

# Advance Care Planning For ALL

NC Coalition on Aging  
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Betsy Barton, MPH, CT  
Director of Special Projects  
Transitions LifeCare



# Session Objectives

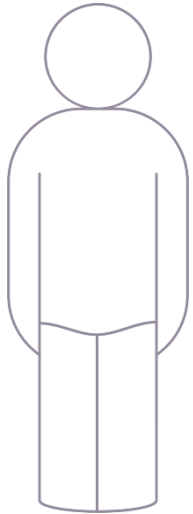
- List three benefits of completing an advance directive.
- Name the legal requirements for a valid Advance Directive in North Carolina
- Describe two insights about your personal priorities regarding care at the end of life.



SIPRESS

*"Don't freak out—it's just a save-the-date."*

# Advance Care Planning



Financial



Health



# Some facts to consider...

90% of people say that talking with their loved ones about end-of-life care is important

*... only 27% have actually done so*

82% of people say it's important to put their wishes in writing

*... only 23% have actually done it*

Video clip:

# 100 Things - Consider the Conversation

[https://www.youtube.com/watch?v=KDWNuY\\_m6Rg](https://www.youtube.com/watch?v=KDWNuY_m6Rg)

# What is the Go Wish Card Game?

- Deck of 36 cards (English and Spanish)
- Each card contains one simple phrase
- “Wild card” encourages customized wishes
- Play the game with your Proxy!!



# How to play Go Wish

Sort the cards into **three** piles:

- Very important to me
- Sort of important
- Unimportant to me

*Use the wild card to list your own item*

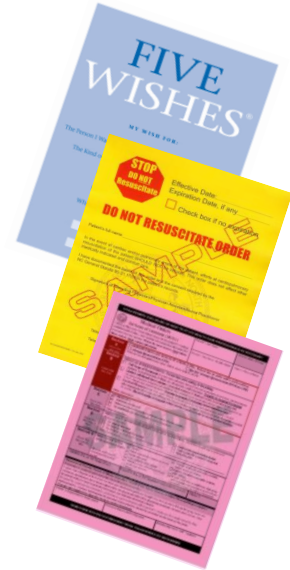
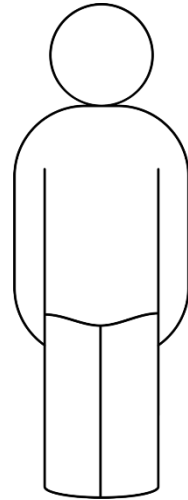
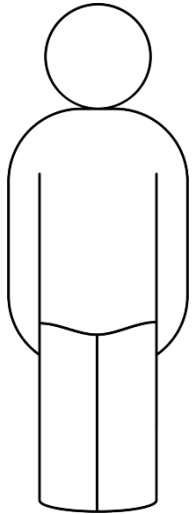
<https://codaalliance.org/go-wish-game/>

# AN ACT OF LOVE:

Talking to Your Family About Serious  
Illness and End of Life

TRAILER - An Act of Love: Talking with Your  
Family About Serious Illness and End of Life

