A Community Forum at the Princeton Public Library
End of Life: Planning is Everything!

Tuesday, August 13, 2019, 7:00 to 8:30 p.m.

Princeton Public Library Community Room
Co-Produced by Leslie Rowley, Hereafter Partners and Dor Mullen, The Suppers Programs

This is an end-of-life literacy event featuring spokespeople with messages regarding palliative and hospice care, estate planning, our legal rights as of August 1 under the New Jersey's Aid in Dying for the Terminally Ill Act, and how to prepare ourselves and our loved ones. Speakers will give brief presentations to be followed by a panel and plenty of time for questions and answers. This session is intended as the first in a series of open and supportive conversations about aging, dying, and death in this community.

Messages from the Planners:
***Leslie Rowley*, Hereafter Partners:** Helping my father navigate the end stage of his life five years ago was life-changing for me, and watching my husband navigate his executorship role for his mother's estate this spring woke me up to a big reality: Many of us in our 30s, 40s, and 50s are underprepared for the eventuality of our loved ones' deaths. Now I've taken on the personal mission of trying to design a set of resources for our cohort and a mechanism for starting this conversation with those of us caught between parents, siblings, and our own inner voices of fear and confusion. I feel so fortunate to be working with Dor to help our entire community navigate this oft-neglected territory.

Leslie Jennings Rowley serves as the Assistant Director of the Kahneman-Treisman Center for Behavioral Science & Public Policy at Princeton's Woodrow Wilson School and was previously the founding Executive Director of Princeton Journeys. She holds a PhD in Psychology and an MBA in international business and lives in Princeton with her husband and two children. She also runs end-of-life discussions under the banner of Hereafter Partners. **hereafterpartners.org**

***Dor Mullen*, The Suppers Programs:** My children have been on my mind with every decision I've made since being diagnosed with stage 4 lung cancer in April. "What is the best job I can possibly do to make this better for them, given that a long life being grandma is not an option?" The answers for me are all in the planning. My priorities are:

- Making my intentions clear about wanted and unwanted treatment
- Having real conversations with loved ones, having more
- Protecting assets
- Cleaning up my messes so loved ones aren't stuck cleaning up my messes
- Making sure all the legal, medical and financial documents are in order

Dor is the Founder of The Suppers Programs and a local environmental activist and community gardener. **thesuppersprograms.org**

Panelists

Roger Martindell, Attorney, Princeton | rogermartindell.com
Roger will be available to answer questions about how to decide what kind of help you need preparing a will and how to do it within your budget. He serves the community by preparing straightforward wills that do not involve complicated trusts and tax planning.

Stephen Goldfine, MD | SamaritanNJ.org
Demystifying Palliative Medicine and Hospice Care
So many times, after experiencing palliative and/or hospice care, patients and families wish they had utilized the care sooner. The reason they delay accessing care is largely connected to the misconceptions they hold. Dr. Goldfine, board certified in palliative, hospice and family medicine, and chief medical officer at Samaritan Healthcare & Hospice, will explain what they are and what they are not, when they should be accessed, and how they can help. Understand your options so that you don't deny yourself, or you loved one, care that can improve quality of life and provide comfort.

George Luciani, CFP, President, Covered Bridge Advisors | cbridgeadvisors.com
End of Life Financial Planning
George orchestrates his clients' financial needs in collaboration with their attorneys and accountants. He will summarize the documents you need to make sure your financial and legal wishes are articulated and your assets are protected: Wills, trusts, college funds, gifting rules and inheritance rules which differ from state to state. He will address such questions as what happens if you have no will and how to plan in the best interest of your heirs. Although this is a brief overview, you will come away with an understanding of the tasks involved in responsible end-of-life financial planning; he will be available for questions and follow up after the event.

Kim Callinan, CEO, Compassion & Choices | CompassionandChoices.org
Update on the NJ Aid in Dying for the Terminally Ill Act
The New Jersey Medical Aid in Dying for the Terminally Ill Act was signed into law by Governor Phil Murphy on April 12, 2019. The law authorizes the practice of medical aid in dying, in which mentally capable adults, with six months or less to live, can request a doctor's prescription for medication that they could decide to take in their final days or weeks to end unbearable suffering and die peacefully. The law went into effect August 1, 2019. Kim will give more details on eligibility and other aspects of accessing the law, both in New Jersey and the other eight jurisdictions where aid in dying is currently available.

