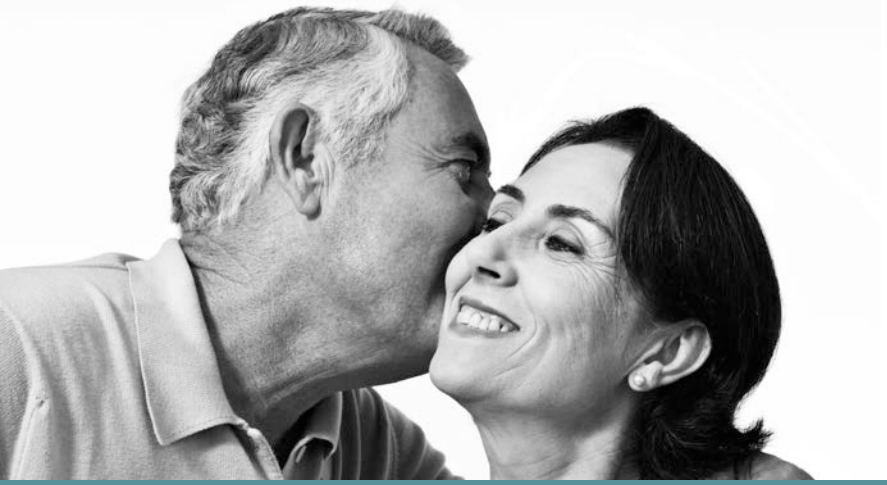

Conversations that Count- You, Your Doctor & Quality of Life

Lawren Hicks MD
Medical Director
John Muir Health Senior Services

JOHN MUIR HEALTH

Consider the Facts

- 80% say that they would want to talk to their MD about end-of-life decisions.
- 7% have actually had that conversation.

Consider the Facts

- 82% agree it's important to put their wishes in writing.
- 23% have actually done it.

- 90% say it's important to talk to their loved ones about end-of-life decisions.
- 27% have actually done so.

Consider the Facts

- 80% say they would want to die at home.
- 63% die in hospital or nursing home.

Imagine your last day on earth…….

- How do you get there?
- We start by talking ……
  a conversation

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The Conversation…

Is about what is **important** to you.

Hopes, goals, and wishes for the future.

Addresses the realities facing us now and in the future that affect our choices near the end of life.

Steps include…

- Questions to consider
- Talk to your loved ones
- Talk to your health care team
- Put your wishes in writing
- Let people know what you want

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Questions to consider

- What is most important to you?
- What are your beliefs?
- What concerns/fears do you have about your condition or treatment?
- Are there medical treatments that might be too much?
- What is the state of your health?
- What supports and resources do you have to help you as you near the end of life?
- What does quality of life mean to you?

Questions to consider

- How do you value quantity vs. quality of life?
- If you had to choose, which would be more important?
- Is there a special occasion you don't want to miss?
- Would you want to avoid pain at all costs even if you might not be able to interact with others?
- How important is it for you to be at home when you die?

Talk to your Loved Ones

- Perhaps pick a holiday gathering or get-together.
- Choose a calm and quiet place.
- No need to cover it all at one time, just establish the “comfort zone.”
- No need to follow structure, “let it happen”, but make sure you express what’s important to you.
- Make a video on your phone or iPad and let people know it’s there!

Talk to your Health Care Team

- Life Prolonging Care (“Full Treatment”) – all options open, including CPR and breathing machines.
- Limited Medical Care (“Selective Treatment”) – most options, short of Intensive Care. (No CPR)
- Comfort Care (“Comfort-Focused Treatment”) – relieve pain, airway care and oxygen . No hospitalization unless comfort needs cannot be met where you are.(No CPR)

Put Your Wishes in Writing

An Advance Health Care Directive is the document that states GENERAL decisions and instructions for medical intervention and other forms of care as one is nearing the end of life.

An Advance Health Care Directive appoints an agent to act as a power of attorney to carry out the choices and instructions specified in the document.

Consider wisely before appointing your agent.

- Talk to the person you are considering as your agent before filling in the form.
- The agent does not have to hold the same beliefs as you, but the agent must put aside their beliefs and carry out your wishes unconditionally.
- The agent must follow your oral or written instructions
- The agent should be available when needed.

FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may 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, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

AGENT'S AUTHORITY:

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

(Add additional sheets if needed.)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

_____

(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately.

_____

(Initial here)

AGENT'S OBLIGATION:

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POSTDEATH AUTHORITY:

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END OF LIFE DECISIONS:

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

_____
(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life:

_____
(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:

I give any needed organs, tissues, or parts _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____

_____

_____
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant _____ *(Initial here)* Research _____ *(Initial here)*

Therapy _____ *(Initial here)* Education _____ *(Initial here)*

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes _____ *(Initial here)* No _____ *(Initial here)*

2. My donated tissue may be used for applications outside of the United States.

Yes _____ *(Initial here)* No _____ *(Initial here)*

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes _____ *(Initial here)* No _____ *(Initial here)*

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE:

Sign and date the form here

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

Address: _____

_____

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

SECOND WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California)

County of _____)

)

On *(date)*_____ before me, *(name and title of the officer)* _____ _____ personally appeared *(name(s) of signer(s))* _____, who proved to me on 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. [Civil Code Section 1189]

Signature: _____ [Seal]
(notary)

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF 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.