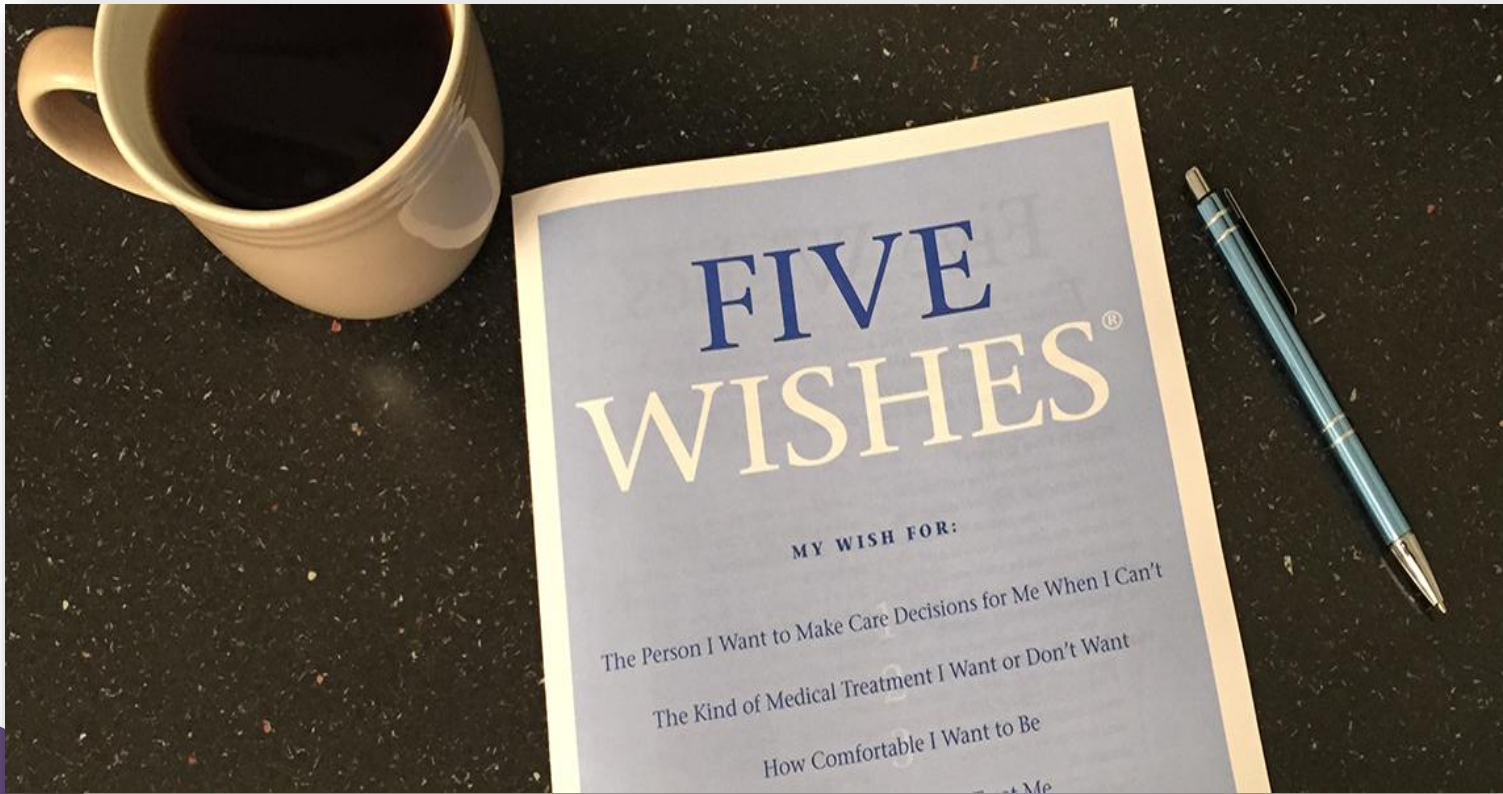
# Advance Care Planning



**Financial**

**Health**

# Five Wishes Form




# Additional Tools to Document EOL Wishes and Preferences

- NC Advance Directive
- Five Wishes
- NC DNR Form
- NC MOST Form
- Conversation Project “Starter Kit”



