Primary Health Medical Group

# Advance Planning Toolkit



## An End-of-Life Decisions Packet for Patients and Families

# Getting Started:

# What Matters Most to You?

The starting point for your end-of-life plan is your own values and priorities. What's important to you? In a situation where you are unable to care for or speak for yourself, what sort of care would you want? What do you not want to happen? As you think about what is important to you should you face this situation, consider the following:

- **Your Personal Beliefs and Values**
  How do your spiritual or religious beliefs affect your attitudes about terminal diseases, treatment decisions, or death and dying? Would you want life-sustaining treatments no matter the circumstance, or would you prefer a natural death in instances where recovery is not possible?
- **Quality of Life Concerns**
  What basic abilities or functions are important to you in order to feel you would want to continue living? For example, do you feel you must be able to recognize loved ones or communicate with others?
- **Types of Life-Sustaining Treatments**
  Are there specific treatments or procedures you know that you would want or definitely would not want if you were diagnosed with a terminal condition and could not make the choice for yourself?
- **Your Support Network**
  If you are in a situation where you cannot make decisions for yourself, your support network becomes paramount. Is there a particular provider you want to help your family direct your care? Are there people you do not want involved in your healthcare decisions?

Finally, as you are going through this process, talking to loved ones about your values, priorities, and ultimately your decisions, is an important part of the process to make sure your wishes are followed. By having these sometimes difficult discussions, you help ensure that you receive the care and procedures you established as important if you are ever in a position where you cannot communicate them yourself. Your provider here at Primary Health can help you not only with your decision-making process, but also in helping you have these conversations with your loved ones.

***One final note:*** The State of Idaho has a comprehensive portion of their website dedicated to Health Care Directives that provides the basic forms for Idaho (requirements do vary state to state) and a FAQ section that answers many questions about the process and your rights. Your provider can answer many of these questions as well, but the site is a good reference and resource for the proper forms and Idaho processes for End-of-Life decision-making. The Idaho Advance Directive website can be found at: **https://sos.idaho.gov/health-care-directive-registry-index/**
The forms that are available on this site are also available in this packet, but if you prefer to do them on the website you are welcome to do so.

# What you will find in this packet

- ☐ The **Idaho Health Care Directive Registry** form (or fill it out electronically at **https://sos.idaho.gov/health-care-directive-registry-index/**). You will only complete this form if you want your healthcare directive in the registry. Doing this does make it available to all healthcare providers who may be caring for you.

- ☐ **Living Will and Durable Power of Attorney for Healthcare** form (or fill it out electronically at **https://sos.idaho.gov/health-care-directive-registry-index/**). This form lists your wishes should you be unable to communicate them yourself and designates who can make decisions for you.

- ☐ Meet with your provider to discuss the **POST** form with them if you currently have diagnoses that could incapacitate you or if you are frail or elderly. If appropriate your provider will fill out the POST form with you and submit it. You can fill it out here with your basic thoughts and then review with your provider as they complete it to submit it online. **Appendix A – Definitions** can help you determine if you need to see your provider about a POST form.

✦ All documents completed and reviewed with your provider? Make sure everything is signed and dated and send to:

Idaho Secretary of State
P.O. Box 83720
Boise, ID 83720-0080

Or, if not filing with the Idaho Healthcare Directory, make sure your healthcare providers, important family members, and your designated representative all have copies so your wishes are easily accessible.

# IDAHO HEALTH CARE DIRECTIVE REGISTRY

I want to:

- ☐ Store a copy of my health care directive in the Registry.
- ☐ Replace my health care directive now in the registry, file number _____, with a new one.
- ☐ Remove my health care directive from the registry.
- ☐ Request a replacement wallet card (no change to my health care directive now in the Registry)

**The personal information below is provided with the understanding that it will be stored in the Idaho Health Care Directive Registry. I certify that the Health Care Directive and Durable Power of Attorney that accompanies this Agreement is my currently effective health care directive, and was duly executed, witnessed and acknowledged in accordance with the laws of the State of Idaho.**

**I understand that use of the health care directive registry is entirely voluntary, and no one is required to register their living will or durable power of attorney with the Idaho Secretary of State. Registration or non-registration of these types of documents has no effect upon their validity. Registration only makes these documents more accessible in time of emergency.**

*Fill in all blanks of this Agreement and enclose your Health Care Directive with this Agreement. We recommend that your Directive be witnessed or notarized.*

| First Name, Middle Name, Last Name | | |
|---|---|---|
| Address | | Date of Birth |
| City, State, Zip Code | County of Residence | Last Four SSN *(optional)* |

***ADDRESS TO RETURN WALLET CARD AND DOCUMENTS (If Different that above)***

| Last Name, First Name, Middle Name |
|---|
| Address |
| City, State, Zip Code |

