



# How to Start the Conversation about Being Mortal: Advance Care Planning for Primary Care

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# ACP: Advance Care Planning


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**ACP helps ensure patient treatment preferences are:**

- Documented
- Regularly Updated
- Respected



# TALK WITH YOUR DOCTOR



**80%**

of people say that, if seriously ill, they would want to talk to their doctor about end-of-life care.

**7%**

report actually having had an **end-of-life conversation** with their doctor.

**ONLY  
25%**

of doctors knew that their patients had advance directives on file.

The  
Conversation  
Project  
National  
Survey in  
2013

# Collaborative Decision Making

**Communication Magic to get to a Shared Decision**

**Patient/Family  
Understanding  
of  
The Illness  
& Prognosis**

**Medical  
providers  
knowledge of  
Medical  
Facts, Labs,  
Pathology, &  
Prognosis**

**Relationship building the Foundation of Respect, Trust, Confidence  
Between the patient and the Medical Team**



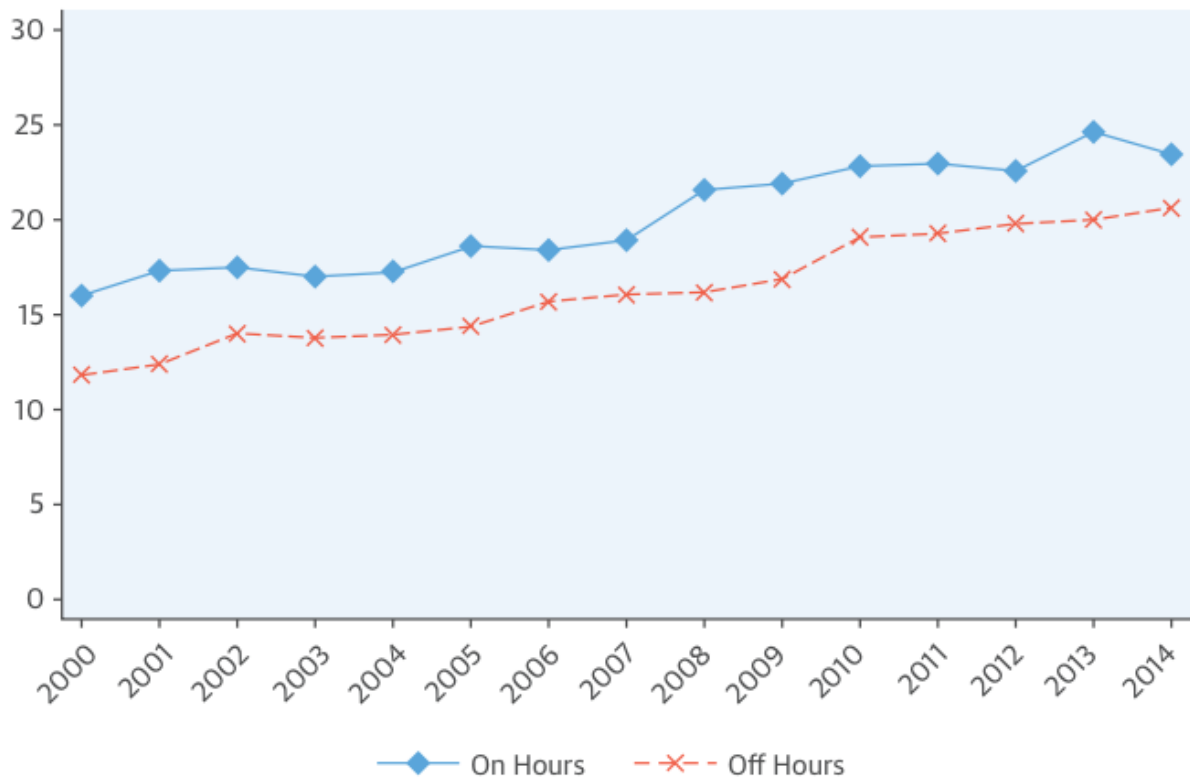
# Goals/Agenda

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1. Be aware of the facts on CPR Survival Rate and in Intubation survival rates for adults in a hospital setting
2. Know the difference of Advance Directives (AD) & POLST Forms
3. Know the benefits of end-of-life (EOL) planning & how to use the billing codes
4. Know how to properly fill out a POLST for the seriously ill, and an Advance Directive (AD) all competent adults
5. Know how to access available AD/POLST Guides and Resources

**CENTRAL ILLUSTRATION** Trends in Survival to Discharge Stratified by Timing of In-Hospital Cardiac Arrest

Survival to Discharge (%)



Ofoma, U.R. et al. J Am Coll Cardiol. 2018;71(4):402-11.