# DNR and MOST Forms



**STOP  
DO NOT  
Resuscitate**

Effective Date: \_\_\_\_\_  
 Expiration Date, if any \_\_\_\_\_

Check box if no expiration

## DO NOT RESUSCITATE ORDER

Patient's full name \_\_\_\_\_

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_

Printed Name of Attending Physician \_\_\_\_\_


Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_


Telephone Number (office) \_\_\_\_\_

Telephone Number (emergency) \_\_\_\_\_

**Do Not Copy      Do Not Alter**

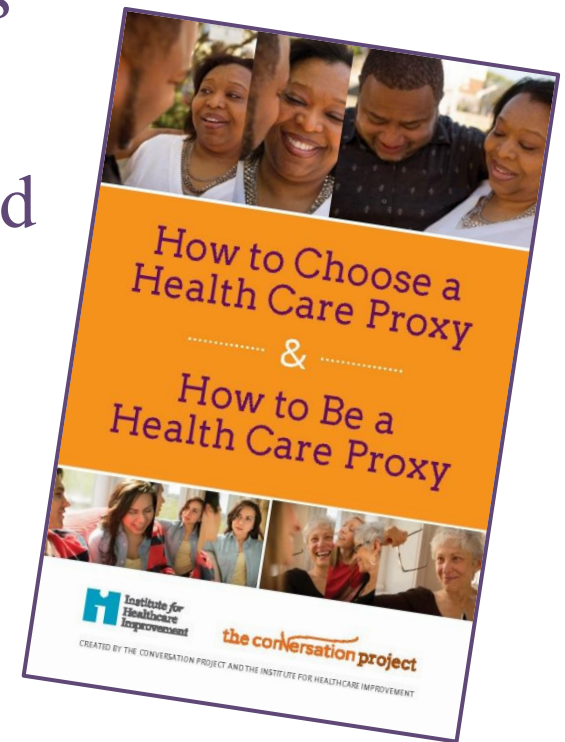


HEALTHCARE FORMS 1-13 Rev. 1/14  
 NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		
 <b>Medical Orders</b> for Scope of Treatment (MOST)	Patient's Last Name: _____	Effective Date of Form: _____
This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. <b>When the need occurs, first follow these orders, then contact physician.</b>		Patient's First Name, Middle Initial: _____ Patient's Date of Birth: _____
<b>Section A</b>	<b>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.</b> <input type="checkbox"/> Attempt Resuscitation (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) <small>When not in cardiopulmonary arrest, follow orders in B, C, and D.</small>	
<b>Section B</b>	<b>MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.</b> <input type="checkbox"/> Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. <b>Transfer to hospital if indicated.</b> <input type="checkbox"/> Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less-invasive airway support such as BiPAP or CPAP. Also provide comfort measures. <b>Transfer to hospital if indicated. Avoid intensive care.</b> <input type="checkbox"/> Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Do not transfer to hospital unless comfort needs cannot be met in current location.</b> <small>Other Instructions: _____</small>	
<b>Section C</b>	<b>ANTIBIOTICS</b> <input type="checkbox"/> Antibiotics if indicated <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs <input type="checkbox"/> No Antibiotics (use other measures to relieve symptoms) <small>Other Instructions: _____</small>	
<b>Section D</b>	<b>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.</b> <input type="checkbox"/> IV fluids if indicated <input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> No IV fluids (provide other measures to ensure comfort) <input type="checkbox"/> Feeding tube long-term if indicated <input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> No feeding tube <small>Other Instructions: _____</small>	
<b>Section E</b>	<b>DISCUSSED WITH AND AGREED TO BY:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Parent or guardian if patient is a minor <input type="checkbox"/> Health care agent <input type="checkbox"/> Legal guardian of the patient <input type="checkbox"/> Attorney-in-fact with power to make health care decisions <input type="checkbox"/> Spouse <input type="checkbox"/> Majority of patient's reasonably available parents and adult children <input type="checkbox"/> Majority of patient's reasonably available adult siblings <input type="checkbox"/> An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient	
MD/DO, PA, or NP Name (Print): _____		MD/DO, PA, or NP Signature and Date (Required): _____
Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file) I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent. <i>If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.</i> <b>You are not required to sign this form to receive treatment.</b>		
Patient or Representative Name (print): _____	Patient or Representative Signature: _____	Relationship (write "self" if patient): _____
<b>SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED</b>		

# Health Care Proxy

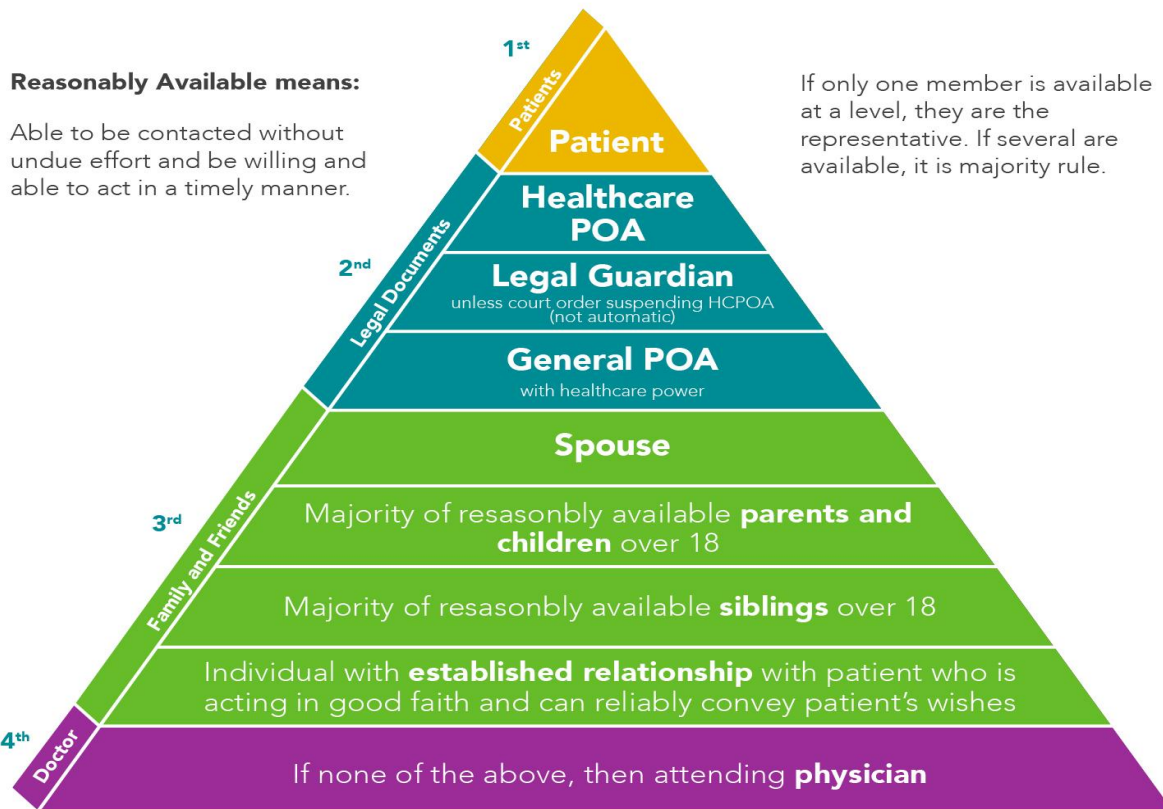
- A well-informed health care proxy who knows about **YOUR WISHES** is the best resource you can have
- They have to know ahead of time, and have a copy of your advance care directive



# Who's the Proxy

## When There is No Advance Directive?

### North Carolina Decision Making Order



# Conclusion

- Start the conversation early
- Fill out, sign and notarize your forms
- Talk to your health care proxy and make sure they know what is important to you
- Talk, to your loved ones, too – to reduce the likelihood of family conflict later on