



END OF LIFE READY

END-OF-LIFE OPTIONS &
ADVANCE CARE PLANNING

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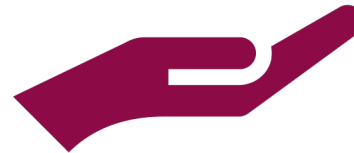


End of Life Washington

Your Life, Your Death, Your Choice



**Education and
Resources**



**Support: Volunteer
Client Advisors**



**Advocacy and
Public Policy**



What This Session Will Cover

- Part 1:
 - Planning Ahead
 - Preparing for the unexpected
- Part 2:
 - End-of-Life Options
 - Dying on your terms

Talking About End-of-Life Issues



PART 1: Planning Ahead




Choose Your Support Team

Complete a Values Worksheet

Review your values and choices

- What does living well mean for you?
- How do you define quality of life?
- How important is your independence?



VALUES WORKSHEET

The following are questions you may want to consider as you make decisions and prepare documents concerning your health care preferences. You may want to write down your answers and provide copies to your family members and health care providers, or simply use the questions as "food for thought" and discussion.

How important to you are the following items?

	VERY IMPORTANT			NOT IMPORTANT	
Letting nature take its course.	4	3	2	1	0
Preserving quality of life.	4	3	2	1	0
Staying true to my spiritual beliefs/traditions	4	3	2	1	0
Living as long as possible, regardless of quality of life.	4	3	2	1	0
Being independent.	4	3	2	1	0
Being comfortable and as pain free as possible.	4	3	2	1	0
Leaving good memories for my family and friends.	4	3	2	1	0
Making a contribution to medical research or teaching.	4	3	2	1	0
Being able to relate to family and friends.	4	3	2	1	0
Being free of physical limitations.	4	3	2	1	0
Being mentally alert and competent.	4	3	2	1	0
Being able to leave money to family, friends, or charity.	4	3	2	1	0
Dying in a short while rather than lingering.	4	3	2	1	0
Avoiding expensive care.	4	3	2	1	0

Create a Set of Advance Directives

- Health Care Directives (Living Will)
- Health Care Agent (Durable Power of Attorney for Health Care)

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. If I initial an item in this section it means that if such an initiated life-threatening event should occur, I would not want to receive life-sustaining treatment. I want my care-givers to focus on comfort care and pain management, and I should be allowed to die as peacefully as possible: (initial all that apply)

☐ a. Unconsciousness or coma that probably will prevent me from communicating permanently.

☐ b. Irreversible dementia such as Alzheimer's Disease.

6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition in which I would not want life-sustaining treatment (as documented in Section 4), or if I experience a quality of life my agent believes I would consider unacceptable, I do not want the following life-sustaining treatments started. If already started, I want them stopped.

(initial all that you do not want.)

☐ All cardiopulmonary resuscitation (CPR) measures to try to restart my heart and breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart regulating drugs, or any other treatment for heart failure.

☐ Artificial ventilation when I can no longer breathe on my own.

☐ Heart-regulating drugs, if my heartbeat becomes irregular.

☐ Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.

☐ Surgeries for the purpose of prolonging my life rather than for providing comfort.

Discontinue if your life course does not work normally.