# CPR SURVIVAL

## Rate to discharge

### Overall was 18.6%.

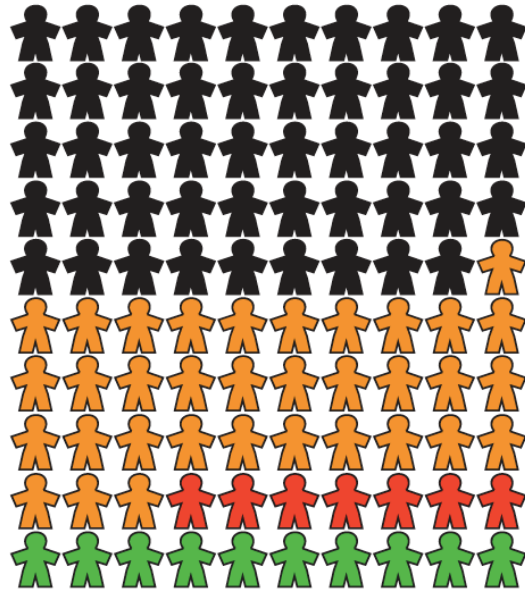
Survival was significantly lower in patients who arrested during off-hours compared with on-hours (16.8% vs. 20.6%;  $p < 0.0001$ )

The mean age was 66.1 years.

(Ofoma, 2018)

The graph shows unadjusted survival to discharge by calendar year in patients who arrested during on-hours (blue) and off-hours (orange).

# Survival Rate of In-Hospital Cardiac Arrests



Among “elderly patients who undergo resuscitation after in-hospital cardiac arrest”, at one year:



49 died during resuscitation



34 died before hospital discharge



7 died after hospital discharge



10 are alive



# 2018 Study: Prognosis After Emergency Department Intubation


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**Study Population: 65 and older** intubated in the ED from **2008 to 2015** from **262** hospitals across the United States - **41,463** Intubations.

After emergency intubation, **33% percent of older adults die** during the index hospitalization.

**Only 24% of survivors** are discharged to **home**.

(Ouchi, 2018)



# 2018 Study: Prognosis After Emergency Department Intubation

(Continued)

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## **Mortality for individuals a by age:**

**29%** for those aged **65 to 74**

**34%** for those aged **75 to 79**

**40%** for those aged **80 to 84**

**43%** for those aged **85 to 89**

**50%** for those aged **90 and older.**

(Ouchi, 2018)

# 2018 Study: Late Mortality after Acute Hypoxic Respiratory Failure

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**US Health & Retirement Study (HRS)** – did a longitudinal cohort of **37,000** adults aged **51** and above in 23,000 households, ongoing since 1992.

**"The median age was 79."**

**"Mortality was high: 42.7% at 30 days, 65.5% at 1 year and 73.3% at 2 years"**

(Prescott, 2018)



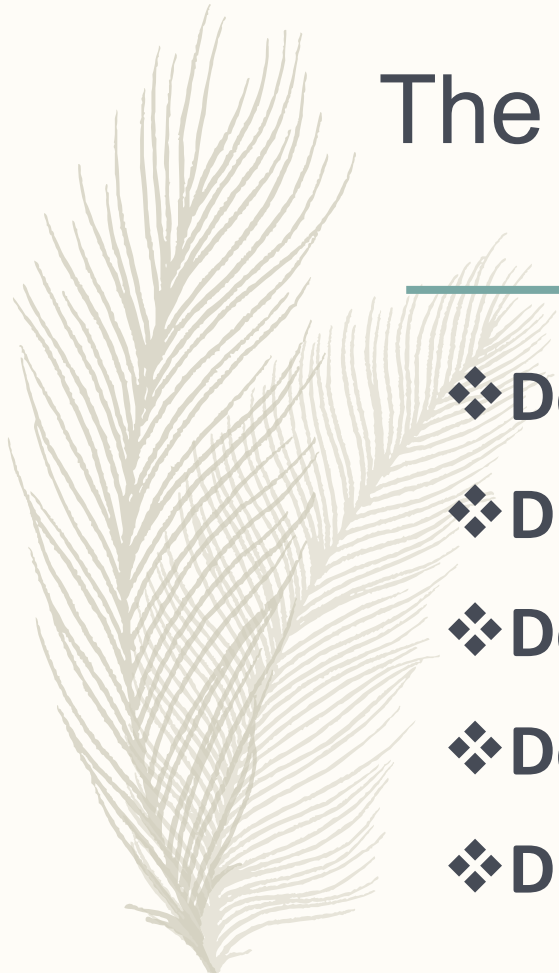
# What are Advance Directives (AD)?

