

Understanding Advance Healthcare Directives



The Purpose of this Presentation:

- To promote the benefits of planning
- To encourage meaningful conversations
- To protect healthcare wishes

Conversations About Advance Care Planning:

- What do you understand about advance care planning?
- What fears or concerns do you have about this type of planning?
- If you have completed an advance directive in the past, what motivated you to complete it?

Conversations About Advance Care Planning:

What is Advance Care Planning for?

- **Planning ahead** for future healthcare decisions **if an unexpected event** (like a car accident or illness) left you **unable to communicate** and make your own healthcare decisions, and **others would need to make decisions** for you.

Conversations About Advance Care Planning:

What is an Advance Directive?

- *Defined as:* “A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated.”

Conversations About Advance Care Planning:

Three types of legal documents:

- Living Will
- Power of Attorney for Healthcare (POA-HC)
- Do Not Resuscitate (DNR) order

Three Types of Legal Documents

Living Will

- A document declaring an individual's wishes and directing their physician to refuse certain life sustaining procedures when the principal's death is imminent due to a terminal condition or when the principal is in a persistent vegetative state.

Three Types of Legal Documents

Power of Attorney for Healthcare (POA-HC)

- A document that authorizes another person (called the “agent”) to make healthcare decisions for the person executing the document (called the “principal”, consistent with the terms of the document and based on the wishes of the principal, effective when the principal is unable to make healthcare decisions.

Three Types of Legal Documents

Do Not Resuscitate (DNR) order:

- A DNR order may only be issued by an attending physician and only applies to a “qualified patient” (an adult who has a terminal condition or would suffer pain or harm from resuscitation or when resuscitation would be unsuccessful). The qualified patient must also request the DNR order, consent to it, and sign the written order.

Conversations About Advance Care Planning:

Who should complete an Advance Care Plan?

- **EVERYONE!**

When should this be completed?

- On or very near your 18th birthday
- Or as soon as possible

Conversations About Advance Care Planning:

Why should this be completed?

- Because we all have the right to our own choices, and to have those choices honored
- Because Wisconsin law treats family members, including spouses, as strangers for decision-making purposes. Wisconsin is NOT a “next of kin” or “family consent” state for adults.
- Because the people who care about you will be very grateful to know what you would have wanted if its ever needed.
- Because doing it later could be too late.

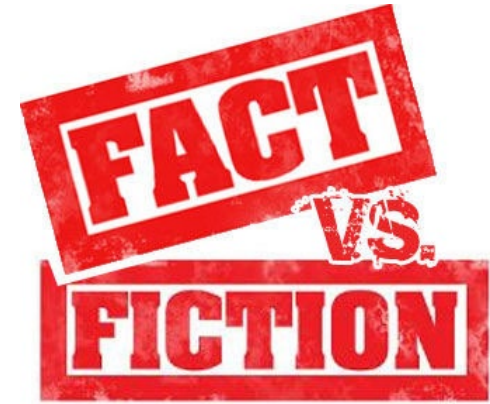
It's a personal choice:

- Advance Care Planning is all about what's right for you – not someone else.
- These decisions are complicated, which is why we encourage you to communicate your values and personal philosophy as much as specific treatment choices.



Fact VS. Fiction

- Talking about this will invite trouble.
- This topic is a downer.
- I don't need to take care of this right now.
- I'll lose control of my choices because I won't be resuscitated.
- If I ever need it, someone else will deal with it.



Conversations About Advance Care Planning:

Three points to consider:

- Discussing and deciding on your goals of care in the event of a severe accident or sudden illness
- Identifying any personal, cultural or religious beliefs that may affect treatment decisions
- Choosing a decision-maker (healthcare agent)

Conversations About Advance Care Planning:

How do you make Advance Care Planning meaningful?

- Reflect on your experiences

Some things that you could talk about:

- Pain control
- Caregiver stress
- Emotional stress
- Time testing treatment

Conversations About Advance Care Planning:

Living Well

- Have you thought about what experiences or activities are most important for you to *live well*?
- Have they changed over time?

Conversations About Advance Care Planning:

Exploring goals for medical care/treatment:

You have a serious accident or sudden illness that leaves you unable to communicate. You are receiving all the medical care required to keep you comfortable, but the doctors believe there is little chance you will ever recover the ability to know who you are or those around you.

What does this situation mean to you?

