Basics of Advance Care Planning

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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

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Health Care Directive vs. Power of Attorney

- Difference –
  - HCD deals with health and health related issues
  - POA deals with finances and real property

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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

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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.

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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?

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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!

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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)

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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)

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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

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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

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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

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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

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Health Care Directives

- Honoring Choices MN or ND
- Provider Order for Life-Sustaining Treatment (POLST)
- Five Wishes

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Honoring Choices® MINNESOTA

An initiative of the Twin Cities Medical Society

Wishes for Health Care: Short Form[1]

Minnesota Health Care Directive[2]

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)

OR 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.)

[1] *A long form is available if you wish to more fully describe your health care wishes.*

[2] *This document will not apply to any intrusive mental health treatments (electroconvulsive therapy or neuroleptic medications).*

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 for?

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 treatment 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 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.

Honoring Choices Minnesota is an initiative of the Twin Cities Medical Society. www.metrodoctors.com 612-362-3704 Revised January 2016

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

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 — CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

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

CHECK ONE (NOTE REQUIREMENTS)

- ☐ **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 — DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

- ☐ **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 — SIGNATURE OF PHYSICIAN / APRN / PA

ALL ITEMS REQUIRED

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.*

INFORMATION FOR

PATIENT NAMED ON THIS FORM

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

E — ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

OPTIONAL SECTION. IF COMPLETED, CHECK ONE FROM EACH CATEGORY

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 — HEALTH CARE PROFESSIONAL WHO PREPARED DOCUMENT

REQUIRED: CHECK BOX OR COMPLETE ALL ITEMS

- ☐ **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.

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

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When to review a HCD ???

5 Ds

- Decade
- Decline in health
- new Diagnosis
- Death
- Divorce

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Questions

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