Advanced Directives and Dementia Care: CMS Updates

MN-DONA Fall Conference

Presented By:
Susan M. Voigt, Esq.
April J. Boxeth, Esq.
Voigt, Rode & Boxeth, LLC
651-209-6161
svoigt@vrb-law.com
aboxeth@vrb-law.com
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MNDONA Fall Conference
October 2, 2013

Susan Voigt and April Boxeth
VOIGT, RODE & BOXETH, LLC

CMS on a Mission

- Three training programs on antipsychotic medication reduction:
  1. Overview of anti-psychotic med use in NHs
  2. Surveying for anti-psychotic drug use in NHs (45 minute interactive video – good survey prep)
  3. Scope and severity guide under F309 and F329
- Effective for surveys October 1, 2013 and after

Video Summary and "Magic Words" for Policy and Procedures

- Identify a systematic, individualized approach implemented for dementia residents
- Systematic process followed for dementia residents
- Define the roles of:
  a. Pharmacist
  b. Physician
  c. Medical director
  d. Direct care staff
  e. Family
  f. Members of IDT
Review the CMS bulletins for F309

- CMS S&C 13-35-NH (5 pages):
  It is "common practice" to use psychopharmacological meds to address behaviors without first examining the "cause". Meds may be "ineffective" and "likely to cause harm" if given without a clinical indication.
  Efficacy, risks, benefits, and harm must be monitored

Causes for Behaviors

- Medical
- Physical
- Functional
- Psychological, psychiatric (must be "specific and significant")
- Emotional
- Social or environmental
  Must be new or worsening behaviors

F309 Guidance Changes

- Pub. 100-04 (4 pages) changes App P of SOM dementia and unnecessary drug use
- Pub 100-04 (48 pages) Changes to App PP – the regulations –
  1) F309 is the "catch all" FTag: "provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being..."
  2) Surveyors must use a dementia resident on antipsychotic meds in the sample
F309 Continued

- *Screening, identifying, and addressing behavioral symptoms flowchart*
- Review F329 changes on unnecessary meds
- Updates Table A in the reg on antipsychotic medications:
  1) indications for use
  2) dosage guidelines and reduction criteria
  3) adverse consequences new information

F309 Surveyor Checklist

- Two page document for review of dementia resident care and assessment by surveyors
- NHs should use for mock survey
- Reviews the following:
  1) Assessment and underlying cause of identification (F272)
  2) Care Planning (F279)
  3) Care Plan implementation (F282 and F222) and revision (F280 and F309)
  4) QA review (F520)

What to do?

- Watch the training video to know what survey will focus on
- Read the Guidance to surveyors under F309 and F329 highlighted in red on the CMS website
- Review medication regime and work with NP and physician and psych to reduce dose if possible
- Use the “magic words” in the assessment (It will make you actually DO the assessment ongoing…)
- Smile like you are on meds!
F-155 Advance Directives

Merger of F155 with F156
- F155 discussed resident’s right to refuse treatment, formulate an advance directive, and refuse to participate in experimental research.
- F156 was previously the regulation which discussed the facility’s requirement for informing resident of the federal rights regarding refusal of treatment and creating advance directives.
- Regulatory language has not changed, just combined
- Interpretive guidance for surveyors has been revised

Federal Regulatory Language

483.10(B)(4) – The resident has the right to refuse treatment, to refuse to participate in experimental research and to formulate an advance directive as specified in paragraph (8) of this section; and
Federal Regulatory Language (continued)

- 483.10(b)(8) : The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable state law.

Overview

INTENT

- Focus on responsibility of providers to ensure each resident’s right for self-determination, including an individual's right to refuse treatment, is honored.
- Facility required to provide, at time of admission, written information concerning resident's right to make decisions re medical care, including right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.
- Resident must also receive a written description of facility’s policies that cover the exercise of these rights.

