
Basics of Advance Care Planning

Staci Metzger & Chelsey Pollert

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HOSPICE
RED RIVER VALLEY

Providing comfort at the end of life's journey

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

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME	PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)	

A

CHECK ONE

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).

When not in cardiopulmonary arrest, follow orders in B.

B

CHECK ONE (NOTE REQUIREMENTS)

MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

- Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.
- Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual 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.
TREATMENT PLAN: Maximize comfort through symptom management.

C

CHECK ALL THAT APPLY

DOCUMENTATION OF DISCUSSION

- Patient (*Patient has capacity*) Court-Appointed Guardian Other Surrogate
 Parent of Minor Health Care Agent Health Care Directive

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED)	NAME (PRINT)	DATE
RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF")		PHONE (WITH AREA CODE)

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

D

ALL ITEMS REQUIRED

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.

NAME (PRINT)	CREDENTIALS (MD, DO, APRN, PA)	PHONE (WITH AREA CODE)
SIGNATURE	DATE	

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org PAGE 1 OF 2

INFORMATION FOR

PATIENT NAMED ON THIS FORM

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

E

OPTIONAL SECTION. IF COMPLETED, CHECK ONE FROM EACH CATEGORY

ADDITIONAL PATIENT PREFERENCES (OPTIONAL)

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- Long-term artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 No artificial nutrition by tube.

ANTIBIOTICS

- Use IV/IM antibiotic treatment.
 Oral antibiotics only (no IV/IM).
 No antibiotics. Use other methods to relieve symptoms when possible.

ADDITIONAL PATIENT PREFERENCES (e.g. dialysis, duration of intubation).

F

REQUIRED: CHECK BOX OR COMPLETE ALL ITEMS

HEALTH CARE PROFESSIONAL WHO PREPARED DOCUMENT

- Same as signing provider (see Section D)

NAME (PRINT)	TITLE	PHONE (WITH AREA CODE)
SIGNATURE	DATE	

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed

to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a health care agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/ APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, health care agent designated in a Health Care Directive, or a person who the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a spouse, domestic partner, adult child, sibling, parent of a minor, other relative or close friend, or closest available relative.

Reviewing POLST

- This POLST should be reviewed periodically, and if:
- The patient is transferred from one care setting or care level to another, or
 - There is a substantial change in the patient's health status, or
 - The patient's treatment preferences change, or
 - The patient's primary medical care provider changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through F and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

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Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org PAGE 2 OF 2

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*When to review
a HCD ???*

5 Ds

Decade

Decline in health

new Diagnosis

Death

Divorce

Questions

Staci Metzger

staci.metzger@hrrv.org

Chelsey Pollert

chelsey.pollert@hrrv.org

1-800-237-4629