Vincent Leonti, MD, Princeton Integrative Health | princetonih.com
Medical Marijuana and Quality of Life
Marijuana has been stigmatized by the government and society for many years. Many people either refuse or delay accessing Medicinal Marijuana due to this stigma. Dr. Leonti is a Board Certified Family Physician and Integrative and Medicinal Marijuana Practitioner practicing at Princeton Integrative Health. He recommends Medicinal Marijuana for qualifying patients to improve their symptoms and Quality of Life. He will discuss Medicinal Marijuana's benefits, precautions, recent changes in the law and the steps to access Medicinal Marijuana.

Tedford Taylor, Pastoral Care Expert and Funeral Consumer Advocate | fcaprinceton.org
Car shoppers choose the make and model, compare features, and, if they're savvy, compare prices at more than one dealer. But it rarely occurs to anyone that they should or even could shop around for funeral goods and services. Ted, Director of Pastoral Care and Training at RWJ University Hospital Hamilton and host of the Mercer County Death Café, will talk about how to plan, budget for, and carry out a meaningful and reasonably priced celebration of life, as well as about disposition options, including green burial.

End-of-Life Planning

Dor's Guide to Planning with Greater Ease, Less Urgency and More Community

I am writing this from the perspective of (my own)/(someone else's) _____ needs.

The priorities and values I want to include in my planning are:

(possible prompts: Family time? Protecting assets? Clarity around wanted v unwanted medical care? Increase/decrease time to be authentic with loved ones? Pleasure? Environmental concerns? Pain management? Quality v quantity of time?)

End of Life Planning Matrix *

Important and Urgent	**Important, Not Urgent**	**Parking Lot**
Example: Crisis, kitchen fire	Example: planning, relationship time	Not ready yet
Not Important, Urgent	**Not Important, Not Urgent**	
Example: Cell phone notifications	Example: Time wasters, dithering	

- **Adapted from the Eisenhower Matrix**

"Need to Know Kit" Checklist

Helpful before Death

Durable Power of Attorney for Health Care (legal document)
State-specific Medical Advanced Directive (consider completing more than one if you travel/live/spend time in more than one)
Personal Statement of Intention / Living Will (not legal document)
State-specific POLST (Practitioner Orders for Life-Sustaining Treatment) with one original copy on your person, one original copy with health care proxy, and one copy in red folder on refrigerator
HIPAA Release Forms to provide access to medical records and insurance information
Durable Financial Power of Attorney (unexecuted copy to the individual given the power; executed copy with attorney to be retrieved when your instructions/threshold of abilities have been met)
Medical insurance and long-term care insurance information
List of accounts (financial, utilities, etc) including institutional contacts, account numbers, balances, payment schedules
Safe deposit box (or any locked) information (where is the key?!)
Organ donation information (registerme.org)
Contact information for attorney, financial planner, certified public accountant, and point person (friend designated to coordinate help with errands, meals, and communication to other friends)
Helpful home details (location of car keys, garage openers, gate codes, location of extra keys)
List your simple pleasures (favorite foods/snacks, pass-times, music poetry, books)
Pet care instructions and preferences

Helpful at Death

"How to be an Executor" notes
Last Will & Testament – executed (signed, witnessed, and dated)
Birth certificate
Marriage/Divorce certificate, prenuptial agreements, military service documents
Life insurance policy (noting policy number, beneficiaries, and agent's contact info)
Driver's License and/or passport (or photocopy)
Social Security Card or photocopy or number
Recent income tax returns
Stock certificates (physical copies)
Real estate documents and deeds
Automobile title and registration (consider transferring to trust before death)
Digital asset information and official access authorizations (inventory of digital assets including email and social media accounts, website logins, domain names, virtual currency accounts and list of fiduciaries who have been designated through each website's online tools or specifically named in will as holding authority to access specific accounts or all digital assets)
Discussion notes on how to handle important items not mentioned in the will
Funeral Home Contacts (NJ requires this for the transport of the body; other states differ)
Body Deposition instructions
Memorial Plan (location, eulogizers, texts, music, beneficiaries of donations in lieu of flowers)
Obituary draft
Family history (written notes, conversations with children, oral history, family tree)
Letters to important individuals
Notes on counseling and bereavement resources

PROXY DIRECTIVE--(Durable Power of Attorney for Health Care)
Designation of Health Care Representative