Overview (continued)

- Facility is responsible to provide information and resources to resident to allow resident to exercise his/her rights;
- Facility staff should not participate directly or influence resident’s decision.
Definitions:

- **Advance Care Planning** means written instruction for provision of health care when individual can no longer make decisions.
- **Cardiopulmonary Resuscitation (CPR)** is a medical intervention where chest compressions and mouth to mouth respirations are provided to restore circulatory and/or respiratory function that has ceased.
- **Durable Power of Attorney for Health Care** is a document delegating the authority to make health care decisions to an agent in the event an individual delegating that authority subsequently becomes incapable of doing so.

Definitions (continued):

- **Health care decision making** refers to the consent, refusal or withdrawal of consent to health care treatment, service or procedures to maintain, diagnose or treat an individual’s condition.
- **Health care decision making capacity** refers to possessing the ability to make health care related treatment decisions.
  - MN law defines decision-making capacity as the ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision.
- **Life-sustaining treatment** is treatment that, based on reasonable medical judgment, could sustain a resident’s life. The term includes both life-sustaining medications and interventions.

Definitions (continued):

- **Legal Representative** is a person designated and authorized by an advance directive or by state law to make a treatment decision for another person if the other person becomes unable to make necessary health care decisions.
  - Also known as:
    - Agent
    - Attorney-in-Fact
    - Proxy
    - Substitute decision-maker
    - Surrogate decision-maker
- **Treatment** refers to any intervention provided for the resident to maintain or restore health and well being to improve the resident’s functional level or to relieve symptoms.
Interpretive Guidance: Establishing and Maintaining Policies and Procedures

- Facility is required to establish, maintain and implement written policies and procedures regarding the resident's right to:
  - Formulate an advance directive;
  - Accept or refuse medical or surgical treatment; and
  - Refuse to participate in experimental research.
- Provides measure for facility to ensure staff are trained and know the policies and implement them consistently.

Facility policies and procedures outline the various steps necessary to promote and implement these rights:

- **ON ADMISSION, FACILITY DETERMINES:**
  - **DOES RESIDENT HAVE AN ADVANCE DIRECTIVE?**
    - **IF NOT, DOES RESIDENT WISH TO CREATE AN ADVANCE DIRECTIVE?**
  - Identify the primary decision-maker (resident and/or legal representative);
  - Assessment of resident's decision-making capacity – is resident able to make relevant health decisions? **IF NOT**,:
    - Who will act as primary decision-maker for resident?
  - Identify situations where health care decision-making is needed; and

- **Establish mechanisms for communicating resident's choice to interdisciplinary team AND**
- **Identify the process (as provided for by State law) for handling situations in which the facility and/or physician do not feel that they can provide care in accordance with resident's advance directives or other wishes.**
Interpretive Guidelines: Informing Resident of Rights

At admission, facility is required to:

- Provide written information concerning resident’s right to make decisions regarding medical care including:
  - the right to accept or refuse medical or surgical treatment, and
  - the right to create an advance directive AND...
- Provide a written description of facility’s policies that govern these rights.

Interpretive Guidelines: Informing Resident of Rights (continued)

- Facility is required to provide to resident community:
  - Education regarding the right to create an advance directive; and
  - Develop and implement policies to ensure this right is upheld.
  - Facility policies should identify any limitations the facility has regarding the implementation of this right.

Interpretive Guidance – Establishing Advance Directives

- What is an Advance Directive?
  - Living will, directive to the attending physician, durable power of attorney for health care, medical power of attorney, pre-existing physician’s order for “do not resuscitate” (DNR), portable order form re life-sustaining treatment (POLST)
Interpretive Guidance – Establishing Advance Directives (continued)

- Facility is responsible for providing the information and resources to the resident in order to exercise these rights BUT:
  - Facility SHOULD NOT directly participate in or influence resident’s decisions.
  - Facility DOES have responsibility to assist the resident if they wish to create an advance directive.

- Facility is responsible to incorporate advance directive into resident’s record.
- Facility is responsible to communicate the resident’s wishes to staff to ensure appropriate care is provided.

