HGFOUNDATION

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?

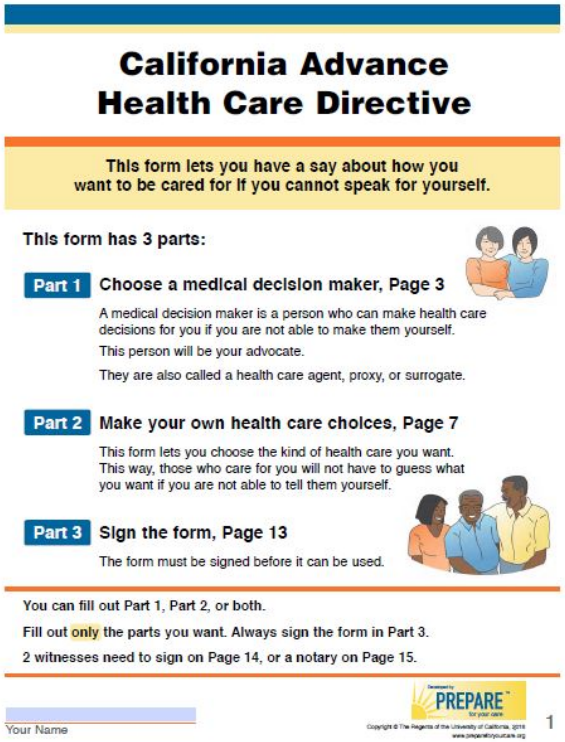
In the midst of the COVID-19 pandemic, people are realizing they are unprepared. It is especially important to think about the care you, or someone you love, would want if faced with serious illness.

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

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

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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.

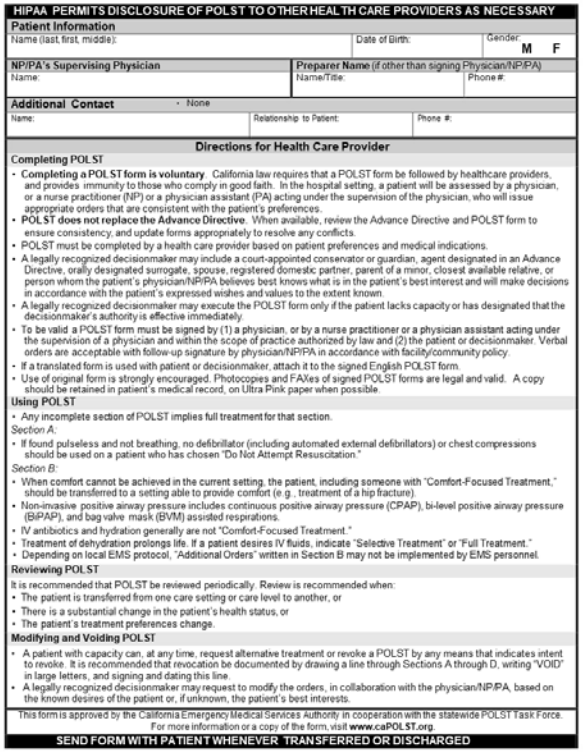
Your Name

PREPARE

1

Advance Health Care Directive

prepareforyourcare.org



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 Name: | **Preparer Name** (if other than signing Physician/NP/PA) 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

