patient of the patient system and the patient preferences and medical indications. A heaply recognized decisionmaker may include a court-appointed consentator or guardian. Appendix the courted will be added to the POLST form only of the patient 1 patient. Specific and will make an accordance with the patient's previous registered domesic pather, parent of a minor, closest available eta a heaply recognized decisionmaker may enclude the POLST form only of the patient (Lecks capacity or has designate in a subjective or the patient's previous which and values to the extent known. A heaply recognized decisionmaker may enclude the POLST form only of the patient of decisionmais orders are acceptable with follow up signature by physican/tPPA in accordance with facility/community policy. If a translated form is used with patient or decisionmaker, attach to the signed English POLST form. Use of original form is astimating and exact accord, on Util a Pilk patient and existent and should be retained in patient maker. Alcone to the possible. Any incomplete section POLST implies full treatment for that section. Section & Hourd bates and not breathing, no definition (including atomated octimal definitiators) or cheat compression about be retained in patient maker. Now house access and not breathing, no definitiator (including atomated octimal definitiators) orefinet ensuing (BPAPA), and Bag					
Directine, enaily designated surrogate, is pouse, registered domesic partner, parent of a mixin <sup>-</sup> closest simulate eta person whom the partner's physican NHPFA belows best knows what is in the partner tables interest and will make a Alegally recognised decisionianism may execute the POLST form only tithe patient tables capacity or has designate the supervision of a physician and whithin the cope of practice authorized by law and (2) the patient of accession and an accessible and an accessible of practice authorized by law and (2) the patient in the case of the case of the supervision of a physician and whithin the cope of practice authorized by law and (2) the patient of decisionmal orders are acceptable with follow up signature by physican VPPA in accordance with facility community policy. If a translated form is used with patient or decisionmaler, attach is the insigned English POLST form and is about be transmitted in patient's material accord, and the Pink page without policy. If a translated form is used with patient of decisionmal and a program of the patient of accession about be transmitted in patient's material accord, and the Pink page without possible. Any incomplete section of POLST implies full treatment for that section. Section B: When conflort cannot be achieved in the current setting, the patient, including someons with "Comfort-Focused Treat should be transferred to a setting table to provide conflot (e.g. treatment of a high facture). Non-invasite on advisation agreement includes conflot (e.g. treatment of Brancetter). For advisorities and not diversiting area (Comfort) focused Treatment. The about be transferred to a setting table to provide conflot (e.g. treatment of a high facture). The distribute any provide active provide conflot (e.g. treatment of a high facture). The advisorities and physican protein Reviewary provides accessing area (Comfort-focused Treatment. The advisorities and physican physican physican revisor (e.g. PA), bi-level positive ainwary (BPAPA),	and provides immunity to those who comply in or a nurse practitioner (NP) or a physician ass appropriate orders that are consistent with the POLST does not replace the Advance Direc ensure consistency, and update forms approp	n good faith. In the hos sistant (PA) acting unde patient's preferences. ctive. When available, riately to resolve any co	pital setting, a patie or the supervision of review the Advance onflicts.	nt will be ass the physicia Directive an	essed by a phys n, who will issue d POLST form to
the supervision of a physician and white this scope of practice authorized by law and (2) the patient or decisionmak orders are accordance with brain provident in the scope of practice authorized by law and (2) the patient or decisionmaker, attach to the signed English Constraint of the scope and FAkes of signed PCUST forms are legal and valid. A should be retained in patient's medical record, on UItra Pink paper when possible. Using POLST Using POLST Section A: Any incomplete section OPOLST implies full treatment for that section. Section B: • Any incomplete section OPOLST implies full treatment for that section. Section B: • If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressive should be used on a patient who has chosen TO block Attempt Resourcitation. Section B: • When comfort cannot be achieved in the cornerst a sting, the patient, including someons with "Comfort-Focused Treat When comfort cannot be achieved in the cornerst asting, the patient, including someons with "Comfort-Focused Treat (BiPAP), and Boy value mark (MM) assided respondences. • Wantibudics and hydration generally are not "Comfort-Focused Treat (BiPAP), and Boy value mark (MM) assided respondences. • It wantibudics and hydration generally are not "Comfort-Focused Treat • Depending on local EMS protocol. "Additional Orders" written in Section B may not be implemented by EMS person <b>Reviewing POLST</b> • The patient is any forme care setting or care level to another, or • There is a substantial change in the patient is health status, or • There is a substantiant preference change. • Manifying and Voiding POLST	A legally recognized decisionmaker may includ Directive, orally designated surrogate, spouse person whom the patient's physician/NPPA b in accordance with the patient's expressed wi A legally recognized decisionmaker may exect decisionmaker's authority is effective immedia	de a court-appointed co e, registered domestic p velieves best knows who shes and values to the ute the POLST form onl ately.	nservator or guardia vartner, parent of a n at is in the patient's extent known. ly if the patient lacks	n, agent des inor, closes best interest capacity or	ignated in an Ad t available relativ and will make d has designated t