Interpretive Guidance - Advance Care Planning

- ONGOING PROCESS
  - Continue discussions between staff and residents initially during assessment and care plan and then periodically
  - Process to inform resident and responsible party regarding health status, treatment options and expected outcomes
  - A means to implement and measure resident choices and reevaluate (routine and significant changes)
Interpretive Guidance: Right to Accept or Refuse Treatment

- Resident may not receive treatment against his/her wishes, and may not be discharged only because he/she refused treatment.
- Facility is expected to determine what and why resident is refusing and must explain the risks of refusal and offer alternative treatments. Specifically, facility is expected to:
  - Determine what the resident is refusing;
  - Assess reasons for refusal;
  - Advise about consequences of refusal;
  - Offer alternative treatments; and
  - Continue to provide all other services.

Interpretive Guidance: Right to Accept or Refuse Treatment (continued)

- Resident being considered for research must be fully informed of treatment and possible outcomes.
- Resident maintains right to refuse or participate.
- Facility must have process in place for approving and overseeing experimental treatments.
- If resident is not capable of understanding, and proxy provides consent of treatment, facility has responsibility to ensure that proxy consent is properly obtained and that essential measures are taken to protect the vulnerable adult from harm during the project.
- Facility must have committee oversight for experimental research involving residents and have a mechanism in place for its oversight.

Investigation:

- Surveyors have a protocol
- And use this protocol for all sampled residents who:
  - Have an advance directive or a condition where advance care planning is relevant;
  - Have any orders related to provision of, life sustaining treatments
  - Has refused treatment; or
  - Is participating in an experimental research activity or project.
Investigation: (continued)

- Observations
- Interviews
  - Resident/Representative
  - Facility Staff
  - Health Care Practitioners and Professionals
- Record review

Compliance

- Facility is in compliance with F155 if it has:
  - Determined whether resident has an advance directive in place or has offered the resident the opportunity to develop an advance directive;
  - Helped the resident exercise these rights based on determining the capacity of the resident to understand information and make treatment decisions, or through the input of the identified legal representation of the resident when resident lacks sufficient decision-making capacity;

Compliance (continued)

- Facility is in compliance with F155 if it has:
  - Incorporated the resident's choices into the medical record and orders related to treatment, care and services; and
  - Monitored the care and services given the resident to make sure they were consistent with the resident's documented goals and choices.
## Minnesota
### Health Care Directive

**Purpose of form**

<table>
<thead>
<tr>
<th>Part I.</th>
<th>Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part II.</td>
<td>Allows you to give written instructions about what you want.</td>
</tr>
<tr>
<td>Part III.</td>
<td>Requires you and others to sign and date to make this legal.</td>
</tr>
</tbody>
</table>

**My personal information**

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Home phone:</td>
<td>( )</td>
</tr>
<tr>
<td>Work phone:</td>
<td>( )</td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>Social security #:</td>
<td></td>
</tr>
</tbody>
</table>

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

### PART 1: Naming an Agent

**Agent duties**

My health care agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions in Part II of this document or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

**Agent roles**

- When naming my health care agent, I must choose one of the following. *Select the option you prefer:*
  - **Act alone**
    - I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.
  - **Act together**
    - I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.
### My primary health care agent

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I appoint:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Agent’s name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home phone:</strong></td>
<td>( ) _________________________</td>
</tr>
<tr>
<td><strong>Work phone:</strong></td>
<td>( ) _________________________</td>
</tr>
</tbody>
</table>

### My first alternate health care agent

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agent’s name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home phone:</strong></td>
<td>( ) _________________________</td>
</tr>
<tr>
<td><strong>Work phone:</strong></td>
<td>( ) _________________________</td>
</tr>
</tbody>
</table>

### My second alternate health care agent

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agent’s name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home phone:</strong></td>
<td>( ) _________________________</td>
</tr>
<tr>
<td><strong>Work phone:</strong></td>
<td>( ) _________________________</td>
</tr>
</tbody>
</table>