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, _____, hereby designate _____,
of _____
_____,
(home address and telephone number of health care representative)

as my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

B) ALTERNATE REPRESENTATIVES: If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

1. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

2. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

_____

_____

_____

_____

D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

1. *name* _____
   address _____
   city _____ *state* _____ *telephone* _____
2. *name* _____
   address _____
   city _____ *state* _____ *telephone* _____

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20_____.

signature _____

address _____

city _____ *state*_____

F) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. *witness*_____
   address _____
   city _____ *state* _____
   signature _____
   date _____

2. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, _____, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

Part One: Statement of My Wishes Concerning My Future Health Care

*In **Part One**, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.*

*In **Section B and C**, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use **Section D**, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part One before completing your directive**.*

B) GENERAL INSTRUCTIONS: To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

Initial ONE of the following two statements with which you agree:

1. _____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition

2. _____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:

a. _____ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

In the space provided, write in the bracketed phrase with which you agree:

To me, terminal condition means that my physicians have determined that:

_____

[I will die within a few days] [I will die within a few weeks]
[I have a life expectancy of approximately _____ or less *(enter 6 months, or 1 year)***]**

b. _____ If there should come a time when I come **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all my medically appropriate care necessary to provide for my personal hygiene and dignity.

c. _____ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph **c.** covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section D** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

_____

_____

_____

_____

C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). *On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

In the space provided, write in the bracketed phrase with which you agree:

1. In the circumstances I initialed on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

_____

[be withheld or withdrawn and that I be allowed to die]
[be provided to the extent medically appropriate]

2. In the circumstances I initialed on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

_____

[not be provided and that I be allowed to die]
[be provided to preserve my life, unless medically inappropriate or futile]

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

_____

_____

_____

D) ADDITIONAL INSTRUCTIONS: *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

_____

_____

_____

E) BRAIN DEATH*: (The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

Initial the following statement only if it applies to you:

_____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

F) AFTER DEATH - ANATOMICAL GIFTS: *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

Initial the statements which express your wishes:

1. _____ **I wish** to make the following anatomical gift to take effect upon my death:

   A. _____ any needed organs or body parts
   B. _____ only the following organs or parts

_____

for the purposes of transplantation, therapy, medical research or education, or

   C. _____ my body for anatomical study, if needed.
   D. _____ special limitations, if any:

_____

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

_____

_____

_____

2. _____ **I do not wish** to make an anatomical gift upon my death.

Part Two: Signature and Witnesses

G) COPIES: The original or a copy of this document has been given to the following people *(NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.):*

1. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

2. *name* _____
   address _____
   city _____ *state* _____
   telephone _____

H) SIGNATURE: By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20_____.

signature _____

address _____

city _____ *state*_____

I) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

2. *witness* _____
   address _____
   city _____ *state* _____
   signature _____
   date _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

PERSON NAME (LAST, FIRST, MIDDLE) _____ DATE OF BIRTH _____

A

GOALS OF CARE

(See reverse for instructions. This section does not constitute a medical order.)

B

MEDICAL INTERVENTIONS: *Person is breathing and/or has a pulse*

- ❑ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.
- ❑ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ❑ Transfer to hospital for medical interventions.
  - ❑ Transfer to hospital only if comfort needs cannot be met in current location.
- ❑ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders:_____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:

Always offer food/fluids by mouth if feasible and desired.

- ❑ No artificial nutrition.
- ❑ Defined trial period of artificial nutrition.
- ❑ Long-term artificial nutrition.

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

- ❑ Attempt resuscitation/CPR
- ❑ Do not attempt resuscitation/DNAR

Allow Natural Death

AIRWAY MANAGEMENT

Person is in respiratory distress with a pulse

- ❑ Intubate/use artificial ventilation as needed
- ❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort.
- ❑ Additional Order (for example defined trial period of mechanical ventilation) _____

E

If I lose my decision-making capacity, I authorize my surrogate decision maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN in keeping with my goals: ❑ Yes ❑ No

- ❑ Health care representative identified in an advance directive
- ❑ Other surrogate decision maker

_____

Print Name of Surrogate (address on reverse) Phone Number

F

SIGNATURES:

I have discussed this information with my physician/APN.