Date: _____ Time: _____ AM / PM

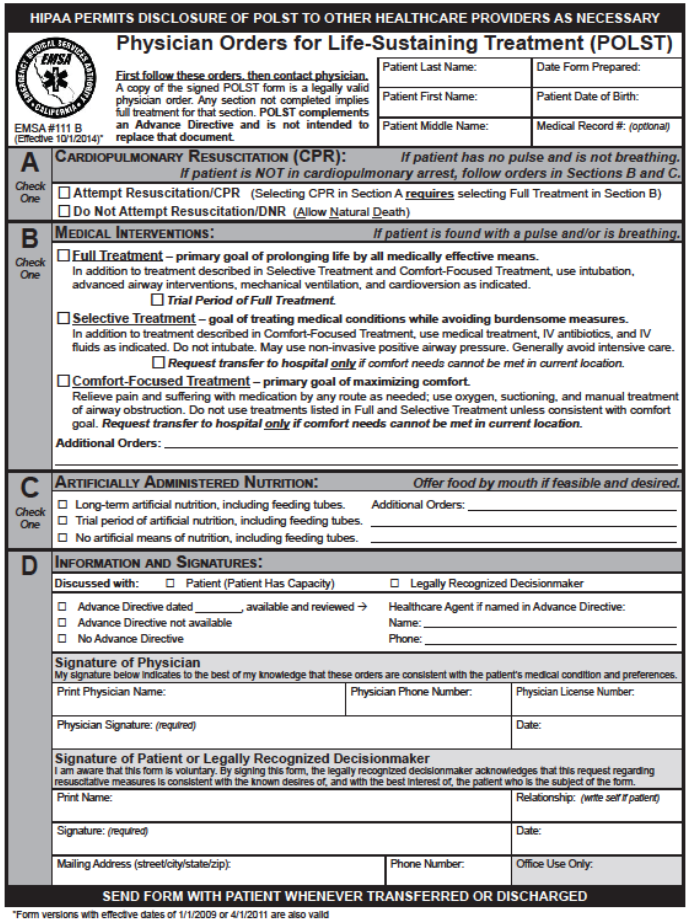
Signature: _____
(patient advocate or ombudsman)

Print name: _____
(patient advocate or ombudsman)

Address: _____

_____

POLST- Physician Orders for Life-Sustaining Treatment



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. 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 → Healthcare Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician
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 Name:	Physician Phone Number:	Physician License Number:
Physician 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 patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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

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Choice *Not To* Prolong Life

I do not want my life prolonged if one or more of the following situations occur:

- I have an incurable and irreversible condition that will result in my death within a relatively short time.
- I become unconscious and to a reasonable degree of medical certainty, will not regain consciousness.
- The likely risks and burdens of treatment outweigh the expected benefits.

Choice *To* Prolong Life

- **I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.**
- **(This would include CPR and Intensive Care.)**

Successful CPR depends on a few critical things

- First is timeliness- it should start immediately after a witnessed collapse. The first 6 minutes are critical.
- Second, the victim should have lungs, heart and blood vessels that are in good shape.
- Thirdly, quick access to a defibrillator is essential. The fibrillating heart needs to be shocked into normal rhythm as quickly as possible.

CPR Success Rates

- IN HOSPITAL CPR – 12% initial success rate, but only 1 in 3 survive to discharge, meaning ultimate success rate of 4%.

- OUT OF HOSPITAL ARREST - Huge Japanese study of 400,000 people — 18% survived procedure, but fewer than 2% survived 1 month with good or moderate cerebral performance.

- Likely not to survive if the patient has sepsis, metastatic cancer, dementia, chronic kidney disease, or is in the ICU.

Feeding Tubes

- Usually a temporary measure.
- They do not prevent aspiration pneumonia.
- They do not improve healing of pressure sores.
- They do not prolong life in advanced stage illness.

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More Considerations for End of Life Care

- Relief from pain
- Alzheimer's and Dementia Care
- Quality of Life / Quantity of Life

Once Advance Directives are Completed….

- Make copies for:
  - agent
  - primary physician
  - hospital
  - family and close friends
  - for home, and to carry with you.
- You may change advance directives at any time for any reason.
- It is likely that some of our choices will change as we age and if so, have the conversation again.

Making this a Legal Document

- Have your document notarized by a notary licensed in the state you live in.

OR

- Have your signature on the document witnessed by two people who are not health care providers to you, any of the agents, or beneficiaries of your estate.

Resources

- The Conversation: A Revolutionary Plan for End of Life Care
  By Angelo Volandes, M.D.
  The Conversation- You Tube video

- Being Mortal: Medicine and What Matters in the End
  By Atul Gawande, M.D.

- East Bay Advanced Care Planning
  http://www.eastbayacp.org/

- John Muir Health- health education, classes, support groups
  http://www.johnmuirhealth.com/