

*Deciding Tomorrow...*

*today.*

*Advance Directives Toolkit*



Your Time. Your Choices.

*Deciding Tomorrow...Today* is a program to help facilitate those important conversations about end of life values, choices and priorities among individuals, family members, friends, faith leaders and healthcare providers both now and in the future. The sooner you talk about your wishes the sooner you and your loved ones will feel comfortable and prepared. This toolkit is designed to help make those important considerations as simple and easy as possible.

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## *I. Information on selecting a healthcare agent with Durable Power of Attorney (DPOA) for healthcare*

What are my healthcare wishes? It's a big question that requires some big decisions. That's why we created a toolkit to help you establish the best advance care plan for you. These tools guide you through important considerations and aid you in making the best decisions possible so you can feel comfortable about having a conversation with loved ones about your healthcare wishes so everyone is on the same page.



In Nevada, you have the right to make decisions regarding the use of life-sustaining treatment. In some cases, patients are unable to make decisions for themselves, which is why it's important to have a designated healthcare agent also called a proxy with Durable Power of Attorney (DPOA).

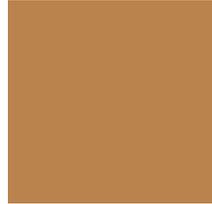
A DPOA is a signed, dated and witnessed document naming another person as your "healthcare agent" or "proxy" to make medical decisions for you in the event you are unable to make them yourself. Of course, it's vital to make this decision before an accident, emergency or illness.

How do I choose a healthcare agent? It's always smart to think about choosing a person you trust to make these decisions and who can effectively communicate your wishes regarding treatment goals, procedures, and

all healthcare related matters in the event that you are unable to make these decisions yourself.

Should you decide to appoint a spouse or close family member to act as your healthcare agent, as many people do, keep in mind that they may be required to make difficult decisions regarding your care, such as the initiation or termination of certain care measures.

You may also decide to choose two people to act as either co-agents, where they serve as equals, or successive agents where the second appointed person will act in the event that the first person cannot. This takes some thought and may require a few conversations.



The following questions can help you determine if you've made the best decisions choosing a healthcare agent:

- Is this person an adult (must be at least 18 years old)?
- Do they agree to accept this role?
- Do they have the emotional and mental ability to uphold your wishes even if they conflict with their own?
- Are they able to communicate effectively on your behalf with healthcare providers?
- Do you view them as calm and focused during emotional times and periods of stress?
- Are they willing to withhold or withdraw life-prolonging equipment if this is your choice?

Once you feel you've made the best choice, complete the DPOA paperwork designating this person (or persons) to be your healthcare agent. In the document, feel free to include any specific requests regarding your treatment goals, preferences and wishes.

When the DPOA paperwork is complete, provide a copy to your healthcare agent, family members and healthcare providers. The most current advance directive document may also be sent to the Nevada Living Will Lockbox. More information on the Nevada Living Will Lockbox is provided in Section 6.

You may revoke or change this document at any time. Revocation is done in writing and appropriately signed and dated. Make sure to provide a copy of the new document to your healthcare providers and any other recipients of the original document.

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## *II. Personal Priorities and Spiritual Values Important to Your Medical Decisions\**

Name & Date \_\_\_\_\_

We all have personal priorities and spiritual beliefs that may affect our medical decisions. This is especially true at the end of life with regard to the use of life-sustaining treatments. To make your values and beliefs clearer, consider answering the questions below. Use more paper if you need more space.

### *Personal Priorities/Concerns (What are my...)*

1. What do I most value about my physical or mental well-being? For example, do you love to be outdoors? To be able to read or listen to music? To be aware of your surroundings and who is with you? Seeing, tasting, touching
  
2. What are my thoughts regarding healthcare at the end-of-life?
  
3. Would I want to be sedated if it were necessary to control pain, even if it makes me drowsy or puts me to sleep much of the time? How do I define acceptable pain?
  
4. Would I want to have a hospice team or other palliative care (i.e. comfort care) available to me?
  
5. What would my plan be for the last day or week of my life? For example:
  - Where would I be?
  - Who would be present?
  - What would I be doing?
  - What would my environment be like?
  - What would I eat if I could eat?
  - What would be my final words or last acts?

6. Who would I like to write a letter to or prepare a taped message for? Perhaps marked for opening at a future time?
7. How do I want to be remembered? (If you write your own epitaph or obituary, what would it say?)
8. What are my wishes for a memorial service? Are there songs or readings I would like, or people I hope would participate?

