TOOLS FOR ADVANCE CARE PLANNING

These tools may be used to assist individuals and families discuss and make final health care decisions:

Five Wishes: This booklet poses thoughtful questions to spur an in-depth thought process and discussion. It is easily understood and user friendly. The" five wishes" include an individual's wishes for:

- The Person to Make Care Decisions for Me When I Can't
- The Kind of Medical Treatment I Want or Don't Want
- How Comfortable I Want to Be
- How I Want People to Treat Me
- What I Want My Loved Ones to Know

The last pages of the booklet include a wallet card and a form to be signed and witnessed. The signed form meets accepted requirements in 42 states. However, though most eldercare attorneys in Georgia support the use of the Five Wishes booklet as an excellent tool to aid in discussion, they encourage use of the Georgia Advance Directive for Health Care as the more widely recognized document.

Available through purchase by calling (888)594-7437 or from the website: www.agingwithdignity.org.

The Critical Conditions Planning Guide: This is a comprehensive and detailed tool. The booklet begins with:

Step 1: "Conversation Starter": This section includes: General Concerns, Views on Prolonging Life before progressing to individual pages allocated to CPR, Tube Feeding, Breathing Machines, Incurable Brain Disease, Organ Donation, and Pain Management. Each page includes a brief case illustration.

Step 2: Is an Individual Worksheet that includes 27 detailed questions. The last page of this section is a signature page where the individual can sign and date the confirmation of preferences

Step 3: The actual Georgia Advance Directive for Health Care document. This guide is available for purchase at: http://www.criticalconditions.org

Georgia Advance Directive for Health Care: This is the state approved widely recognized document. In effect since 2007, this document combines living will and power of attorney for healthcare. It is actually less cumbersome than you might expect. No notary is required: only signature of 2 witnesses. The advance directive for health care has four parts:

Part I: Health Care Agent: this part allows you to choose someone to make health care decisions for you when you cannot make health care decisions for yourself.

Part II. Treatment Preferences: this part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness.

Part III. Guardianship: this part allows you to nominate a person to be your guardian should one ever be needed.

Part IV: Effectiveness and Signatures: this part requires your signature and the signature of 2 witnesses.

There is no charge for this document and can be found at: http://www.hhc.org/documents/English-GA-Advance-Directive-for-Health-Care_0.pdf

POLST: Physician Orders for Life-Sustaining Treatment: This document does not replace the Georgia Advance Directive. This document is intended to be portable and should follow patient back and forth from hospital, to rehab to long term care facility. A physician must sign and date the document based on or all of the following: A discussion with a competent patient, a review of patient's Advance Directive, A discussion with the Patient's Authorized Representative, Verbal consent from the patient for an "allow natural death" order. The document should be reviewed when the patient is transferred from one care setting or care level to another. There is no charge for the POLST form and the website is: http://dph.georgia.gov/POLST

Differences Between the Advance Directive and POLST

A Physician Order for Life-Sustaining Treatment (POLST) is a form for those who have a serious medical condition or illness. It does not replace the Advance Directive, but rather complements it. Filling out the POLST form is entirely voluntary.

POLST	Advance Directive
For seriously ill/frail at any age	For anyone over 18
Completed by a physician and patient	Completed by an individual
Specific orders for current treatment	General instructions for future treatment
Signed by physician and patient or authorized patient representative	Signed by individual and two witnesses (neither attorney nor notary is needed)

Georgia's POLST Form is produced by the Georgia Department of Public Health and is available at:

www.gapolst.org

POLST GEORGIA

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

One conversation can make all the difference.

POLST GEORGIA

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

There are a million reasons to avoid having the conversation. But it's critically important, and...

You can do it.

Consider the facts.

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

56% have not communicated their end-of-life wishes

Source: Survey of Californians by the California HealthCare Foundation (2012)

70% of people say they prefer to die at home

70% die in a hospital, nursing home, or long-term-care facility

Source: Centers for Disease Control (2005)

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care

7% report having had an end-of-life conversation with their doctor

Source: Survey of Californians by the California HealthCare Foundation (2012)

82% of people say it's important to put their wishes in writing

23% have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012)

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT GMCF

This material from the Institute for Healthcare Improvement (IHI) was adapted by Alliant GMCF, the Medicare Quality Improvement Organization for Georgia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 10SOW-GA-POLST-13-13