TRAIN THE ADVOCATE

ADVANCE CARE PLANNING

Alaska End-of-Life Alliance
April 30, 2024

compassion & choices
Care and Choice at the End of Life

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FIRST OFF, THANK YOU FOR AGREEING TO FACILITATE ADVANCE CARE PLANNING (ACP) WORKSHOPS IN YOUR COMMUNITY!

Thanks to you, more Alaskans will be aware of how important ACP is.

They will take the first steps in the lifelong process of thinking about what matters to them and the kind of care they want at different stages of their lives.

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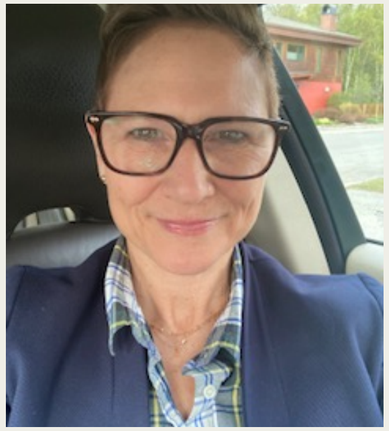
WHO WE ARE

Denise Hendrickson



Julie Raymond - Yakoubian

Rachel Bernhardt

Brehan Corveau

Aims Villanueva-Alf

Linda Johnson

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A G E N D A

PART 1 - Today

- ACP – What is it?
- Advance Directives
- Your Role as Facilitators
- How to Organize a Workshop

PART 2 - May 21, 2024

- Step-by-Step Guide to Delivering the Workshop

Part 3 - You Deliver the Workshop

Part 4 - December 2024 Debrief/Close-out

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Find some paper and write down 5 things that are the most important to you at the EOL.

- Examples:
  - Time with loved ones, being with pets, free from pain, not being a burden, free from anxiety, practicing spiritual/religious beliefs, to die at home, having a healthcare team you trust, etc.

  - Keep list handy!

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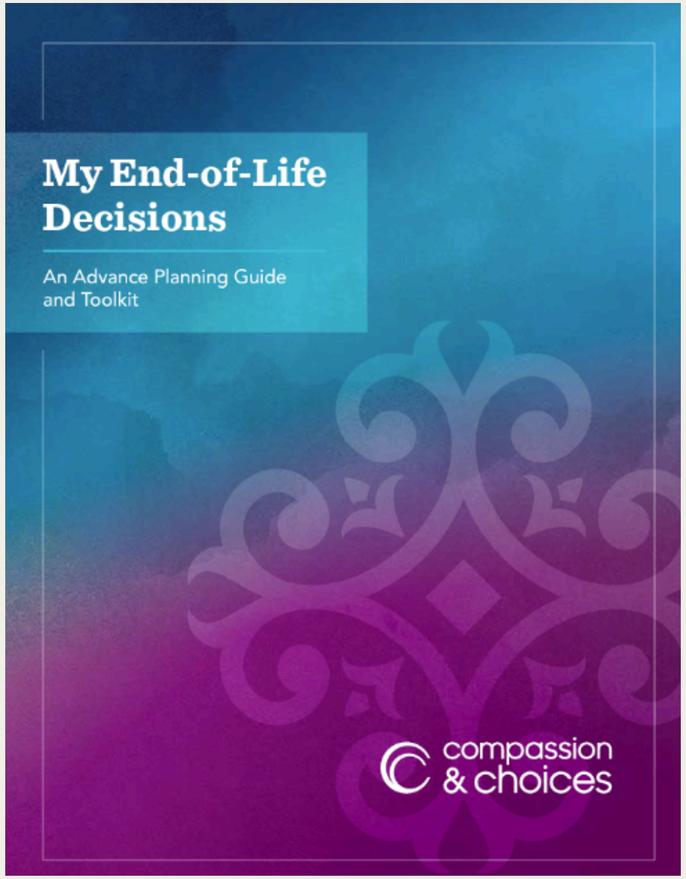