Print Name_____

Signature_____

- ❑ Person Named Above
- ❑ Health Care Representative/Legal Guardian
- ❑ Spouse/Civil Union Partner
- ❑ Parent of Minor
- ❑ Other Surrogate

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

_____

PRINT - Physician/APN Name Phone Number

_____

Physician/APN Signature (Mandatory) Date/Time

_____

Professional License Number

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

PRINT PERSON'S NAME (LAST, FIRST, MIDDLE) DATE OF BIRTH

PRINT PERSON'S ADDRESS

CONTACT INFORMATION

PRINT SURROGATE HEALTH CARE DECISION MAKER ADDRESS PHONE NUMBER

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician or advance practice nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

MODIFYING AND VOIDING POLST - *An individual with decision making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

SECTION A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.

SECTION B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

SECTION C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

SECTION D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

SECTION E

This section is applicable in situations where the person has decision making capacity when the POLST form is completed. A surrogate may only void or modify an existing POLST form, or execute a new one, if named in this section by the person.

SECTION F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From _____ to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

Get **help**

with conversations about difficult medical decisions and end-of-life care.

Visit us online to access free resources and videos for patients, family caregivers and healthcare professionals. Downloads are available in multiple languages.

goalsofcare.org

Let's talk

ACP Guide

Leads you through the process of Advance Care Planning as you discuss, decide, and document your wishes for care at the end of your life

4Step 1 2 3 4 iCarePlan
Goals of Care Coalition of NJ

4SiCP

Individualized, simple, 4-step approach to help patients make difficult medical decisions and to assist healthcare providers in having the conversation

POLST

POLST

Specific medical orders, known as Practitioners Orders for Life-Sustaining Treatment, to be honored by healthcare providers during a medical crisis

Goals of Care Coalition of New Jersey

Helping patients get the care they need and no less, and the care they want and no more.

Stay in touch: goalsofcare.org facebook.com/goalsofcare @goalsofcare

RHONE | BRYANT LLC
COUNSELLOR *at* LAW

Virginia Bryant, Esquire
Admitted NJ, NY, PA, & MA

email:
vbryant@rhonebryant.com

TO: My Executor

As you take over as Executor of my Estate, I urge you to meet with my estate planning attorneys as soon as possible to discuss the details of administering my Estate. My attorney will explain to you the various things which will need to be done. My attorney will have a complete list of all the tasks involved and, if you wish, my attorney will take primary responsibility for seeing that these tasks are accomplished. However, just to give you an idea of what is involved, these tasks will probably include the following:

1. Review my Last Will & Testament, particularly the sections dealing with my beneficiaries, the distribution of property, and the Executor's powers. Determine if any of the assets are to be immediately distributed, or if they are to remain in trust for later distribution to the beneficiaries.

2. Order death certificates. Death certificates will probably be needed to obtain the proceeds of any life insurance policies and for other transfers. I recommend ordering three or four certified copies of the death certificate to begin with. These can be ordered from the funeral home or from the local county health department.

3. Check safe deposit box and checking account. If I have a safe deposit box, it should be checked for any instructions which I may have left for actions to be taken after my death. It is also important to prepare an inventory of the contents of the box. You will need a copy of the death certificate, together with the safe deposit box key, to gain access to my box.

4. Notify all life insurance companies of my death. This can be done by calling the local agent, if applicable, or writing a letter to the company's main office. Some companies require a certified copy of the death certificate; some companies will accept a photocopy of the death certificate or even a copy of the newspaper obituary notice.

5. Prepare an inventory of all of the assets in the Estate, including their values as of the date of death. This is necessary to determine a new cost basis for these assets in order to take advantage of the "step-up" in the basis of the assets if that is available. This will minimize the taxable gain when the assets are sold. It may be advisable to obtain a written valuation of one or more of my assets. I recommend getting a written opinion on the fair market value of any real estate. If the real estate has significant value, I recommend obtaining an appraisal from a qualified appraiser.

The market value of securities can be obtained by checking online for the day of death or by calling a stockbroker. Many brokers will provide these figures in writing, particularly if I had an account with them. The market value at the date of death becomes the new cost basis. The total value of all my property (including property passing to a trust by virtue of my Will) will determine whether it will be necessary to file federal and state estate tax returns.

6. Review business agreements. Review any business agreements, contracts, stock certificates, partnership agreements, etc., to which I am a party. If the property includes a business interest, it will be important to document the value of this interest. This is particularly important if the estate is likely to be taxable or if the business interest is going to be sold. To obtain this valuation I recommend hiring a qualified appraiser of business interests or a CPA who is experienced at valuing businesses.