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- AD documents: Living Will & Healthcare Power of Attorney (POA) allow an individual to put into writing wishes concerning treatment at the end of life.
- ADs need to be **witnessed but not notarized in UTAH**, and **don't need a lawyer** to be official.
- **ADs are not medical orders**

# The 5 D's of Advance Directives

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- ❖ **Decade**
  - ❖ **Divorce**
  - ❖ **Death**
  - ❖ **Decline**
  - ❖ **Diagnosis (NEW)**



# Anyone over 18 should have an AD:

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- Hospitals routinely ask about living wills or an Advance Directive (AD) but rarely is the document **scanned** into the Electronic Medical Record (EMR)
- Medical Power of Attorney forms can be scanned into EMR, and updated as needed.
- **Do you have an AD scanned into an EMR?**



# **No AD, Who speaks for YOU?**

Utah Comprehensive Health Care Decisions Act: 2009

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1. Spouse
2. Adult Child
3. Parent
4. Adult sibling
5. Adult Grandchild
6. Grandparent
7. Close friend

## Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)\*

**Part I:** *Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.*

**Part II:** *Allows you to record your wishes about health care in writing.*

**Part III:** *Tells you how to revoke or change this directive.*

**Part IV:** *Makes your directive legal.*

### My Personal Information

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Birth Date: \_\_\_\_\_

### Part I: My Agent (Health Care Power of Attorney)

#### A. No Agent

*If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.*

**I do not want to choose an agent.**

#### B. My Agent

Agent's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_

#### C. My Alternate Agent

*This person will serve as your agent if your agent, named above, is unable or unwilling to serve.*

Alternate Agent's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_

**D. Agent's Authority**

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

**E. Other Authority**

My agent has the powers below only if I initial the "yes" option that precedes the statement. I authorize my agent to:

- YES  NO Get copies of my medical records at any time, even when I can speak for myself.
- YES  NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

**F. Limits/Expansion of Authority**

I wish to limit or expand the powers of my health care agent as follows:

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**G. Nomination of Guardian**

*Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.*

- YES  NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

**H. Consent to Participate in Medical Research**

- YES  NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

**I. Organ Donation**

- YES  NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

## Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

*Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

Option 1	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	<b>I choose to let my agent decide.</b> I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.
Additional comments:	

Option 2	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	<b>I choose to prolong life.</b> Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.
Additional comments:	

Option 3	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	<b>I choose not to receive care for the purpose of prolonging life,</b> including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.
<i>If you choose this option, you must also choose either (a) or (b), below</i>	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	(b) My health care provider should withhold or withdraw life-sustaining care if <i>at least one</i> of the initialed conditions is met:
<i>If you selected (a), above, do not choose any options under (b).</i>	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: x-small;">I have a progressive illness that will cause death</div>
	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: x-small;">I am close to death and am unlikely to recover</div>
	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: x-small;">I cannot communicate and it is unlikely that my condition will improve</div>
	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: x-small;">I do not recognize my friends or family and it is unlikely that my condition will improve</div>
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: x-small;">I am in a persistent vegetative state</div>	
Additional comments:	

Option 4	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">Initial</div>	I do not wish to express preferences about health care wishes in this directive.
Additional comments	

Name: \_\_\_\_\_

**Part II: My Health Care Wishes (continued)**

*Additional instructions about your health care wishes:*

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*If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.*

**Part III: Revoking or Changing a Directive**

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. *(If you sign more than one Advance Health Care Directive, the most recent one applies.)*

**Part IV: Making My Directive Legal**

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

*If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.*

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**Name:** \_\_\_\_\_



# The Surprise Question

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**Would I be surprised if this patient  
died within the next year?**

**YES**

[discuss AD]

**NO**

[discuss POLST]

