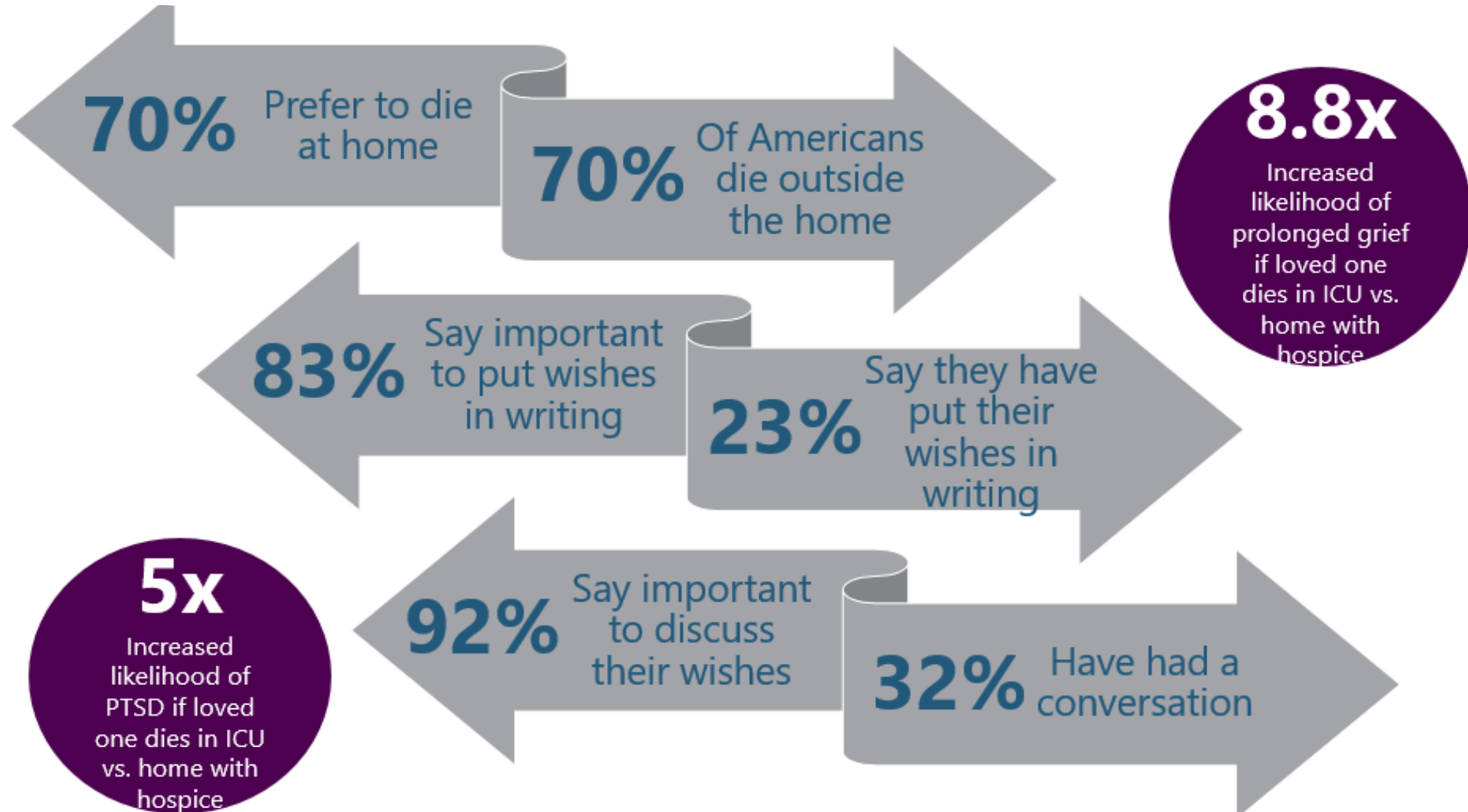


Understanding Advance Care Planning and Advance Directives



WHY DO I NEED TO DO THIS?