7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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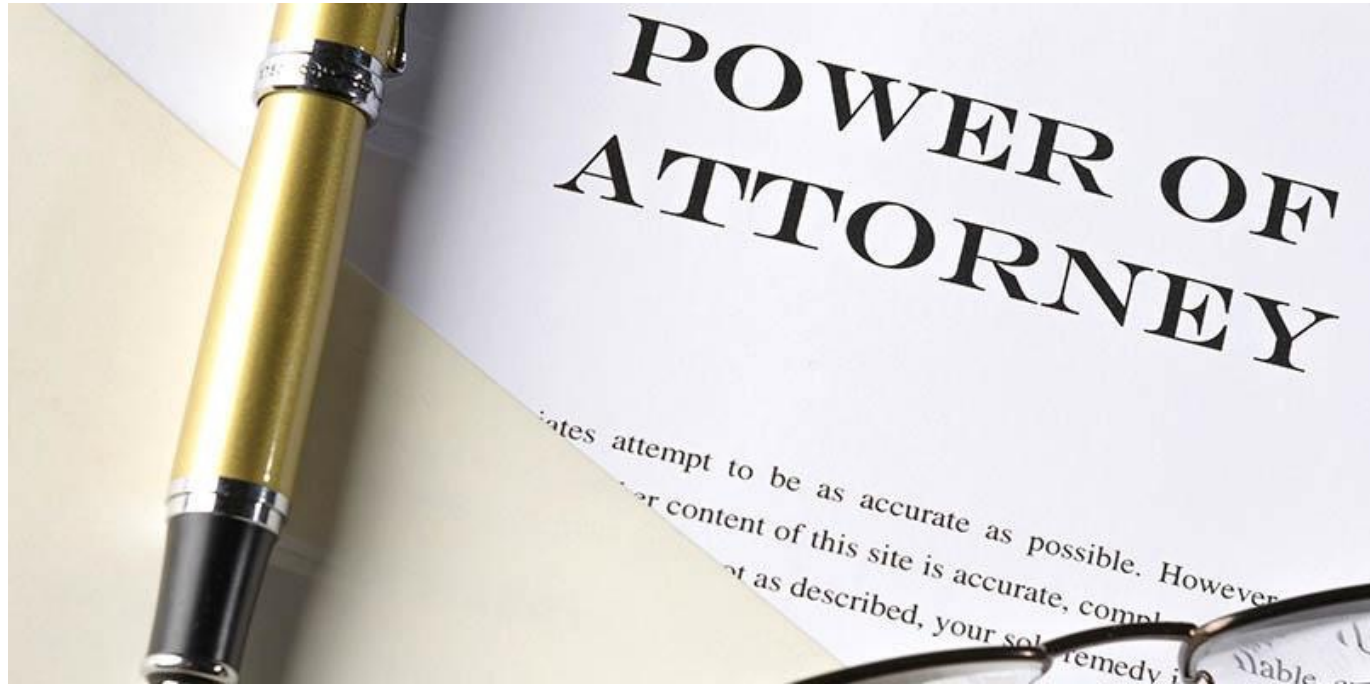
Complete a Health Care Directive

- Life-sustaining treatments you *do* and *do not* want

<p>4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT</p> <p>I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. If I initial an item in this section it means that if such an initiated life-threatening event should occur, I would not want to receive life-sustaining treatment. I want to focus on comfort care and pain management, and I should be allowed to do what I want, as long as it is reasonable and possible: (initial all that apply)</p> <p><input type="checkbox"/> a. Unconsciousness or coma that probably will prevent me from coming back permanently.</p> <p><input type="checkbox"/> b. Irreversible dementia such as Alzheimer's Disease.</p>	<p>10. IF A COURT APPOINTS A GUARDIAN FOR ME</p> <p>If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.</p> <p>11. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED</p> <p>This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document. Note: The signed and witnessed Advance Directive with the latest date will take precedence over older Advance Directives.</p> <p>12. SUMMARY AND SIGNATURE</p> <p>I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective, even if I become incompetent or otherwise disabled.</p> <p>_____ Signature</p> <p>_____ Date</p> <p>(Sign only in the presence of two witnesses and a notary, if notarizing.)</p> <p><small>© End of Life Washington, updated 10/19/20 • Commercial distribution prohibited • Copying permitted for personal use only • Page 18 of 20</small></p>
<p>6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT</p> <p>If I experience a condition in which I would not want life-sustaining treatment (Section 4), or if I experience a quality of life my agent believes I would consider <u>do not want</u> the following life-sustaining treatments started. If already started, I want them stopped.</p> <p>(Initial all that you <u>do not</u> want.)</p> <p><input type="checkbox"/> All cardiopulmonary resuscitation (CPR) measures to try to restart my breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart-regulating drugs, or any other treatment for heart failure.</p> <p><input type="checkbox"/> Artificial ventilation when I can no longer breathe on my own.</p> <p><input type="checkbox"/> Heart-regulating drugs, if my heartbeat becomes irregular.</p> <p><input type="checkbox"/> Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.</p> <p><input type="checkbox"/> Surgeries for the purpose of prolonging my life rather than for providing comfort.</p> <p><small>Check one if you believe you do not work normally:</small></p>	
<p>7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION</p> <p>If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.</p> <p><small>© End of Life Washington • Commercial distribution prohibited • Copying permitted for personal use only</small></p>	

