



A parent...a resident...ourselves...we carefully plan vacations, moves to a new city, retirement; but many of us aren't planning the approach to care we want when we're unable to speak for ourselves or when we are at the end of life. According to the study *The Final Chapter: Californians' Attitudes & Experiences with Death & Dying* conducted by the California HealthCare Foundation and the Coalition for Compassionate Care of California (CCCC), 85% of those surveyed think that end-of-life planning is important. However, only 23% have actually put their advance care decisions in writing.

Of course, this is completely understandable. End-of-life issues are hard topics to bring up and discuss with loved ones. But it is an important thing to do, nonetheless. We all have different ideas of what we want when it comes to care. Some may want only specific medical interventions, or may want interventions just in certain instances. It's hard to make quick decisions in emotionally charged situations, and what you think loved ones want may be different than what they would have chosen for themselves.

Advance care planning is the process of thinking about preferences for care at the end of life, and then having that conversation with family members. Advance planning can help ensure that your preferences are recognized and honored and also ease the decision-making process for family and loved ones.

The process begins by setting aside some time to think about your care options. Ask yourself questions like, "If I couldn't communicate, who would I want to make medical decisions for me?" A website called PREPARE for Future Care, developed by UC San Francisco, can walk you through this first step. In addition, the Coalition for Compassionate Care of California (CCCC) website

Consider, Discuss, Document: The Importance of Advance Care Planning

Photo: Advance care planning for seriously ill individuals focuses on thoughtful discussions between the physician and the patient. Photo used with permission from New York's MOLST Program (CompassionAndSupport.org.)

has an advance care planning conversation guide as well as information on care options, such as CPR, to help you understand what is involved and what to consider when making a decision.

The second and most important step in advance care planning is the discussion with family. Choose a time and place that is calming and free of distraction. If you're having trouble getting started, the CCCC website has many good resources to help facilitate this conversation.

Documenting your preferences comes next. For this step, you will need different tools depending, in part, on your situation. The Advance Health Care Directive form provides a recognized document for expressing your preferences and naming a surrogate to make decisions on your behalf if you become unable to do so. This document can be changed at any time. For copies of the form, talk to your health care provider or attorney, or visit CCCC website.

For those with a serious illness, a Physician Order for Life Sustaining Treatment (POLST) is a way to communicate end-of-life choices on an easily recognizable form that can travel between care settings and is immediately actionable by health care providers. POLST is different from a DNR in that it addresses a range of treatment options, and may order CPR, whereas a DNR only addresses resuscitation and only allows for forgoing treatment.■

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POLST in RCFEs

- ✦ POSLT should accompany the resident to the hospital or other care setting
- ✦ POLST must be signed by the physician
- ✦ POSLT should be on bright pink paper, but any color is valid
- ✦ POLST is not required under any circumstances

POLST Fact Sheet

CALA developed a list of question and answers, in collaboration with the Coalition for Compassionate Care, in order to help Assisted Living providers understand POLST and its role in Assisted Living communities. CALA members can access this Q&A on the CALA website www.CAassistedliving.org.

www.coalitionccc.org/advance-health-planning.php

www.calhospice.org

www.prepareforyourcare.org

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