PROJECT ECHO: GERIATRIC EDUCATION SERIES

Advance Care Planning

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OBJECTIVES:

- **Objective 1**
  - Define Advance Care Planning and End of Life communication and its core elements

- **Objective 2**
  - Discuss barriers to Advance Care Planning and End of Life communication

- **Objective 3**
  - Be able to apply communication principles in order to initiate the conversation surrounding EOL
ADVANCE CARE PLANNING

- Process of discussion and conversation
- Allows opportunity to discuss and communicate care preferences with loved ones and care providers
- Informs and empowers the individual to control their current and future treatment
- Goal of preparing for care at the end of life
- Individual’s goals aligned with medical care they receive from beginning to end
POLST VS ADVANCE DIRECTIVE (AD)

- **POLST – Physician Order for Life Sustaining Treatment**
  - Called different things in different states (MOLST, MOST, POST......etc.)
  - Medical order for specific medical treatments you want during a medical emergency
  - Only for those with serious illness or advanced frailty near EOL

- **Advance Directive**
  - Called different things in different states (living will, health care power of attorney...etc.)
  - Legal document that provides guidance about types of treatments you may want to receive in case of a future, unknown medical emergency
  - A surrogate is named to make medical treatment decisions when you cannot speak for yourself

- All adults should have an Advance Directive, but not all should have a POLST Paradigm Form
POLST VS. ADVANCE DIRECTIVE

How An Advance Directive and POLST Form Work Together

All Adults

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Advanced Illness or Frailty (at any age)

Complete a POLST Form

Update POLST as Health Status Changes

Treatment Wishes Honored

Adapted with permission from California POLST Education Program
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WHY IS ACP IMPORTANT?

- Ensures individuals receive care that is consistent with their goals and values
  - Consistency between an individual’s wishes and the actual care he/she receives considered important aspects of both patient-centered care and quality EOL care

- Early conversations about ACP associated with better outcomes
  - Increases quality of life and peacefulness throughout the late stages of illness for both the individual and their families
  - Helps achieve a “good death”

- Can help close the gap of a fragmented health care system
ACP remains significantly underutilized
- U.S. – 1/3 have Advance Directive
- <50% of terminal patients have an Advance Directive

More than ¼ of all adults have given little to or no thought to their end of life wishes
- Fewer have put those wishes in writing or through conversation

End of Life (EOL) care continually being seen as inadequate
- Poor knowledge of an individual’s care preferences at EOL
- Individual’s cared for in a way they would not have chosen

Death and Mortality difficult to talk about
90% of people believe that talking with their loved ones about end-of-life care is important, but only 27% have actually done so.

60% of people think that making sure their family is not burdened by tough decisions is “extremely important,” but 56% have not communicated their end-of-life wishes.

80% say that if they were seriously ill, they would want to talk with their doctor about end-of-life care. Sadly, only 7% have had an end-of-life conversation with their doctor.

82% of the population thinks it is important to put their wishes in writing, but only 23% have actually done so.
Many barriers to initiating ACP
- ACP many times initiated too late

Decreased quality of life – Receiving too much care

“Most Life-sustaining treatments prolong the death process, not the living process”

“Victims of a larger system that encourages excessive treatment”
OLDER ADULTS AND CHRONIC ILLNESS

- Older adult (OA) population growing rapidly
  - 2006 – 12.4% of U.S. Population
  - 2030 – 45% of U.S. population

- Nevada’s OA population vs. U.S. OA population

- Rural areas to see largest increase in number of older adults (OA)

- Major shift in leading cause of death
  - Infectious disease and acute illness → chronic disease and degenerative illness

- 2 out of every 3 with multiple chronic conditions
  - 2010 – 75% with one or more chronic condition
  - Disabilities linked to chronic disease
RURAL COMMUNITIES

- Many challenges facing rural populations

- Rural vs. Urban communities
  - Lower self-rated health status
  - Many preventable disease risk factors
  - Higher rates of chronic disease
  - Limited access to health services