### *Spiritual/Religious matters of importance to you*

9. How would I describe my spiritual or religious life?
10. What gives my life its purpose and meaning?
11. What is important for others to know about the spiritual or religious part of my life?
12. What do I need for comfort and support as I near the end of life? Pray with a member of the clergy? To talk to someone about my life's meaning? Be read to from spiritual or philosophical texts? Have music playing in my room? To be held?
13. Are there priorities/values you want others to know?

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### *III. Definitions of “Life-Sustaining” Interventions*

What type of life-prolonging or sustaining intervention do I want? There are three kinds to consider: cardiopulmonary resuscitation (CPR), artificial provision of nutrition and hydration, and active treatment to fight disease.

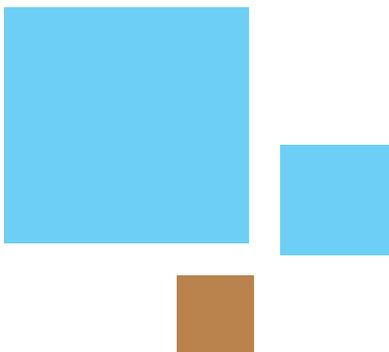
#### *Cardiopulmonary Resuscitation<sup>1</sup>*

Cardiopulmonary resuscitation, commonly known as “CPR,” is the act of reviving someone whose heart and/or breathing have stopped. In a hospital setting, when a patient’s heart stops, extraordinary measures are used to restart

their heart. Treatments often include the use of CPR, electrical shocks to the heart, injectable medications and often, a ventilator.

While CPR does benefit some patients, it is not always the best choice, especially for those with multiple medical problems and terminal illnesses. It is best to have a frank, open discussion with your healthcare provider regarding the benefits and risks of CPR for your specific disease and goals.

CPR is a standard order in a care facility and must have a written order restricting its use if the person or their designated agent chooses so. The order for a “DNR” or Do Not Resuscitate must be given by a physician and the family or patient must request this.



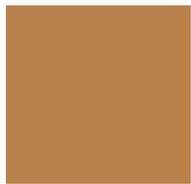
## *Pros*

- CPR is effective for a person who is healthy prior to the cardiac event.

## *Cons*

- CPR is rarely effective for persons with two or more medical problems, those who are dependent on others for care (such as nursing home residents) and those with a terminal disease.
- Once performed, CPR must be followed by other life prolonging measures such as advanced medical care and hospitalization.
- Frail patients have an increased risk of their ribs being broken and a lung or spleen being punctured during CPR.
- Brain damage is possible and likely in patients who have not been revived in a short amount of time. This means a person could experience small changes in their mentation or could be permanently unconscious.

## *Artificial Hydration and Nutrition<sup>2</sup>*



There are occasionally times when a person is unable to eat or drink normally. At this point, it is sometimes appropriate to find other means to feed and hydrate a person. Tube feedings may be considered and can occur in one of two ways. A person may have a tube inserted through their nose into their stomach, called a nasogastric tube, or they may have a tube surgically placed in the stomach, called a gastrostomy tube. These two devices allow water, liquid nutritional supplements and medications to be administered to a person who is unable to take these items safely by mouth.



General intravenous (IV) hydration is another means of providing fluids to a patient who cannot directly take them anymore due to disease or illness. A person can receive hydration with various liquid preparations via a vein in the arm. This is common in the hospital setting.



Many physicians believe that the use of tube feedings during end-of-life care is more of a risk than a benefit to terminally ill patients. Physicians who advocate for the removal or cessation of artificial feedings and hydration often see the inability to take in food or water by mouth as a terminal medical condition. They view the death of such patients as occurring from the terminal disease, not from starvation or dehydration, and therefore allow the patient to have a natural passing. They believe that choosing not to force feed a patient is not choosing to end their life, but rather, choosing not to prolong their suffering.

<sup>2</sup> Dunn, H. (2009). *Hard choices for loving people*. A&A Publishers, Inc. Landsdowne, VA.

## *Artificial Hydration and Nutrition Continued...*

### *Pros*

- Beneficial for those who cannot swallow safely such as patients who have had a stroke or a short-term disability affecting their mouth or oral function.
- Can prolong life, although for most people it does not.

