My Voice – My Decisions
An Advance Care Planning Guide

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Advance Care Planning

Advance Care Planning is for everyone not just the elderly. According to the Coalition for Compassionate Care of California the advance care planning discussion starts at age 18 and continues for the rest of your life. As you go through life we may face medical crises or serious injuries and may not have the ability to express our healthcare wishes.

The advance care planning process allows us to explore and express your healthcare wishes including identifying someone who would act on your behalf if you are unable to make your wishes known. Once you have explored your wishes, you can document those wishes on an Advance Healthcare Directive form, which can be updated at any time as your life and wishes change.

A Physician Order for Life-Sustaining Treatment (POLST) is another option in which you can document your healthcare wishes. This document is usually completed by patients who are terminally ill or frail and is signed by the patient’s physician.

The purpose of this guide is to help you explore, express and document your wishes. This guide will only focus on completing the Advance Healthcare Directive.

\[ \text{Wishes Explored} + \text{Wishes Expressed} = \text{Wishes Honored} \]

Exploring Healthcare Wishes
- Who would you select as your healthcare agent to speak on your behalf and ensure that your wishes are honored?
- Where and how would you like to spend the last days of your life?
- What are your faith, spiritual, religious or cultural wishes that you want your family and healthcare provider to know about?
- What healthcare options would you like at the end-of-life? Would you want “everything” done, “nothing at all” or something in the middle?

Expressing Wishes
- You can document your wishes on an Advance Healthcare Directive form.
- You can inform your healthcare provider of your wishes.
- You can ensure that a copy of your Advance Healthcare Directive is included in your health records.

Honoring Wishes
- When the time comes, your family and healthcare providers will use the Advance Healthcare Directive to guide the decision making process on your behalf.
- Your voice is heard and honored.

What are the steps of Advance Care Planning?
- Exploring your wishes
- Having a conversation with your family about your wishes
- Selecting a healthcare agent who will ensure that your wishes are honored
- Completing the Advance Healthcare Directive form
- Ensuring your healthcare agent is aware of your wishes and has a copy of your Advance Healthcare Directive
- Informing your healthcare providers and providing them with a copy of your Advance Healthcare Directive
Common Words/Definitions

Advance Healthcare Directive – A legal document that expresses the patient’s healthcare wishes and identifies a person to act on the patient’s behalf if they are unable to communicate their wishes. This document should be completed by anyone 18 years or older and can be updated as the patient’s life and wishes change. This document has to be witnessed or notarized.

Artificial nutrition (feeding tube) and fluids – It is common that dying patients have little to no appetite as the body does not require nutrition or fluids during the end-of-life process. However, if the patient chooses this option the artificial nutrition and fluids are provided intravenously (IV) or through a tube down the nose to the stomach or a tube surgically placed into the stomach. Complications include discomfort and water build-up in the legs and lungs.

Conservator – Is a person who has been court-appointed and been given the authority to make healthcare decisions for a patient.

CPR or cardiopulmonary resuscitation – Cardio = heart, Pulmonary = lungs, Resuscitation= to revive. When a person’s heart stops beating or respiration stops, CPR is automatically started unless there are instructions not to do so, known as DNR (Do Not Resuscitate). CPR may involve pressing hard on the chest to keep the blood pumping, providing electrical shocks to start the heart and administering medications through the veins to restore the heart rate and breathing. Some potential risks of CPR include broken ribs, punctured lungs, breastbone fracture, bruising, burns, damage to the windpipe and/or damage to the mouth. The success rate of CPR tends to be low and patients do not return to the same quality of life.

Dialysis – This option is offered when the patient’s kidneys are no longer functioning. A dialysis machine cleans your blood if your kidneys stop working. Dialysis usually occurs 3 times per week and can be permanent. At the end of life dialysis does not cure illness or prevent death.