- Importance of making ACP more accessible
BARRIERS TO ADVANCE CARE PLANNING

- **Individual Characteristics:**
  - Lack of knowledge on Advance Care Planning
  - Discomfort in having conversation surrounding EOL care
  - Fear of upsetting family members and loved ones
  - Reluctance to think about future health care problems
  - Denial of current terminal illness
  - Belief that care provider should be responsible in initiating conversation
BARRIERS TO ADVANCE CARE PLANNING

- Care Provider Characteristics:
  - Age
  - Lack of knowledge surrounding Advance Care Planning
  - Lack of skill in dealing with EOL and initiating EOL conversations
  - Lack of skill in defining the right moment to initiate discussions
  - Attitudes – “job to cure people”
  - Fear of depriving hope
  - Damaging clinician – patient relationship
  - Belief that the individual is responsible in initiating conversation
“DOCTORS DIE DIFFERENTLY”

- Clinicians often forego same end-of-life treatments they offer to patients

- Knowledge about medicine and its limits

- Fears about litigation and getting into trouble

- Stigma of death = failure (clinicians and families)

- 64% of clinicians have created an AD compared to approximately 20% of the general public (2003)
In the past, no billing code for Advance Care Planning

Beginning January, 2016 – Advance Care Planning now billable
  - Coinsurance and deductible still applies unless with Annual Wellness Visit (modifier 33)

- CPT Code 99497 ($86)
  - 0-30 minutes

- CPT Code 99498 ($75)
  - Additional 30 minutes
  - If more time used, each additional 30 minutes billed separately using same code

Can occur at the same time as Annual Wellness visit or during another separate visit
START THE CONVERSATION

- Initiating the conversation found to be one of the greatest challenges

- Creating an environment allowing for ACP to take place

- Allow for open communication that is a life-long process

- We need to start having more conversations and increase discussion surrounding ACP

- ACP benefits the individual, their families and loved ones, as well as clinicians
The Conversation Project – theconversationproject.org

- Starter Kit – assists an individual or family members to prepare to have the conversation regarding EOL
- How to Talk with your Doctor guide
- Helps address key issues/questions
- Questions such as:
  - What matters most in life, and what matters at the EOL?
  - How much information an individual wants and how involved they want to be
  - What does an individual want friends, family, or care providers to know about EOL care
  - How to start the conversation
Step 1 Get Ready

You will have many questions as you get ready for the conversation. Here are two to help you get started:

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

Do you have any particular concerns that you want to be sure to talk about? (For example, making sure finances are in order; or making sure a particular family member is taken care of.)

REMEMBER:
- You don't need to have the conversation just yet. It's okay to just start thinking about it.
- You can start out by writing a letter—to yourself, a loved one, or a friend.
- You might consider having a practice conversation with a friend.
- Having the conversation may reveal that you and your loved ones disagree. That's okay. It's important to simply know this, and to continue talking about it now—not during a medical crisis.
- Having the conversation isn't just a one-time thing. It's the first in a series of conversations over time.

Step 2 Get Set

What's most important to you as you think about how you want to live at the end of your life? What do you value most? Thinking about this will help you get ready to have the conversation.

Now finish this sentence: What matters to me at the end of life is...
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)

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

WHERE I STAND SCALES
Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

As a patient, I'd like to know...

- 1: Only the basics about my condition and my treatment
- 2: The basics about my condition and treatment, plus a bit about my future care
- 3: My basic condition and treatment plus a plan for my care in the next few years
- 4: All the details about my condition and treatment
- 5: All the details about my condition and treatment, plus how I want to be involved in the decision-making

As doctors treat me, I would like...