### *Cons*

- Feeding tubes carry the risk of pneumonia from aspirated fluids or displacement.
- Artificial feedings cause fluid in the lungs making breathing harder, increasing the need for suctioning, increasing edema in the body, which in turn increases pressure and pain around tumors and body parts.
- Does not allow for the natural release of pain-relieving chemicals in the body that occur as a person becomes dehydrated which can give a “mild euphoria” to the patient.
- IV sites frequently have to be changed often requiring multiple needle sticks.

## *Active Treatment to Fight Disease*

There are a variety of intensive treatments that you may encounter during a hospital stay when you are ill, including a ventilator, dialysis, invasive internal monitoring, electric pacemaker and other devices for heart function, major surgery, antibiotics, blood transfusion and chemotherapy. Below is a description of each.

A VENTILATOR, which may also be called a respirator, is a machine commonly used in hospitals to assist a person to breathe if they are unable to breathe on their own. Ventilators can be beneficial in short-term crisis; however, there are multiple risks and complications associated with this treatment.

DIALYSIS is another common treatment that involves the use of a machine to filter the blood when the kidneys are no longer able to do so. This treatment can be for acute illnesses or while one is awaiting a kidney transplant, or is a permanent treatment for more serious kidney issues.

INVASIVE INTERNAL MONITORING is the use of tubes and catheters inserted into veins to deliver fluids, medications, take blood samples and monitor pressure readings. These can be temporary options that are meant to be removed within days to months, such as intravenous lines or more permanent options which can stay in place for years, such as implanted ports.

ELECTRIC PACEMAKERS and other devices for the heart are also used as active treatments for people who have an irregular heart beat or have risks of cardiac arrest (their heart stopping). These are often implanted devices that require surgery.

MAJOR SURGERY is another treatment option that people are often forced to consider when they are ill. This may include surgery that drastically alters the body, but can also relieve pain and restore function depending on the severity of the issue.

ANTIBIOTICS are frequently used to fight infections and may come in a pill form or given intravenously. Risk is involved anytime you take medication, as normal flora can be “killed off.”

BLOOD TRANSFUSIONS are necessary at times to restore the amount of blood in a person who has severe bleeding or who is not making the correct amounts of certain blood components. Blood transfusions always carry a risk as often the donor blood comes from another person.

CHEMOTHERAPY and radiation are common treatments used in the treatment of cancer. Chemotherapy uses drugs to attempt to stop and slow the growth of cancer while radiation therapy uses radiation to shrink tumors and kill cancer cells. Both chemotherapy and radiation are not without risks and adverse effects.

### *Summary*

Patients with multiple medical problems, or who are dependent on others, benefit from CPR less than 2% of the time. The risks of CPR usually outweigh the benefits for terminally-ill patients and reduce the possibility of a peaceful death. It is important to remember, that patients and family members have the right to request an order to not attempt resuscitation. For healthy patients who have a temporary and difficult time eating, feeding tubes can help get them through that period. Although unconscious patients can be maintained for years with a feeding tube, it is difficult to decide to withdraw such treatment, therefore it is something to really contemplate in advance. Patients may leave instructions that may include trying a treatment for a limited period. Other treatments to fight disease, such as ventilators, dialysis, chemotherapy and others mentioned may serve to alleviate symptoms, and can also prolong suffering and therefore, should be carefully considered for patients with a life limiting illness.



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## *IV. The Proxy Quiz for Family and Healthcare Providers*

It is important for your healthcare agent or proxy, family and healthcare providers to truly understand your values and priorities about end of life care. The following quiz can help you gauge how well they know your wishes.

### *The Proxy Quiz for Family or Healthcare Provider\**

How well does my family, proxy or healthcare provider know my healthcare wishes? This short test can give you some sense of how well you have communicated your wishes to them. Consider this a tool to promote better conversation and understanding.

#### *Instructions:*

##### *Step 1:*

Answer the 10 questions using the Personal Medical Preference test which follows.

##### *Step 2:*

Ask your healthcare proxy, family member or close friend to complete the Proxy Understanding of your Personal Medical Preferences test. The questions are the same. Don't reveal your answers until after they take the test. They should answer the questions in the way they think you would answer. (Try the same test with your healthcare provider, too.)

##### *Step 3:*

Count one point for each question to which you and your proxy (or you and your doctor) give the same answer. The proxy score is rated as follows:

POINTS	GRADE	
10	Superior	... You are doing a great job communicating!
8-9	Good	... You just need some fine-tuning!
6-7	Fair	... More discussion is needed.
5 or below	Poor	... You have a lot of talking to do!