Healthcare Agent – The healthcare agent is someone the patient selects who is 18 years or older, a family member or a friend and is able to honor the patient’s healthcare wishes. The healthcare agent cannot be your healthcare provider (physician or member of the hospital staff).

Hospice – Hospice is a specialized form of healthcare which is designed to alleviate physical, emotional, social and spiritual discomfort of an individual who is experiencing the last phase of life due to a terminal disease. Hospice also provides supportive care to the patient’s family/caregivers through the use of a highly trained multidisciplinary staff.

Palliative Care – Palliative care aims to relieve suffering and improve the quality of living and end of life. It focuses on comfort versus cure. It can be delivered concurrently with life-prolonging care or as the main focus of care. It begins at the time of diagnosis or any point in an illness that is life-threatening or debilitating and continues into the family bereavement period. The services continue as long as the conditions and their treatments pose significant burdens to the patient and patient’s family until a reversal is achieved or death results.

Respirator or ventilator (breathing machine) – This treatment option allows a machine to breathe for the patient. A breathing tube is placed down the throat and into the lungs. That tube is attached to a machine which pumps air into the lungs and breathes for the patient. The patient is not able to talk when the machine is on. Complications include lung infections, bleeding, damage to vocal cords, and damage to the throat.

Transfusion of Blood Products – To put blood products in your veins.
Step One – Selecting a Healthcare Agent

The healthcare agent is someone you select who is 18 years or older, a family member or a friend and is able to honor your healthcare wishes. Your healthcare agent cannot be your healthcare provider (physician or member of the hospital staff).

Consider the following in selecting a Healthcare Agent:
- Someone you trust, like a family member or friend
- Someone who knows you well and is able to honor and respect your wishes
- Someone who is able to handle difficult decisions in a calm manner
- Someone who is able to communicate with your healthcare team, and family or significant others

Common decisions that the Healthcare Agent may make include:
- Deciding where you will receive care and who will provide it
- Deciding if blood and/or blood products will be provided to you
- Choosing medical treatments that may affect your quality of life
- Speaking with the healthcare team regarding your treatment options
- Speaking with the healthcare team regarding discharge options and the initiation of funeral or burial arrangements after you die
- Ensuring that your healthcare wishes are honored by the healthcare team and family

Step Two – Exploring Healthcare Wishes

Where would you like to spend the last days of your life?
- Home with family and friends
- In a community facility with family and friends (for example, nursing facility, a hospice home, etc.)
- In the hospital with family and friends
- Other __________________________

How would you like to spend the last days of your life?
- To take care of unfinished business
- To have dignity and respect
- To have my pastor/rabbi/faith leader with me
- To be kept clean
- To be involved in all decisions regarding my care
- To discuss my feelings and emotions
- To be around my pets
- To be listening to music
- To be comfortable, free from pain
- To be with family and friends
- Not be connected to machines
- Not to die alone
- Not being a burden to my family
- To have the opportunity to say goodbye to family and friends
- Praying
- Other __________________________

What are your faith, spiritual, religious or cultural wishes that you want your family and health care provider to know about?

Please list __________________________
Consider the following end-of-life options:

*Let’s put this into perspective as we begin this section.* You are not being asked about routine or urgent medical care. You are being asked to consider choices when you are at the end-of-life (unable to survive without life support machines).

So you have to ask yourself:

*If I am unable to recover, do I want to be kept alive on life support machines?*

**Option One: Allow Natural Death** - If it is determined that the treatment will be of no benefit and may cause pain or discomfort, and you select this option on your Advance Healthcare Directive, all treatment will be stopped and you will be allowed a natural death.

**Option Two: Choice To Prolong Life** - Your healthcare providers will do everything possible to keep you alive if your Advance Healthcare Directive indicates that you have chosen this option. However, there are limits to what the healthcare team can provide especially if they feel it will not provide you with meaningful results and the treatment will cause you to have pain and discomfort.

With Option Two – Choice To Prolong Life, listed below are additional treatments that you may request. Please see definitions on page 3.