Planning is bringing the future into the present so that you can do something about it now. Alan Lakein



What is Advance Care Planning

Durable Power of
Attorney-Healthcare &
Healthcare Directive

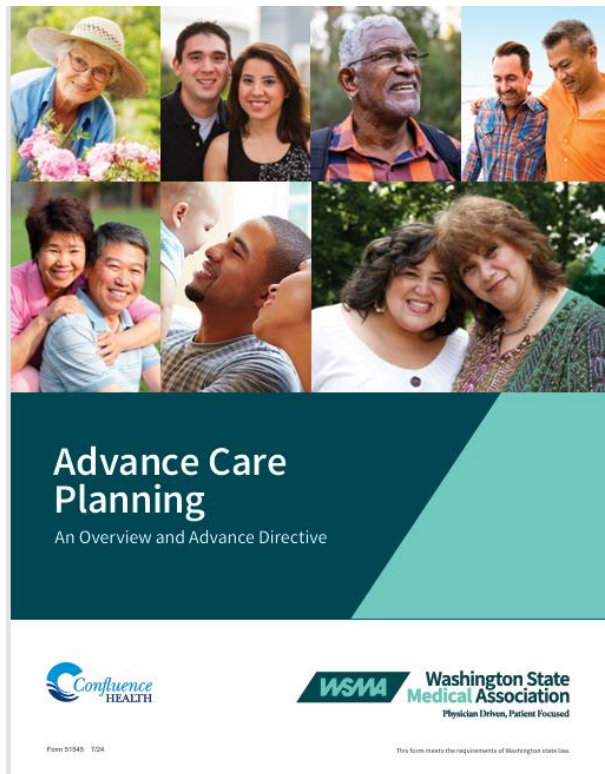


Advance Care Planning Documentation

	Advance Directives		POLST
	Durable Power of Attorney for Health-Care (DPOA-HC)	Health Care Directive (i.e., Living Will)	
What is it?	Legal document	Legal document	Medical orders
What does it do?	Names health care agent. The DPOA-HC also prepares the health care agent by including an individual's goals, values, and preferences.	In addition to documenting goals, values and preferences, the HCD specifically addresses whether to withhold or withdraw life-sustaining treatment at the end of life.	Provides actionable orders on CPR and Medical Interventions.
Who is it for?	Any adult with capacity.	Any adult with capacity.	Individuals with a serious life-limiting medical condition, regardless of capacity.
Who can complete?	Only the individual.	Only the individual.	Individuals or their legal medical decision maker with MD, DO, PA-C, ARNP
How is it used?	Used primarily in a hospital setting when individual does not have capacity.	Used primarily in a hospital setting when individual does not have capacity.	Used by emergency medical services in out-of-hospital emergencies; provides guidance in hospital.

How do I get the paperwork?

Advance Care Planning | Confluence Health



Get help or complete on your own

- We can help you complete your Advance Directive and Power of Attorney for Health Care at no cost.

OR

- You can access or download the form and complete on your own.
- To have your wishes honored BE sure to confirm it is in your medical record.

Designating a Durable Power of Attorney for Healthcare is **VERY** important



Who Makes a Good
Power of Attorney for
Healthcare-DPOA-HC
(or Health Care Agent)

- A good DPOA-HC (or health care agent) should:
 - **Agree** to the role
 - **Talk** about your goals, values, and preferences
 - **Follow** your decisions, even if they don't agree
 - **Make** decisions in difficult moments

Advance Directive: Durable Power of Attorney for Health Care

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My information:

FULL NAME: _____ PRONOUNS (optional): _____
(i.e., he/she/they)

ADDRESS, CITY, STATE, ZIP: _____

DATE OF BIRTH: / /
(mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: _____ PRONOUNS (optional): _____

RELATIONSHIP: _____ BEST PHONE: () _____ ALTERNATE PHONE: () _____

ADDRESS, CITY, STATE, ZIP: _____

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First alternate

FULL NAME: _____ PRONOUNS (optional): _____

RELATIONSHIP: _____ BEST PHONE: () _____ ALTERNATE PHONE: () _____

ADDRESS, CITY, STATE, ZIP: _____

Second alternate

FULL NAME: _____ PRONOUNS (optional): _____

RELATIONSHIP: _____ BEST PHONE: () _____ ALTERNATE PHONE: () _____

ADDRESS, CITY, STATE, ZIP: _____



PRINTED NAME: _____

DATE OF BIRTH: / /
(mm/dd/yyyy)

Tips for completing the Confluence Health document

This is YOUR document
 YOUR words
 YOUR choices

It's best to name a minimum of two people. Living nearby is helpful, but not required.

