



Conversations that Matter: Advance Care Planning for Rural Families

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Introduction and Welcome Letter

Thank you for your interest in teaching others about advance care planning. This is an important topic for individuals and their families. *Conversations That Matter: Advance Care Planning For Rural Families* is the result of a collaboration between North Dakota State University Extension, the College of Nursing at South Dakota State University, and SDSU Extension. This booklet is designed to be used to facilitate community education events in a variety of settings, including churches, lunch and learn events, community centers, and many more. These materials are designed to be used with adults of all ages.

The materials in this booklet were piloted with sociology students at South Dakota State University. Based on the results of the evaluation, the materials were refined to clarify some aspects of advance care planning. It is our hope to continue to improve the content of these materials. If you have questions or comments, please contact Leacey E. Brown, SDSU Extension Gerontology Field Specialist at either leacey.brown@sdstate.edu or (605) 394-1722.



Advance Care Planning Lesson Plan

Objectives

1. Increase understanding of the purpose of advance care planning.
2. Describe the difference between long term care planning and advance care planning.
3. Increase knowledge about the role of healthcare agent/proxy.

Overview

This lesson will introduce attendees to the topic of advance care planning. Attendees will watch a short video (5 minutes) that provides an overview of the topic. This video helps to ensure that attendees have the same level of knowledge and understanding. This video should be watched prior to attending the in-person session or prior to reading and discussing the case studies in small groups. This allows the in-person time to be focused on analyzing and applying the concepts and knowledge learned from the video.

Time requirements: 60 to 75 minutes

Target Audience: Adults age 18 and older

Number of participants: 15 to 20

Materials

- Advance Healthcare Planning video: <https://youtu.be/XCPIDpZU4CO>
- Handouts
 - Advance care planning case studies
 - Advance care planning lesson evaluation
 - How to get started with advance care planning
 - Myths and realities of advance care planning
 - Common advance care planning terms
- Flip chart/chalk board/dry erase board
- Markers/chalk
- Computer
- Speakers
- Internet access

Procedure

1. Welcome and introductions
 - a. Ice Breaker: ask each attendee to introduce themselves and share why they decided to attend this class.
 - b. Description of lesson purpose: increase knowledge about advance care planning and identify strategies to ensure their healthcare preferences are honored.
 - c. Overview of lesson structure
 - i. Watch video
 - ii. Small group discussion
 - iii. Report back to larger group
 - iv. Review key content/main ideas
2. Watch video: <https://youtu.be/XCPIDpZU4CQ>
3. Break larger group into 4 groups.
4. Give each group one case study and allow 5 to 10 minutes to read case study and answer questions.
5. One person from each group will report on their case study, using the following questions as a guide. Ask for a volunteer to record responses to questions on a chalk board or flipchart.
 - a. Identify which case study they had and provide a brief summary
 - b. Describe key issues/problems
 - c. What were the main theme(s) of the group discussion?
6. Review of Advance Care Planning: Key Content and Main Ideas Review
7. Conclusion
 - a. Thank the audience for their attendance and participation.
 - b. Distribute and collect the evaluation form.



Advance Care Planning: Key Content & Main Ideas Review

Instructions

After the group has discussed the case studies and reported to the larger group, the material below will revisit some of the content covered in the video and clear up common misconceptions. Ask for a volunteer from the audience to answer the following questions. Notes provide key elements that often require clarification.

Question 1: Describe the similarities and differences between a financial power of attorney and a medical power of attorney.

- a. Both designate someone to make decisions and act on your behalf.
- b. A financial power of attorney is typically active immediately, unless it includes specific language stating that it does not become active unless you become incapacitated.
- c. Medical power of attorney typically do not become active until a person is unable to communicate and make decisions for themselves. These typically become active when the patient does not have decision making capacity (e.g., unconscious after a serious accident).

Question 2: What is the difference between a Medical Power of Attorney and a Living Will?

- a. Medical Power of Attorney may be completed with the aid of an attorney and designates a person to speak on your behalf if you become incapacitated.
- b. A living will is a document typically provided by health care providers that allows you to write down the type of care you would like to receive in specific circumstances, if you are terminally ill and are unable to speak for yourself.
- c. A living will does not require the assistance of an attorney to complete. However, many states require living wills to be signed before two witnesses and before a public notary.

