

**Useful Resources**

**Link**

NJ DOH (Instruction Directive & Proxy Directive)	<a href="http://www.nj.gov/health/advancedirective/ad/forums-faqs/">http://www.nj.gov/health/advancedirective/ad/forums-faqs/</a>
Aging with Dignity (5 Wishes)	<a href="https://www.agingwithdignity.org/five-wishes">https://www.agingwithdignity.org/five-wishes</a>
Goals of Care (POLST)	<a href="http://www.goalsofcare.org/nj-polst/nj-polst-form/">http://www.goalsofcare.org/nj-polst/nj-polst-form/</a>
Death Over Dinner	<a href="http://deathoverdinner.org/">http://deathoverdinner.org/</a>
National Institute on Aging	<a href="https://www.nia.nih.gov/health/publication/advance-care-planning/">https://www.nia.nih.gov/health/publication/advance-care-planning/</a>
New Jersey Hospital Association	<a href="http://bit.ly/2j9omKk">http://bit.ly/2j9omKk</a>
Advance Care Planning Decisions	<a href="https://acpdecisions.org/products/videos/">https://acpdecisions.org/products/videos/</a>
Family Caregiver Alliance	<a href="http://bit.ly/2k8Q7SR">http://bit.ly/2k8Q7SR</a>
Conversation Starter Kit	<a href="http://theconversationproject.org/starter-kit/intro/">http://theconversationproject.org/starter-kit/intro/</a>
Toolkit for Health Care Advance Planning	<a href="http://bit.ly/1nSihdi">http://bit.ly/1nSihdi</a>
CSU Institute for Palliative Care	<a href="https://csupalliativecare.org">https://csupalliativecare.org</a>

**Good Books to Read**

- Being Mortal, Atul Gawande
- Can't We Talk About Something More Pleasant?, Roz Chast
- Final Exam, Pauline Chen
- The Conversation: A Revolutionary Plan for End-Of-Life Care, Angelo Volandes
- The Best Care Possible, Ira Byock
- When Breath Becomes Air, Paul Kalanithi

**Good Films to Watch**

- Amour
- Being Mortal: PBS Frontline Documentary
- Consider the Conversation
- Life As A House
- The Bucket List
- The Diving Bell and the Butterfly

*Conversation of Your Life (COYL) is a program of the New Jersey Health Care Quality Institute's Mayors Wellness Campaign. The program aims to bring advance care planning conversations to NJ communities. Conversation of Your Life is generously supported by The Horizon Foundation for New Jersey. To learn more, visit [www.njhqci.org/COYL](http://www.njhqci.org/COYL).*



**What is advance care planning and why is it important?**

Advance care planning consists of sharing your preferences for end-of-life care with loved ones and doctors and putting them in writing, so in the case that you are unable to speak for yourself, the health care treatment you receive at the end of life is consistent with what you want. More than anything, advance care planning is a gift of clarity for both you and your family. Indicating your preferences for end-of-life care well ahead of time saves your loved ones from having to make emotionally taxing decisions on your behalf; instead, they can have clarity in their actions and focus on spending time with you.



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We understand that advance care planning can be daunting – not only because it is difficult for many of us to think about aging and death, but also because there are a lot of terms and forms that can complicate the process. This *checklist* simplifies things for you, so you can start—and finish—your advance care planning journey.

### 1. Consider.

- Consider your own priorities for end-of-life care.
- Consider what might happen if you don't discuss end-of-life care and become unable to make healthcare decisions for yourself.

### 2. Communicate.

- Communicate your end-of-life care wishes with your loved ones and doctors.

### 3. Create.

- Designate your health care agent (the person who can legally make decisions for you if you are incapable of making them on your own), and formalize this relationship by signing your *Proxy Directive*.
- Put your end-of-life care wishes in writing. There are several options. You do not need to fill out all of these forms. Take a look at them and decide what is right for you.
  - *New Jersey Instruction Directive* (requires two witness signatures **or** notarization)
  - *5 Wishes* (requires two witness signatures)
  - *POLST* (requires signature of attending doctor or nurse practitioner)
- Share your advance directives with loved ones and your healthcare providers.
- Keep your advance directives in an accessible and secure location.
- Revisit your advance directives and end-of-life conversations every few years.

## Advance Care Planning: Useful Terms

### Advance Directive:

An advance directive is a legal document that allows you to spell out your decisions about end-of-life care ahead of time. Each state's advance directive varies. In New Jersey, you do not need a lawyer to complete an advance directive. If you choose to get your advance directive notarized, you don't need additional witnesses; if you choose not to get your advance directive notarized, you must sign and date it in front of two adult witnesses who must also sign and date the document. The form can be updated and/or cancelled at any time. In New Jersey there are two parts to the Advance Directive—the Living Will (Instruction Directive) and the Power of Attorney (Proxy Directive).

### Living Will (Instruction Directive):

A living will is a written, legal document that spells out medical treatments you would and would not want to be used to keep you alive, as well as other decisions such as pain management or organ donation. Have conversations with your primary care doctor, family, friends, and anyone you feel comfortable with to determine your personal wishes regarding these issues.

### Durable Power of Attorney for Health Care (Proxy Directive):

The proxy directive is where you name a person to make decisions for you when you are unable to do so. This person can be anyone—family or friend—except for your personal doctor. The Proxy Directive will only go into effect if you are no longer able to speak for yourself.

### Five Wishes:

The Five Wishes is an alternative form that is acceptable as an Advance Directive in the state of New Jersey. The Five Wishes form is written in everyday language and has become the most popular Advance Directive in America.

## Practitioner Orders for Life-Sustaining Treatment (POLST):

A POLST form is a medical order indicating your preferences for end-of-life care. In most states, this form is intended for use only during the final stages of life. In New Jersey, the POLST form can be filled out at any time. It is filled out with your doctor or nurse practitioner based on the contents of your directives, discussions with your doctor or nurse practitioner, and your treatment preferences.

POLST forms are intended for people who have already been diagnosed with serious illness, so even if you have one before, it is important to speak with your doctor or nurse practitioner regularly and update your POLST form as your preferences change as you age. The POLST serves as practitioner-ordered instructions—not unlike a prescription—to ensure that, in case of an emergency, you receive the treatment you prefer. A POLST travels with you, at whatever facility you are being cared for.

## Hospice

Hospice offers medical care toward a different goal: maintaining or improving quality of life for someone whose illness, disease or condition is unlikely to be cured. Each patient's individualized care plan is updated as needed to address the physical, emotional and spiritual pain that often accompanies terminal illness. Hospice care also offers practical support for the caregiver(s) during the illness and grief support after the death. Hospice is something more that is available to the patient and the entire family when curative measures have been exhausted and life prognosis is six months or less.

## Palliative Care

A comprehensive approach to treating serious illness that focuses on the physical, psychological and spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering and controlling pain and symptoms. Palliative care may be given at any time during a patient's illness, from diagnosis on.