



My Voice – My Decisions

An Advance Care Planning Guide

PIH Health

12401 Washington Blvd
Whittier, CA 90602
P: 562.698.0811
TDD: 562.696.9267
www.pihhealth.org

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.

Wishes Explored + Wishes Expressed = 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 health care 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 be with family and friends |
| • To have dignity and respect | • Not be connected to machines |
| • To have my pastor/rabbi/faith leader with me | • Not to die alone |
| • To be kept clean | • Not being a burden to my family |
| • To be involved in all decisions regarding my care | • To have the opportunity to say goodbye to family and friends |
| • To discuss my feelings and emotions | • Praying |
| • To be around my pets | • Other _____ |
| • To be listening to music | _____ |
| • To be comfortable, free from pain | _____ |

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 3 – 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:

- Pastoral Services at 562.698.0811 Ext. 12504
- Social Work Services at 562.698.0811 Ext. 12453

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
Putitinwriting.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: _____



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 _____
(patient)

Date of Birth _____

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:

(add additional sheets if needed)

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:

(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 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 _____ (patient) Print Name _____ (patient)

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 _____ (first witness) Print Name _____ (first witness)

Address _____ Telephone _____

SECOND WITNESS

Date _____ Time _____ AM/PM

Signature _____ (second witness) Print Name _____ (second witness)

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 _____ (witness) Print Name _____ (witness)



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.
(Civil Code Section 1189)

Witness my hand and official seal.

Signature _____
(notary)

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 _____