- 1: My doctors to do what they think is best
- 2: A say in some of the decisions
- 3: A say in most decisions
- 4: To have a say in every decision
- 5: All the details about my condition and treatment
Step 3 Go

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

**MARK ALL THAT APPLY:**

1. **WHO do you want to talk to?**
   - □ Mom
   - □ Dad
   - □ Child/Children
   - □ Partner/Spouse
   - □ Sister/Brother
   - □ Faith leader (Minister, Priest, Rabbi, Imam, etc.)
   - □ Friend
   - □ Doctor
   - □ Caregiver
   - □ Other: ____________________________

2. **WHEN would be a good time to talk?**
   - □ The next holiday
   - □ Before my child goes to college
   - □ Before my next trip
   - □ Before I get sick again
   - □ Before the baby arrives
   - □ The next time I visit my parents/adult children
   - □ At the next family gathering
   - □ Other: ____________________________

3. **WHERE would you feel comfortable talking?**
   - □ At the kitchen table
   - □ At a favorite restaurant
   - □ In the car
   - □ On a walk
   - □ Sitting in a park
   - □ At my place of worship
   - □ Other: ____________________________

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

**How to start**

Here are some ways you could break the ice:

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

**What to talk about:**

- When you think about the last phase of your life, what’s most important to you? How would you like this phase to be?
- Do you have any particular concerns about your health? About the last phase of your life?
- What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*
- Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you’re not able to? *(This person is your health care proxy.)*
- Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?
- Are there any disagreements or family tensions that you’re concerned about?
- Are there important milestones you’d like to be there for, if possible? *(The birth of your grandchild, your 80th birthday)*
Congratulations! You have had “the conversation” — hopefully, the first of many. You can use the following questions to collect your thoughts about how your first talk went, and to think about what you’d like to talk about in future conversations.

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

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

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

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

Now that you have had the conversation, you’re ready to think about completing two important legal documents to make sure your wishes are clearly stated — and respected when the time comes.

☐ Choose a Health Care Proxy

A health care proxy (also known as a durable power of attorney for health care) is a legal document in which you appoint another person (a proxy or agent) to express your wishes and make health care decisions for you if you cannot speak for yourself. Choose someone who knows your wishes well — a person you trust to speak for you if you’re not able to speak for yourself.

☐ Complete an Advance Directive

An Advance Directive, also known as a Living Will, is a legal document in which you state your wishes regarding end-of-life medical care — including the types of treatments you do and do not want — in case you are no longer able to make decisions or communicate your wishes. (Note: This is different from your Last Will and Testament, which is used to distribute assets.)
Ariadne Labs - https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

- More care provider-focused – Serious Illness Conversation Guide
- Steps 1-6 in how to start the conversation and document it
  - Set up
  - Assess
  - Share
  - Explore
  - Close
- Provides “patient-tested language” with each step
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<th>CONVERSATION FLOW</th>
<th>PATIENT-TESTED LANGUAGE</th>
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| 1. *Set up the conversation*  
  Introduce the idea and benefits  
  Ask permission | “I’m hoping we can talk about where things are with your illness and where they might be going — *is this okay?*” |
| 2. *Assess illness understanding and information preferences* | “What is your *understanding* now of where you are with your illness?”  
  “How much *information* about what is likely to be ahead with your illness would you like from me?” |
| 3. *Share prognosis*  
  Tailor information to patient preference  
  Allow silence, explore emotion | **Prognosis:**  
  “I’m worried that time may be short.”  
  or “This may be as strong as you feel.” |
| 4. *Explore key topics*  
  Goals  
  Fears and worries  
  Sources of strength  
  Critical abilities  
  Tradeoffs  
  Family | “What are your most important *goals* if your health situation worsens?”  
  “What are your biggest *fears and worries* about the future with your health?”  
  “What gives you *strength* as you think about the future with your illness?”  
  “What *abilities* are so critical to your life that you can’t imagine living without them?”  
  “If you become sicker, *how much are you willing to go through* for the possibility of gaining more time?”  
  “How much does your *family* know about your priorities and wishes?” |
| 5. *Close the conversation*  
  Summarize what you’ve heard  
  Make a recommendation  
  Affirm your commitment to the patient | “*It sounds like* _________ is very important to you.”  
  “Given your goals and priorities and what we know about your illness at this stage, I *recommend*...”  
  “We’re in this together.” |
| 6. *Document your conversation* | |
TOOLS/RESOURCES

- PREPARE – [https://prepareforyourcare.org](https://prepareforyourcare.org)
  - Step-by-step process to assist in starting the conversation
  - Guides an individual through the process of thinking, reflecting and communicating, to better prepare for AD completion
  - Provides clear guidance through text and short videos
  - Helps to answer key questions - Steps 1-5:
    - Choose a medical decision maker
    - Decide what matters most in life
    - Choose flexibility for your decision maker
    - Tell others about your medical wishes
    - Ask doctors the right questions
PREPARE
A program to help you make medical decisions for yourself and others

Step 1: Choose a Medical Decision Maker
Choose someone you trust to help make decisions for you in case you become too sick to make your own decisions.