POLST Form

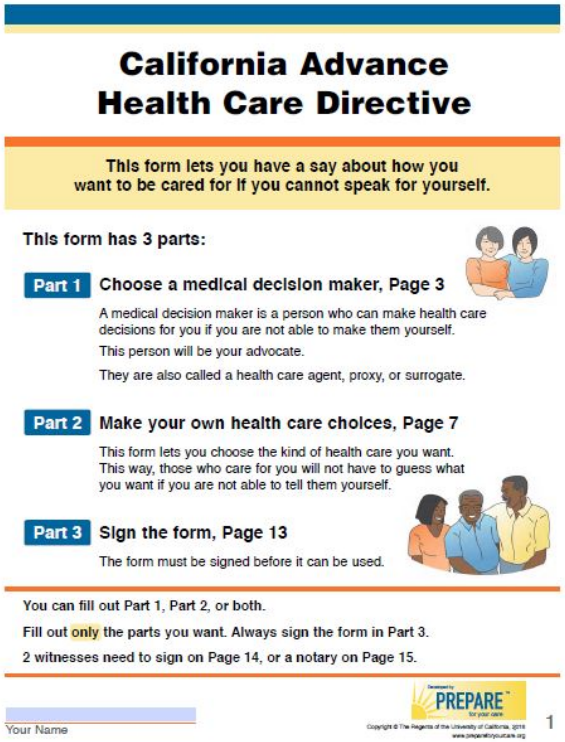
capolst.org

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



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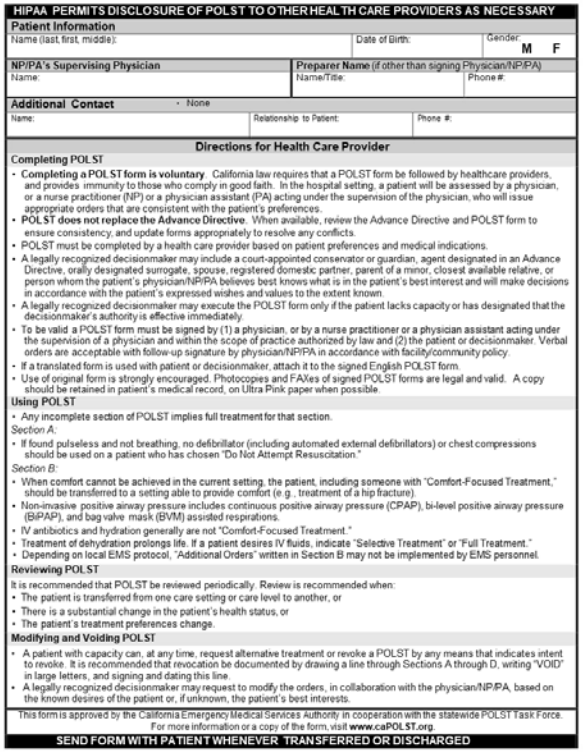

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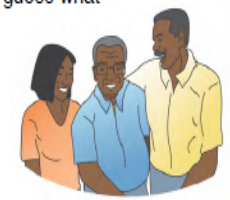

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Your Name

Developed by PREPARE™ for your care

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.

Part 1 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?

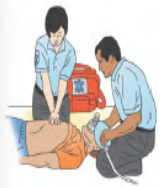
If you are not able to make your own decisions, your doctors will turn to family and friends or a judge to make decisions for you. This person may not know what you want.

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

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.

- **Dialysis**
  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 autopsy or organ donation
- decide about burial or cremation

Your Name

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:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

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

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

Your Name

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.

Your Name

Part 2 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.

- ☐ Your family or friends
- ☐ Your pets
- ☐ Hobbies, such as gardening, hiking, and cooking
  - Your hobbies
- ☐ Working or volunteering
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion
- ☐ Something else

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

Your Name

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 live as long as possible, no matter what.	Equally Important	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

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

My main goal is to live as long as possible, no matter what.	Equally Important	My main goal is to focus on quality of life and being comfortable.

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

Your Name

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 ☐ in the hospital ☐ either ☐ I am not sure

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

Your Name

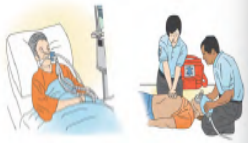
How Do You Balance Quality of Life with Medical Care?

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.



Check the one choice you most agree with.

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?

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?

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

Your Name

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 _____ today'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.

Have your witnesses sign their names and write the date.

By signing, I promise that _____ signed this form.
(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

_____ _____
sign your name — date

_____ _____
print your first name — print your last name

_____ _____ _____ _____
address — city — state — zip code

Witness #2

_____ _____
sign your name — date

_____ _____
print your first name — print your last name

_____ _____ _____ _____
address — city — state — zip code

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

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 _____ (Date) before me, _____ (Here insert name and title of the officer), personally appeared _____ (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

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.