### (If needed) Reasons for naming health care provider

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. *Select the option that applies:*

- [ ] That person is related to me by blood, marriage, registered domestic partnership, or adoption.
- [ ] My reasons for wanting to appoint that person as my agent are:

### Powers of my agent

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure
- Stop or not start health care which is keeping or might keep me alive
- Choose my health care providers
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.
If I WANT my agent to have any of the following powers I need to check the box in front of each statement below:

- I also authorize my agent to:
  - [ ] Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.
  - [ ] In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent’s understanding of my values, preferences, or instructions.
  - [ ] Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.
  - [ ] Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.
  - [ ] Make health care decisions for me even if I am able to decide or speak for myself.

I wish to limit the powers of my health care agent in the following way(s):

PART II: Health Care Instructions

- I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations)

- I am attaching additional instructions concerning my health care values and preferences. Select one: [ ] Yes  [ ] No

- I authorize donation of organs, tissue, or other body parts after my death. Select one: [ ] Yes  [ ] No
PART III: Making This Document Legal

My signature/mark and date

I agree with everything in this document and have made this document willingly:

My signature: ________________________________

Date: ________________________________

(day / month / year)

Notary Public OR Witnesses

Notary Public

STATE OF MINNESOTA

County of ____________________________

This document was signed or acknowledged before me this __________ (day)
of __________, ________ by the above named principal.

(month) ____________________________ (year)

Signature of Notary Public

Two Witnesses

This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.

Witness Signature: ________________________________

Address: ________________________________

Date: ________________________________

(month / day / year)

Witness Signature: ________________________________

Address: ________________________________

Date: ________________________________

(month / day / year)
# Health Care Instructions Worksheet
## Part II of Minnesota Health Care Directive

### My Health Care Goals

Having a sense of what is important to you can help your decisionmakers make health care decisions under different and complex circumstances. Read each statement below and on a scale of “0” to “4,” rate how important each of the health care goals are to you. In this case, “4” means “Extremely Important” and “0” means “Not Important At All.” Remember reasonable medical care should always include maintaining a person’s comfort, hygiene, and human dignity.

<table>
<thead>
<tr>
<th>HEALTH CARE GOALS</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How Important Is Pain Control?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Being as comfortable and free from pain as possible</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• Having pain controlled, even if my ability to think clearly is reduced</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• Having pain controlled, even if it shortens my life</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td><strong>How Important Is the Use of Life Prolonging Treatment When:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I have a reasonable chance of recovering both physically and mentally (50/50+)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I have some physical limitations but can socially relate to those I care about</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I can live a longer life no matter what my physical or mental health</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I have little or no chance of doing everyday activities I enjoy</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I am not able to socially relate to those I care about</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I have a terminal illness and treatment will only prolong when I die</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I have severe and permanent brain injury and there is little chance of regaining consciousness</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• I have severe dementia or confusion and my condition will only get worse</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td><strong>Importance of Finances and Health Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Having my wishes followed regardless of whether or not my finances are exhausted</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• Not being a financial burden to those around me</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>• Not having my health care costs affect the financial situations of those I care about</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

I also want my decisionmakers to know the following things are important to me when receiving health care: ____________

Minneapolis Health Care Directive / 6 of 10 pages
My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

<table>
<thead>
<tr>
<th>Medical Procedure</th>
<th>When It Is Used and Its Effects</th>
<th>My Feelings About This Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator/Respirator A breathing machine</td>
<td>When you cannot breathe on your own</td>
<td></td>
</tr>
<tr>
<td>A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure</td>
<td>You cannot talk or eat by mouth on this machine</td>
<td></td>
</tr>
</tbody>
</table>
| Nutrition support and hydration                        | When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely.  
Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins. |                                  |
| Cardiopulmonary Resuscitation (CPR)                    | Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube in your throat. |                                  |
| A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure. | A mechanical means of cleaning the blood when kidneys are not working.                          |                                  |
My feelings or concerns about other medical treatments include:

If I am pregnant, my feelings about medical treatment would include:

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care:

My religion/spirituality/ is:

My congregation/spiritual community (name, city, state):

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted.  ○ Yes   ○ No

If yes, the person to be contacted is (name/contact information)
Feelings about Quality and Length of Life

I have the following beliefs about whether life should be preserved as long as possible:

The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

- [ ] At home
- [ ] At a hospital. Which one?
- [ ] At a nursing home. Which one?
- [ ] Through hospice services/care. Which one?

- [ ] From other health care providers. Which ones?

Other wishes I have about my care if I am dying
My Wishes About Donating Organs, Tissues, or Other Body Parts

Select the option that applies:

- [ ] I DO NOT wish to donate organs, tissue, or other body parts when I die
- [ ] I DO wish to donate organs, tissue, or other body parts when I die
- [ ] Any needed organs, tissue, or other body parts
- [ ] Only the following listed organs, tissue, or body parts

Limitations or special wishes I have include:

Additional Health Care Instructions

My decision makers should also know these things about me to help them make decisions about my health care:

I agree that these are my health care instructions and have completed this willingly.

My signature: __________________________________________

Date completed: ____________________________ (month / day / year)

- This worksheet is an attachment to my Health Care Directive:
  
  Select one:  [ ] Yes  [ ] No

Minnesota Health Care Directive / 10 of 10 pages
Introduction

I have created this document with much thought to give my treatment choices and personal preferences if I cannot communicate my wishes or make my own health care decisions. I have also appointed a health care agent to speak for me. My agent is able to make medical decisions for me, including the decision to decline treatments that I do not want. Any document created before this is no longer legal or valid.

My name: ____________________________
My date of birth: ______________________
My address: ___________________________
My telephone number: __________________ My cell: ____________________________

Part 1: My Health Care Agent

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.* My health care agent must follow my health care instructions in this document and any other instructions given to my agent and must make decisions that are in my best interest.

My primary (main) health care agent is:
Name: ____________________________Relationship: ____________________________
Telephone numbers: (H) ____________ (Cell) ____________
(W) ____________________________
Address: ____________________________

* I understand that my agent cannot be a health care provider or employee of a health care provider giving direct care to me unless I am related to that person by blood or marriage, registered domestic partnership, or adoption, or provide a clear reason why I want that person to serve as my agent. If my agent is a health care provider or an employee of a health care provider, my reason for choosing him or her is: ____________________________

For health care provider/clinic use only

Name__________________________
Date__________________________

EMMS Foundation: www.metrodoctors.com  612-362-3704   Revised August 2011
If I cancel my primary agent’s authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name as my alternate agent:

**Alternate health care agent:**
Name: __________________________ Relationship: __________________________
Telephone numbers: (H)_________________ (Cell)_________________
(W)________________________
Address: ______________________________________________________________

**Powers of my health care agent:**
My health care agent automatically has all the following powers when I am unable to speak for myself:

A. Make choices for me about my medical care. This includes taking out or not putting in tube feedings, tests, medicine, surgery and decisions of treatments if I am pregnant and all types of mental health treatment, including intrusive mental health treatments or medications. If treatment has already begun, my agent can continue it or stop it based on my instructions.

B. Interpret any instruction I have given in this form according to his or her understanding of my wishes, values and beliefs.

C. Review and release my medical records and personal files as needed for my medical care.

D. Arrange for my medical care and treatment in Minnesota or any other state or location he or she thinks is appropriate.

E. Decide which health providers and organizations provide my medical treatment.

Comments or restrictions on the above (e.g., persons you would or would not want to be involved in making decisions on your behalf or limitations on the above powers for your agent):

**Additional powers of my health care agent:** *(If I want my agent to have any of the following powers, I will check the box in front of each statement below)*

☐ Arrange for and make decisions about the care of my body after death.