Use of original form is strongly encouraged. Photocopes and FAKes of signed POLST forms are legal and valid. A 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:         (Found possible and not be achieved thing, the patient including summaries and the patient who has chosen "Do Not Attempt Resuscitation".     Section A:         (Not possible and the current setting, the patient, including summaries with "Comfort-Focused Treat should be used on a patient who has chosen "Do Not Attempt Resuscitation".         (Not increase a bachieved in the current setting, the patient, including someone with "Comfort-Focused Treat should be transferred to a string table to provide comfort (e.g., transmitter di a la fracture).         Non-increase positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway (BBAPA) and begravher make (RMM) assided responsitive.         Vi Pant body ration generally are not "Comfort-Focused Treatment."         Teratiment of dehydration prolongs lifts. If a patient desires IV Mubia, including someone with "Comfort-Focused Treatment."         Depanding on local EMS protocol. "Additional Orders" wintten in Section B may not be implemented by EMS person         Reviewing POLST         The patient is transferred from one care setting or care level to another, or         The patient is transferred to a setting or care level to another, or         The patient is transment preference change.         Modifying and Voiding POLST         A patient with exacting the atom the reference change.         Modifying and Voiding POLST         A patient with a reduction be documented by drawing a line through Sections A through D, writin         intarge terms on a disting that in the reference of the reference of resonse a setting or care level to another, or         There is a substantial change in the patient' shealth status, or	the supervision of a physician and within the s orders are acceptable with follow-up signature	cope of practice author by physician/NP/PA in	rized by law and (2) accordance with fa	the patient o cility/commu	r decisionmaker
Any incomplete section of POLST implies full treatment for that section.     Section A:     If found pulseless and not breathing, no definitiator (including automated external defabrillators) or chest compression     should be used on a patient who has chosen "Do Not Attempt Resuscitation."     Section B:         Vhen comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treat         should be transferred to a setting able to provide comfort (e.g., treatment of a high fracture).         Non-invasive positive ainvary pressure (CPAP), bi-level positive ainvary         (BPAP), and bag valve mask (BYM) assisted respirations.         Vantibucio: associate ainvary pressure (CPAP), bi-level positive ainvary         (BPAP), and bag valve mask (BYM) assisted respirations.         Vantibucio: associated and hydratory generating are not "Comfort-Focused Treatment."         Teatment of dehydration presentary are not.         Teatment of cannot be achieved and the patient desires in Mudac, indicate "Selective Treatment" or "Pull Treatment         Teatment of dehydration presentary are not.         Teatment of bary data in presentary or additional orders written in Section Bray not be implemented by EMS person         Reviewing POLST         There is a subclination from one care setting or care level to another, or         The patient is transferred from one care setting or care level to another, or         There is a subclination chore in the patient should be transferred from one care setting or care level to another, or         Mente is a subclination chore in the patient should be transferred by EMS person         Mente is a subclination chore in the patient should be transferred by the chore approximation to another or         Applient is transferred from one care setting or care level to another, or         Mente is a subclination chore in the patient should be transferred by the chore applient be transferred by the chore applient be able to anoble.         Applie	Use of original form is strongly encouraged. Pf should be retained in patient's medical record	hotocopies and FAXes (	of signed POLST for		and valid. A co
Section A: If Sund puscless and not breathing, no defbrillator (including automated external defbrillators) or chest compressis should be used on a patient who has chosen "Do Not Attempt Resuscitation." Section 8: Vene comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Tress should be transferred to a setting able to provide comfort (e.g., transmitter di a hip facture). Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway (BiPAP), and begravier mark (EVM) assided responsitions. V antibiotics and hydration generally are not "Comfort-Focused Treatment." Treatment of dehydration proinsing list. If a patient desires IV Multia, indicate "Selective Treatment" or "Full Treatment Depending on local EMS protocol. "Additional Orders" written in Section B may not be implemented by EMS person <b>Reviewing POLST</b> 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 is transment preference schange. <b>Modifying and Voiding POLST</b> A patient with equacity can, at any time, request alternative transment of revelse a POLST by any means that indicat to travelse. It is recommended that threocation be documented by drawing a line through Sections A through D, writti in targe letters, and signing and during this line.		continent for that cartin			
should be used on a patient who has chosen "Do Not Attempt Resuscitation". Section 8: • When conflort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treat should be transferred to a setting labe to provide comfort (e.g., transmitter of a high facture). • Non-invasive positive ainway pressure includes continuous positive ainway pressure (CPAP), bi-level positive ainway (BiPAP), and begraview mark (KPM) assisted respressions. • IV antibiotics and hydration generally are not "Comfort-Focused Treatment." • Treatment of dehydration prolongs life. If a patient desires IV Muids, includes "Selective Treatment" or "Full Treatment • Depending on local EMS protocol. "Additional Orders" wintten in Section B may not be implemented by EMS person <b>Reviewing POLST</b> The patient is transferred from one care setting or care level to another, or • There is a substantial charge in the patient's health status, or • The patient is transferred from one care schang or care level to another, or • There is a substantial charge in the patient's health status, or • The patient is transmet preference schang. <b>Modifying and Violing POLSI</b> • Apatient with equacity can at any time, request learnative transmet or revoles a POLST by any means that indicat to revole. It is recommended that renocation be documented by drawing a line through Sections A through D, writtin in large letters, and signing and dating this line.		rearment for that sectio	n.		