Choose Your Health Care Agent

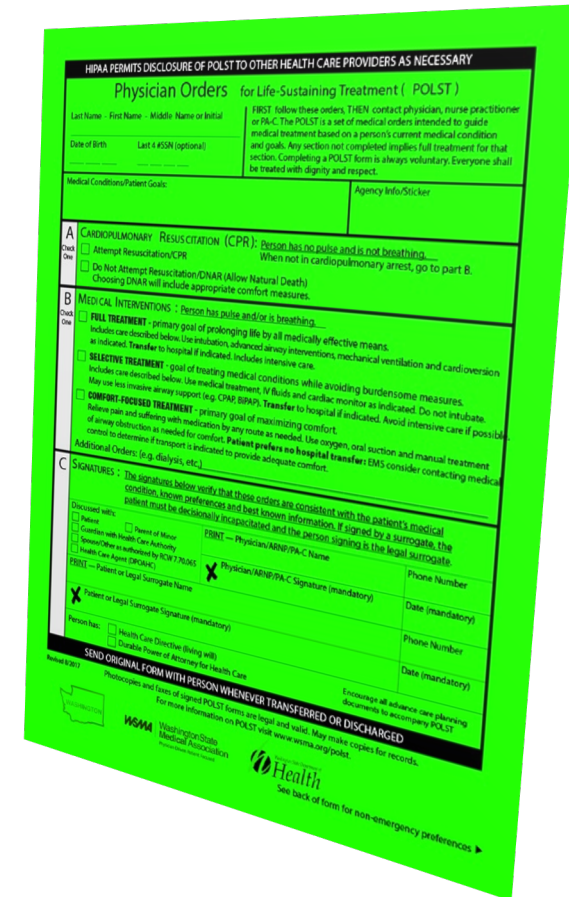
Create a Durable Power of Attorney for Health Care



Evaluate Need for a POLST

Portable or Physician Order for Life-Sustaining Treatment

- Diagnosis of serious illness or end stage of life
- Medical order that documents your choice regarding life-sustaining treatment



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial _____
Date of Birth _____ Last 4 Digits (optional) _____

Medical Conditions/Patient Goals: _____
Agency Info/Slider: _____

A CARDIOPULMONARY - RESUSCITATION (CPR): Person has no pulse and is not breathing. When not in cardiopulmonary arrest, go to part B.
☐ Attempt Resuscitation/CPR
☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death) Choosing DNAR will include appropriate comfort measures.