Question 3: What is the difference between long term care planning and advance care planning?

- a. Long term care refers to options for people who are not able to provide routine, daily care for themselves (bathing, cooking, medication management, cleaning, etc.).

- b. Long term care planning refers to making decisions about where you want to receive daily care (e.g., assisted living or at home) and how you will pay for this care.
- c. Many individuals who require daily assistance are often able to communicate their preferences and make decisions for themselves.
- d. Advance care planning is for situations when a person cannot communicate or make decisions, often due to an accident or sudden medical incident (e.g., stroke).
- e. Advance care planning may also be relevant for routine medical procedures (e.g., surgery), if complications take place.

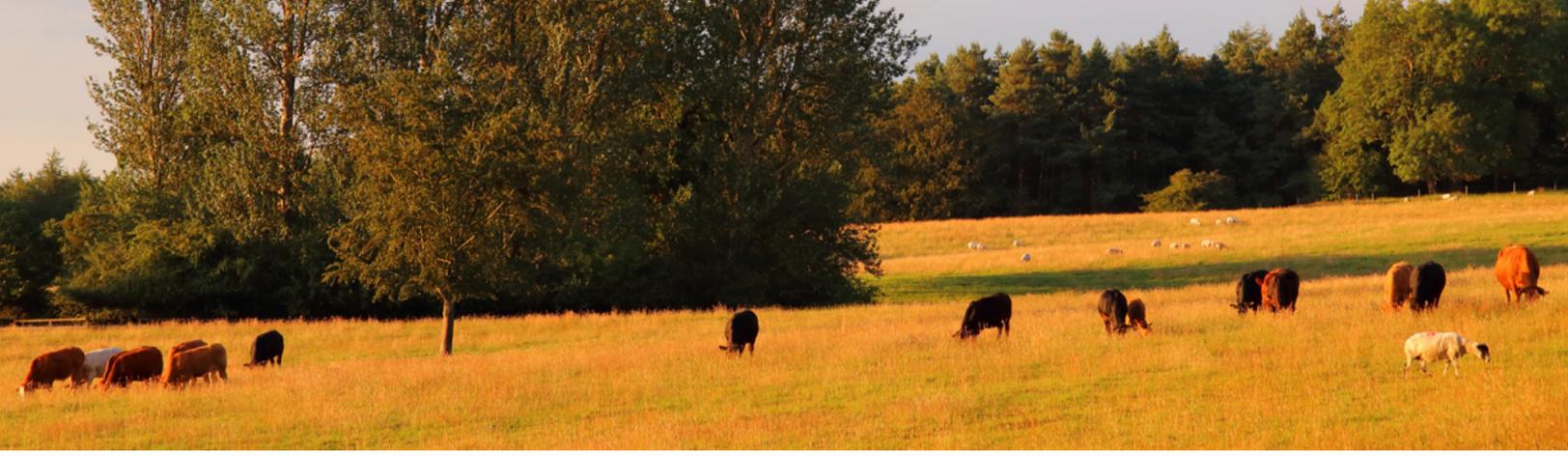
Question 4: When does the health care proxy or agent make medical decisions on your behalf?

- a. The healthcare agent or proxy ensures your preferences for healthcare are honored when it is determined you are not able to make healthcare decisions.
- b. Incapacitation refers to situations when a person is either physically or mentally unable to communicate their preferences, make decisions, or act on their own behalf.
 - i. Incapacitation can be a temporary situation such as being injured during an accident.
- c. The agent or proxy can only make decisions when it is determined you are not able to make healthcare decisions. You will not lose control of your medical care, if you develop an advance care plan and name an agent or proxy.

Question 5: What is the role of the health care proxy/agent?

- a. The duty of a proxy or agent is to make medical decisions for you that you would make for yourself, if you were not able to communicate your preferences and wishes.
- b. This is a person that you have discussed your preferences with and has agreed to follow your wishes.
- c. If you have not identified a healthcare agent or proxy, your closest family member will be asked to make decisions (spouse, adult children, parents, siblings, etc.)