☐ Continue as my health care agent even if a dissolution, annulment or termination of our marriage or domestic partnership is in process or has been completed.

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**For health care provider/clinic use only**

Name________________________
Date__________________________

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When I so delegate, make health care decisions for me even if I am able to decide or speak for myself.

Part 2: My Health Care Instructions

My choices and preferences for my health care are as follows. I ask my agent to represent them, and my doctors (and/or health care team) to honor them, should I become unable to communicate or make my own choices. I have checked the box below for the option I prefer for each circumstance.

Note: You do not need to provide written instructions about treatments to extend your life, but it is helpful to do so. If you choose not to, your health care agent will make decisions based on your spoken directions or on what is considered to be in your best interest if your wishes are unknown.

1. Treatments to prolong my life:

   If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am:

   □ I want to stop or withhold all treatments that are prolonging my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.

   or

   □ I do want all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer helpful.

   Comments or directions to health care providers:

With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow.

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2. Cardiopulmonary resuscitation. CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) diseases and/or impaired functioning. I understand that recovery from CPR can be painful and difficult. Therefore:

☐ I do not want CPR attempted if my heart or breathing stops, but rather, want to permit a natural death.

or

☐ I want CPR attempted unless my doctor determines any of the following:

- I have an incurable illness or injury and am dying; or
- I have no reasonable chance of survival if my heart or breathing stops, or
- I have little chance of long-term survival if my heart or breathing stops and the process of resuscitation would cause significant suffering

or

☐ I want CPR attempted if my heart or breathing stops.

3. Treatment Preferences.

☐ I have attached treatment preferences for my specific health condition(s). These statements describe my treatment choices. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as foods and fluids by mouth if I am able to swallow.

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Name ___________________________ Date ___________________________
Part 3: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings:

1. The things that make life most worth living to me are:

2. My beliefs about when life would be no longer worth living:

3. My choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings etc.):

4. My thoughts and feelings about how and where I would like to die:

5. If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

6. Religious affiliation
I am of the ____________________ faith, and am a member of ________________________________ faith community in (city) ___________________. Please attempt to notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

7. Organ donation (leave blank if you have no preference).

☐ I do want to donate my eyes, tissues and/or organs, if able. My specific wishes (if any) are:

☐ I do not want to donate my eyes, tissues and/or organs.

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Name __________________________
Date __________________________

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8. Other wishes/instructions:
Part 4: Legal Authority

Under Minnesota law, you must have this document signed and dated in the presence of two witnesses or a notary public.

I have made this document willingly, I am thinking clearly, and this document expresses my wishes about my future health care decisions:

Signature: ___________________________ Date: __________________________

If I cannot sign my name, I ask the following person to sign for me: __________________________

Signature (of person asked to sign): __________________________

Statement of Witnesses:
I personally witnessed the signing of this document, and I certify that I am not appointed as a health care agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial this line: ______. At least one witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness Number One:
Signature: ___________________________ Date: __________________________
Print name: ___________________________
Address: ___________________________

Witness Number Two:
Signature: ___________________________ Date: __________________________
Print name: ___________________________
Address: ___________________________

or

Notary Public:

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. I am not named as a health care agent in this document.

Signature of notary: ___________________________

Notary stamp:

For health care provider/clinic use only

Name ___________________________
Date ___________________________
Part 5: Next Steps

Now that you have completed your health care directive, you should also take the following steps.

- Tell the person you named as your health care agent, if you haven’t already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of your health care directive to your doctor. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the “Five D’s” occur:
  - Decade – when you start each new decade of your life.
  - Death – whenever you experience the death of a loved one.
  - Divorce – when you experience a divorce or other major family change.
  - Diagnosis – when you are diagnosed with a serious health condition.
  - Decline – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Copies of this document have been given to:

Primary (Main) Health Care Agent  Name: ________________________________
Telephone: ____________________  Cell: ________________________________

Alternate Health Care Agent  Name: ________________________________
Telephone: ____________________  Cell: ________________________________

Health Care Provider/Clinic
Name: ________________________________  Telephone: ____________________
Name: ________________________________  Telephone: ____________________
Name: ________________________________  Telephone: ____________________

If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.

