Advance Care Planning and Health Care Directives

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Agenda:

- Overview of Advance Care Planning and Health Care Directives
- Ideas on how to talk with patients about Advanced Care Planning
- Review Health Care Directive Forms and steps in completing one
- Review POLST Form
- Additional Resources

Advance Care Planning

- Advance care planning is making decisions about the healthcare you would want to receive if you're facing a medical crisis, have a chronic condition or terminal illness. These are your decisions to make based on your personal values, preferences, and discussions with your loved ones.

Advance Care Planning Includes:

- Understanding possible future situations and decisions
- Deciding what types of treatment you would or would not want should you be diagnosed with a life-limiting illness.
- Sharing your personal values with your loved ones.
- Completing advance directives to put into writing what types of treatment you would or would not want – and who you chose to speak for you – should you be unable to speak for yourself.

Advance care planning is important because:

- Helps people start thinking and talking about future healthcare decisions
- If you had a sudden event like a car accident or a stroke or an illness like dementia and could not make your own decisions who would make those decisions for you?
- In the current situation, if you had Covid-19 what treatments would you want pursued, how long would you want to be on a ventilator, what type of quality of life would be acceptable to you if lived.
- Give family directions and peace of mind, they know they did the right thing, prevent disagreements

Three main decisions

- Who will be your health care decision maker – health care agent
- What beliefs and values might impact your decisions about healthcare
- What healthcare would you like in specific situations

Types of Directives

- Health Care Directives / Power of Attorney for Health Care
- Living Wills
- Financial/Durable Power of Attorney
- Provider Orders for Life-Sustaining Treatment/Resuscitation Orders

Additional considerations for the current pandemic

- Urgency of completing a HCD
- Potential for high infection rate and number of people who may need hospitalization and breathing support
- Increased risk for people with underlying conditions or chronic health conditions (all the people we see regularly)
- Risks for all age groups
- Limits on visitors affecting communication

Promoting ACP and the completion of a HCD

- How to initiate the conversation
- What to talk about
- Completing a form
- Next steps

Initiating the Conversation

- Ask permission: "I would like to talk about how you would like to be cared for if you got really sick. Is that okay?"
- Offer it as a 'new' service or initiative you're offering
- Many people are scared about what could happen to them if they had COVID-19. Offer to talk with them about concerns and then offer assistance with a HCD
- Required assessment question for many: do you have an updated Health Care Directive?
- Acknowledge and normalize that it can be an uncomfortable thing to talk about.
- What do you know about advanced care planning and health care directives?

Provide explanation of ACP and HCDs as needed

- Advance Care Planning: the thinking and talking about future health care decision. Choosing a health care agent. Talking with your agent about your goals and values.
- Advance Directive: the form or document where you write down your goals, values and preferences and who you have chosen to make health care decision for you.

Explore the Patient's health situation and health related experiences

- What do they understand about their illness
- Have there been any recent changes
- What problems do they think they may have in the future from their illness
- Do they have any question about their illness that they want to talk with a nurse or doctor about
- Have they been in the hospital recently, did they learn anything from that experience
- Do that have any experience with family or friend have a serious illness, what did they learn from that experience

Review the three decisions of advanced care planning

- Who will be your health care decision maker – health care agent
- What beliefs and values might impact your decisions
- What healthcare would you like in specific situations

Who will be your health care decision maker – health care agent

- Agent should accept this role
- Be willing to talk with you about goals, values and preferences
- Make decisions in difficult moments
- Someone you trust to carry out your wishes- they are speaking for you.

What beliefs and values might impact your decisions

- cultural, religious, spiritual or personal beliefs
- what does quality of life mean to you
- What's important to you
- Catholic HCD, WI addendum, prayer, other religions restrict use of blood products

Talk about what 'quality of life' means to the patient

- If you had a good day, what would happen, what would you do, who would you talk with
- For patients with chronic illness: what worries you most about your illness, what fears do you have.
- What type of limitations would make you question whether or not life were worth living.

What healthcare would you like in specific situations

- If you have a sudden illness or injury.
- If you have a severe, permanent brain injury or severe stroke or dementia
- If you didn't know who you were, or who you were with?
- If your doctor determined there was no "bridge to recovery"

Considerations

- Antibiotics
- Artificial Fluid and nutrition
- Breathing support
- Code status, DNR/CPR
- IVs
- Pain medications
- Hospice and palliative care

Honoring Choices Information Sheets

- General guide
- Terms to Know
- Artificial Hydration and Nutrition
- Cardiopulmonary Resuscitation
- Help with Breathing
- Health Care Agent
- Implantable Cardioverter-Defibrillator
- Dialysis

Honoring Choices® MINNESOTA

An initiative of the Twin Cities Medical Society

Advance Care Planning Information:

General Guide

Advance Care Planning
Knowing your voice is heard when making decisions about health care is important. Advance Care Planning is the process of preparing for a time when you may not be able to make your own medical decisions. The best time to make these decisions is when you are able to make your own choices.

Health Care Agent
Discussing and sharing your wishes with your loved ones, health care team and health care agent is important. A health care agent makes health care decisions based on your wishes if you are unable to communicate.

Health Care Directive
By writing a Health Care Directive, you can make your voice heard so your wishes are followed. A Health Care Directive is a written plan outlining your values and priorities for your future medical treatment.