The tests are on the following pages...

## *Step 1: Personal Medical Preferences*

Complete this questionnaire by yourself.

1. If I had Alzheimer's disease, which progressed to the point where I was not able to recognize or converse with loved ones and had difficulty swallowing, would I want to be fed by a tube to my stomach?  
a. Yes      b. No      c. I am uncertain
  
2. Which of the following do I fear most near the end of life?  
a. Being in pain      b. Losing the ability to think      c. Being a financial burden on loved ones  
d. Other \_\_\_\_\_
  
3. If I were ill and doctors were recommending chemotherapy and explained I may experience very severe side effects, such as pain, nausea, vomiting and weakness that could last 2-3 months...  
Would I be willing to endure the side effects if the chance of regaining my current health was less than one percent?  
a. Yes      b. No      c. I am uncertain
  
4. If my condition is clearly terminal, but the chemotherapy might give me six additional months of life, would I want chemotherapy even though it may have severe side effects (frequent pain, nausea, vomiting and weakness)?  
a. Yes      b. No      c. I am uncertain
  
5. If I were terminally ill with a very painful condition, would I want to be sedated as last resort, even to the point of unconsciousness, if it were necessary to control my pain?  
a. Yes      b. No      c. I am uncertain
  
6. Imagine having moderate dementia causing mental confusion and making it difficult to recognize and interact with friends and loved ones. If it caused circulatory problems, which resulted in one leg being amputated because it developed gangrene, and the other leg developed gangrene and the doctor recommends amputation because the condition could be fatal.  
Would you want the operation?  
a. Yes      b. No      c. I am uncertain

### *Step 1: Personal Medical Preferences Continued*

7. Is it more important for me to: (a) have specific treatment preferences followed at the end of life even if family members or friends disagree, or (b) have family and friends all in agreement and comfortable with whatever decision is made?
- a. Have specific preferences followed, even if there is disagreement  
b. Have family and friends all in agreement      c. I am uncertain
8. Imagine becoming physically frail and needing help with the most routine daily activities – dressing, bathing, eating and going to the toilet. You live in a nursing home and your mind is fairly clear and capable most of the time. You have had pneumonia or other lung infections four times in the last year. Each time you had to be hospitalized for several days and were given antibiotics through an IV tube. If you were to get pneumonia again, would you want aggressive antibiotic treatment again or just comfort care until death comes?
- a. Antibiotic treatment    b. Comfort care only      c. I am uncertain
9. Imagine being in a permanent coma and becoming dependent on a tube inserted into your stomach for nutrition and hydration. Would it be important to you that decisions about your treatment be guided by particular religious beliefs or spiritual values that you hold?
- a. Yes      b. No      c. I am uncertain
10. If my heart, kidneys, pancreas, lungs and liver could all be used in transplant operations to save lives, would I want to donate them at death?
- a. Yes      b. No      c. I am uncertain

## *Step 2: Proxy Understanding of Your Personal Medical Preferences*

If you have been asked to complete this simple 10-question quiz by a family member, friend or patient, please do so considering how YOU think he or she would respond to each question. As you consider each question, place their name in the blank space.

1. Imagine that \_\_\_\_\_ had Alzheimer's disease, which progressed to the point where he or she is not able to recognize or converse with your loved ones. When swallowing was very difficult, would \_\_\_\_\_ want to be fed by a tube?  
a. Yes      b. No      c. I am uncertain
  
2. Which of the following does \_\_\_\_\_ fear *most* near the end of life?  
a. Being in pain      b. Losing the ability to think      c. Being a financial burden on loved ones  
d. Other \_\_\_\_\_
  
3. Imagine that \_\_\_\_\_ is now seriously ill and healthcare providers are recommending chemotherapy. He or she may experience very severe side effects, such as pain, nausea vomiting and weakness that could last 2-3 months. Would \_\_\_\_\_ be willing to endure the side effects if the chance of regaining his or her current health was less than one percent  
a. Yes      b. No      c. I am uncertain
  
4. In the same scenario, suppose that his or her condition is clearly terminal, but the chemotherapy might give an additional six months of life. Would \_\_\_\_\_ want the chemotherapy even though it may have severe side effects (frequent pain, nausea, vomiting, and weakness)?  
a. Yes      b. No      c. I am uncertain
  
