Basics of Advance Care Planning

Staci Metzger & Chelsey Pollert
November 15th, 2022
Captain of the ship ....
Common Names for Health Care Directive

• Health Care Directive
• Health Care Power of Attorney
• Power of Attorney for Health Care
• Living Will
• Health Care Declaration
• Honoring Choices
• Five Wishes
• Advance Directive
Health Care Directive vs. Power of Attorney

• Difference –
  – HCD deals with health and health related issues
  – POA deals with finances and real property
Who may MAKE a Health Care Directive?

An individual age eighteen (18) with capacity to execute a health care directive

Capacity – ability to understand and appreciate benefits and harms/risks of health care decisions

Remember that decision making capacity can be fluid and may change throughout the day, week, or month
Health Care Agent

• Adult given authority to make a health care decision
  – The agent is not able to make decisions until you are UNABLE to communicate, make your wishes/goals known or lack capacity.
How to choose an agent?

- Ideally, choose 1 person and list 1 or 2 for backup
- Is this person willing to take on this role and responsibility?
- Do they understand your wishes?
- Will they make the decision you want, even if they disagree?
- Can they make decisions under stressful situation?
Who may be Appointed Health Care Agent?

Principal may appoint an individual 18 years of age or older

It may NOT be:

- Individual assigned the task of determining decision-making capacity
- Health care provider
- Employee of the principal’s health care provider unless

Who will be the best to serve as health care agent requires conversation and thought!
What Decisions does the Health Care Agent have the Authority to Make?

Health care decisions
• Any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a person's physical or mental condition – nutrition, intubation, organ donation (neither MN nor ND may authorize assisted suicide)

Choose health care providers

Where Principal lives

Where Principal receives care and support

Review or disclose medical records

Establish personal security safeguards (think visitors)

Consent to mental health treatment (sometimes intrusive)
What Decisions does the Health Care Agent have the Authority to Make? (cont.)

• Medical Records:
  – A health care agent has the same authority to receive, review, and obtain copies of Principal’s medical records as the Principal.
Responsibilities of Health Care Agent

Health care agent must act in good-faith consistent with a legally sufficient health care directive.

If there is not sufficient guidance, a health care agent MUST act in the best interests of the Principal considering the Principal’s overall general health conditions, prognosis, and personal values – this should force us to THINK about WHO the Principal is appointing.

A health care agent has a personal obligation to the principal to make health care decisions authorized by the health care directive – but this is not a legal duty to act (see above).
A Principal’s Considerations

• Life-prolonging treatments
  – CPR
  – Pain management
  – Ventilation
  – Dialysis
  – Antibiotics
  – Use of blood products
• End of life
• Mental health
• Faith-based values and beliefs
A Principal’s Considerations (cont.)

- Gender transition
- Organ donation
- Autopsy
- Disposition of remains/funeral
- Reference to other documents
  - Provider Order for Life-Sustaining Treatment (POLST)
  - Do Not Resuscitate (DNR) – this is NOT the same as a health care directive
  - Do Not Intubate (DNI)
- Pregnancy – consider how an individual would like pregnancy to affect health care decision making by agent
When is a Health Care Directive Effective?

- When the document is signed
- BUT …
  - As long as the principal has the capacity to make health care decisions, decisions are made by the principal
  - The real question is when is the health care directive effective for the health care agent(s)?
    - Health care directive is legally sufficient; and
    - The principal lacks decision-making capacity – generally physicians are making this decision
Requirements for Valid Health Care Directive

• Legally Sufficient Requirements:
  – Be in writing
  – Be dated
  – State the Principal’s name
  – Executed by a Principal with capacity
  – (MN) Include health care instruction, a health care power of attorney or both
  – Notarized or Witnessed by two (2) disinterested persons

• A photocopy of a health care directive is presumed to be a true and accurate copy of the executed original
Revocation of Health Care Directives

• May be revoked in whole or in part
• Principal must have capacity to revoke
  – Burn, shred, deface, cancel, destroys, etc.
  – Executes a statement
  – Verbally expresses the intent to revoke
  – Executes a subsequent health care directive
• If several health care directives are identified, the most recent health care directive takes precedence
Health Care Directives

- Honoring Choices MN or ND
- Provider Order for Life-Sustaining Treatment (POLST)
- Five Wishes
Wishes for Health Care: Short Form
Minnesota Health Care Directive
See other side for completion directions

Full Name: ___________________________ Date of birth: ___________________________

1. I appoint the following person to serve as my primary (main) health care agent. This person will make health care decisions for me if I cannot communicate or make these decisions myself:

   Name ___________________________ Relationship ___________________________
   Cell phone ______________________ Other phone ___________________________

   (Optional): I appoint this person as my alternate health care agent in the event my primary health care agent is not available:

   Name ___________________________ Relationship ___________________________
   Cell phone ______________________ Other phone ___________________________

2. (Optional): I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about specific medical treatments or situations): If you need more space, continue on other side:

   _______________________________________________________________________

   _______________________________________________________________________

   _______________________________________________________________________

   _______________________________________________________________________

   _______________________________________________________________________

Signature ___________________________ Date ___________________________

Notary Public in the State of Minnesota

County of ___________________________

Notary seal ___________________________

In my presence on ______________________ [date], ______________________ [name]
acknowledged his or her signature on this document, or acknowledged that he or she
authorized the person signing this document to sign on his or her behalf.