For health care provider/clinic use only

Name ________________________________  Date ____________________________
145C.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 1a. *Act in good faith.* "Act in good faith" means to act consistently with a legally sufficient health care directive of the principal, a living will executed under chapter 145B, a declaration regarding intrusive mental health treatment executed under section 253B.03, subdivision 6d, or information otherwise made known by the principal, unless the actor has actual knowledge of the modification or revocation of the information expressed. If these sources of information do not provide adequate guidance to the actor, "act in good faith" means acting in the best interests of the principal, considering the principal's overall general health condition and prognosis and the principal's personal values to the extent known. Notwithstanding any instruction of the principal, a health care agent, health care provider, or any other person is not acting in good faith if the person violates the provisions of section 609.215 prohibiting assisted suicide.

Subd. 1b. Decision-making capacity. "Decision-making capacity" means the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

Subd. 2. Health care agent. "Health care agent" means an individual age 18 or older who is appointed by a principal in a health care power of attorney to make health care decisions on behalf of the principal. "Health care agent" may also be referred to as "agent."

Subd. 3. Health care power of attorney. "Health care power of attorney" means an instrument appointing one or more health care agents to make health care decisions for the principal.

Subd. 4. Health care. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a person's physical or mental condition. "Health care" includes the provision of nutrition or hydration parenterally or through intubation but does not include any treatment, service, or procedure that violates the provisions of section 609.215 prohibiting assisted suicide. "Health care" also includes the establishment of a person's abode within or without the state and personal security safeguards for a person, to the extent decisions on these matters relate to the health care needs of the person.

Subd. 5. Health care decision. "Health care decision" means the consent, refusal of consent, or withdrawal of consent to health care.

Subd. 5a. Health care directive. "Health care directive" means a written instrument that complies with section 145C.03 and includes one or more health care instructions, a health care power of attorney, or both; or a durable power of attorney for health care executed under this chapter before August 1, 1998.

Subd. 6. Health care provider. "Health care provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care directly or through an arrangement with other health care providers, including health maintenance organizations licensed under chapter 62D.

Subd. 7. Health care facility. "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47, an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts 9555.5105 to 9555.6265, or a hospice provider licensed under sections 144A.75 to 144A.755.
145C.02 HEALTH CARE DIRECTIVE.

A principal with the capacity to do so may execute a health care directive. A health care directive may include one or more health care instructions to direct health care providers, others assisting with health care, family members, and a health care agent. A health care directive may include a health care power of attorney to appoint a health care agent to make health care decisions for the principal when the principal, in the judgment of the principal's attending physician, lacks decision-making capacity, unless otherwise specified in the health care directive.

History: 1993 c 312 s 3; 1998 c 399 s 12
145C.03 REQUIREMENTS.

Subdivision 1. Legal sufficiency. To be legally sufficient in this state, a health care directive must:

(1) be in writing;
(2) be dated;
(3) state the principal's name;
(4) be executed by a principal with capacity to do so with the signature of the principal or with the signature of another person authorized by the principal to sign on behalf of the principal;
(5) contain verification of the principal's signature or the signature of the person authorized by the principal to sign on behalf of the principal, either by a notary public or by witnesses as provided under this chapter; and
(6) include a health care instruction, a health care power of attorney, or both.

Subd. 2. Individuals ineligible to act as health care agent. (a) An individual appointed by the principal under section 145C.05, subdivision 2, paragraph (b), to make the determination of the principal's decision-making capacity is not eligible to act as the health care agent.