5. If \_\_\_\_\_ were terminally ill with a very painful condition, would he or she want to be sedated, even to the point of unconsciousness, if it were necessary to control the pain?  
a. Yes      b. No      c. I am uncertain
  
6. Imagine that \_\_\_\_\_ has moderate dementia causing mental confusion making it difficult to recognize and interact with friends and loved ones. He or she also has circulatory problems, which resulted in one leg being amputated because it developed gangrene. Now, the other leg develops gangrene and the doctor recommends amputation because the condition could be fatal. Would \_\_\_\_\_ want the operation?      a. Yes      b. No      c. I am uncertain

## *Step 2: Proxy Understanding of Your Personal Medical Preferences Continued*

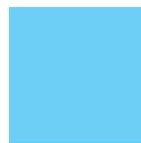
7. Is it more important for \_\_\_\_\_ to: (a) have his or her specific treatment preferences followed at the end of life even if family members or friends disagree, or (b) have family and friends all in agreement and comfortable with whatever decision is made?
- a. Have specific preferences followed, even if there is disagreement  
b. Have family and friends all in agreement      c. I am uncertain
8. Imagine that \_\_\_\_\_ is physically frail and needs help with the most routine daily activities – dressing, eating, and personal care. He or she lives in a nursing home and his or her mind is fairly clear and capable most of the time. He or she has had pneumonia or other lung infections four times in the last year—each time having to be hospitalized for several days and given antibiotics through an IV tube. The next time \_\_\_\_\_ gets pneumonia, would he or she want aggressive antibiotic treatment again or just comfort care until death comes?
- a. Antibiotic treatment      b. Comfort care only      c. I am uncertain
8. Imagine that \_\_\_\_\_ is in a permanent coma and dependent on a tube inserted into the stomach for nutrition and hydration. Would it be important to \_\_\_\_\_ that decisions about his or her treatment be guided by particular religious beliefs or spiritual values?
- a. Yes      b. No      c. I am uncertain
10. If \_\_\_\_\_'s heart, kidneys, pancreas, lungs and liver could all be used in transplant operations to save lives, would he or she want to donate them at death?
- a. Yes      b. No      c. I am uncertain

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## *V. Tips for Sharing your Decisions and Values with your Healthcare Provider, Family and Other Important People*

In order for your loved ones to truly understand your end of life wishes, it will be necessary to have several conversations over time. These discussions will help everyone remain on the same page about you and your care, and will help loved ones feel at peace with the decisions you've made. How we die lives on in the minds of those around us and with some planning and conversations, they will be left with a good memory that will help them in their grief and recovery process. For some, these conversations may be tearful and may require vulnerability but may also lead to bonding and strengthening of your relationships. Others may choose to keep conversations focused on instructions and facts, and that's ok too.

Once you have completed your advance directive give a copy to your healthcare agent and keep a copy at your bedside, taped to the inside of your medicine cabinet or on your refrigerator. Take it with you to hospital visits, when seeing new healthcare providers or give to paramedics in an emergency.



## *Healthcare Provider*

Start by making an appointment with your physician or healthcare provider. Let the staff know that you would like to discuss your advance directives to ensure the healthcare provider will make time for this important subject. Have a frank conversation with your physician(s) regarding your healthcare goals so they fully understand what your end of life wishes are. Your healthcare provider will need a copy of your advance directives. Be sure to immediately inform them of any changes or revocations to your advance directive as they occur.

### YOU MAY SAY SUCH THINGS AS...

- “I want to have a conversation about my wishes and goals for healthcare.”
- “Have you heard about (insert your preferred advance directive preparation tool here)? Here is what I’ve come up with so far.”
- “My friend died while they were reviving her in a hospital and I don’t want that. Here’s what I would prefer...”
- “I do not want to die at home. If possible, I’d like to be (in a hospital, hospice, etc.)” or “I prefer to die at home, if possible.”

If you are facing a life-limiting illness, inform your healthcare provider about important milestones you hope to make such as a birthday, wedding, etc. so he or she can discuss if these are viable goals and tailor your care towards these wishes, if possible.

It is your right to insist that your healthcare provider speak with you about this. If there is a lack of time, you may suggest scheduling another appointment.