- Artificial nutrition (tube feeding) and fluids
- Cardiopulmonary resuscitation (CPR)
- Dialysis
- Respirator or ventilator
- Transfusion of blood products

With either option, the healthcare team will meet with your healthcare agent to discuss options and seek guidance. We want to ensure that your voice is heard and your wishes are honored.

**List any other wishes or important information:**

Please list ____________________________________________

**Step Three – Expressing Wishes**

Now that you have explored your wishes, it is time to document those wishes on an Advance Healthcare Directive. As you start to complete your Advance Healthcare Directive, please remember the choices you made above.

If you need assistance you can always call:

PIH Health Hospital - Whittier Pastoral Services  562.698.0811 Ext. 12500
Social Work Services  562.698.0811 Ext. 12453

PIH Health Hospital - Downey Patient Planning and Review/Social Services  562.904.5313

PIH Health Physicians Patient Services Representatives  562.947.8478 Ext. 81299
Social Services - Ambulatory  562.947.8478 Ext. 82513

Once you complete your Advance Healthcare Directive, please remember to:

- Inform your healthcare agent
- Inform your family
- Inform your healthcare providers
**Additional Resources**

**Advance Health Care Directive Registry – California**
916.653.3984
sos.ca.gov/ahcdr

**Aging With Dignity and Five Wishes**
888.594.7437
agingwithdignity.org

**American Bar Association**
800.285.2221
americanbar.org/aba.html

**American Hospital Association**
800.424.4301
Putilinwriting.org

**California Hospital Association**
916.443.7401
Calhealth.org

**California Medical Association**
800.786.4262
cmanet.org

**Caring Connections**
800.658.8898
caringinfo.org

**Coalition for Compassionate Care of California**
916.489.2222
coalitionccc.org and capolst.org

**The Conversation Project**
theconversationproject.org

**Hospice Association of America**
202.546.4759
nahc.org/HAA

**Prepare for Your Care**
415.735.1106
prepareforyourcare.org

**U.S. Department of Veterans Affairs**
losangeles.va.gov/patients/advance.asp

Notes: ________________________________

____________________________________

____________________________________

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____________________________________
ADVANCE HEALTHCARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as your healthcare agent to make healthcare 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 healthcare agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your healthcare agent may not be an operator or employee of a community care facility, a residential care facility where you are receiving care, your supervising healthcare provider or an employee of the healthcare 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 healthcare 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 healthcare 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 healthcare, including cardiopulmonary resuscitation.
5. Donate your organs, skin or tissue; authorize an autopsy and direct disposition of remains.

However, your healthcare agent will not be able to commit you to a mental health facility, 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 healthcare, whether or not you appoint a healthcare 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 comfortable allowing your healthcare agent to make end-of-life decisions for you, you do not need to fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other healthcare providers you may have, to any healthcare institution at which you are receiving care, and to any healthcare agents you have named. You should talk to the person you have named as healthcare 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 Healthcare Directive or replace this form at any time.
Print Name _________________________________ Date of Birth ____________

(patient)

PART 1
POWER OF ATTORNEY FOR HEALTHCARE

DESIGNATION OF HEALTHCARE AGENT
I designate the following individual as my agent to make healthcare decisions for me:

Name of individual you choose as a healthcare agent ________________________________

Address _______________________________________________________________________

Telephone Numbers Mobile ___________________ Home __________________
Work _____________________________

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make healthcare decisions for me, I designate as my first alternate agent:

Name of individual you choose as first alternate healthcare agent ________________________________

Address _______________________________________________________________________

Telephone Numbers Mobile ___________________ Home __________________
Work _____________________________

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 healthcare decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate healthcare agent ________________________________

Address _______________________________________________________________________

Telephone Numbers Mobile ___________________ Home __________________
Work _____________________________
HEALTHCARE AGENT’S AUTHORITY
My healthcare agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, except as I state here:

(Initial here)

WHEN HEALTHCARE AGENT’S AUTHORITY BECOMES EFFECTIVE
My healthcare agent’s authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions.