_____
Signature of Registrant

_____
Printed Name

_____
Date

*Sign and date this Agreement and send to:*
**Idaho Secretary of State**
**P.O. Box 83720**
**Boise, ID 83720-0080**
**(208) 334-2852 (phone)**
**hcdr@sos.idaho.gov**

# LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Date of Directive: _____

Name of person executing Directive: _____

Address of person executing Directive: _____

_____

## A Living Will
## A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:

   a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:

      1. That such injury, disease, illness or condition is terminal; and
      2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
      3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

   **OR**

   b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Check one box and initial the line after such box:

☐ _____ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

**OR**

☐ _____ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows:

*(If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)*

Check one box and initial the line after such box:

☐ _____ A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

☐ _____ B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

☐ _____ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

**OR**

☐ _____ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check one box and initial the line after such box:

☐ _____ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

**OR**

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

A Durable Power of Attorney for Health Care

**1. DESIGNATION OF HEALTH CARE AGENT**

*None of the following may be designated as your agent:*

*(1) your treating health care provider;*
*(2) a non-relative employee of your treating health care provider;*
*(3) an operator of a community care facility; or*
*(4) a non-relative employee of an operator of a community care facility.*

*If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.*

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.

*(Insert name, address and telephone number of one individual only as your agent to make health care decisions for you.)*

Name of Health Care Agent: _____

Address of Health Care Agent: _____

Telephone Number of Health Care Agent: _____

For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical condition.

## 2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

## 3. GENERAL STATEMENT OF AUTHORITY GRANTED

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

*(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

## 4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

*(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations:

*(You may attach additional pages or documents if you need more space to complete your statement.)*

## 5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

A. General Grant of Power and Authority

Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

(1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
(2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;
(3) Consent to the disclosure of this information; and
(4) Consent to the donation of any of my organs for medical purposes.

*(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)*

B. HIPAA Release Authority

My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

## 6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice"; and
(b) Any necessary waiver or release from liability required by a hospital or physician.

## 7. DESIGNATION OF ALTERNATE AGENTS

*(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1 above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is thereafter dissolved.)*

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive, such persons to serve in the order listed below:

A. First Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

B. Second Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

C. Third Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

**8. PRIOR DESIGNATIONS REVOKED**

I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

*(You must date and sign this Living Will and Durable Power of Attorney for Health Care.)*

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at:

_____

(Signature) (City, State)

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# Idaho Physician Orders for Scope of Treatment (POST)

**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT**

- This form must be signed by an authorized practitioner in **Section E** to be valid
- **If any section is NOT COMPLETE provide the most comprehensive treatment in that section**
- **EMS:** If questions arise contact on-line **Medical Control**

Last name_____

First name_____

Date of birth____/____/_____

Last four digits of SS # __ __ __ __

☐ Male ☐ Female

**Section A** Select 1 **OR** 2

**Cardiopulmonary Resuscitation:** Patient is not breathing and/or does not have a pulse

☐ **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions

☐ **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

**Additional resuscitation instructions:** _____

**Section B** Select only **ONE** box

**Medical interventions:** Patient has a pulse and is breathing

☐ **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**

☐ **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.

☐ **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

**Section C**

**Artificial Fluids and Nutrition:**

☐ Yes ☐ No Feeding tube

☐ Yes ☐ No IV fluids

Other instructions:_____

**Antibiotics and blood products:**

☐ Yes ☐ No Antibiotics

☐ Yes ☐ No Blood products

Other instructions: _____

**Section D**

**Advance Directives:** The following documents also exist:

☐ Living Will ☐ DPAHC ☐ Other

**Section E**

☐ **I request that this document be submitted to the Idaho Health Care Directive Registry**

**Patient/Surrogate Signature:** X _____

Print Patient/Surrogate name | Relationship (Self, Spouse, etc.) | Date

**Physician/APRN/PA Signature:** X _____ Phone #____-____-_____

Print Physician/APRN/PA name | ID license number | Date

**Discussed with:** ☐ Patient ☐ Spouse ☐ DPAHC ☐ Other

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference

*****ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED*****

*****PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED*****

*****COPY OF ORIGINAL LEGALLY VALID*****

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Orig 7/2007; Rev 7/2012

## Directions for Healthcare professionals

**Completing the POST**

- Use of the form is designed for persons with advanced chronic, progressive and/or end-stage illness
- For information on how to complete the POST online go to this site http://www.sos.idaho.gov/, click on the "Health Care Directive Registry" link, then click on "POST Login" link, then click on the "Instructions" link
- The POST form is also available for on-line completion on the Idaho Secretary of State Health Care Registry Website: http://www.sos.idaho.gov/general/hcdr.htm
- In order to be valid, the POST form must be completed by a physician (phyisican assistant when delegated) or Advanced Practice Registered Nurse (APRN) using patient preferences and medical indications
    - If the goal is to support quality of life using only comfort measures in the last phases of life, then select number 1 in section A
    - If the goal is to support both function and quality of life then any selection in section A may be appropriate
    - If the goal is for aggressive treatment and to live as long as possible then select number 2 in section A
- The patient/surrogate should be instructed to initial the first box in Section E if they would like to request their POST be submitted to the Idaho Healthcare Directive registry
- If applicable, provide the patient with information on how to obtain a DNR POST necklace or bracelet. To do so, go to the following web address to download the order form: www.idahoendoflife.org