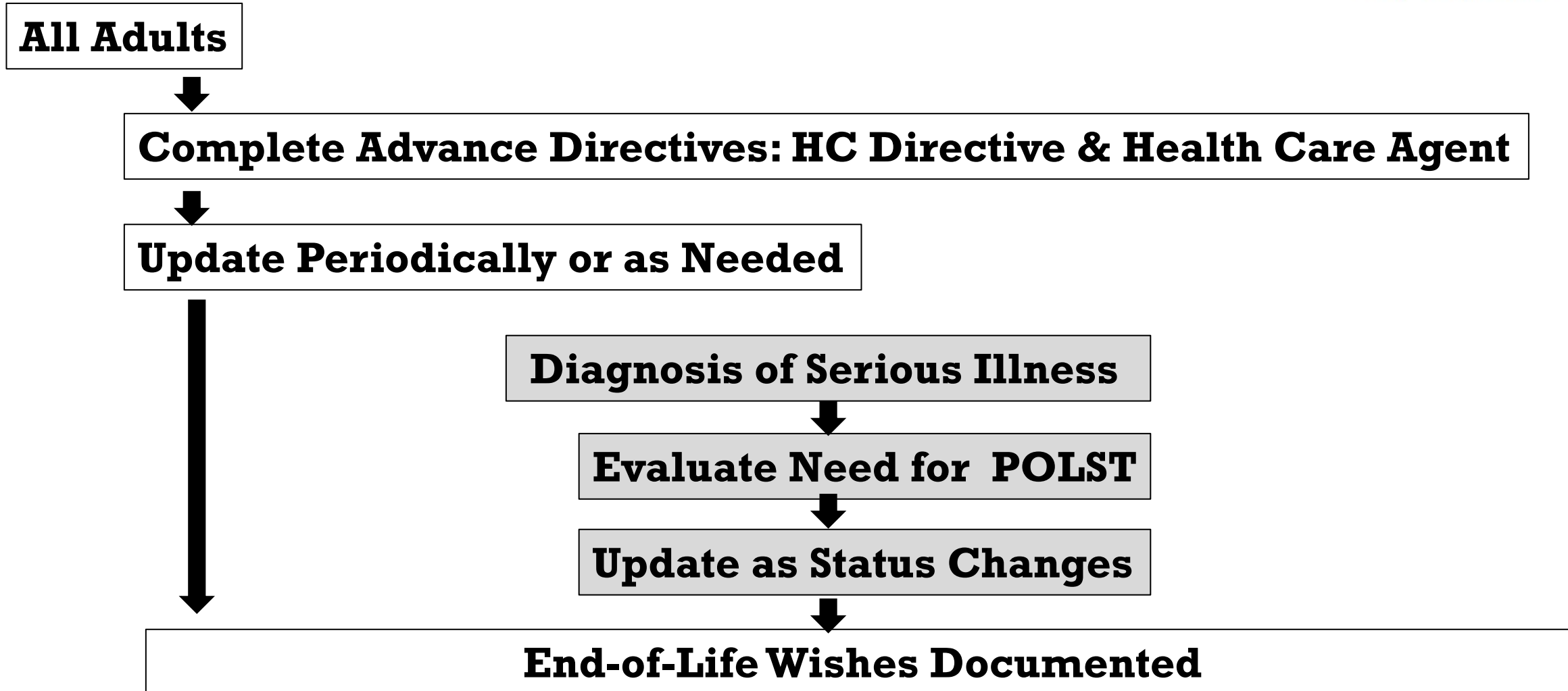
B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
FULL TREATMENT: primary goal of prolonging life by all medically effective means. Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
☐ **SELECTIVE TREATMENT:** goal of treating medical conditions while avoiding burdensome measures. May use less invasive airway supporting (CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.
☐ **COMFORT-FOCUSED TREATMENT:** primary goal of 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. Patient prefers no hospital transfer EMS consider contacting medical personnel to determine if transport is indicated to provide adequate comfort.

Additional Orders: (e.g., dialysis, etc.) _____

C SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Proxy of Patient
☐ Credentialed Health Care Authority ☐ Physician/APP/NP/PA-C Name _____
☐ Health Care Agent (Durable) ☒ Physician/APP/NP/PA-C Signature (mandatory) _____
 Patient or Legal Surrogate Signature _____
 Person Type: ☐ Health Care Director (living will) ☐ Durable Proxy of Attorney for Health Care
 SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
 Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
 Encourage all advance care planning documents to accompany POLST.
 For more information on POLST visit www.wa.gov/polst.
 See back of form for non-emergency preferences.