Accurate phone numbers are essential

The 1st person listed is who we will call 1st

p.s.

A Healthcare Agent is the same as Power of Attorney for Healthcare



Why Should I Choose My DPOA-HC (or Health Care Agent)

- If a health care agent isn't named...
- **It's already decided** in the Washington State Medical Decision Maker Hierarchy RCW chapter 7.70.065

PREPARING A HEALTH CARE AGENT

Consider sharing the following. Be specific. Add pages if needed. Cross out any sections you prefer not to complete.

What matters most to me?

This section helps you think about what matters most to you. This information can guide the people who matter to you—like your health care agent and loved ones—to make health care decisions for you if you cannot make them yourself.

- What do you love to do, mentally and physically, that you can't imagine living without (e.g., being able to care for yourself, staying in your own home, knowing who you are and who you are with, etc.)?

- What do you value most in your life? _____

What are my beliefs, preferences, and practices?

It is important for the people who matter to you—like your health care agent and loved ones—and your health care team to know about your beliefs, preferences, and practices.

- What provides you support, comfort, and strength during difficult times (e.g., touch, music, temperature, environment, who is in the room, etc.)?

- Are there medical treatments you would want or not want? (e.g., blood transfusion, pain management, artificial feeding, etc.)?

- Do you have specific beliefs that you would like to guide your medical treatment? _____

I would want the following person(s) contacted to support my beliefs, preferences, and practices: (They will not have power to make health care decisions.)

NAME: _____ ROLE: _____

PHONE: () _____ ORGANIZATION: _____



WSMA Washington State
Medical Association
Physician Driven, Patient Focused

Form 51545 7/24

PRINTED NAME: _____

DATE OF BIRTH: / /
(mm/dd/yyyy)

REV05/2024

This page gives your designated Healthcare Agent ideas or reminders about what is important to you.

This helps them make decisions for you in times of crisis.

What or who helps you cope?

This is not about CPR and Life Support
(that's on the next page)

i.e., maybe your church has set beliefs, maybe you always want a second opinion, or always trust a certain person or don't want care that will take you out of your area or...

If a section does not apply to you—just draw a line through it

PREPARING A HEALTH CARE AGENT

In answering the following questions, I am sharing my health care preferences. If I cannot make health care decisions for myself, I want my health care agent to use this information to guide their decisions. I understand that this information can guide my care, but it might not be possible to follow my wishes exactly in every situation.

CPR: What are my wishes?

Standard care in Washington state is to provide cardiopulmonary resuscitation (CPR) to people if their heart and breathing stop. This section can guide your health care agent and health care team on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as "code status").

If I am hospitalized and my heart and breathing stop:

- ☐ I want CPR attempted.
- ☐ I want CPR attempted, unless there has been a change in my health, and I have:
 - Little chance of living a life that aligns with the goals and values I have stated in this form and/or discussed with my health care agent; or
 - A disease or injury that cannot be cured, and I am likely to die soon; or
 - Little chance of survival even if my heart is started again.
- ☐ I do not want CPR attempted. I want to be allowed to die naturally. (Talk to your health care team about a POLST form.)

Life support: What are my wishes?

Your response below is intended to guide your health care agent. Answering this question does not make this form a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information on a health care directive, visit www.washingtonlawhelp.org or talk with your physician or health care team.

If I am so sick or injured that I am likely to die soon or am in a coma and unlikely to recover, I want my health care agent to:

- ☐ Use all life-support treatments to keep me alive even if there is little chance of recovery. I want to stay on life support.
- ☐ Continue to try all life-support treatments that my health care team thinks might help extend my life (you can give a time frame for how long to continue to try all life support – days/weeks/months/years: _____).
If the treatments do not work and there is little chance of living a life that aligns with my goals and values, I do not want to stay on life support. At that point, allow me to die naturally.
- ☐ Allow me to die naturally. I do not want to be on life support. If life-support treatments have been started, I want them to be stopped.
- ☐ I want my health care agent to decide for me.