When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treat should be transferred to a setting labe to provide comfort (g. g. treatment of a high facture).     Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway (BiPAP), and bug valve mask (BVM) assided responsitions.     Vi antibiotics and hydration generally are not "Comfort-Focused Treatment."     Treatment of dehydration prolongs like. If a patient desires IV Multia, includate "Selective Treatment" or "Full Treatment Depending on local EMS protocol. "Additional Orders" written in Section B may not be implemented by EMS person <b>Reviewing POLST</b> 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 is transment preferences change.     Modifying and Voiding POLST     A patient with equacity and any time, request alternative to revolve a POLST by any means that indicat to revolve. It is recommended that renocation be documented by drawing a line through Sections A through D, writtin in targe letters, and singing and dating this line.	should be used on a patient who has chosen "	llator (including automa 'Do Not Attempt Resus	ted external defibril citation."	ators) or che	st compressions
Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP); bi-level positive airway (B/PAP), and beg valve mask (KPM) assided responsations.     Vi antibuics and hydration generally are not "Comfort-Focused Treatment".     Teatment of dehydration polonga life. If a patient desires IV fluid, includate "Selector Treatment" or "Full Treatment Depending on local EMS protocol. "Additional Orders" written in Section B may not be implemented by EMS person Reviewing POLST     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 is transferred from one care schang or care level to another, or     There is a substantial change in the patient's health status, or     The patient is transferred from one care schang or care level to another, or     A patient with change in the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with change the patient's health status, or     A patient with change and the patient's health status, or     A patient with change and the patient's health status, or     A patient with any contence schange.     Modifying and Yorking a line through Sections A through D, writir     in tange letters, and signing and dation this line.	When comfort cannot be achieved in the current				Focused Treatm
• Treatment of dehydration prolongs life. If a patient desires // Mulds, indicate "Selective Treatment" or "Full Treatment • Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS person Reviewing POLST It is recommended that POLST be reviewed pariodically. Review is recommended when: • The patient is transferred from one care setting or care level to another, or • 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 is transment preferences change. Modifying and Volding POLST • A patient with exactly care level to another to revolve a POLST by any means that indicat to revolve. It is recommended that previous the dating this line. • The patient is a displayed and dating this line. • The patient with exactly care and any time, request alternative treatment or levences. • The revolve is a displayed and dating this line. • The patient with exactly care and any time. • The patient with exactly care any time. • The	Non-invasive positive airway pressure includes	continuous positive air			ositive airway pr
It is in accommended that POLST be reviewed particularly. <i>Reviews recommended</i> when: The patient is transferred from more are esting or care level to another, or There is a substantial change in the patient's health status, or The patient is transment preferences change. Modifying and Violing POLST A patient with equacity can at any time, request alternative transment or revole a POLST by any means that indicat to revole. It is recommended that renceation be documented by drawing a line through Sections A through D, writhr in large letters, and signing and dating this line.	Treatment of dehydration prolongs life. If a pati	ent desires IV fluids, in	dicate "Selective Tre		
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 transment preferences change. Modifying and Voiding POLST     A patient with brackpacity can, at any time, request alternative treatment or revoke a POLST by any means that indicat     to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, write     in targe letters, and signing and dating this line.	eviewing POLST		-		
<ul> <li>There is a substantial change in the patient's health status, or</li> <li>The patient's transmet preferences change.</li> <li>Modifying and Voiding POLST</li> <li>A patient with equation year, and you have a substantiation of the patient's transmet or revolve a POLST by any means that indicat to revolve. It is recommended that rencoation be documented by drawing a line through Sections A through D, writin in large letters, and signing and dating this line.</li> </ul>					
Modifying and Volding POLST A patient with capacity can, at my time, request alternative treatment or revoke a POLST by any means that indicat to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writin in large letters, and signing and dation this line.	There is a substantial change in the patient's h		1, 01		
<ul> <li>A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicat to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writi in large letters, and signing and dating this line.</li> </ul>					
	A patient with capacity can, at any time, reque to revoke. It is recommended that revocation b	be documented by draw			
the known desires of the patient or, if unknown, the patient's best interests.	in large letters, and signing and dating this line				