A good decision maker will:
- ask doctors questions
- respect your wishes

If there is no one to choose right now, do Steps 2, 4, and 5.

How to say it:
“If I get sick in the future and cannot make my own decisions, would you work with my doctors and help make medical decisions for me?”

OR

“I do not want to make my own medical decisions. Would you talk to the doctors and help make medical decisions for me now and in the future?”

Step 2: Decide What Matters Most in Life
This can help you decide on medical care that is right for you.

Five questions can help you decide what matters for your medical care:

1. What is most important in life? Friends? Family? Religion?
2. What experiences have you had with serious illness or death?
3. Can you imagine health experiences worse than death?
4. Is it most important to you to:
   - Live as long as possible, even with pain or disability?
   - Or, try treatments for a period of time, but stop if you are suffering?
   - Or, focus on quality of life and comfort, even if your life is shorter?
5. Have you changed your mind about what matters most in your life over time?
Step 3: Choose Flexibility for Your Decision Maker

**Flexibility** gives your decision maker leeway to work with your doctors and possibly change your prior medical decisions if something else is better for you at that time.

**How to say it:**

**Total Flexibility:**
“I trust you to work with my doctors. It is OK if you have to change my prior decisions if something is better for me at that time.”

**Some Flexibility:**
“It is OK if you have to change my prior decisions. But, there are some decisions that I never want you to change. These decisions are…”

**No Flexibility:**
“Follow my wishes exactly, no matter what.”

Step 4: Tell Others About Your Medical Wishes

This will help you get the medical care you want.

**How to say it:**

**To your decision maker and doctors:**
“This is what is most important in my life and for my medical care…”

**To your doctor and family and friends:**
“I chose this person to be my decision maker and I want to give them (TOTAL, SOME, or NO) flexibility to make decisions for me.”

Your doctors can help you put your medical wishes on an advance directive form.

Step 5: Ask Doctors the Right Questions

- Write down questions ahead of time.
- Bring someone with you.
- Tell doctors at the **start of the visit** if you have questions.

**How to say it:**

If your doctor recommends something, ask about the:

- **Benefits** – the good things that could happen
- **Risks** – the bad things that could happen
- **Options** for different kinds of treatment
- **What your life will be like** after treatment

Make sure you understand:
“What I’m hearing you say is… Is this right?”

**Your Action Plan**

By __________________________
I will __________________________

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Aging with Dignity – Five Wishes -

“Changing the way we talk about and plan for care at the end of life”

Resource that can be utilized by individuals and families, as well as different organizations to identify their 5 wishes
- The person I want to make care decisions for me when I can’t
- The kind of medical treatment I want or don’t want
- How comfortable I want to be
- How I want people to treat me
- What I want my loves ones to know

Legally meets requirements for an AD in 42 US states and the District of Columbia
- Otherwise is attached to state’s required forms
- 2 witnesses
WISH 1
The Person I Want To Make Health Care Decisions For Me When I Can’t Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

• My attending or treating doctor finds I am no longer able to make health care choices, AND
• Another health care professional agrees that this is true.

If my state has a different way of finding that I am not able to make health care choices, then my state’s way should be followed.

The Person I Choose As My Health Care Agent Is:

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If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

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<th>Second Choice Name</th>
<th>Third Choice Name</th>
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Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they may be emotionally involved. Sometimes they are the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be at least 18 years or older (in Colorado, 21 years or older) and should not be:

• Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
• An employee or spouse of an employee of your health care provider.
• Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

print your name

birthday
WISH 2
My Wish For The Kind Of Medical Treatment
I Want Or Don’t Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What “Life-Support Treatment” Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.

If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below.

