Learning Objectives

• Understand the essential components of a Health Care Directive

• Pinpoint the responsibilities of a Health Care Agent and the ideal characteristics of an Agent

• Identify documents that supplement Health Care Directives

• Acquire tips for discussing advanced care planning with your loved ones

• Obtain ideas for building a care team
There are only four kinds of people in the world: those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers.
Reminders

• Make Decisions Early
  • Crisis planning is not planning
  • Options may be limited by situation
  • Care received may not be desired
• Create a Team *and make your wishes known*
• *Plan for the worst, so you can live your best!*
Health Care Directive

- Health Care Directive | “The Artist Formerly Known As...”
  - Advanced Directive
  - Living Will
  - Power of Attorney for Health Care
- Defined by Minn. Stat. §145C.02
Major Players

- Principal
- Agent(s)
- Successor Agent(s)
Health Care Directive
Forms
Importance of Health Care Directive

- Protects autonomy
- Appoints legal decision-maker
- Serves as guide for care providers
Components

• Designation of an Agent
• Directions for decision making
• Release of medical records
• Appointment of Guardian
• Intrusive mental health treatment
Components

- Impact of pregnancy on wishes
- Anatomical gifts
- Funeral/memorial wishes
- Instructions re: artificial nutrition and hydration
- *Any direction you wish regarding your care!*
No Directive?

- No clear path
- Default treatment
- Guardianship
  - Court proceeding is required
Role of Agent

• Individual(s) making decisions for you if incapacitated
• May be Spouse | Trusted Family | Close Friend
  • May be Professional | Nonprofit Organization
• Should be **willing and able** to carry out your wishes
“Good” Agents

- Clearly understands you and your wishes
  - And accepts your wishes
- Unafraid to ask questions of medical professionals
- May need to be assertive to ensure wishes are respected
- Strong communicator with loved ones
• Providers Orders for Life Sustaining Treatment | POLST
  • End of Life Decision Making
  • Doctor’s Order
  • Emergency Responders
  • Relationship between POLST & HCD
POLST: Provider Orders for Life Sustaining Treatment

**Hypoxia PERMITs Disclosure of POLST to Other Health Care Providers as Necessary**

**Provider Orders for Life-Sustaining Treatment (POLST)**

**A.** Check One Goal

- Cardiopulmonary Resuscitation (CPR)
- Do Not Attempt Resuscitation

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**B.** Check One Goal

- Comfort Care: Do not intubate but use medication, oxygen, oral suction, and manual cleaning of airways, etc. as needed for immediate comfort
- Limit Interventions and Treat Reversible Conditions
- Provide life-sustaining treatment

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**C.** Check All That Apply

- Antibiotics
- Antihypertensive
- Anticoagulation

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**Additional Orders:**

- FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.

Downloaded from http://www.tidyforms.com
The “Talk”
The “Talk”

- Communicate your wishes and values
- Clarify what you mean
  - What does heroic measures mean to you?
  - When is life no longer worth living?
  - What does a good death look like?
- Can diminish Agent(s)’ anguish
The “Talk”

• Conversation Starters
  • No “right way”
  • Not necessarily one time
  • Use someone else’s experiences
The “Talk”

- Conversation Starters
  - Use the news
  - Use worksheets
  - Use letter, tape, video recordings
  - Blame attorney!
The “Talk”

- Resistance
  - “I can’t talk about this”
  - “There’s nothing we need to discuss”
  - “It’s in God’s hands”
The “Talk”

- Responses
  - Be firm and straightforward
  - Point out consequences of not talking
  - Ask someone to be your spokesperson
Who Should Hold Copies?

• You
• Your Agent
• Your medical professionals
• Your immediate family or close friends
• Care facility (if applicable)
Storing Documents

- Original Document: Safe and accessible place
  - *Copies of Directives are just as good as originals*
- Electronic medical record
- Acknowledge existence on Driver’s License
- Some faith communities may store
- Some attorneys may store
Assemble Care Planning Team

- Elder Law Attorney
- Life Care Coordinator | Social Worker
- Public Benefits Specialist
- Authorized/appointed loved ones
Assemble Care Planning Team

- Care Providers
- Medical Professionals
- Professional Fiduciaries (if needed)
- Financial Advisor
- Accountant
Assemble Care Planning Team

- Placement Assistance (+/-)
- Death Doula
- Therapist
- Support Group
- Medicare Insurance Specialist
- Funeral preplanner | Celebrant
Action Steps

- Consider your Values and Legacy
- Identify your Team or Key Players
- Meet with an Attorney
- Execute Documents
- Have “the Talk”
- Review Annually
Get Organized

• Health Care Directive
• HIPAA Release Form
• Doctor Contact Information
• Current Medication List
• Clinic Notes
• Appointment Schedules
Get Organized

- Health insurance information
- Other insurance information (home, auto, life, long)
- Asset and income detail list
- Financial statements
- Online account access information
- Tax filings
Update Regularly

• Annual review and consider
  • Health status
  • Diagnosis
  • Change in family or values
  • Personal experiences
How to Change or Amend?

- Execute a new Directive
- Revoke former
  - Physically | In writing | Verbally
  - In new Directive
- Disseminate to important people
Thank You!

This has been prepared for informational purposes only. This information is not legal advice. Legal advice is dependent upon the specific circumstances of each situation. The information contained in this presentation should not replace the advice of competent legal counsel licensed in your state.