## Differences between POLST and advance directives

CHARACTERISTICS	POLST	ADVANCE DIRECTIVES
<b>Population</b>	For the seriously ill	All adults
<b>Time frame</b>	Current care	Future care
<b>Who completes the form</b>	Health care professionals	Patients
<b>Resulting form</b>	Medical orders (POLST)	Advance directive
<b>Health care agent or surrogate role</b>	Can engage in discussion if patient lacks capacity	Cannot complete
<b>Portability</b>	Provider responsibility	Patient/family responsibility
<b>Periodic review</b>	Provider responsibility	Patient/family responsibility

POLST = Physician Orders for Life-Sustaining Treatment

POLST.org 2013. Advanced Care Planning for the Seriously Ill. What is POLST. Retrieved from <http://www.polst.org/wp-content/uploads/2015/01/2013.09.26-Final-POLST-Article.pdf>



# What is a POLST / MOLST?

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“Physician Order of Life Sustaining Treatment”

“Medical Order of Life Sustaining Treatment”

Medical orders that can be followed by Emergency Medical Services (EMS), Hospitals, and Extended Care Facilities (ECF)

Medical Order vs. Legal Documents





# POLST: Provider Order for Life-Sustaining treatment

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- Any seriously ill person & reflects the AD (Living Will & POA)
- POLST is a Medical Order that is transferable & follows with the patient.
- Must be completed and signed by the Medical Provider & Patient or Healthcare Proxy.
- Should include conversation with patient &/or family
- Should be based upon patient's values & desires and Goals of Care
- Series of decisions and choices: **resuscitation, intubation/ventilation, intravenous fluids, antibiotics, artificial feeding, comfort measures, & transfer to hospital if needed to maintain comfort.**
- Part of one's medical record that may be changed or rescinded .

# Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order  
Bureau of Licensing and Certification, Utah Department of Health  
State of Utah Rule R432-31 v3.1 February 2019 (<http://health.utah.gov/hflcra/forms.php>)

Patient's Last Name  First Name/Middle Initial  Effective Date of this Order

Date of Birth  Last 4 of SSN  Address (street/city/state/zip)

Medical Provider's Name (MD/DO/PA/APRN)  Medical Provider's Phone

Brief description of patient's medical condition

Patient's stated goals for medical care

### A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)  Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)  I do not wish to express a preference (selecting resuscitation (DNR) (Allow Natural Death) this may lead to attempt to resuscitate)

### B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

**FULL TREATMENT:** Prolonging life by all medically effective means. Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.

**LIMITED ADDITIONAL INTERVENTIONS:** Treating medical conditions while avoiding burdensome measures. Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.

**COMFORT MEASURES:** MAXIMIZING comfort and dignity. Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.

**NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

### C. ARTIFICIAL NUTRITION

Long term artificial nutrition with feeding tube  Trial period of artificial nutrition with feeding tube  No artificial nutrition  I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

### D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

Advance Directive available, reviewed and confirmed without conflicts  No Advance Directive available

Health care agent named in Advance Directive  Phone Number

I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.  I, the patient, want this order to be followed strictly.

Discussed with:

### REQUIRED SIGNATURES

Print Name  Relationship: (write self if patient)  Signature

Signature of Medical Provider (MD/DO/PA/APRN) <small>Two signatures required for minors</small>	Print Name	License Number	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of licensed professional preparing form	Print Name	Title	Date
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# Provider Order for Life-Sustaining Treatment (POLST)

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Bureau of Licensing and Certification, Utah Department of Health  
State of Utah Rule R432-31 v3.1 February 2019 (<http://health.utah.gov/hflcra/forms.php>)

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Date of Birth	<input type="text"/>	Last 4 of SS#	<input type="text"/>	Address (street/city/state/zip)	<input type="text"/>
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Medical Provider's Name (MD/DO/PA/APRN)	<input type="text"/>	Medical Provider's Phone	<input type="text"/>
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- Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)     Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)     I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

### B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

- FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.
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**C. ARTIFICIAL NUTRITION**

Long term artificial nutrition with feeding tube       Trial period of artificial nutrition with feeding tube       No artificial nutrition       I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of licensed professional preparing form	Print Name	Title	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



# **Benefits of ADs and POLST Forms**

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**Allows an individual to express their wishes on what is important at the end of their life.**

**Reduces the emotional burden and cost of unwanted interventions**

**Reduces futile care**

# ACP Codes for Billing 99497 & 99498

CPT CODES	BILLING CODE DESCRIPTION
99497	First 30 minutes of a Face-to-Face Discussion on ACP with patient, family members, &/or surrogate
99498	Second 30 minutes of a Face-to-Face Discussion on ACP with patient, family members, &/or surrogate

Effective January 1, 2016, Medicare will pay **\$86** for 30 minutes of ACP in a physician's office (99497) and **\$75** for 30 additional minutes of consultation (99498). Hospitalists can bill these codes too.