Conversations About Advance Care Planning:

1. If I have a **TERMINAL CONDITION**, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I have a terminal condition.
- NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

- YES, I want life-sustaining procedures used if I am in a persistent vegetative state .
- NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I am in a persistent vegetative state.
- NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

Conversations About Advance Care Planning:

Exploring religious, cultural or personal beliefs:

- What helps you when you face serious challenges in your life?
- Do you have beliefs that might influence your preferences for using life-sustaining treatment interventions?
- Do you need to discuss these beliefs or clarify any concerns with others?

Conversations About Advance Care Planning:

Things to think about when choosing a healthcare agent:

- Responsibilities of a health care agent include – making choices about medical care, reviewing and releasing medical records, arranging for medical care and treatment, making decisions on living situation, deciding which providers can provide treatment.

Consider choosing a person who:

- Can make difficult decisions under pressure or in emotional situations.
- Understands your preference, values and goals.
- That you know and trust to follow your preferences, even if they are different from their own.

Conversations About Advance Care Planning:

Starting the conversation with a prospective agent:

- “I was thinking about what happened to ____ and it made me realize...”
- “Even though I’m okay right now, I’m worried that ____, and I want to be more prepared.”
- “If I get sick or hurt in the future and can’t make my own decisions, would you work with my doctors and help make medical decisions for me?”

Conversations About Advance Care Planning:

Designation of healthcare agent:

If I am no longer able to make healthcare decisions for myself, due to my incapacity, I hereby designate _____ (print name, address, and telephone number) to be my healthcare agent for the purpose of making healthcare decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate _____ (print name, address, and telephone number) to be my alternate healthcare agent for the purpose of making healthcare decisions on my behalf.

Conversations About Advance Care Planning:

Admission to nursing homes or community-based residential facilities:

My healthcare agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked “Yes” to the following, my healthcare agent may admit me for a purpose other than recuperative care or respite care, but if I have checked “No” to the following, my healthcare agent may not so admit me to:

1. A nursing home – Yes No
2. A community-based residential facility -- Yes No

If I have not checked either “Yes” or “No” immediately above, my healthcare agent may admit me only for short-term stays for recuperative care or respite care.

Conversations About Advance Care Planning:

Provision of feeding tube:

If I have checked “Yes” to the following, my healthcare agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgement, this will cause me pain or will reduce my comfort. If I have checked “No” to the following, my healthcare agent may not have a feeding tube withheld or withdrawn from me.

My healthcare agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube -- Yes No

If I have not checked either “Yes” or “No” immediately above, my healthcare agent may not have a feeding tube withdrawn from me.

Conversations About Advance Care Planning:

Statement of desires, special provisions or limitations:

In exercising authority under this document, my healthcare agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state. (Add more items if needed.)

1. _____
2. _____
3. _____

Conversations About Advance Care Planning:

Statement of witnesses:

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for healthcare is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership or adoption, and am not directly financially responsible for the principal's healthcare. I am not a healthcare provider who is serving the principal at this time, an employee of the healthcare provider, other than a chaplain or a social worker, or an inpatient healthcare facility in which the declarant is a patient. I am not the principal's healthcare agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1

(Print Name) _____ Date _____

Address _____

Signature _____

Conversations About Advance Care Planning:

Next Steps:

- Give copies to your healthcare agents and healthcare professionals.
- Keep a copy for yourself where it can be easily found.
- Talk to the rest of your family and close friends. Tell them who your healthcare agent is and what your wishes are.
- Take a copy with you if you are admitted to the hospital or nursing home and ask for it to be entered into your medical record.
- Periodically review your advance directive. It is a process, as our wishes may change as our circumstances change.

The 5 D's:

It's important to review your Power of Attorney for healthcare at times of change and transitions:

- Decade
- Divorce (document is void if your ex-husband is your primary agent)
- Decline
- Diagnosis
- Death

Conversations About Advance Care Planning:

For fillable forms, and more information/tips on having conversations with family members and friends on this important topic, go to:

<http://www.theconversationproject.org/> (Conversation Starter Kit)

The State of Wisconsin Power of Attorney for Health Care form can be found online at:

<http://www.dhs.wisconsin.gov/forms/advdir>

**“A goal
without a
plan is just
a wish.”**

– Antoine de Saint-Exupéry



Let's leave on a light note!



<https://www.youtube.com/watch?v=igZvuCJv4VQ>



Hospice Alliance

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