Additional directions

If I am dying and my medical care, support system, and resources allow, my preference would be to die:

- ☐ At my home or the home of a loved one (with hospice if desired).
- ☐ In a medical facility.
- ☐ I do not have a preference.
- ☐ Other (please describe): _____

continued >

You may want to consult a medical professional if you are unsure on this section.

This means a medical professional will be responding quickly

However, IF you are already seriously ill, CPR might restart your heart but not improve other conditions that you would then be "living with"

If you decide you do not want CPR, contact your Dr. to discuss a POLST form (see next page)

Living on life support would likely mean you could not live at home or in your community

The next page on the document talks about CPR in the hospital- review this before deciding.

AN INITIATIVE OF  Washington State
Hospital Association

 **Foundation**
for Health Care Improvement

CPR GUIDE

This guide explains what CPR is. It helps you decide
if you want CPR attempted in a hospital or health care facility.

Talk to your doctor or health care professional about the benefits and risks that apply to you.

What is CPR?

Cardiopulmonary Resuscitation, or CPR, is a procedure that tries to restart your heart and breathing if they stop. If you receive CPR in a hospital, health care professionals will:

- use deep pushing on your chest to move the blood
- insert a breathing tube into your lungs to help get oxygen into your body
- use a defibrillator or automated external defibrillator (AED) to shock your heart
- use medications to try to restart your heart and help blood flow through your body

Will CPR work for you?

- CPR works best if your body is healthy and CPR is started right after your heart stops.
- CPR is not as successful if you are elderly or have a serious illness.
- National studies show that 18–30% of people who receive CPR in a hospital survive and are discharged. 28% of those who survive have significant neurological disability.
- National studies show that 2% of nursing home residents who receive out-of-hospital CPR survive.

What happens after CPR?

Most people who need CPR do not survive. If people do survive, some return to their current health state and others have new disabilities.

- You might need to stay on a ventilator (breathing machine) because of weakened lungs.
- You might have bruised or broken ribs from the chest compressions.
- You might have brain damage because your brain did not get enough oxygen.



What decisions can I make about CPR?

Your decision about whether you want CPR attempted in a hospital may fall into one of the following categories.

Yes I want CPR attempted if my heart and breathing stop.

Maybe I want CPR attempted if my heart and breathing stop, unless there has been a change in my health, and I have:

- Little chance of living a life that I find meaningful, as discussed with my health care agent; or
- A disease or injury that cannot be cured, and I am likely to die soon; or
- Little chance of survival even if my heart and breathing are started again.

No I do not want CPR attempted if my heart and breathing stop. I want to be allowed to die naturally.

Standard care in Washington state is to provide CPR to people if their heart and breathing stop—unless otherwise documented. Sharing your CPR wishes on an advance directive can guide your health care agent and health care professionals on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as “code status”).

Some people who choose not to receive CPR in a hospital also do not want CPR in other settings. In this situation you should ask your physician or health care professional about completing Portable Orders for Life-Sustaining Treatment (POLST). POLST is a medical order that communicates health care decisions to emergency responders and other medical professionals.

**It is important to talk to your health care agent, loved ones,
and health care professionals about your CPR wishes.**

*Additional resources can be found at www.wsma.org and www.wsha.org
including an advance directive to record and share your wishes.*

Additional directions *(continued)*

Additional information you want your health care agent, health care team, or others to know about your health care wishes. You may include a statement such as "At the time of my death I am/am not an organ donor and my wish is..." (e.g., cremation, burial, human composting, etc.). Note that your wishes for organ donation and plans for your remains may be documented separately.

AUTHORIZING A HEALTH CARE AGENT

Authority I give my agent: I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing members of the health care team; (d) changing my health care insurers; (e) signing a Portable Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to or placing me in another facility, private home, or other places; and (g) accessing my medical records and information.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: _____

DATE: _____

Witnesses or notary requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

OPTION 1 – TWO WITNESSES

Witness attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: _____

DATE: _____

NAME PRINTED: _____

WITNESS #2 SIGNATURE: _____

DATE: _____

NAME PRINTED: _____

OPTION 2 – NOTARY

STATE OF WASHINGTON)

COUNTY OF _____)

This record was acknowledged before me on this _____ day of _____,

by (name of individual): _____

Signature: _____

Title: _____

Exp: _____

Rules for witnesses:


- ☒ Must be at least 18 years of age and competent.
- ☐ Cannot be related to you or your health care agent by blood, marriage, or state-registered domestic partnership.
- ☐ Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- ☐ Cannot be your designated health care agent.