I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a Do Not Resuscitate form or bracelet. Many states require a person to have a Do Not Resuscitate form filled out and signed by a doctor. This form lets ambulance personnel know that you don’t want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a Do Not Resuscitate form filled out.

WISH 3
My Wish For How Comfortable I Want To Be.
(Please cross out anything that you don’t agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.

WISH 4
My Wish For How I Want People To Treat Me.
(Please cross out anything that you don’t agree with.)

- I wish to have people with me when possible.
- I wish to have someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don’t seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.

- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.
WISH 5
My Wish For What I Want My Loved Ones To Know.
(Please cross out anything that you don’t agree with.)

• I wish to have my family and friends know that I love them.

• I wish to be forgiven for the times I have hurt my family, friends, and others.

• I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.

• I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.

• I wish for all of my family members to make peace with each other before my death, if they can.

• I wish for my family and friends to thank about what I was like before I became seriously ill. I want them to remember me this way after my death.

If anyone asks how I want to be remembered, please say the following about me:

______________________________________________________________

If there is to be a memorial service for me, I wish for this service to include the following
(list music, songs, readings or other specific requests that you have):

______________________________________________________________

(If you have any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

______________________________________________________________

Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, __________________________, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature: __________________________________________________________

Address: __________________________________________________________

Phone: __________________________ Date: __________________________

Witness Statement - (2 witnesses needed):
I, the witness, declare that the person who signed or acknowledged this form (hereinafter “person”) is personally known to me, that he/she signed or acknowledged this Health Care Agent and/or Living Will form(s) in my presence and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

• The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,

• The person’s health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,

• An employee of the person’s health care provider.

(Some states may have fewer rules about who may be a witness. Unless you know your state’s rules, please follow the above.)

Signature of Witness #1: __________________________

Printed Name of Witness: __________________________

Address: __________________________________________

Phone: __________________________

Signature of Witness #2: __________________________

Printed Name of Witness: __________________________

Address: __________________________________________

Phone: __________________________

Notarization - only required for residents of Missouri, North Carolina, South Carolina and West Virginia

• If you live in Missouri, only your signature should be notarized.

• If you live in North Carolina, South Carolina or West Virginia,

On this ______ day of ________, 20____, the said ________________________________,

______________________________________________________________,

______________________________________________________________,

known to me (or satisfactorily proven) to be the person named in the

foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: __________________________

Notary Public
### SANFORD CENTER OF AGING

**Conversation included usage of Cardiopulmonary Resuscitation (CPR):**
- [ ] Attempt CPR
- [ ] Do Not Attempt CPR

**Medical Interventions Discussed:**
- [ ] Comfort Measures Only
- [ ] Limited Medical Interventions
  - [ ] Administer antibiotics by mouth as necessary
  - [ ] Antibiotics intravenously (IV) as necessary

**Other Instructions:**

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**Artificially Administered Fluids and Nutrition**

**Feeding Tube:**
- [ ] yes
- [ ] no

**IV Fluids:**
- [ ] yes
- [ ] no

**Other Instructions:**

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**Other Limitations of Medical Interventions:**

**Hospitalization:**
- [ ] yes
- [ ] no

**Laboratory Work:**
- [ ] yes
- [ ] no

**Hyperalimentation:**
- [ ] yes
- [ ] no

**Hemodialysis:**
- [ ] yes
- [ ] no

**Other Instructions:**

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**Full Treatment:**
- [ ] yes
- [ ] no

**Other Instructions:**

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5 QUESTIONS TO ASK AT END OF LIFE

- Dr. Atul Gawande, surgeon and writer

- What we need to know:
  - 1. What is your understanding of where you are and of your illness?
  - 2. Your fears or worries for the future
  - 3. Your goals and priorities
  - 4. What outcomes are unacceptable to you? What are you willing to sacrifice or not?
  - 5. What would a good day look like?

- Assists in understanding what the goal really is — what are you really fighting for?
One Conversation Can make All the Difference.....
REFERENCES


PREPARE. (2012). Retrieved from [https://prepareforyourcare.org](https://prepareforyourcare.org)