## **POLST Form** capolst.org



# PREPARE for your care

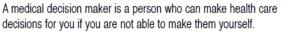
### **California Advance Health Care Directive**

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

#### This form has 3 parts:



#### Part 1 Choose a medical decision maker, Page 3



This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

#### Part 2

#### Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

#### Sign the form, Page 13 Part 3

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notary on Page 15.



#### Part 1: Choose your medical decision maker

#### This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

#### What should I do with this form?

- · Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

#### What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- · Lawyers can help too. This form does not give legal advice.

#### What if I want to make health care choices that are not on this form?

• On Page 12, you can write down anything else that is important to you.

#### When should I fill out this form again?

- If you change your mind about your health care choices
- · If your health changes
- If your medical decision maker changes

If your spouse is your decision maker, and you divorce, that person will no longer be your decision maker.

Give the new form to your medical decision maker and medical providers. Destroy old forms.

Share this form and your choices with your family, friends, and medical providers.



#### Choose your medical decision maker

Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

#### A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- · can talk to you about your wishes
- · can be there for you when you need them



- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- · is not afraid to ask doctors questions and speak up about your wishes

Legally, your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

#### What will happen if I do not choose a medical decision maker?

If you are not able to make your own decisions, your doctors will turn to family and friends or a judge to make decisions for you. This person may not know what you want.

### If you are not able, your medical decision maker can choose these things for you:

- · doctors, nurses, social workers, caregivers
- · hospitals, clinics, nursing homes
- · medications, tests, or treatments
- who can look at your medical information
- · what happens to your body and organs after you die



#### 2

#### Part 1: Choose your medical decision maker

#### California Advance Health Care Directive

Here are more decisions your medical decision maker can make:

#### Start or stop life support or medical treatments, such as:



#### CPR or cardiopulmonary resuscitation

cardio = heart • pulmonary = lungs • resuscitation = try to bring back

#### This may involve:

- pressing hard on your chest to try to keep your blood pumping
- · electrical shocks to try to jump start your heart
- · medicines in your veins

#### Breathing machine or ventilator

The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.

#### Dialvsis

A machine that tries to clean your blood if your kidneys stop working.