HANDOUTS



Advance Care Planning: Case Studies

Case study 1 – Ranch Accident

It was early fall on the ranch. It was time to bring the cattle in to winter pasture. While loading up the horses in the trailer, Bill was kicked in the head. He immediately lost consciousness. His crew tried to bring him around with no luck. Emergency services were called and he was medevacked to a larger community to receive care. Bill's wife, Anna, had to drive an hour to get to the hospital. When Anna arrived, Bill was stable, but the doctor was concerned about intracranial hematomas and hemorrhages along with skull, facial, and spine fractures. The nurse was asking Anna questions about Bill's medical history to complete Bill's hospital admission. Anna was so upset; she just wanted to know if Bill was going to be okay. While Anna waited for the CAT scan to be performed, she was calling to make arrangements for someone to care for the kids for the evening. Hours later the doctor came to talk to Anna. He said Bill had hematomas that required surgery to relieve the pressure on the brain. Fortunately, there were no broken bones. They were calling in a neurosurgeon to perform the procedure. In the meantime, the doctor needed to go over information about the surgery (time, risks, etc.) and receive Anna's consent to perform the procedure. Anna was so tired she could barely process what she was being told about the procedure.

Discussion Questions

1. What are your initial thoughts about the circumstances described in the case study?
2. What issues or problems do you see here? How does this impact decision making?
3. How would the health care proxy/agent ensure Bill's preferences for care are honored?
4. How could advance care planning make this difficult situation easier?



Case study 2 – Thanksgiving Accident

November is a beautiful time in the Midwest. It was Thanksgiving week and the Smith family was planning to travel a few hours to spend the holiday with family. On Thanksgiving Day, they woke up to a beautiful white landscape. It had snowed overnight. It was only a few inches so the family decided to make the trip. While on the way an unfortunate event occurred, a deer darted out of the ditch in front of the car. The driver did everything right, but the roads were snow covered and the car went sliding off the road and barreled into a tree. The mother and father were both unconscious and pinned in their seat. The children in the back seat were scared but okay. Fortunately, a family in a different car traveling behind the Smith family saw what happened. They arrived at the scene and dialed 911. While waiting for help to arrive, the good Samaritan talked calmly to the children trying to make them feel better. They looked okay but he didn't want to risk moving them in case they had injuries that could not be seen. When help arrived, emergency services had to use the Jaws of Life to free the mother and father from the car. By the time the mother was freed from the car, she was beginning to regain consciousness. She was disoriented but seemed to only have a minor head injury. Unfortunately, the steering wheel had been wedged against the father's chest and the emergency professionals were concerned about internal bleeding and other injuries. Because of the difference in severity of injuries, the mother and children were taken to the nearest hospital and the father was medevacked to an urban community with more specialists available to treat him.

Discussion Questions

1. What are your initial thoughts about the circumstances described in the case study?
2. What issues or problems do you see here? How does this impact decision making?
3. How would the health care proxy/agent ensure the Smith's family preferences for care are honored?
4. How could advance care planning make this difficult situation easier?



Case study 3 – Unexpected Lump

Nancy was healthy overall, but she had recently noticed some bleeding. Since she went through menopause 35 years ago, she knew she needed to see her doctor. After not finding anything during the physical exam, the doctor recommended an ultrasound. Nancy attended the appointment for the ultrasound and then waited to hear the results. A week later the doctor called her in to review the results. Nancy decided to bring her daughter, Melanie, with her. During the appointment, the doctor reported that a mass had been found on Nancy's uterus. It was about the size of a quarter. The doctor explained that the ultrasound could not tell us if the mass was cancer or not. A biopsy was needed. Once that test was completed, then the doctor would be able to talk about next steps which might include chemotherapy, surgery, or nothing at all. Nancy was upset. She told the doctor she needed some time to think about what was best for her.

Discussion Questions

1. What are your initial thoughts about the circumstances described in the case study?
2. What issues or problems do you see here? How does this impact decision making?
3. How would the health care proxy/agent ensure Nancy's preferences for care are honored?
4. How could advance care planning make this difficult situation easier?