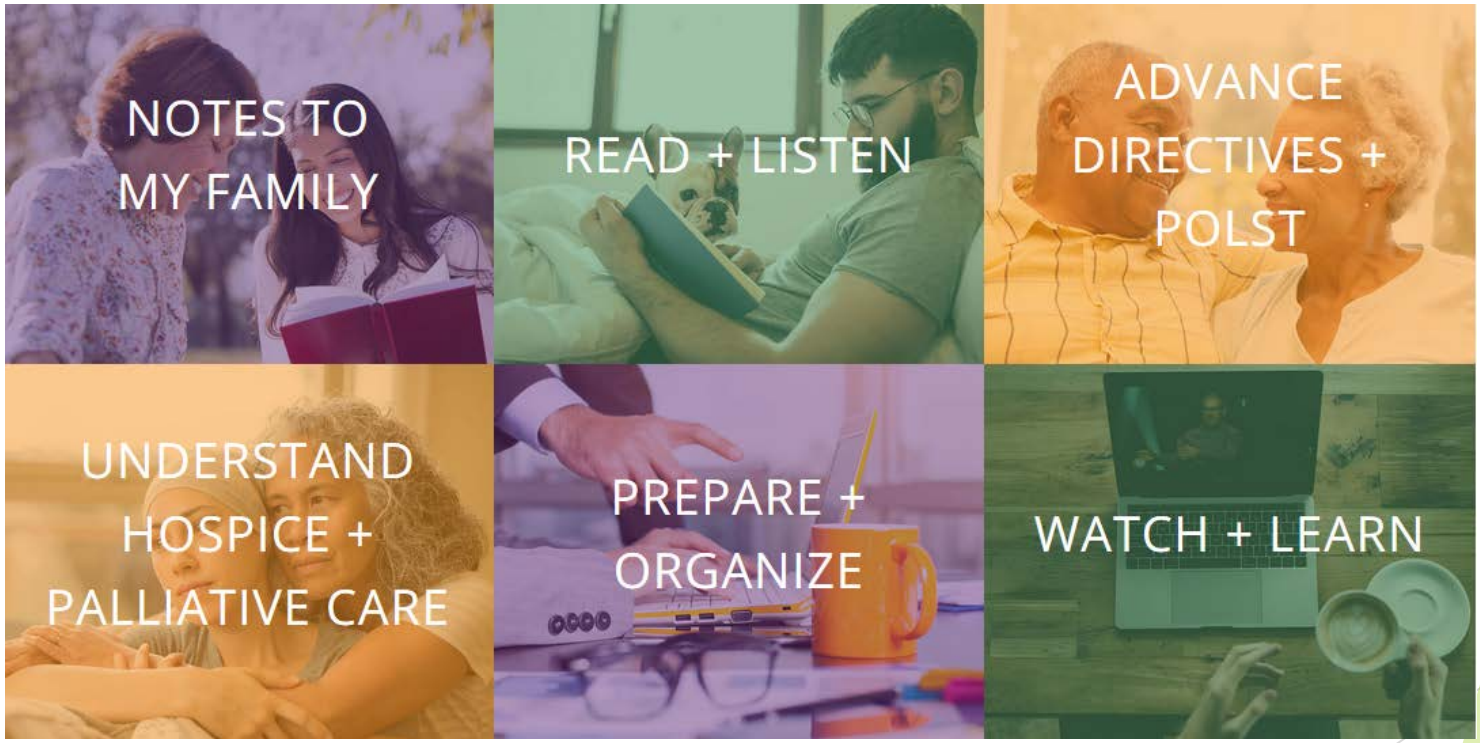
Signing, witnessing, and/or notarizing during shelter in place

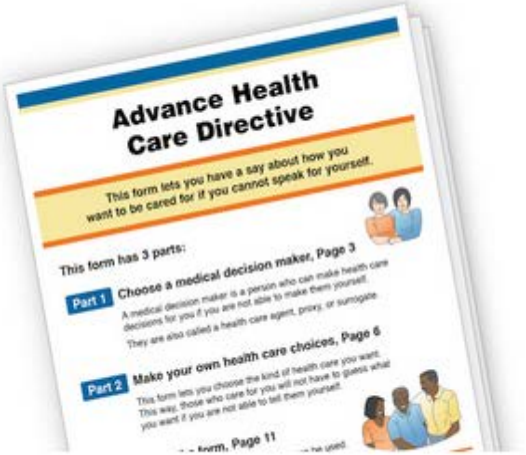
Even without getting it signed, there are benefits to completing an AHCD:

- **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.

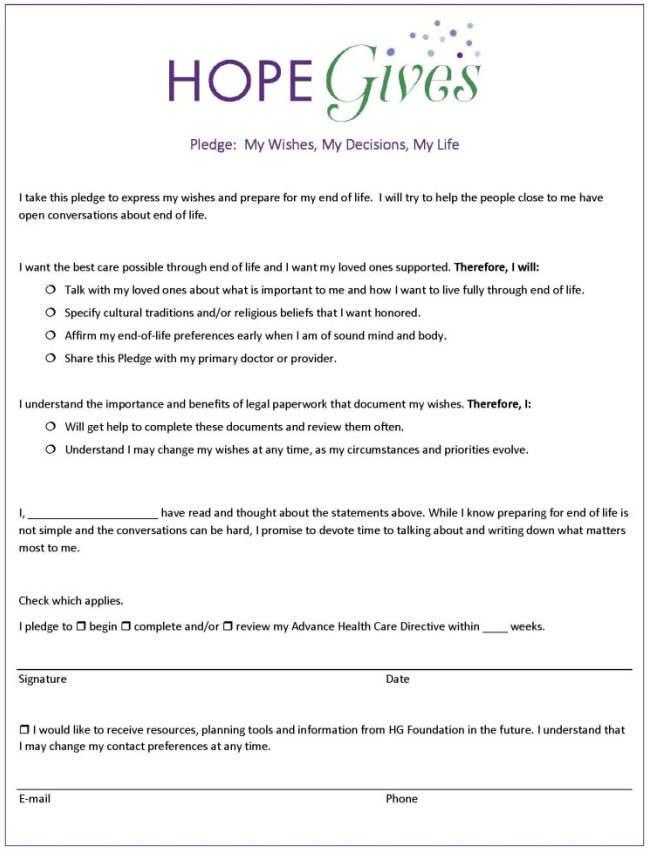
Click Here to Start PREPARE

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

Español

What's next?

Take the HOPE*Gives* Pledge at hospicegiving.org



HOPE *Gives*

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:**

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

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

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

I, _____ 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 HOPE*Gives* 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 HOPE*Gives* 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