# Challenges for End of Life Conversations

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Caregivers are **overwhelmed**

**Avoidance** of discussing issues until the problem is forced into the open in a tense, emotional environment.

**Abundant** tools exist for starting this conversation but are **underutilized**.

**Painful treatments** continue that do not improve the quality of life

**Cultural differences** complicate how to discuss the topic with sensitivity and respect

**Providers** are hesitant to discuss end of life, since we were trained to cure.



# Cultural Challenges

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Talking about Death is Taboo

Language barriers and use of interpreters

Traditional head of household may not be the best spokesperson for the patient

Traditions for the body after death can vary



# Examples of Cultural Beliefs

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Navajo & Several other cultures believe:

Discussing the death of someone to their face is taboo. Negative words and thoughts about health become self-fulfilling

Religious Faith Based

Reluctance to discuss the possibility of death based on the belief that miracles can happen, and acknowledging mortality may be giving up

Middle Eastern:

May lose trust in the medical providers if DNR code is offered as an option since death is in the hands of God



# Goals of Care Conversation “CAPTURES”

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**C:** Capacity

**A:** Authorized Surrogate and Advance Directives

**P:** Perceptions of Illness and Prognosis

**T:** Target Patient’s Values and Goals

**U:** Understand Treatment Options

**R:** Recommendations

**E:** Exploration of Challenges and Empathetic Response

**S:** Summary

# Collaborative Decision Making

**Communication Magic to get to a Shared Decision**

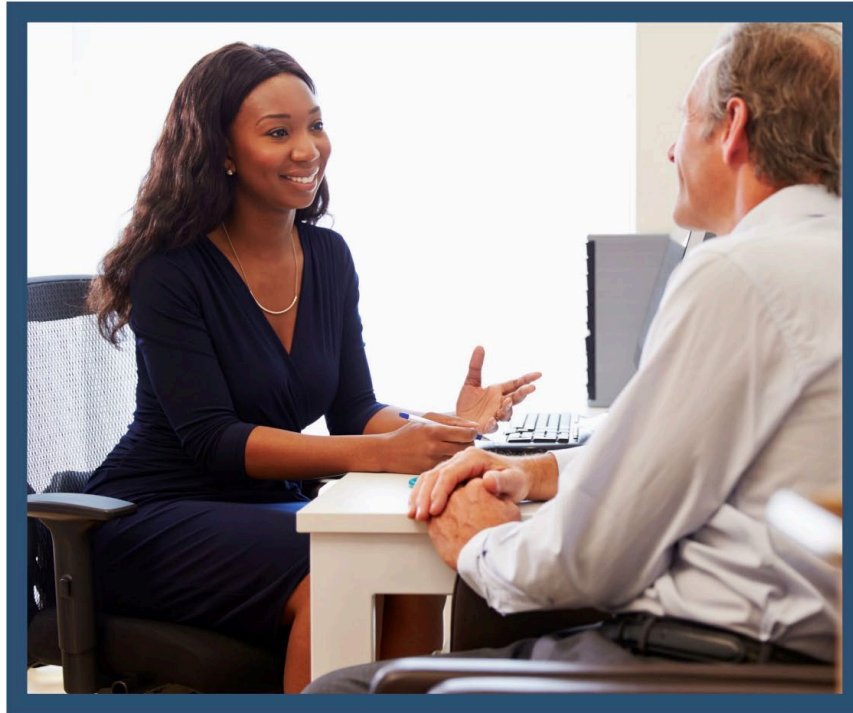
**Patient/Family  
Understanding  
of  
The Illness  
& Prognosis**

**Medical  
providers  
knowledge of  
Medical  
Facts, Labs,  
Pathology, &  
Prognosis**

**Relationship building the Foundation of Respect, Trust, Confidence  
Between the patient and the Medical Team**

# POLST

## Conversation Guide



<https://healthinsight.org/tools-and-resources/send/48-educational-resources/639-polst-conversation-guide>