Case study 4 – The stroke

Summer time is full of family fun! Janet enjoyed the extra time with her boys, Caleb and Ben. Both boys were involved in 4-H shooting sports. While at one of the competitions, Janet noticed that her leg was feeling numb. She figured she had been sitting for too long so she decided to stand up and stretch her legs a bit. Suddenly she became very dizzy and had a sharp headache. As she looked around, she felt disoriented and uncertain where she was. Janet was having a stroke. She crumpled to the ground. Bystanders saw her fall and came to her aid. They called 911 and she was rushed to the local hospital.

Discussion Questions

1. What are your initial thoughts about the circumstances described in the case study?
2. What issues or problems do you see here? How does this impact decision making?
3. How would the health care proxy/agent ensure Janet's preferences for care are honored?
4. How could advance care planning make this difficult situation easier?



Advance Care Planning: **Lesson Evaluation**

Instructions: Please rate your level of agreement with the following statements.

1. As a result of this session, I have more knowledge about advance care planning.
 - Strongly disagree
 - Disagree
 - Somewhat disagree
 - Somewhat agree
 - Agree
 - Strongly agree

2. As a result of this session, I understand the difference between advance care planning and long term care planning.
 - Strongly disagree
 - Disagree
 - Somewhat disagree
 - Somewhat agree
 - Agree
 - Strongly agree

3. As a result of this session, I plan to create, review, or update my advance care plan.
 - Strongly disagree
 - Disagree
 - Somewhat disagree
 - Somewhat agree
 - Agree
 - Strongly agree

4. Comments or additional feedback:



How to get started with advance care planning

1. Discuss your preferences
 - a. Starter questions by Atul Gawande (Source - Being Mortal: Medicine and What Matters in the End):
 - i. What do I understand about my health today and likely outcomes?
 - ii. What questions do I have for my provider about my health?
 - iii. What are my fears and worries?
 - iv. What are my goals and priorities?
 - v. What tradeoffs am I willing/not willing to make?
 - vi. How would a good day look?
 - b. Include family and loved ones in the conversation.
 - c. Include clergy or other spiritual/religious adviser in the conversation.
 - d. Trained volunteers are available to help you have the conversation between you and your healthcare proxy or agent:
 - i. Honoring Choices North Dakota – 701-989-6228
 1. Website: <https://www.honoringchoicesnd.org/>
 - ii. South Dakota Quality Conversations Program
 1. Website: <https://www.advancedcareplanningsd.com/>
 - e. Most important: give yourself and your loved ones time to process this discussion. It may be the most difficult conversation of your life. You and your loved ones will take comfort in knowing they are making decisions that honor you, if needed.
2. Put it in writing
 - a. Request an advance directive form from your medical provider. Some medical providers have made their advance directive forms available for download from their website.
 - b. Identify one person to serve as your healthcare agent or proxy.
 - c. If you have a chronic health condition, it may be helpful to visit with your medical providers about your health care wishes

- d. Review and complete the form carefully.
 - e. Sign the form before a Notary Public.
3. Give copies of the advance healthcare directive to:
- a. Your healthcare agent or proxy.
 - b. Your healthcare provider.
 - c. Store a copy with other important paperwork in a place that is easily accessible to others, including your proxy or agent.
4. Review Regularly
- a. Marriage, divorce, loss of a loved one, medical diagnosis, or end-of-life decline impact your healthcare planning preferences so review the document at least every year.



Helpful Resources

Disclaimer: The following is presented for informational purposes only. Neither NDSU Extension or SDSU Extension endorse the services, methods or products described herein, and makes no representations or warranties of any kind regarding them.

Comfort One (Do not resuscitate) South Dakota

An order that tells emergency medical service personnel to not start emergency rescue techniques (CPR) if a breathing or cardiac failure happens. It is a signed medical order. It is signed by or on the behalf of a person and a medical provider. This document is appropriate for persons living in the community setting. Emergency service personnel identify if a person has a Comfort One from the Comfort One form, or if the person is wearing a Comfort One bracelet. If a person does not have a Comfort One, emergency medical service personnel, by law, are to start CPR. For more information, please visit the South Dakota Department of Health website: <https://doh.sd.gov/providers/ruralhealth/ems/advanced-directives.aspx>.