(b) The following individuals are not eligible to act as the health care agent, unless the individual appointed is related to the principal by blood, marriage, registered domestic partnership, or adoption, or unless the principal has otherwise specified in the health care directive:

(1) a health care provider attending the principal on the date of execution of the health care directive or on the date the health care agent must make decisions for the principal; or
(2) an employee of a health care provider attending the principal on the date of execution of the health care directive or on the date the health care agent must make decisions for the principal.

Subd. 3. Individuals ineligible to act as witnesses or notary public. (a) A health care agent or alternate health care agent appointed in a health care power of attorney may not act as a witness or notary public for the execution of the health care directive that includes the health care power of attorney.

(b) At least one witness to the execution of the health care directive must not be a health care provider providing direct care to the principal or an employee of a health care provider providing direct care to the principal on the date of execution. A person notarizing a health care directive may be an employee of a health care provider providing direct care to the principal.

History: 1993 c 312 s 4; 1998 c 399 s 13
145C.06 WHEN EFFECTIVE.

A health care directive is effective for a health care decision when:

(1) it meets the requirements of section 145C.03, subdivision 1; and

(2) the principal, in the determination of the attending physician of the principal, lacks
decision-making capacity to make the health care decision; or if other conditions for effectiveness
otherwise specified by the principal have been met.

A health care directive is not effective for a health care decision when the principal, in the
determination of the attending physician of the principal, recovers decision-making capacity; or if
other conditions for effectiveness otherwise specified by the principal have been met.

History: 1993 c 312 s 7; 1998 c 399 s 17
145C.10 PRESUMPTIONS.

(a) The principal is presumed to have the capacity to execute a health care directive and to revoke a health care directive, absent clear and convincing evidence to the contrary.

(b) A health care provider or health care agent may presume that a health care directive is legally sufficient absent actual knowledge to the contrary. A health care directive is presumed to be properly executed, absent clear and convincing evidence to the contrary.

(c) A health care agent, and a health care provider acting pursuant to the direction of a health care agent, are presumed to be acting in good faith, absent clear and convincing evidence to the contrary.

(d) A health care directive is presumed to remain in effect until the principal modifies or revokes it, absent clear and convincing evidence to the contrary.

(e) This chapter does not create a presumption concerning the intention of an individual who has not executed a health care directive and, except as otherwise provided by section 145C.15, does not impair or supersede any right or responsibility of an individual to consent, refuse to consent, or withdraw consent to health care on behalf of another in the absence of a health care directive.

(f) A copy of a health care directive is presumed to be a true and accurate copy of the executed original, absent clear and convincing evidence to the contrary, and must be given the same effect as an original.

(g) When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is a real possibility that if health care to sustain her life and the life of the fetus is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions described in section 145C.05, subdivision 2, paragraph (a), clause (10), that are to the contrary, or, in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary.

History: 1993 c 312 s 11; 1998 c 399 s 21
2012 Minnesota Statutes

145C.11 IMMUNITIES.

Subdivision 1. Health care agent. A health care agent is not subject to criminal prosecution or civil liability if the health care agent acts in good faith.

Subd. 2. Health care provider. (a) With respect to health care provided to a patient with a health care directive, a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider acts in good faith and in accordance with applicable standards of care.

(b) A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider relies on a health care decision made by the health care agent and the following requirements are satisfied:

(1) the health care provider believes in good faith that the decision was made by a health care agent appointed to make the decision and has no actual knowledge that the health care directive has been revoked; and

(2) the health care provider believes in good faith that the health care agent is acting in good faith.

(c) A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the health care agent to withhold or withdraw that treatment, is not subject to criminal prosecution, civil liability, or professional disciplinary action if that health care provider promptly took all reasonable steps to:

(1) notify the health care agent of the health care provider's unwillingness to comply;

(2) document the notification in the principal's medical record; and

(3) permit the health care agent to arrange to transfer care of the principal to another health care provider willing to comply with the decision of the health care agent.

History: 1993 c 312 s 12; 1998 c 399 s 22