Advance Directives & POLST



PART 1: Planning Ahead



Summary & Questions

- ✓ **Choose Your Support Team**
- ✓ **Complete a Values Worksheet**
- ✓ **Create a set of Advance Directives**
 - **Complete Health Care Directive**
 - **Choose your Health Care Agent**
- ✓ **Evaluate need for a POLST**

PART 2: End-of-Life Options



Know You Always Have a Choice



Accept or Refuse Treatment

Comfort Care

Palliative

- Any stage of disease
- Same time as curative treatment
- Paid for by insurance/self

Reduces Pain & Stress

Offer complex symptom relief related to serious illness

Physical and Psychosocial relief

Hospice

- 6 months or less prognosis
- Excludes curative treatment
- Paid by Medicaid, Medicare, Insurance
- Home, facility, or hospital
- Includes resources for family and support team

Hastening Death, Ending Suffering



Medical Aid in Dying (MAID)

Allows someone terminally ill to control the timing of their death to reduce anxiety, pain, and/or suffering

Death With Dignity Act (DWD)

- ✓ Terminal illness with less than 6 months to live
- ✓ Resident of WA State
- ✓ 18 years of age or older
- ✓ Capable of self-administering
- ✓ Two doctors who can and will support DWD
- ✓ Decision-making capacity

Death With Dignity Participants

Support available from EOLWA
Volunteer Client Advisors (VCAs)

Begin process when eligible

- Waiting period and identifying supportive physicians, excludes 40-50% of individuals

18-104 Years Old

70% Cancer

7% ALS

6% COPD

6% Heart Disease

2% Parkinson's/MS

9% Other

When Medical Aid in Dying Is Not an Option



Voluntary Stopping Eating and Drinking

VSED is a voluntary choice to hasten death by removing nutrition and hydration to allow the body to naturally die within 1-2 weeks

Support: Collaboration with palliative, hospice, and others care providers to manage symptoms

VSED in Washington State

Collaboration with entire care team essential

Clients have been suffering from various diseases:

- Parkinson's
- Huntington's
- ALS
- Early Alzheimer's
- Muscular Dystrophy
- Neurodegenerative diseases
- Autoimmune diseases
- Severe Arthritis

PART 2: End-of-Life Options



Summary & Questions?

- ✓ Know you always have a choice
 - Stopping or refusing treatment
 - Medical Aid in Dying (MAID)
 - Voluntary Stopping Eating & Drinking (VSED)