The process of advance care planning (ACP) involves conversations throughout life about your values, beliefs and goals for future health care. ACP conversations focus on your health care goals and what is important to you.

- As you get older, goals, values and priorities often change. Your health status may change, too. Revisiting your decisions and plans regularly is important.
- Give yourself and others peace of mind. Plan ahead while you are able.

Documenting your wishes in a Health Care Directive is important. The document outlines your values and priorities for future medical treatment and can identify your health care agent. A Health Care Directive limits confusion and helps everyone prepare for the unexpected.

Getting started

Start by thinking about what is most important to you. Talk with your loved ones to share your thoughts. Even if you feel close to loved ones, they may not know what you would want unless you tell them. The goal of ACP is to help others understand what health care choices you would make if you could not communicate.

Choosing a health care agent

Choosing a health care agent is key to planning ahead. Your health care agent is the person who will speak for you if you are unable to make decisions for yourself. To choose the best person to be your health care agent, ask yourself:

- Do I trust this person to be able to make tough decisions?
- Will this person honor my wishes even if he or she does not agree with my wishes?
- Can this person make important decisions under stressful situations?
- Can this person stand up for me even if family members or others disagree?
- Is this person likely to be available in case of an emergency?

Completing a Health Care Directive

Do I need a lawyer to complete my Health Care Directive?

No, as long as you meet these legal requirements:

- You must be at least 18 years old, and able to understand and communicate your wishes
- Your directive must be in writing, state your full name, be signed by you and dated
- Your directive must list 1 or both of the following: a named health care agent, and health care or treatment instructions
- In Minnesota, your signature on your directive must be witnessed by 2 adults or a notary public
  - Neither of the 2 adults can be your agent. Only 1 of the adults can work for your health care organization.
  - Witness requirements vary state to state. If you complete a directive in another state, check the state requirements.

Forms

Honoring Choices Forms

- 9 page Health Care Directive
- 4 page Health Care Directive
- 2 page Wishes for Health Care: Short Form

POLST - Provider Orders for Life Sustaining Treatment

Honoring Choices Minnesota Health Care Directives/POLST/Directions

- 9 Page Form
- 4 Page Form
- 2 Page Short Form
- Completing Your Health Care Directive 9 Page
- Completing Your Health Care Directive 4 Page

Reminders for HCDs

- Strongly recommended that a person chose just one agent although they can list more than one. Clarify co-agents' roles.
- Can leave spaces blank or N/A
- Designation of DNR in a HCD is not a POLST and a POLST should be completed if that is the patient's current wishes
- They not provide guidance or authority for invasive psychiatric interventions – MN Psychiatric HCD in addition
- Notary OR Two adult witnesses. Only one witness can be an employee of the patient's health care provider. Witnesses can be family members but NOT an agent on the directive.
- Make sure signature and witness dates are the same

Next Steps for Patients

- Give your health care agent(s) a copy
- Give your health care provider a copy
- Make sure the rest of your family knows you have one, where it is and what it says
- Keep a copy where it can be easily found
- Review and change as needed, five Ds
  - Every Decade, death of an agent, divorce, diagnosis, decline

Provider Orders for Life Sustaining Treatment

- An actual doctor's order to direct caregivers, family and first responders in the community
- Appropriate for anyone with a serious illness, chronic illness, frailty or terminal illness
- POLST

Resources

- Minnesota Honoring Choices:
- http://honoringchoices.org
- Health Care Directive forms and guides to completing health care directives:
- https://honoringchoices.org/health-care-directives/english
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- Information sheets:
- https://honoringchoices.org/tools-resources/informational-materials
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- Wisconsin Honoring Choices:
- https://www.wismed.org/wisconsin/wismed/about-us/honoring-choices/wismed/about-us/honoring-choices.aspx
- Health Care Directive form and description. Form is on the left menu bar.
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- MN Catholic Health Care Directive Info and Form:
- https://www.mncatholic.org/advocacyarea/catholic-end-of-life-care-decisions/
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- WI Catholic Health Care Directive Addendum:
- https://diolc.org/files/ministries/WI%20Catholic%20Addendum%20to%20Power%20of%20Attorney%20for%20Health%20Care.pdf

Resources continued . . .

- MN Statutory Short Form Power of Attorney for Finances Form and Information sheet (2020):
- https://www.lawhelpmn.org/sites/default/files/2020-02/S-08%20Powers%20of%20Attorney.pdf
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- Physician's Orders for Life Sustaining Treatment (POLST) form and info:
- https://www.mnmed.org/advocacy/improving-health-of-minnesotans/POLST-Communications
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- Wisconsin DNR Bracelet Information and form:
- https://www.dhs.wisconsin.gov/ems/dnr.htm
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- Other resources:
- Legal Aid Service of Northeast Minnesota,(218) 623-8100
- Senior Citizen's Law Project
- Self-Help Program, 218) 726-2611
- http://www.lasnem.org/
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- Duluth Volunteer Attorney Program, 218-723-4005 - Call Legal Aid first
- http://www.volunteerattorney.org/
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- Minnesota Board on Aging/Senior Linkage Line, (800) 333-2433
- http://www.mnaging.org/
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