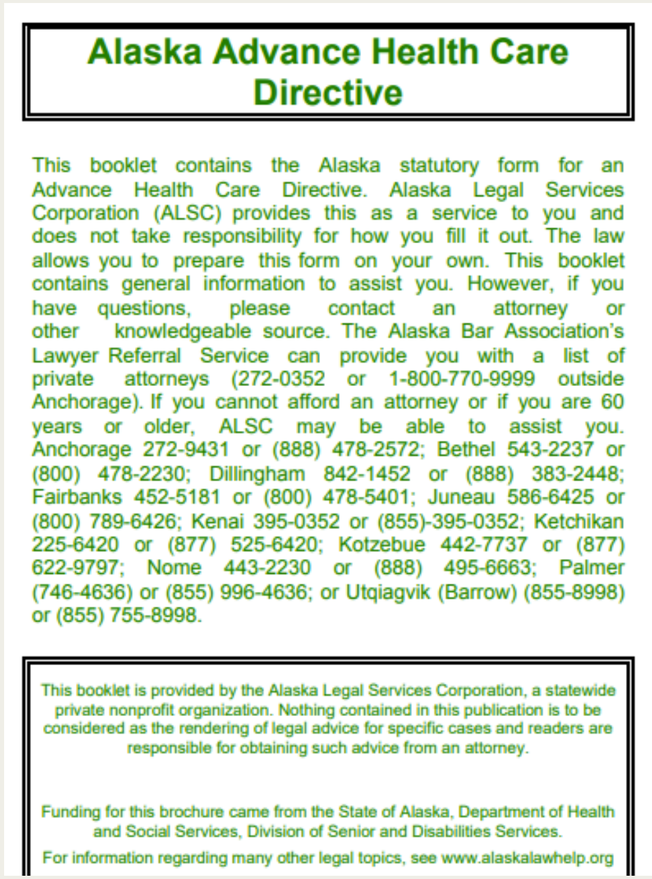

Alaska Advance Health Care Directive

This booklet contains the Alaska statutory form for an Advance Health Care Directive. Alaska Legal Services Corporation (ALSC) provides this as a service to you and does not take responsibility for how you fill it out. The law allows you to prepare this form on your own. This booklet contains general information to assist you. However, if you have questions, please contact an attorney or other knowledgeable source. The Alaska Bar Association's Lawyer Referral Service can provide you with a list of private attorneys (272-0352 or 1-800-770-9999 outside Anchorage). If you cannot afford an attorney or if you are 60 years or older, ALSC may be able to assist you. Anchorage 272-9431 or (888) 478-2572; Bethel 543-2237 or (800) 478-2230; Dillingham 842-1452 or (888) 383-2448; Fairbanks 452-5181 or (800) 478-5401; Juneau 586-6425 or (800) 789-6426; Kenai 395-0352 or (855)-395-0352; Ketchikan 225-6420 or (877) 525-6420; Kotzebue 442-7737 or (877) 622-9797; Nome 443-2230 or (888) 495-6663; Palmer (746-4636) or (855) 996-4636; or Utqiagvik (Barrow) (855-8998) or (855) 755-8998.

This booklet is provided by the Alaska Legal Services Corporation, a statewide private nonprofit organization. Nothing contained in this publication is to be considered as the rendering of legal advice for specific cases and readers are responsible for obtaining such advice from an attorney.

Funding for this brochure came from the State of Alaska, Department of Health and Social Services, Division of Senior and Disabilities Services.

For information regarding many other legal topics, see www.alaskalawhelp.org

Compassion & Choices and Alaska Advance Health Care Directive

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Your Conversation Starter Guide

How to talk about what matters to you and have a say in your health care.

Institute for Healthcare Improvement

the conversation project

Medical Record #:

Alaska POLST (Physician Orders for Life Sustaining Treatment) Form

lth care providers should complete this form only after a conversation with their patient or the patient's representative.
POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a
ious life-limiting medical condition, which may include advanced frailty.

ient Information. **Having a POLST form is always voluntary.**

is is a medical order,
t an Advance Directive.

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

nitial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

ssess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals.
sider a time-trial of interventions based on goals and specific outcomes.