Review: Most Important Step



Know and Confirm Who Will Support You

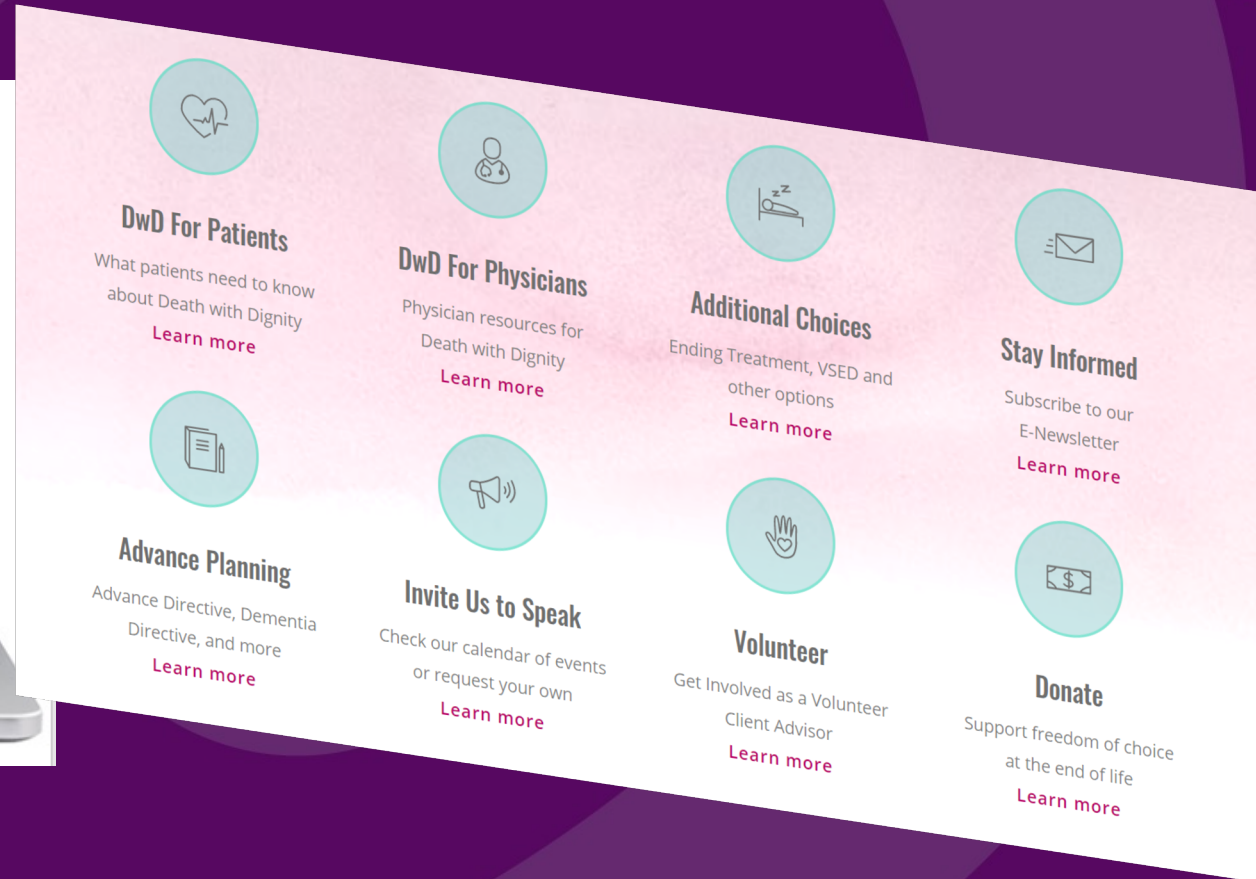
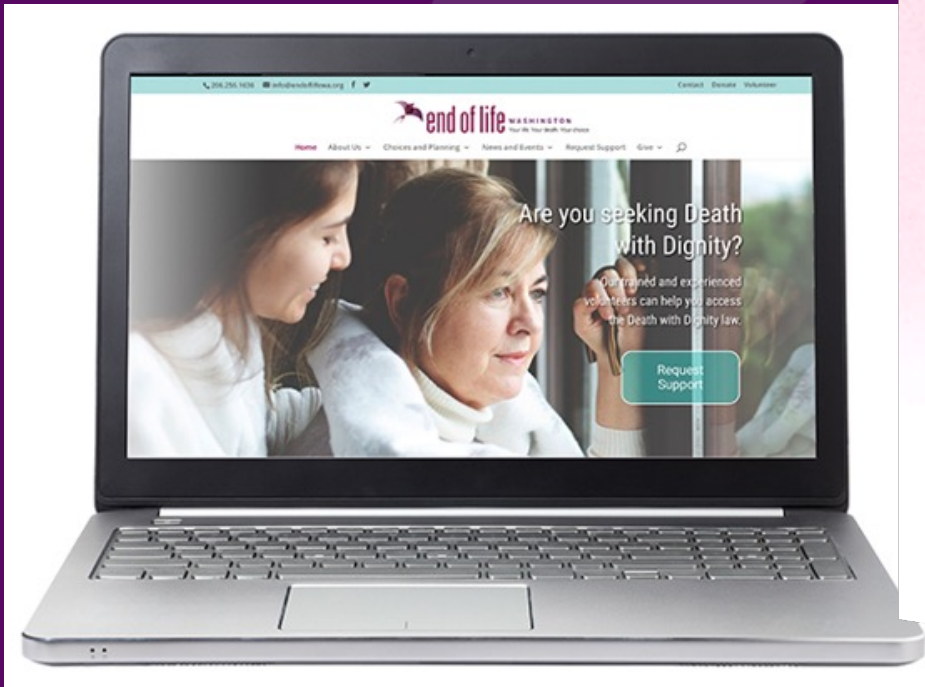
End-of-Life Choice	Required Facilitator	Support & Resources
Advance Directives: Health Care Directive & Health Care Agent	Notary or Two Witnesses	End of Life Washington Friends & Family Health Care providers Death Doulas Spiritual/Religious leaders
POLST	Doctor	
Refusing or Stopping Treatment	Doctor	
Hospice and Palliative Care	Doctor	
Death with Dignity (Medical Aid in Dying)	Two Supportive Doctors	
Voluntary Stopping Eating and Drinking (VSED, SED, CFO)	Encourage Doctor/Hospice Involvement	