## *The Physician Orders for Life-Sustaining Treatment (POLST)*

Nevada state law requires an attending physician complete a form that summarizes wishes of an individual regarding life-sustaining treatment with a patient who has a life expectancy of less than five years. The POLST form details what the patient wants in terms of medical treatment including CPR, feeding tubes and medical interventions if the patient is not breathing or is without a pulse. The form is signed by both the physician and the patient or healthcare agent and helps healthcare providers understand the person’s wishes at a glance, but it is NOT a substitute for a properly prepared advance directive (living will) and DPOA for healthcare. The POLST form is available at [www.nevadapolst.org](http://www.nevadapolst.org).

## *DPOA/Healthcare Proxy*

Have a frank discussion with your primary decision maker(s) regarding what you do or do not want in your final stage of life. It is wise to make this person(s) a copy of your advance directive and be sure to immediately inform this person of any changes to your advance directive.

- “I was thinking about what happened to my friend and it made me think about what will happen to me...”

- “I need to think about the future. Are you willing to help me with that?”
- “Even though I am doing ok right now, I’d like to prepare for the future...”
- “I have made some major decisions and I’d like you to know and understand what they are.”

Continue to explain your specific goals and wishes. Be sure that this person is willing and able to carry out your wishes even if it goes against their own personal preferences, or other family members or friends disagree.

#### IMPORTANT TOPICS TO COVER:

- What kind of treatments do I want or not want?
- Where do I want my care to be given (home, nursing home, hospital, hospice facility)?
- What is most important to me in my final stage of life?
- Are there situations that I would consider worse than death (such as living with a feeding tube, being on a ventilator, etc.)?
- At what point do I want to shift the focus of my care from cure to comfort?

#### *Family/Friends*

It is also important to advise your family and friends of your choice even if they are not going to be your designated decision maker. It’s often better to discuss your wishes and goals now, prior to becoming ill, to avoid surprises when your loved ones hear of your desires. Discuss topics like those in the list above to fully explain your desires and goals.

#### *Spiritual Leader*

If a spiritual leader is a key part of your life, speak to this person the same way you would a friend or family member. Be honest and share as much as you feel comfortable discussing. Use the questions and tips from above. Be sure to immediately inform this person of any changes to your advance directive.

#### *Final Tips:*

**Do** understand that this may be difficult for some of your loved ones to discuss.

**Don’t** feel rushed. This is just the beginning of many conversations.

**Do** be patient. This can be a difficult subject to talk about.

**Do** understand that you can always make changes to your advance directive.

**Don’t** judge others. Death is very individualized and may mean different things to different people.

**Do** give loved ones time to “digest” if needed.

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## VI. *Information about the Nevada Living Will Lockbox*

Once you have completed your written advance directive, you may keep a copy in the “Nevada Living Will Lockbox” with the Nevada Secretary of State. In order to register your documents, go to: [www.nvsos.gov](http://www.nvsos.gov), download the Registration Agreement form, fill it out and mail the agreement along with a copy of your advance directive to the Lockbox. Once the Registration Agreement form and copy of the advance directive is received, an electronic reproduction of the advance directive will be stored in the Lockbox. Within 10 business days of submittal, you will be provided with a wallet card containing the registration number to be used for access to documents. The form will be available to you and may be retrieved by your healthcare providers in case of an emergency.

Another statewide community based Health Information Exchange (HIE) can be accessed at [www. healthinevada.org](http://www.healthinevada.org)

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## VII. *Leaving a Legacy*

*The only thing you take with you when you're gone is what you leave behind.*

~ John Allston

You will leave a legacy. What kind do you want to leave? Leaving a recorded message about your life, experiences, wisdom or a significant event in your life is a wonderful gift to leave for your family and friends. There are many things you can do, including leaving a charitable bequest, striving to be your best or making your life about helping others.

When I hear the word “legacy,” what comes to mind? As we age or battle a terminal illness we begin to contemplate our legacy. It’s important to consider legacy early to allow us to tailor our lives and decisions to what we hope to achieve and leave behind. This can be a positive experience bringing on self-reflection and restructuring of our lives and objectives. Legacy is about life and living. Working to create a legacy helps us find meaning in life.

The definition of legacy is a gift of property, especially personal property such as money, by will; a bequest.<sup>3</sup> However, it can also be a non-material gift of wisdom and experience. Leaving money or possessions can be easily done with the development of a last will and testament. You will need a lawyer who specializes in estate law to produce this document. You may choose to leave your assets to your family, friends or to a beloved organization.