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location, unless another treatment preference is documented in Section C of this form.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

dditional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
S protocols may limit emergency responder ability to act on orders in this section.)

Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

IGNATURE: Patient or Patient Representative (optional)

derstand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the
ent's representative, the treatments are consistent with the patient's known wishes and in their best interest.

The Conversation Project & POLST

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WHAT IS ADVANCE CARE PLANNING?

- Advance Care Planning (ACP) is a lifelong process of thinking (and talking) about what matters to you — your values, goals and preferences — and the care you would like to receive.

- ACP is also about talking to the people who matter most to you — and to your health care professionals — about your wishes.

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IMPORTANCE OF ADVANCE CARE PLANNING

- Offers ***peace of mind*** and ***eliminates confusion***
- It’s pre-plannings, so if/when unexpected event happens, ***loved ones are more prepared***
- Ensures your loved ones and health care team ***honors your wishes***
    - You receive medical care you want and don’t want
- Allows you to **choose a health care agent** to act on your behalf

MOST PEOPLE AGREE THIS IS IMPORTANT

80%

say it’s important to put their wishes in writing

37%

have actually done so

Genewick JE, Lipski DM, Schupack KM, et al.. Characteristics of patients with existing advance directives: evaluating motivations around advance care planning. Am J Hosp Palliat Med 2018;35(4):664–668; doi: 10.1177/1049909117731738

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BARRIERS TO ACP

- Barriers:
  - Don’t know enough about ACP or their role in making decisions about their health care.
  - Think that ACP is only for people nearing end of life.
  - Don’t know where to go for tools and resources.
  - Uncomfortable talking to family and friends about their wishes.

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WHAT IS AN ADVANCE DIRECTIVE?

- You can use an Advance Directive to:
  - say **<u>who</u>** (Durable Power of Attorney for Health Care) you want to speak for you and
  - what kind of **<u>treatments</u>** (Health Care Directive, Living Will) you want.

- These documents are called **“advance”** because you prepare *before* healthcare decisions need to be made.
- They are called **“directives”** because they state who will speak on your behalf and what should be done.

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Find the paper on which you wrote the 5 things that were most important to you at the EOL.

Cross out 2, so that there are 3 remaining.

Keep list handy!

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GOALS OF THE WORKSHOP YOU OFFER

After participating, your participants will:

- Be more knowledgeable about ACP and understand that it is a lifelong process.
- Be aware of the tools and resources that can assist with ACP.
- Walk away with a complete Advance Directive.
  - *If you do not already have a signed AD, prepare yours prior to training others!*

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YOUR ROLE AS THE FACILITATOR

As a workshop facilitator, your role is to:

- Create a comfortable and safe space where participants can talk about ACP.
- Provide key information about ACP in a way that all participants can understand.
- Share examples and stories that illustrate the importance of ACP as well as the ACP process.
- Answer questions and encourage participants to be part of the conversation.

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HOW TO PLAN FOR YOUR WORKSHOP

Planning the Workshop

- Choose a venue and date
- Advertise/promote the workshop
    - Set up a way to register
- Discussions to prepare participants
- Prepare handouts
- Arrange for equipment
- Plan for refreshments

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Find the paper on which you wrote the 5 things that were most important to you at the EOL.

Cross out 2, so that there is 1 remaining.

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KEY TAKE AWAYS FOR YOUR PARTICIPANTS

- To identify what is important
- To document their wishes
- That these wishes and documents are shared with friends/family/support systems/Dr’s
- And to *continue* the conversation!

DON’T FORGET TO CREATE YOUR OWN ADVANCE DIRECTIVE!

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NEXT STEPS

- Bring questions or email prior to 5/21
  info@alaskaendoflifealliance.com
- Next call: **May 21st (6:30-8:30pm)**
- **HOMEWORK:** Review Advance Directive & Materials
- Recording will be sent out

RESOURCES

- Your Guide to Choosing a Health Care Proxy
- Your Guide to Being a Health Care Proxy
- What Matters to Me Workbook
- Your Conversation Starter Guide