Conversation Starter Kit

The Conversation Starter Kit is a useful tool to help you have the conversation with a family member, friend, or other loved one about wishes regarding end-of-life care. It is available in several languages. All of the Starter Kits are available to download and print for free. Visit The Conversation Project website to download the kits: <https://theconversationproject.org/starter-kits/>

Hello Game by My Gift of Grace

My Gift of Grace is a conversation game. In the box, you'll find an instruction sheet, 47 Question Cards, and 32 Thank You chips. During each turn, all the players have a chance to share their answers to the same question, trading chips as part of the game play. Questions in the game cover a wide variety of topics about living and dying well, and games can last anywhere from 20 minutes to three hours or more. The game can be played by families, co-workers, teams, strangers, or a mix of any of these. There are no age restrictions or experiences you need to have before you play. The game adjusts itself to the level of comfort of the players and to how long a group wishes to play. To learn more, please visit the My Gift of Grace website: <http://www.mygiftofgrace.com/>

National Healthcare Decisions Day (NHDD) website

National Healthcare Decisions Day (NHDD) exists to inspire, educate, and empower the public and providers about the importance of advance care planning. NHDD is an initiative to encourage patients to express their wishes regarding healthcare and for providers and facilities to respect those wishes, whatever they may be. This website has many tools available to help individuals and families explore the topic of advance care planning. To learn more, please visit the NHDD website: <https://www.nhdd.org/>

Medical Orders for Scope of Treatment (MOST) - South Dakota

Available in South Dakota. It is a medical provider's order that outlines a plan of care respecting the patient's wishes concerning care at end of life. MOST is not a legal document. It is a transportable medical order signed by a health care provider for individuals with a terminal illness. The goal of the MOST initiative is to inform and empower patients to clearly state their end-of-life care wishes, and to authorize health care providers to carry out those wishes. This form is valid across all care settings and in all facilities, including the home. MOST is a medical order, not an advance directive. An advance directive is a legal document and a way to name a durable power of attorney for healthcare (a healthcare agent) and/or a living will (providing general treatment wishes). Patients diagnosed with a terminal condition should have both documents as a part of their advance care plan. To learn more, please visit <https://doh.sd.gov/providers/most/>

Physicians Orders for Life-Sustaining Treatment (POLST) – North Dakota

Available in North Dakota. It is a signed medical order that communicates a patient's wishes for emergency treatment when the person is seriously ill, frail, or at the end of life. This document lists a patient's wishes for cardiopulmonary resuscitation (CPR), breathing support (ventilators), treatments for life-threatening problems, and being taken or admitted to the hospital. This form is valid across all care settings and in all facilities, including the home. The patient keeps a copy of the form in case emergency responders need to know their choices. To learn more, please visit <https://www.honoringchoicesnd.org/polst/>.

The Go Wish Game

Go Wish gives you an easy, even entertaining way to talk about what is most important to you. The cards help you find words to talk about what is important if you were to be living a life that may be shortened by serious illness. To learn more, please visit the Go Wish website: <http://www.gowish.org/index.php>.

Tool Kit for Health Care Advance Planning by the American Bar Association

This tool kit contains a variety of self-help worksheets, suggestions, and resources. There are currently 9 tools in all, each clearly labeled and user-friendly. The Tool Kit does not create a formal advance directive for you. Instead, it helps you do the much harder job of discovering, clarifying, and communicating what is important to you in the face of serious illness. To access this tool kit, please visit the American Bar Association website: https://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/consumer_s_toolkit_for_health_care_advance_planning/.

PREPARE for Your Care

PREPARE for Your Care is an easy-to-use website that provides video stories to help people engage in advance care planning. These videos are divided into 5 steps: choosing a medical decision maker, deciding what matters most in life, choosing flexibility for your decision maker, telling others about your medical wishes, and asking doctors the right questions. To access this resource please visit: <https://prepareforyourcare.org/welcome>.