**\*\*\*Examples of Empathic Responses\*\*\***

<b>Naming</b>	<b>Understanding</b>	<b>Respecting</b>	<b>Supporting</b>	<b>Exploring</b>	<b>"I Wish"</b>
This must be . . . <ul style="list-style-type: none"> <li>• Frustrating</li> <li>• Overwhelming</li> <li>• Scary</li> <li>• Difficult</li> <li>• Challenging</li> <li>• Hard</li> </ul>	What you just said really helps me understand the situation better.	I really admire your <ul style="list-style-type: none"> <li>• Faith</li> <li>• Strength</li> <li>• Commitment to your family</li> <li>• Thoughtfulness</li> <li>• Love for your family</li> </ul>	We will do our very best to make sure you have what you need.	Could you say more about what you mean when you say . . . <ul style="list-style-type: none"> <li>• I don't want to give up</li> <li>• I am hoping for a miracle</li> </ul>	I wish we had a treatment that would cure you [make your illness go away]. *[Remember we do have palliative treatments to offer the patient]
I'm wondering if you are feeling . . . <ul style="list-style-type: none"> <li>• Sad</li> <li>• Scared</li> <li>• Anxious</li> <li>• Nervous</li> <li>• Angry</li> </ul>	This really helps me better understand what you are thinking.	You (or your dad, mom, child, spouse) are/is such a strong person and have/has been through so much.	Our team is here to help you with this.	Help me understand more about . . .	I wish I had better news.
It sounds like you may be feeling . . .	I can see how important this is to you.	I can really see how [strong, dedicated, loving, caring, etc.] you are.	We will work hard to get you the support that you need.	Can you say more about that?	I wish the situation were different.
In this situation some people might feel . . .	Dealing with this illness has been such a big part of your life and taken so much energy.	You are such a [strong, caring, dedicated] person.	We are committed to help you in any way we can.	Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you?	I wish that for you too.  [In response to what a patient or family members wishes, such as a miracle]
I can see how dealing with this might be . . . <ul style="list-style-type: none"> <li>• Hard on you</li> <li>• Frustrating</li> <li>• Challenging</li> <li>• Scary</li> </ul>		I'm really impressed by all that you've done to manage your illness [help your loved one deal with their illness].	We will be here for you.		I wish we weren't in this spot right now.



**Utah Web Resources:**

leaving  well

*living well through the end of life*

<http://leaving-well.org>

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The Leaving Well Coalition exists to ensure every person in Utah has the opportunity to live well to the end of life by sharing the conversation about their values, making their wishes known and receiving the end-of-life care they desire.



# Leaving Well Web site: Links to Utah AD & POLST Form

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## Utah Advanced Directive Form:

[http://leavingwell.org/upload/Utah\\_Advance\\_Directive\\_2009.pdf](http://leavingwell.org/upload/Utah_Advance_Directive_2009.pdf)

## Utah POLST:

[http://leaving-well.org/upload/Utah\\_POLST.pdf](http://leaving-well.org/upload/Utah_POLST.pdf)

# The Conversation Project

<https://theconversationproject.org/>



## Your Conversation Starter Kit

When it comes to end-of-life care, talking matters.



## How to Choose a Health Care Proxy

..... & .....

## How to Be a Health Care Proxy



## Your Conversation Starter Kit

For Families and Loved Ones of People with Alzheimer's Disease or Other Forms of Dementia



# Prepare for Your Care

*[PrepareForYourCare.org](https://PrepareForYourCare.org)*

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PREPARE for Your Care is an online resource that helps people learn about and prepare for medical decision making.

This evidenced-based tool features video stories in English and Spanish and guides users as they explore their wishes and learn how to discuss them with family, friends, and medical providers.

The website also offers PREPARE written pamphlets as well as a Toolkit to help put on a PREPARE Group Movie Event.

These Movie Events can be used in group medical visits or in the community.

PREPARE also offers easy-to-read, legally-binding advance directives for all 50 states in English and Spanish.



## PREPARE Question Guide

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**PREPARE is a program to help you:**

- Have a voice in YOUR medical care
- Talk with your doctors
- Give your family and friends peace of mind

**Step 1: Choose a Medical Decision Maker**

**Step 2: Decide What Matters Most in Life**

**Step 3: Choose Flexibility for Your Decision Maker**

**Step 4: Tell Others About Your Wishes**

**Step 5: Ask Doctors the Right Questions**

# A Soul Doctor & A Jazz Singer

<https://www.youtube.com/watch?v=Dnnu43Zt-oA>





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