Do **NOT** sign until you are in front of a notary or two appropriate witnesses.

Be sure to follow the rules for a witness


Have either 2 witnesses OR a Notary

Notaries can be found at most banks

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
 <p>Washington POLST Portable Orders for Life-Sustaining Treatment A Participating Program of National POLST</p>		LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL DATE OF BIRTH / / GENDER (optional) PRONOUNS (optional)	
This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary. <small>IMPORTANT: See page 2 for complete instructions.</small>			
MEDICAL CONDITIONS/INDIVIDUAL GOALS:		AGENCY INFO / PHONE (if applicable)	
A Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing. <small>CHECK ONE</small> <input type="checkbox"/> YES – Attempt Resuscitation / CPR (choose FULL TREATMENT in Section B) <small>When not in cardiopulmonary arrest, go to Section B.</small> <input type="checkbox"/> NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death			
B Level of Medical Interventions: When the individual has a pulse and/or is breathing. <small>CHECK ONE</small> <p>Any of these treatment levels may be paired with DNAR / Allow Natural Death above.</p> <input type="checkbox"/> FULL TREATMENT – Primary goal is prolonging life by all medically effective means. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. <small>Transfer to hospital if indicated. Includes intensive care.</small> <input type="checkbox"/> SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. <small>Transfer to hospital if indicated. Avoid intensive care if possible.</small> <input type="checkbox"/> COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. <small>Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.</small> Additional orders (e.g., blood products, dialysis): _____			
C Signatures: A legal medical decision maker (see page 2) may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.			
Discussed with: <input type="checkbox"/> Individual <input type="checkbox"/> Parent(s) of minor <input type="checkbox"/> Guardian with health care authority <input type="checkbox"/> Legal health care agent(s) by DPOA-HC <input type="checkbox"/> Other medical decision maker by 7.70.065 RCW		SIGNATURE – MD/DO/ARNP/PA-C (mandatory) PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory) DATE (mandatory) PHONE	
SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory) PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)		RELATIONSHIP DATE (mandatory) PHONE	
Individual has: <input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Health Care Directive (Living Will) <small>Encourage all advance care planning documents to accompany POLST.</small>			
SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED			



Washington State
Medical Association
Physician Driven, Patient Focused



Washington State Department of
Health

All copies, digital images, faxes of signed POLST forms are valid.
 See page 2 for preferences regarding medically assisted nutrition.
 For more information on POLST, visit www.wsma.org/POLST.

REV 04/2021
Page 1

What is a POLST - Portable Orders for Life-Sustaining Treatment

- For the seriously ill or medically frail (any age)
- Medical orders for specific procedures to be carried out by 911 Emergency Responders or facility staff for:
 - CPR
 - Interventions, like ventilation (breathing tube)
- **Must be signed by either Dr/ARNP/PA-C**
- **Patient/Legal representative**
- **Please contact your medical team for further assistance if you DO NOT WANT CPR**



- **Keep the original, *give copies* to your healthcare agents and healthcare professionals**
 - **Keep a copy where it can be *easily found***
 - **Take a copy with you if you go to a new medical facility or when traveling**
-



- ***Talk* to the rest of *your family* and close friends. Tell them who your healthcare agents are and what your wishes are**

**time to
UPDATE**

**Review your
documents
regularly**

The 6 D's

- Every **D****ecade** (Happy Birthday! Review forms)
- After the **D****eath** of a loved one
- After a **D****ivorce**
- Receive a new **D****iagnosis**
- If you have a **D****ecline** in your health
- If you moved **D****istance**

Be sure your documents get into your medical record

1

Upload them into your My Chart

OR

2

Hand deliver them to your PCP- Primary Care Provider

OR

3

Mail a copy to
Attn Medical Records c/o
Confluence Health P.O. Box
1887 Wenatchee WA 98807
(and call your PCP within 1
week to assure receipt)

Need more



help?



Call us