Signature of Notary ___________________________

My commission expires ______________________ [date]

Q. Statement of two (2) Witnesses

Witness 1 ___________________________
Witness 2 ___________________________
Date signed: ______________________ Date signed: ______________________
Print Name: __________________ Print Name: __________________

(Witnesses must be 18 years of age or older and cannot be your primary or alternate health care agent.
One witness cannot be your health care provider or an employee of your health care provider.)

Do I have to complete this Health Care Directive?
No. You may complete it today or at a later date, or you can decline to complete it. However, completing this form will help
make sure you get the care you want. Putting your choices in writing helps loved ones know if they're doing what you would
want.

What information am I being asked?

Question 1: This question is about your health care "agent." Your agent is someone you choose to speak and make health care
decisions for you if you cannot. Consider naming a family member or friend who knows you well and understands your
values. Showing your agent this document and talking about it with him or her is important. Make extra copies to share
with your health care agent, health care providers, and other important people in your life.

Question 2 (Optional): This question is about health care and other wishes you may have. You may be as specific or general
as you like. You may include:

   • your goals, values, and preferences about medical care
   • the types of medical treatments you would want or not want
   • how you want your agent or agents to decide
   • where you would like to receive care (such as at home or in a hospital)
   • whether or not you would like to donate your organs, tissues, and eyes

Notary Public or Witnesses

A notary public or 2 witnesses must verify your signature on this Health Care Directive. The witnesses must be 18 years of age
or older, and cannot be your primary or alternate health care agent. At least one witness cannot be your health care provider
or an employee of your health care provider.

What should I do after I complete this Health Care Directive?

Tell the people you named as your primary and alternate health care agents, if you have not already done so. Make sure they
feel able to do this important job for you in the future. Give a copy of your health care directive to your health care provider.
Keep additional copies for your records and to share with your health care agents and family or others as you wish.

Who can I talk with if I have questions?

Your health care provider can answer your questions or concerns. He or she may refer you to an Advance Care Planning
Facilitator for help.

Use the space below to continue your wishes about your health care (Question 2 from front page), or to add comments.
Cardiopulmonary Resuscitation (CPR): Patient has no pulse and is not breathing.

A. Cardiopulmonary Resuscitation (CPR): Patient has no pulse and is not breathing.
- [ ] Attempt Resuscitation / CPR (Note: selecting this requires selecting “Full Treatment” in Section B).
- [ ] Do Not Attempt Resuscitation / DNR (Allow Natural Death).

B. Medical Treatments: Patient has pulse and/or is breathing.
- [ ] Full Treatment: Invasive, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital if indicated. All patients will receive comfort-focused treatments.
- [ ] Selective Treatment: Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway, or mechanical ventilation. May consider invasive airway support (e.g., CPAP/BI-PAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
- [ ] Comfort-Focused Treatment (Allow Natural Death): Refuse pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction, and mechanical treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

C. Documentation of Discussion:
- [ ] Patient (Patient has capacity)
- [ ] Court-Appointed Guardian
- [ ] Parent of Minor
- [ ] Health Care Agent
- [ ] Health Care Proxy

Signature of Patient or Surrogate:

Signature is strongly recommended.

SIGNATURE: __________________________
SIGNATURE DATE: __/__/____
NAME (PRINT): _______________________
RELATIONSHIP TO PATIENT: __________
PHONE: ______________________________

Signature attests that these orders reflect the patient’s treatment wishes. Absence of signature does not negate the above orders.

Signature of Physician / APRN / PA:

My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s current medical condition and preferences.

SIGNATURE: __________________________
SIGNATURE DATE: __/__/____
NAME (PRINT): _______________________
CREDENTIALS: _____, DOB: __/__/____
PHONE (WITH AREA CODE) ____________________

NOTE TO PATIENTS AND SURROGATES:
The POLST form is always voluntary. It is important to understand that if a patient is already on LIFE SUPPORT, ALL LIFE SUPPORT can be turned OFF immediately. Patient choice is always respected. It is important that all medical care providers are aware of all treatment options, goals and desires of the patient and are informed of the patient’s wishes. If the POLST form is present, your medical orders will be guided by the POLST form.
When to review a HCD?

5 Ds

- Decade
- Decline in health
- New Diagnosis
- Death
- Divorce
Questions

Staci Metzger  Chelsey Pollert
staci.metzger@hrrv.org  chelsey.pollert@hrrv.org
1-800-237-4629