#### Feeding Tube

A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

- Blood and water transfusions (IV) To put blood and water into your body.
- Surgery
- Medicines



#### End of life decisions your medical decision maker can make:

- · call in a religious or spiritual leader
- decide if you die at home or in the hospital
   decide about burial or cremation
- decide about autopsy or organ donation

#### Part 1: Choose your medical decision maker

#### California Advance Health Care Directive

#### By signing this form, you allow your medical decision maker to:

- · agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- · decide what happens to your body after you die, such as funeral plans and organ donation

If there are decisions you do not want them to make, write them here:

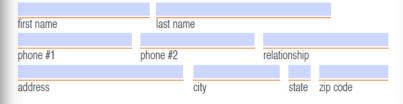
#### When can my medical decision maker make decisions for me?

- ONLY after I am not able to make my own decisions
- NOW, right after I sign this form

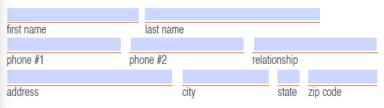
If you want, you can write why you feel this way.

#### Write the name of your medical decision maker.

I want this person to make my medical decisions if I am not able to make my own:



#### If the first person cannot do it, then I want this person to make my medical decisions:





#### Part 1: Choose your medical decision maker

#### California Advance Health Care Directive

#### rait 2: Make your (

Why did you choose your medical decision maker?

If you want, you can write why you chose your #1 and #2 decision makers. Or, write down anyone you would NOT want to help make medical decisions for you.

#### How strictly do you want your medical decision maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your medical decision maker. You can write your wishes in Part 2 of this form.

#### Put an X next to the one sentence you most agree with.

- Total Flexibility: It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- Some Flexibility: It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:

No Flexibility: I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.

Please share your wishes with your family, friends, and medical providers.

Part 2: Make your own health care choices



Make your own health care choices

Fill out only the questions you want.

#### How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

**Please note:** Medical providers cannot make decisions for you. They can only give information to help with decision making.

#### How do you prefer to make medical decisions?

- I prefer to make medical decisions on my own without input from others.
- I prefer to make medical decisions only after input from others.
- I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

#### What Matters Most in Life? Quality of life differs for each person.

What Is Most Important In Your Life? Check as many as you want.

Not being a burden on your family				
Religion or spirituality: Your religion				

What brings your life joy? What are you most looking forward to in life?

Your Name

6

#### Part 2: Make your own health care choices

#### California Advance Health Care Directive

What Matters Most for your Medical Care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- · They have to be kept alive on machines and are suffering
- · They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

• These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. What is important to you? Your goals may differ today in your current health than at the end of life.

#### TODAY, IN YOUR CURRENT HEALTH

Put an X along this line to show how you feel today, in your current health.



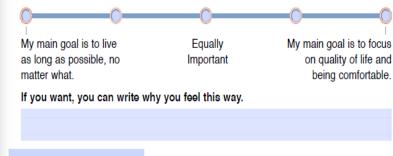
My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

#### AT THE END OF LIFE

Your Name

Put an X along this line to show how you would feel if you were so sick that you may die soon.



#### Part 2: Make your own health care choices

California Advance Health Care Directive

Quality of life differs for each person at the end of life. What would be most important to you?

#### AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

• Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life? Check as many as you want.

- Being in a coma and not able to wake up or talk to my family and friends
- Not being able to live without being hooked up to machines
- Not being able to think for myself, such as severe dementia
- Not being able to feed, bathe, or take care of myself
- Not being able to live on my own, such as in a nursing home
- Having constant, severe pain or discomfort
- Something else
- **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

What experiences have you had with serious illness or with someone close to you who was very sick or dying?

• If you want, you can write down what went well or did not go well, and why.

#### If you were dying, where would you want to be?

at home

I am not sure

What else would be important, such as food, music, pets, or people you want around you?

Your Name

8

#### Part 2: Make your own health care choices

#### California Advance Health Care Directive

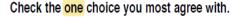
#### How Do You Balance Quality of Life with Medical Care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.



If you were so sick that you may die soon, what would you prefer?