Myths and Realities of Advance Care Planning

MYTH 1: There is only one type of power of attorney.

REALITY 1: Many patients (and their families) think if they have power of attorney for financial matters, they also have power of attorney for health care. These are typically separate legal documents, but can be combined into one comprehensive document prepared by an attorney.

MYTH 2: Advance care planning should not begin on an outpatient basis.

REALITY 2: Many studies have shown that patients want their doctors to talk about advance care planning with them before they become ill. Many patients have a positive response when advance care planning discussions are held during outpatient visits.

MYTH 3: An advance directive means “don’t provide medical care”.

REALITY 3: Advance directives do not say “don’t give me medical care”. They say, “give me the medical care I would ask for, if I could not speak for myself”.

MYTH 4: Once a person names a proxy or agent in an advance directive they lose control of their own care.

REALITY 4: As long as a person has decision making capacity, he/she has control of their medical care. A doctor determines if a person has decision-making capacity.

MYTH 5: A lawyer is required to complete an advance directive.

REALITY 5: A lawyer may be helpful, but is not required. Again, check your own state requirements for the number of witnesses or the need for a notary public seal.

MYTH 6: Doctors and other health care providers (doctors, nurses, specialist, etc.) are not legally required to follow advance directives.

REALITY 6: Doctors and other health care providers (doctors, nurses, specialist, etc.) are required to follow advance directives.

MYTH 7: My doctor can be my proxy or agent while caring for me as a patient.

REALITY 7: If a doctor is named as your agent or proxy, they can no longer be your doctor.

MYTH 8: Only older people need advance directives.

REALITY 8: Tragedies can happen at any age, so every adult should have advance care planning in place. Family members and health care providers (doctors, nurses, specialist, etc.) should be made aware of those plans.

MYTH 9: Once advance directives are signed, they cannot be changed.

REALITY 9: Advance directives can be changed at any time; they should be reviewed at least every year and updated whenever major life changes occur. A lawyer does not need to be involved to create initial directives or to revise them.

MYTH 10: If I am living at home and my advance directive states that I do not want CPR, I will not be resuscitated by Emergency Medical Service (EMS) responders.

REALITY 10: Your advanced directive cannot usually be followed in this situation. When 911 is called, EMS responders must provide life-sustaining treatment, UNLESS you have an Out-of-Hospital Do-Not-Resuscitate (DNR) order, such as Comfort One South Dakota (<https://doh.sd.gov/providers/ruralhealth/ems/advanced-directives.aspx>) or North Dakota POLST (<https://www.honoringchoicesnd.org/polst/>).

MYTH 11: My doctor is the only one who needs a copy of my advance directive.

REALITY 11: It is important to have your advance directive available when needed in an emergency. For this reason, the following people and places are recommended for having a copy of your advance directive.

- Physician
- Hospital(s) most likely to treat you
- Each of your healthcare agents or proxies
- Family members close to you
- Your lawyer
- Keep a copy in your glovebox of your vehicle
- Keep a copy in your home where it can be easily found

Common Advance Care Planning Terms

- **Advance care planning (ACP)** – A process for setting goals and plans with respect to medical care and treatments. It requires conversations between the individual and his or her family, key health care providers, and anyone else who may be involved in decision-making. It can begin at any point in a person’s life, regardless of his or her current health state and, ideally, is documented in an advance directive or recorded in your medical record, revisited periodically, and becomes more specific as your health status changes.
- **Advance directive** – The general term for any document in which you provide instructions about your health care wishes or appoint someone to make medical treatment decisions for you when you are no longer able to make them for yourself. Living wills and durable powers of attorney for health care are both types of advanced directives.
- **Antibiotics or antiviral medications** can be used to treat many infections. If you were near the end of life, would you want infections to be treated aggressively or would you rather let infections run their course?
- **Capacity** means a patient’s ability to make medical decisions. Does he or she have the ability to understand the medical problem? Does he or she understand the risks and benefits of the treatment options? The word does not mean the same as competency. Competency is a legal status ordered by the court.
- **Cardiopulmonary resuscitation (CPR)** attempts to restart the heart when it has stopped beating. Determine if and when you would want to be resuscitated by CPR or by a device that delivers an electric shock to stimulate the heart.
- **Comfort care** includes any number of interventions that may be used to keep you comfortable and manage pain while abiding by your other treatment wishes. This may include being allowed to die at home, getting pain medications, being fed ice chips to soothe mouth dryness, and avoiding invasive tests or treatments (medical procedures that break the skin and likely require follow up medical care).
- **Dialysis** removes waste from your blood and manages fluid levels if your kidneys no longer function. Determine if, when, and for how long you would want to receive this treatment.
- **Donating your body** for scientific study also can be specified. Contact a local medical school, university, or donation program for information on how to register for a planned donation for research.
- **Durable power of attorney for healthcare (or Healthcare Proxy)** – A type of advance directive in which you appoint someone else to make all medical treatment decisions for you, if you cannot make them for yourself. The person you name is called your agent, proxy, representative, or surrogate. You can also include instructions or guidelines for decision-making.

