Advance Care Planning Definitions

Advance Care Planning: Advance care planning is making choices about what you would want if you were too sick to talk. The three steps are:

- Thinking about what is important to you
- Thinking about what kind of choices you might have to make
- Telling others what you would like by talking to them and writing Advance Care Planning documents.

Advance Care Planning documents (advance directives) can be changed at any time and completed by anyone over 18. They include these two forms:

- Durable Power of Attorney for Health Care (DPOA): names a person you trust to make choices about your healthcare in the event that you were too sick to talk
- Health Care Directive and/or Living Will: outlines what care you would want if you were too sick to talk

The last step, telling other people what is important to you and what you would want if you were too sick to talk, is one of the most important parts of the process. The VMC Advance Care Planning website has tools that can assist you with finishing documents and having conversations.

1. **Code status:** A medical order showing if a patient wants *cardiopulmonary resuscitation* (CPR) and other medical treatment. All patients will receive CPR and medical treatment to extend their life unless shown otherwise.
    - **CPR:** Emergency care to try to restart a patient's heart and breathing if they stop. This care may include pressing on a patient's chest, putting in a breathing tube to get oxygen into a patient's body, and/or electric shock and medicines.

2. **Durable Power of Attorney for Health Care**: A durable power of attorney for health care is a legal form where a patient can name a person they trust to make health care decisions for them if he or she is too sick to talk. It is important for that person of trust to know what is important to the patient ahead of time. This form must be notarized OR witnessed by two people (only some people may witness).

3. **Health Care Agent/Proxy**: A person(s) a patient trusts who is named in a Durable Power of Attorney for Health Care form. The person makes choices about a patient's care if they are too sick to talk.

4. **Health Care Directive (or Living Will):** A legal form where a person states the kind of care they would want. It also guides health care staff and a health care agent when a patient is too sick to talk. This form must be notarized OR witnessed by two people (only some people may witness).

5. **Hospice**: Care to reduce a patient's symptoms and help them to be comfortable at the end of their life. To qualify for hospice, a doctor must think that a patient is likely to live six months or less. The goal of treatment changes from helping a patient to live as long as possible, to instead be as comfortable as possible. Hospice care is given by a team at home (person's home, nursing home, adult family home).

6. **Life-sustaining treatment**: Care to keep a patient alive by helping or taking the place of a body's functions. Some examples are CPR, a breathing machine, a feeding tube and kidney dialysis. Treatments like these may be used for a short time until a patient can recover and function on their own. They can also be used for a long time, even when there is no chance a patient will get better.

7. **Palliative Care**: A service for patients of any age with any kind of serious illness and at any stage of their illness. The goal of care is to ease a patient's symptoms and reduce the stress they may feel because of their illness. Unlike hospice care, palliative care can be given along with health care that is meant to cure an illness.

8. **Permanent unconscious condition:** When a patient is not likely to wake up from a coma or vegetative state and two doctors think there is little chance the patient will get better.

9. **Terminal condition**: When a doctor thinks a patient cannot be cured and is likely to die from the illness.

10. **POLST** (Physician Orders for Life-Sustaining Treatment): A form that lists a patient's wishes for health care, including if they want CPR or a breathing machine. A POLST is usually for patients with a serious illness and must be filled out and signed with a doctor, nurse practitioner or physician assistant.

11. **Surrogate decision-maker**: If a patient has not completed a Durable Power of Attorney for Healthcare form, then Washington state law decides who can make health care choices for a patient when they are too sick to talk. The state list in order: 1) appointed guardian, 2) appointed Durable Power of Attorney for Healthcare, 3) spouse or registered domestic partner, 4) adult children of the patient, 5) parents of the patient, 6) siblings of the patient, 7) adult grandchildren of the patient, 8) adult nieces and nephews of the patient, 9) adult aunts and uncles of the patient, 10) a close friend (with limitations and requirements) of the patient. If there is a group of relatives that include more than one person, then the whole group must agree to the health care decision.