- Try all life support treatments that my doctors think might help. I want to stay on life support treatments even if there is little hope of getting better or living a life I value.
- Do a trial of life support treatments that my doctors think might help. But, I DO NOT want to stay on life support treatments if the treatments do not work and there is little hope of getting better or living a life I value.
- I do not want life support treatments, and I want to focus on being comfortable. I prefer to have a natural death.

What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?

#### Part 2: Make your own health care choices

California Advance Health Care Directive

Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

#### ORGAN DONATION

Some people decide to donate their organs or body parts. What do you prefer?

I want to donate my organs or body parts.

Which organ or body part do you want to donate?

- Any organ or body part
- Only



I do not want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

#### AUTOPSY

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- I want an autopsy.
- I do not want an autopsy.

- I only want an autopsy if there are questions about my death.

#### FUNERAL OR BURIAL WISHES

What should your medical providers and decision maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

- · Do you have religious or spiritual wishes?
- Do you have funeral or burial wishes?

Your Name

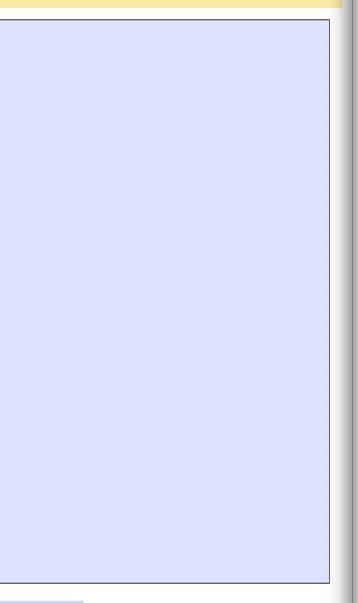
10

#### Part 2: Make your own health care choices

California Advance Health Care Directive

California Advance Health Care Directive

What else should your medical providers and medical decision maker know about you and your choices for medical care?



### Part 3 Sign the form

Part 3: Sign the form



#### Before this form can be used, you must:

- · sign this form if you are 18 years of age or older
- · have two witnesses or a notary sign the form

#### Sign your name and write the date.

sign your name	to	day's date		
print your first name	print your last name	date of birth		
address	city	state	zip code	

#### Witnesses or Notary

Before this form can be used, you must have 2 witnesses or a notary sign the form. The job of a notary is to make sure it is you signing the form.

#### Your witnesses must:

- be 18 years of age or older
- know you
- · agree that it was you that signed this form

#### Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live (if you live in a nursing home go to Page 15)

#### Also, one witness cannot:

- · be related to you in any way
- benefit financially (get any money or property) after you die

Witnesses need to sign their names on Page 14. If you do not have witnesses, a notary must sign on Page 15.



#### Part 3: Sign the form

California Advance Health Care Directive

signed this form.

#### Have your witnesses sign their names and write the date.

By signing, I promise that

(the person named on Page 13)

They were thinking clearly and were not forced to sign it.

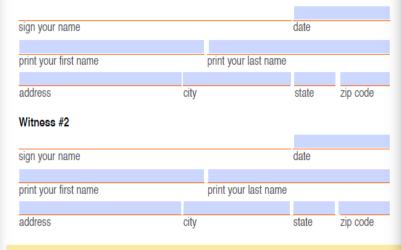
#### I also promise that:

- I know this person or they can prove who they are
- . I am 18 years of age or older
- · I am not their medical decision maker
- I am not their health care provider
- · I do not work for their health care provider
- · I do not work where they live

#### One witness must also promise that:

- I am not related to them by blood, marriage, or adoption
- . I will not benefit financially (get any money or property) after they die

#### Witness #1



#### You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org



#### Part 3: Sign the form

#### California Advance Health Care Directive

Notary Public: Take this form to a notary public ONLY if two witnesses have not signed this form. Bring photo ID (driver's license, passport, etc.).

#### CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California	County of		
On	before me,		, personally
appeared		Here insert name and title of the officer	
		Names(s) of Signer(s)	

who proved to me the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal.