7. Review and pay all bills. Review any bills or accounts which it is claimed that I owe and pay the ones which I do owe.

8. File income tax returns and pay income taxes. It will probably be necessary to file my final income tax return. My attorney and CPA can determine this.

9. Collect all my credit cards and cancel them.

10. Distribute my personal effects. Distribute any personal effects and household furnishings as provided in my Last Will & Testament, including any written memorandum of instructions.

11. Determine if a disclaimer is appropriate. It may be appropriate for one or more of the beneficiaries to disclaim an interest in all or part of his or her share, so that the property will automatically pass to the next beneficiary in line. This absolutely must be done within nine months after the date of death. My attorney will be able to assist you in determining whether any disclaimer is appropriate.

12. File federal estate tax Form 706. This form will need to be filed only if federal estate taxes are due. If it is necessary to file IRS Form 706 my attorney and my CPA will assist with this.

13. File New Jersey estate and inheritance tax forms. These forms will need to be filed only if New Jersey death taxes are due.

14. Distribute the assets. After all my bills and the expenses of administering my Estate have been paid, the final step is to distribute the remaining property. Pay careful attention to the distribution and allocation of assets to insure that this is done in accordance with my wishes. It may be appropriate to sell some assets and distribute the cash to facilitate equal division among my heirs, provided that this is in accordance with my Last Will & Testament. I recommend, if it can be accomplished, that any beneficiary who wishes to receive a distribution of property in kind, rather than a distribution of cash, be allowed to do so.

There will probably be many other tasks to be done in this post mortem administration of my Estate, many of which involve legal, financial or tax issues. This is why I recommend that you work with my attorney and the other members of my planning "team" such as my CPA, my insurance agent, and financial advisor.

Thank you for being my Executor.

Palliative Medical Partners vs. Hospice

A Philosophy and Program Comparison

Palliative Medical Partners is focused on helping patients relieve their pain and symptoms — such as shortness of breath, fatigue, nausea, constipation, loss of appetite and difficulty sleeping — so that they and their families can live each day with a better quality of life. Patients find palliative care helpful at any stage of serious illness — even while they are receiving curative or life-prolonging treatments.

FIRST STEPS: Your Referral — Our Nurse Assessment
(800) 229-8183

Palliative Medical Partners Relieving pain, managing symptoms, enhancing life	Hospice Embracing those touched by illness and grief
PROGNOSIS Services provided to seriously ill patients (and their families) coping with pain, distressing symptoms, stress or other serious side effects of the illness or treatments that are meant to cure. Care is not dependent on a limited-life prognosis.	**PROGNOSIS** Services provided to seriously ill patients (and their families) who have a prognosis of six months or less, in their doctor's best judgment, if disease follows its normal course.
ELIGIBILITY/REFERRAL Patients may be referred at time of diagnosis, during, or in in the immediate months following treatments (chemotherapy, radiation, dialysis, physical therapy, etc.).	**ELIGIBILITY/REFERRAL** Patient is not receiving curative treatments and has a life expectancy of 6 months or less (see "Prognosis" above).
CARE TEAM Palliative-trained, board certified physician, advanced practice nurse working in collaboration with the patient's personal physician or specialist.	**CARE TEAM** Board-certified hospice physician, patient's personal physician(s) and specialists, RN & LPN, Master's prepared social worker, spiritual support counselor, certified home health aide, bereavement counselor, trained volunteer, dedicated on-call staff; dietary counseling, physicial, occupational and speech therapist consults as needed
SAMARITAN SERVICES Palliative consultation and follow-up visits at the hospital, home or facility; information, referral and coordination of community resources, support for navigating healthcare options and decisions.	**SAMARITAN SERVICES** Clinical care team visits at home, long-term care facility or hospital; Four levels of hospice care: routine, continuous, respite and inpatient care; wound care specialists; certified massage, music, pet and aromatherapy practitioners as appropriate.
ADDITIONAL BENEFITS See "Services" above.	**ADDITIONAL BENEFITS** Covered pharmaceuticals and supplies, durable medical equipment, 24 hour on-call services.
REIMBURSEMENT Covered by Medicare, Medicaid, and some commercial insurers with applicable co-payments and deductibles; sliding scale for the uninsured.	**REIMBURSEMENT** Covered by Medicare, Medicaid, VA, and most commercial insurers with applicable co-payments and deductibles; sliding scale for the uninsured.