**Using the POST**

- If any section is NOT COMPLETE provide the most comprehensive treatment in that section
- An automatic external defibrillator (AED) should not be used if the patient has selected "Do not resuscitate" or "No" to "defibrillation" in section A
- Oral fluids and nutrition must always be offered if medically feasible
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only" should be transferred to a setting conducive to achieving comfort
- Artificially administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.
- A patient with capacity or the surrogate (if patient lacks capacity) can temporarily suspend or revoke the POST at any time and request alternative treatment

**Reviewing the POST**

- The POST shall be reviewed:

1. Each time the physician, PA or APRN examines the patient, or at least every seven days, for patients who are hospitalized,

OR

2. Each time the patient is transferred from one care setting or level of care to another,

OR

3. Each time there is substantial change in the patient health status,

OR

4. Each time the patient's treatment preferences change

Failure to meet these review requirements does not affect the POST form's validity or enforceability. As conditions warrant, the physician or nurse practitioner may issue a superseding POST form in consultation with the patient or the patient's agent.

## Information for Patients

1. Anytime you access healthcare please make your healthcare provider aware that you have a POST
2. If you have a necklace, bracelet or a Health Care Directive card, please show them your Healthcare Directive ID number. Otherwise, you may want to carry a copy of your POST with you.
3. Please inform family members and/or friends if you wish them to be aware that you have a POST
4. Your POST is honored in any healthcare setting in the State of Idaho and in some other states (check with State laws)
5. You have the right at any time to revoke or initiate a new POST to reflect your current wishes
6. Display your POST form in a prominent location in your home. On the refrigerator is most recommended.

# Appendix A - Definitions

This Appendix lists the definitions and purpose of the different end-of-life planning documents.

## Advance Directive

The advance directive clarifies your end-of-life preferences if you become unable to make or communicate medical treatment decisions yourself. The advance directive includes a living will ("what I want") and a medical durable power of attorney ("who will speak for me"). It may also include other documents such as addendums based on the patient's needs or circumstances.

## Idaho Health Care Directive Registry

This form registers the patient's End-of-Life documents in the Idaho Health Care Directive Registry so they will be accessible to all healthcare personnel at any given time. Registering advance directives and POST forms with the Directive Registry ensures that healthcare personnel have access to the patient's wishes in regards to their care no matter the situation.

## POST (Physician Orders for Scope of Treatment)

The POST form is completed with your primary medical provider. They will fill it out and submit it based on discussions with you. The purpose of the POST form is to help patients get the medical treatments they want and avoid treatments they do not want when they are seriously ill or frail. The POST form is a portable medical order that emergency personnel can follow even when a patient can't speak for themselves. This makes it different than an advance directive because it is a doctor's orders. This means it will override the emergency personnel's directive to do everything possible to save a life (that's the law!), including CPR and putting a patient on a breathing machine. An advance directive does not override emergency treatment and therefore isn't enacted until discussions can take place with your providers. The discussion with the provider should include the following:

- Patient diagnosis – What disease(s) or medical conditions does the patient have?
- Patient prognosis – What is the likely course of the disease or condition? What will happen to the patient over time?
- Treatment options – What treatments are available to the patient? How do they help? What are the side effects?
- Goals of care – What is important to the patient? What makes a good quality of life?

# Appendix B – Contacts/Resources

End-of-Life decision making can be a difficult and emotional process. As you enter in to this process, make sure to ask the questions you have. There are a lot of resources for you and for your loved ones as you figure out what is most important to you and navigate filling out forms and getting them to the correct people.

### Contact #1 – Your Provider here at Primary Health!

**My Provider Name:** _____ **Clinic Phone:** _____

### Contact #2 – Idaho Secretary of State Office

**Phone:** 208-334-2852 **Address:** 450 N. 4th Street, Boise, ID 83702 **Email:** hcdr@sos.idaho.gov

## Resources:

### Idaho Secretary of State Health Care Directive Registry (electronic Advance Directive forms)
https://sos.idaho.gov/health-care-directive-registry-index/

### Idaho Secretary of State Health Care Directive Registry FAQ:
https://sos.idaho.gov/health-care-directive-registry-faq/

### National Polst Paradigm – Understanding the POST form
https://polst.org/

### Compassion and Choices End-of-Life Decisions Planning Guide and Toolkit – Very in-depth explanations and overviews of forms, choices, and help for going through the process
https://www.compassionandchoices.org/resource/my-end-of-life-decisions-an-advance-planning-guide-and-toolkit/