#### Signature\_

Signature of Notary Public
Description of Attached Document
Title or type of document:
Date: Number of pages:
Capacity(ies) Claimed by Signer(s)
Signer's Name:
O Individual
O Guardian or conservator
O Other

(Notary Seal)

#### For California Nursing Home Residents ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

#### STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code."

sign your name			date	
print your first name		print your last name		
address	city		state	zip code

Sopright © The Regents of the University of California, 2016. All rights reserved. Revised 2019. No one may reproduce his form by any means for commercial purposes or add to or modily this form in any way without a licensing agreement and written permission from the Regents. The Regents makes no warranties about this form. To learn more about this and the smit of use, go to www.prepareforyourcer.com



15

Copyright © The Regents of the University of California, 2016

## Signing, witnessing, and/or notarizing during shelter in place

- Mobile notary Armida Valenzuela (831) 320-5003
- Mobile notary Lucy Jensen (831) 229-0663
- Mobile notary Henry Cho (831) 444-9160
- Legal Services for Seniors (Monterey County) – (831) 899-0492
- Use technology: Scan/fax (the most secure), email, or send pictures of the form from your cell phone.

# Signing, witnessing, and/or notarizing during shelter in place

Even without getting it signed, there are benefits to completing an AHCD:

- The form helps you understand the decisions you may need to make
- Completing it helps family and health care providers know your wishes.
- You can also record your AHCD conversations with your witnesses and health care decision maker.



This form and more resources can be found on the HG Foundation website resources page

### hospicegiving.org/resources





### PREPARE Easy-to-Read Advance Directives:

Free to fill out and print for all states.

Get the PREPARE Advance Directive

# prepareforyourcare.org/welcome

# PREPARE is a step-by-step program with video stories to help you:

- Have a voice in YOUR medical care
- Talk with your doctors
- Give your family and friends peace of mind
- Fill out an advance directive form to put your wishes in writing.



Click the video above to learn more.

#### Click Here to Start PREPARE

It has video stories and can help you fill out an advance

directive.



## What's next?

### Take the HOPEGives Pledge at hospicegiving.org



Pledge: My Wishes, My Decisions, My Life

I take this pledge to express my wishes and prepare for my end of life. I will try to help the people close to me have open conversations about end of life.

I want the best care possible through end of life and I want my loved ones supported. Therefore, I will:

- O Talk with my loved ones about what is important to me and how I want to live fully through end of life.
- O Specify cultural traditions and/or religious beliefs that I want honored
- O Affirm my end-of-life preferences early when I am of sound mind and body.
- O Share this Pledge with my primary doctor or provider.

I understand the importance and benefits of legal paperwork that document my wishes. Therefore, I:

- O Will get help to complete these documents and review them often.
- O Understand I may change my wishes at any time, as my circumstances and priorities evolve.

have read and thought about the statements above. While I know preparing for end of life is not simple and the conversations can be hard, I promise to devote time to talking about and writing down what matters most to me.

Check which applies.

I pledge to 🗆 begin 🗖 complete and/or 🗖 review my Advance Health Care Directive within \_\_\_\_\_ weeks.

Signature

Date

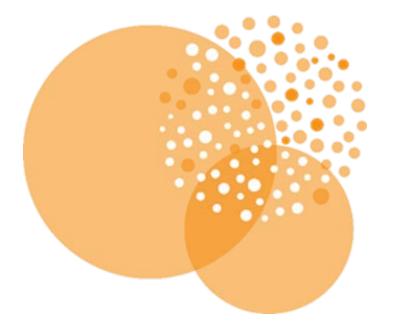
 I would like to receive resources, planning tools and information from HG Foundation in the future. I understand that I may change my contact preferences at any time.

E-mail

Phone

Read about our movement **HOPEGives on our website:** hospicegiving.org/hopegives

Be part of our quest to make conversations about end-of-life easier and more approachable.



# **Final Questions & Answers**

# Thank you for attending this workshop

### **Final Reminders...**

- Take the HOPEGives Pledge
- Have the Conversation with your loved ones and your doctor
- Review and complete the ACHD form
- Contact HG Foundation if you need assistance
- Review your plan annually
- Tell others to join a future workshop
- Join other workshops or visit our website for more resources



# **Hospice Giving Foundation** is here to help

- Visit our website for guides, documents, and information:
  - hospicegiving.org/resources
- Contact Hospice Giving Foundation for direct assistance:
  - Philip Geiger, Director of Outreach pgeiger@hospicegiving.org
  - Call 831.333.9023