Samaritan℠
Healthcare & Hospice

Referrals: (800) 229-8183
SamaritanNJ.org

REV091318

End-of-Life Literacy Event

August 13, 2019

- Get your three amigos: Attorney, Certified Financial Planner, CPA. They all (should) work under a “fiduciary” legal authority (your best interest)

- Review your Long-Term-Care issues before age 60 (and/or when you are healthy) with family and professionals who don’t connect product with their recommendations.

- End-of-life issues are not predictable but inevitable – financial costs can exceed $100,000/year while emotional preferences are personal.

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Medical Aid in Dying for the Terminally Ill Act: Information for New Jersey Residents

compassion & choices
Care and Choice at the End of Life

New Jersey is now the ninth jurisdiction in the U.S. to authorize medical aid in dying. The Medical Aid in Dying for the Terminally Ill Act allows a mentally capable, terminally ill adult with six months or less to live to request medical aid-in-dying medication from their doctor which they choose to self-administer, if their suffering becomes unbearable, to bring about a peaceful death. The law was signed by Governor Phil Murphy on April 12, 2019.

Who is Eligible for Medical Aid in Dying

To be eligible for medical aid in dying under the Medical Aid in Dying for the Terminally Ill Act, a person must be:

1. An adult
2. Terminally ill
3. Given a prognosis of six months or less to live
4. Mentally capable of making their own healthcare decisions.

In addition, a person must meet the following requirements:

- A resident of New Jersey
- Acting voluntarily
- Capable of self-administering the medical aid-in-dying drug.

Steps for Using the Law to Access Medical Aid in Dying

In addition to meeting the requirements, there is a process that must be followed in order to qualify for a prescription for medical aid-in-dying medication.

- A person must make a total of three (3) voluntary requests —two oral requests at least 15 days apart directly to their doctor and one written request using the statutory form and signed by two witnesses. These requests cannot be made by a designee or third party (including relatives or anyone with power of attorney), and the requests cannot be made via an advance healthcare directive.
- Two New Jersey physicians must agree that the requestor is eligible to use the Medical Aid in Dying for the Terminally Ill Act. One physician prescribes the medication, and the other provides a consulting opinion.
- A person must prove residency in the state of New Jersey by one of the following means:
  - Possession of a driver's license or other identification issued by the state of New Jersey
  - Registration to vote in New Jersey
  - Filing of a New Jersey tax return for the most recent tax year.

- Any other government record that the attending physician reasonably believes to demonstrate the individuals current residency in the state

➔ A person must give fully informed consent after being given information by their doctor about all other end-of-life options.

Note: A person may at any time withdraw the request for the aid-in-dying drug or decide not to ingest the medication.

Rules Regarding Witnesses to Medical Aid-in-Dying Requests

Two witnesses must sign the statutory written request form in the presence of the person requesting medical aid-in-dying medication. This form will be available on the State Department of Health website, or you can find it at www.CompassionandChoices.org/New-Jersey.

The law requires that:

➔ The two adult witnesses attest that, to the best of their knowledge and belief, the person requesting the medication:
- Appears to be of sound mind and not under duress, fraud or undue influence.
- Voluntarily signed the request in their presence

➔ Only one of the two witnesses may be related by blood, marriage or adoption; or be a person entitled to a portion of the person's estate upon death.

➔ Only one of the two witnesses may own, operate or be employed at a healthcare facility where the qualified individual is receiving medical treatment or resides.

➔ The attending physician, consulting physician or mental health specialist may NOT be one of the witnesses.

No Adverse Effect on a Person's Will or Insurance

The law specifically mandates that wills, insurance, contracts and annuities are not affected if a qualified individual requests or ingests medical aid-in-dying medication. The law specifies that a death resulting from self-administering medical aid-in-dying medication is not suicide.

Talking to Your Doctor About Medical Aid in Dying

Ask your doctors now whether they will support your end-of-life choices, including medical aid in dying. This will encourage them to listen to your priorities and become prepared to provide you with the care you may want in the future. If your medical providers are unable or unwilling to support your end-of-life choices, you have the option to change your care to a healthcare team that puts your wishes first.