- **DNR** – Do not resuscitate; allow natural death. Written or verbal medical order.
- **Emergency medical services (EMS)** refers to a group of agencies that provide emergency care. This care is usually to persons outside of healthcare facilities. EMS personnel generally include paramedics, first responders and other ambulance crew.
- **Hospice** is for a person that a doctor says may die within the next six months. Hospice supports the patient and family. Hospice is made up of a team of people with special training. The team helps with pain and symptom control, spiritual needs, money, and legal issues. They help with other needs as well. Care may be provided at home or in the hospital, nursing home, or other settings.
- **Intubation** refers to “endotracheal intubation.” A tube is inserted through the mouth or nose into the trachea (windpipe). It is used to create and maintain an open airway to help the patient breathe.
- **Life-sustaining treatments** replace or support a vital body function (also called life support treatments). This can include CPR, breathing tubes, nutrition and hydration through tubes and IV’s, kidney dialysis, and other treatments.
- **Living will** – A type of advance directive in which you state your wishes about care and treatment you want or don’t want if you are no longer able to speak for yourself. Normally, living wills address one’s preferences about end-of-life medical treatments, but they can also communicate your wishes, values, or goals about any other aspect of your care and treatment. These documents are signed and notarized.
- **Mechanical ventilation** is also known as a ‘breathing machine’. A machine forces air into the lungs through a tube that is inserted into the nose or throat. The machine does the breathing work for the lungs to keep oxygen moving that is necessary for life.
- **Natural death** - Death by natural causes, as recorded by coroners and on death certificates and associated documents, is death resulting of an illness or an internal malfunction of the body not directly caused by external forces, typically due to old age, but not always.
- **Organ and tissue donations** for transplantation can be specified in your living will. If your organs are removed for donation, you will be kept on life-sustaining treatment temporarily until the procedure is complete. To help your health care agent avoid any confusion, you may want to state in your living will that you understand the need for this temporary intervention.
- **Palliative care** is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient’s prognosis. This care is appropriate at any age and at any stage in a serious illness.

- **POLST/MOLST/POST** – “Physician Orders for Life-Sustaining Treatment” (also referred to by other terms, such as “Medical Orders for Life-Sustaining Treatment” or “Provider Orders for Scope of Treatment”) Is a set of medical orders in a standardized format. These orders address key critical care decisions consistent with the patient’s goals for care and results from a clinical process. A key goal is to facilitate shared, informed medical decision making and also communicate care goals of patients with health care providers (doctors, nurses, specialist, etc.).
- **Tube feeding (artificial hydration and nutrition)** supplies the body with nutrients and fluids intravenously or via a tube in the stomach. Decide if, when, and for how long you would want to be fed in this manner.
- **Ventilator (respirator)** is a machine that pushes air into the lungs. To do this, a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own; cannot breathe well enough to get oxygen to the cells of the body; or rid the body of carbon dioxide, which is vital for life.
- **Withholding or withdrawing treatment** means to stop life-sustaining treatments. It can also mean to stop treatments after they have been used for a certain amount of time. This is generally done when treatments are no longer helping to improve a patient’s health or the treatment is causing more symptoms.