(Initial here)

OR

My agent’s authority to make healthcare decisions for me takes effect immediately.

(Initial here)

AGENT’S OBLIGATION
My healthcare agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, 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 healthcare 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 POST DEATH AUTHORITY
My healthcare 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:

(Initial here)

NOMINATION OF CONSERVATOR
If a conservator 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 HEALTHCARE

If you are comfortable allowing your healthcare agent to make end-of-life decisions for you, you do not need to fill out Part 2 of this form. 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 healthcare providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with my choice below:

Allow Natural Death *(Initial applicable items):*

___ If I have an incurable and irreversible condition that will result in my death, I choose NOT to prolong my life.

___ If I will not regain consciousness; or regain meaningful quality of life, I choose NOT to prolong my life.

___ If the likely risks and burdens of treatment would outweigh the expected benefits, I choose NOT to prolong my life.

OR

Choice To Prolong Life *(Initial applicable items):*

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

Initial the applicable treatments that you would want:

___ Artificial Nutrition (feeding tube) and Fluids ___ Dialysis

___ CPR or Cardiopulmonary Resuscitation ___ Respirator or Ventilator

___ Transfusion of Blood Products

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)*

RELIEF FROM PAIN
I direct that treatment for alleviation of pain or discomfort be provided at all times except as I state in the following space:

______________________

*(add additional sheets if needed)*
PART 3
DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death
   *(Initial applicable item)*
   ___ I give any needed organs, tissues or parts, OR
   ___ I do NOT authorize the donation of any organs, tissues or parts, OR
   ___ I give the following organs, tissues or parts only __________________________

II. If you wish to donate organs, tissues, or parts, you must complete II and III.
   My gift is for the following purposes:
   *(Initial applicable items)*
   ___ Transplant     ___ Therapy     ___ Research     ___ Education

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.
   *(Initial applicable items)*
   ___ Yes  ___ No My donated skin may be used for cosmetic purposes
   ___ Yes  ___ No My donated tissue may be used for applications outside the United
   States
   ___ Yes  ___ No My donated tissue may be used by for-profit tissue processors and
distributors

PART 4
DESIGNATION OF PRIMARY PHYSICIAN(S) (OPTIONAL)

I designate the following physician as my primary physician:

Print Name ____________________________  Telephone __________________

(name of physician)

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 alternate primary physician:

Print Name ____________________________  Telephone __________________

(name of physician)

Address ________________________________
PART 5
SIGNATURE
Sign and date the form here
This form will not be valid unless it is signed by you AND
  • by two qualified adult witnesses, OR
  • acknowledged before a notary public

Date ____________________ Time ___________ AM/PM
Signature ____________________ Print Name ____________________
Address ____________________

WITNESS STATEMENT
Note: One of the witnesses cannot be related to the individual executing this Advance Healthcare Directive, please read the Additional Statement of Witness below.

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Healthcare 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 Healthcare 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 Healthcare Directive, and (5) that I am not the individual’s healthcare provider, an employee of the individual’s healthcare 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
Date ____________________ Time ___________ AM/PM
Signature ____________________ Print Name ____________________
Address ____________________ Telephone ____________________

SECOND WITNESS
Date ____________________ Time ___________ AM/PM
Signature ____________________ Print Name ____________________
Address ____________________ Telephone ____________________

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 Healthcare 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 ____________________ Print Name ____________________
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.

(Civil Code § 1189)

NOTARY PUBLIC

State of California
County of __________________________

On ______________ 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.

Signature __________________________________________
(Notary Public)

PLACE NOTARY SEAL ABOVE

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 ________________________________ Print Name ________________________________
(patient advocate or ombudsman) (patient advocate or ombudsman)

Address ________________________________