Doctors can call Compassion & Choices' Doc2Doc consultation line at 800-247-7421 for a free, confidential consultation and information on end-of-life care with medical directors who have extensive medical aid-in-dying experience.

Learn More

You can find forms, videos and resources for patients and doctors at CompassionAndChoices.org/New-Jersey

Princeton Integrative Health
134 Franklin Corner Road, Suite 101B
Lawrenceville, NJ 08648
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drvince@princetonih.com
www.princetonih.com

Princeton Integrative Health
Repair. Rebalance. Restore.

--About Medicinal Marijuana

Medicinal Marijuana was first legalized in NJ in 2010. The original law was fairly restrictive in terms of the qualifying conditions. In 2018, the list of qualifying conditions was expanded. Approximately 51,000 people are enrolled in the medicinal marijuana program, with 3,000 more patients enrolling monthly.

--Medicinal Marijuana and End of Life Care

Cannabis can be a powerful palliative option for end of life care.

It can help reduce Pain, Nausea, Anxiety, Depression and Sleep problems.

It can reduce or replace opioids for pain control and the need for sleep medications.

Have a discussion with your Palliative Care Team or your Primary Care Doctor about Medicinal Marijuana.

--**Contraindications**: Cannabis shouldn't be used if the patient has delirium as it can worsen this condition. Caution should be taken with preexisting low blood pressure or dizziness issues. Caution is advised with certain medications.

--**Eligibility**:

For the purposes of today's discussion, any terminal illness with a prognosis of less than 12 months to live is a qualifying condition. If you want the full list of qualifying conditions, the NJ DOH Division of Medical Marijuana website is:

https://www.nj.gov/health/medicalmarijuana/patients/

--**Insurance**: Since Marijuana is not legal at the Federal level, there is no insurance coverage for Medicinal Marijuana.

If you have further questions about whether Medicinal Marijuana is right for you, call our office at 609-512-1468.

Vincent Leonti, MD

Funeral Advice You Can Trust

Most people know more about how to buy a car than about how to buy funeral services. Car shoppers choose the make and model, compare features, and, if they're savvy, compare prices at more than one dealer. But it rarely occurs to anyone that they should or even could shop around for funeral goods and services. Most people simply use their local funeral home, even though location is no measure of quality or value. Or, they use the funeral home their family has used previously, even if they were unhappy with the funeral director.

To compound the problem, people get all their information about funeral planning from... a funeral home! That's like walking into a car dealership and saying "what do I need?" and then buying whatever they tell you to buy at whatever price they list. While most funeral directors are compassionate, caring people, they are **salespeople** running a **for-profit business.**

Did you know that prices differ enormously from one funeral home to the next?

- Direct cremation ranges from $550—$5,065. For the same service!
- A plain cardboard cremation box can cost you $20—$671
- Driving the body from the place of death to the funeral home: $175—$785
- A graveside service: $100—$1,295

You can shop online for almost everything so it would be nice to be able to compare prices on funeral home websites. However, only 6% of NJ funeral homes post their prices online. We asked every funeral home in NJ for their price list. 28% sent them directly, 28% needed two to seven requests before sending it, and a whopping 30% either didn't respond at all or outright refused. Isn't that strange behavior from a business trying to sell something? Can you imagine calling a restaurant, asking them to send you a menu, and being told "The menu is really too complicated for the layperson to understand" or "we don't give out the menu unless you come in person to get it." Yikes! What are they thinking?

Do you know your rights? By law, funeral homes are required to:

- Give you prices over the phone
- Give you a printed price list at the start of any conversation about funeral planning
- Let you buy a casket online for a fraction of the funeral home price (or make one) and not charge you a handling or other fee

Loads more information at funeralnj.org including about:

Green Burial is a way of caring for the dead that conserves natural resources, reduces carbon emissions, and preserves native habitats. https://fcaprinceton.org/green-burial/

Home Funerals offer many benefits; more time and freedom for family to say goodbye, to channel their grief and find a sense of purpose through the physical preparation of the body, a more personalized ritual that reflects the life of the deceased and provides a better transition for those left behind, and a cost of hundreds versus thousands of dollars.
https://fcaprinceton.org/home-funerals

Funeral Consumers Alliance is a volunteer-run, not-for-profit organization that is not associated with the funeral industry. We provide objective support, education and advocacy. We offer tools to empower you to make informed, thoughtful decisions about funeral and memorial arrangements before they are needed. **http://funerals.org**