How will people remember me despite my assets that I leave behind? You can leave a legacy in many ways. Something you have created can be a legacy. Musicians, actors, cinematographers, authors and inventors all leave behind the legacy of their work. Those who create space to empower people leave behind a legacy as well. This includes entrepreneurs, spiritual leaders and educational innovators who create institutions that change and affect our current society. You can also leave a legacy based on your actions and influences.

<sup>3</sup> <http://dictionary.reference.com/browse/legacy>

20 <sup>4</sup> <http://julliangordon.com/4-ways-to-leave-your-legacy>

What type of non-material legacy would I like to leave behind? This may include a legacy of excellence, encouragement, purpose or love.<sup>5</sup> The following table will help to determine the type of legacy you would like to establish and review the tips to guide you toward that goal.

TYPE OF LEGACY	WAYS TO ACHIEVE THIS GOAL
A Legacy of Excellence—one that inspires others	<ul style="list-style-type: none"> <li>• Strive to be your best every day</li> <li>• Set goals and act to achieve them</li> <li>• Act as a positive role model to your children, friends and family</li> </ul>
A Legacy of Encouragement—one that uplifts others	<ul style="list-style-type: none"> <li>• Be uplifting to those around you</li> <li>• Encourage others to do and be their best</li> </ul>
A Legacy of Purpose—one that has specific goals and morals	<ul style="list-style-type: none"> <li>• Make your life about something “bigger than you”</li> <li>• Use your strengths and talents for a higher purpose</li> </ul>
A Legacy of Love—one that embraces all in love	<ul style="list-style-type: none"> <li>• Provide unconditional love to those around you</li> </ul>

## VIII. Workshops and Technical Assistance

Trained facilitators can present workshops on advance care planning and provide technical assistance in completing the process.



Please refer to the website for training materials:  
[www.decidingtomorrowtoday.org](http://www.decidingtomorrowtoday.org)

<sup>5</sup> <http://jongordon.com/blog/5-ways-to-leave-a-legacy-2/>

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## *IX. Resources*

**ACP Decisions**, offers videos on advance care planning: <https://www.acpdecisions.org/patients/>

**Advance Care Planning**, an overview and tutorial for advance care planning: <http://www.gundersenhealth.org/advance-care>

**Advance Care Planning for Hospice**, a definition of advance care planning: <http://www.nhpco.org/advance-care-planning>

**Advance Care Planning with Your Patients**, an article regarding the importance and appropriate timing of speaking to your patients regarding advance directives: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3219475/>

**Advance Directives and the Physician: Talking with Healthy Patients about Dying**, shows importance of speaking about advance directives: <http://web.utk.edu/~jhardwig/AdvanceDir.pdf>

**American College of Physicians Internist**, tips on talking to your patients about advance directives: <http://www.acpinternist.org/archives/1999/03/advdir.htm>

**Code Alliance**, a community based non-profit with the unique goal of assisting individuals and their families in preparing for the final days of life. Go Wish Cards can be purchased to assist in advance care planning: <http://www.codaalliance.org/>

**Consider the Conversation**, films produced with the goal of inspiring a culture change in end of life care that is more personal: <http://www.considertheconversation.org/>

**Consumer's Toolkit for Healthcare Advance Planning**, contains a set of 10 tools to assist physicians in communicating with patients regarding advance care planning: [http://www.americanbar.org/groups/law\\_aging/resources/health\\_care\\_decision\\_making/consumer\\_s\\_toolkit\\_for\\_health\\_care\\_advance\\_planning.html](http://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/consumer_s_toolkit_for_health_care_advance_planning.html)

**Gunderson Health**, offers advance care planning training and education: <http://www.gundersenhealth.org/respecting-choices>

**The Conversation Project**, provides multiple resources for talking about end of life care and completing the advance care planning process: <http://theconversationproject.org/>

**The Other Talk**, is a guide on talking with adult children about the future: <http://theothertalk.com/>

**Implementing Advance Directives in Office Practice**, includes discussion points and popular phrases and tips for physicians talking with their patients about advance care planning: <http://www.aafp.org/afp/2012/0301/p461.html>

**Leave a Legacy**, provides information on donating to all types of non-profit organizations: [www.leavealegacyct.org](http://www.leavealegacyct.org)

**Making Decisions with Families at End of Life**, article providing insight into the importance of advance care planning: <http://www.aafp.org/afp/2004/0815/p719.html>