Check the Boxes

End of Life Ready Checklist for Health

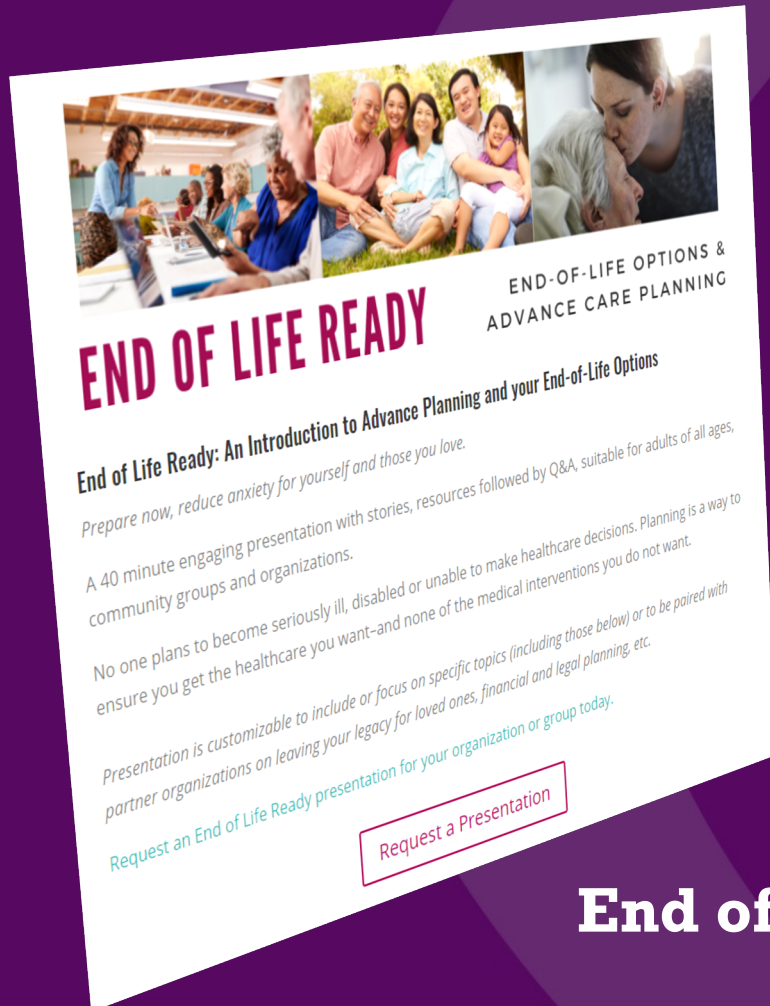
- ☐ **Identify a support team** including Health Care Agent, physicians, and care providers that support my choices: Directives, Stopping Treatment, Death With Dignity, VSED
- ☐ **Complete Advance Directives:** Health Care Directive & DPOA for Healthcare (Named Health Care Agent)
- ☐ **Evaluate** need for POLST, Dementia, and Feeding/Drinking Directives
- ☐ **Discuss and provide copies** of Advance Directives to support team

EOLWA Resources



End of Life WA (206) 256-1636 www.endoflifewa.org

Help Us Educate Others



Friends

Family & Loved Ones

Health Care Providers

Communities

Organizations

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THANK YOU