**A Physician's Guide to Talking about End of Life Care**, a four-step approach to conducting end of life discussions: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495357/>

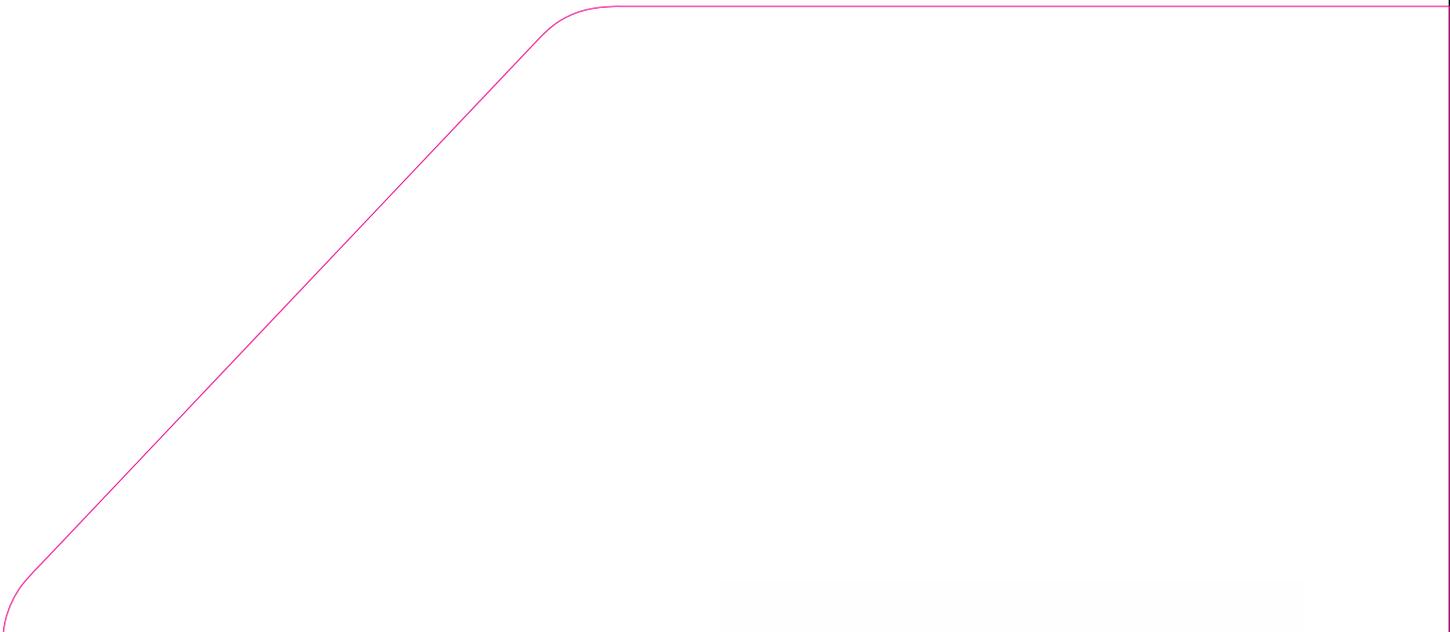
**Prepare**, an online assistance tool to help in preparing to make medical decisions in end of life care. Available in English or Spanish: <https://www.prepareforyourcare.org/>

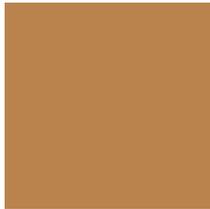
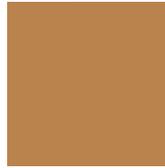
**ProHealth Care**, provides an advance care planning toolkit: <http://www.prohealthcare.org/advanced-care-planning-toolkit.aspx>

**Start the Conversation**, provides a description of the options in advance care planning, a starter kit and ways to start the planning: <http://www.starttheconversationvt.org/>

**Talking about Advance Care Planning**, provides a conversation guide in the discussion of end of life care: <http://coalitionccc.org/tools-resources/advance-care-planning-resources/>

**VITALtalk**, offers educational videos for healthcare professionals: [www.vitaltalk.org](http://www.vitaltalk.org)





*Presented by:*

**Nathan Adelson**  
HOSPICE

*When it's time for a trusted partner*

[www.decidingtomorrowtoday.org](http://www.decidingtomorrowtoday.org)

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