Talk now.

# Get lasting peace of mind.

## Advance Care Planning Toolkit

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## Your health care decisions are important.

Advance care planning (ACP) gives adults (18 years of age and older) an opportunity to plan and record their health care choices in case they become seriously ill or injured and are not able to express what they want. These choices may include specific instructions for care at the end of your life.

Visit our webpage for more information, tools, and stories to help you with your planning and events to assist you in completing your Advance Care Planning and Advance Directive documents:

**ECUHealth.org/AdvanceCare**

# FIVE STEPS TO ADVANCE CARE PLANNING

Advance care planning is a ***process*** that helps you decide what care you would want or would not want if you have a health crisis and are not able to communicate for yourself.

It is best to complete the process while you are well, and not in a health crisis. This gives you time to consider carefully what matters most to you, and the treatment decisions you might make. This guide will walk you through the process of completing your advance care plan, step-by-step, including legal Advance Directive documents.

## There are five key steps to completing your Advance Care Plan.

1. **Think About** - Think about what matters most to you
2. **Talk About** - Talk about it with your family, friends, and health care provider(s)
3. **Put it in Writing** - Document your choices and decisions in a legal form such as Advance Directives
4. **Share** - Share Your Advance Directives with your family, friends and health care providers
5. **Review** - Review your documents periodically, at least once a year

# STEP 1 - Think About

The first step is thinking about what matters most to you to influence future health care decisions.

- Advance care planning is a process. It should not be rushed. Give yourself plenty of time to think through what you would prefer to have happen (or not happen) if you need medical care.
- Talk with family, friends, your health care provider, pastor/clergy, or others. They may be able to help you think about your choices and what matters most to you.
- Write out your thoughts on the next page, in a journal or a letter to help you sort out your feelings.

## Quality of Life……*Think About*

What gives your life value, meaning, and purpose? What does "quality of life" mean to you?

What would you miss most if you couldn't walk, talk, eat, or think normally?

What would you be willing to give up or tolerate to keep what matters most to you?

Is quality of life more important to you than how long you live? Or do you want to live as long as possible, no matter what?

## Health Care Experiences……*Think About*

Think about good or bad health experiences you know about and how they influence your choices for future care?

Has anyone close to you died? Do you think their death was a "good" death or "bad" death? Why?

Do you have any medical problems or conditions? Do you expect them to get worse? Will your medical problems change your quality of life? If so, how?

Are you having medical treatments for your problem/condition? Are you thinking about having any new medical treatment(s)? Will this affect your quality of life? If so, how?

## End of Life Care……*Think About*

Think about medical treatments near the end of your life. Are there circumstances when you would want CPR, mechanical ventilation, artificial nutrition, or artificial hydration?

Are there treatments you know you would want?

Are there treatments you know you would NOT want?

Can you imagine a time you would want to stop having curative treatments and only use *comfort measures* to keep you as comfortable as possible in the time you have left?

Where do you prefer to spend your last few months, weeks, or days? Home? Nursing Home? Hospital?

## Someone to Speak For You……*Think About*

Who would you want to speak for you about health care decisions if you could not communicate for yourself? Would they be able to make decisions based on what you want?

Have you told this person what you would want? Have you told anyone?

How much do you want your family or other loved ones to be involved in your health care?

## Final Wishes……*Think About*

What do you want to do or say before you die?

Do you want your organs donated after you die? Have you discussed this with your family or loved ones?

Would you prefer to be buried or cremated or have other specific instructions on what to do with your body?

# STEP 2 – Talk About

Now that you have thought about end of life choices and what matters most to you, share your thoughts with

- your family
- those closest to you
- your health care providers
- anyone who is likely to be involved in your future health care decisions.

## This can be a hard conversation to start.

Many people are afraid about how their family or loved ones might react and probably need to discuss more than once. The more you talk about it, the more comfortable you and your family will become. Here are some ideas for starting your conversation:

*"There's something really important to me that I've been thinking about for a while that I want to share."*

*"Did you hear what happened with _____? That got me thinking, and I want to make sure you know what my preferences for care are, in case you ever have to speak for me."*

*"I really want you to be my health care agent so you can speak for me if I can't. I would like to share my care choices with you. Will you be my voice one day if I can't speak for myself?*

*"It would have been so much better for _____if we had known about what he/she wanted at the end of life. I want to make sure you know what matters to me so you can feel good about honoring my choices. Can you talk with me now?"*

*"In thinking about what is most important to me, I have been considering the quality of life that I would want if I were in an accident or something happened where I couldn't speak for myself. I'm hoping I can have a discussion with you about my goals for care."*

# STEP 3 - Put it in Writing

After thinking through your choices and having these discussions with your loved ones, it's time to record your choices in an Advance Directive document. By taking this step, you give your loved ones and your medical team the information they need to be able to legally honor your choices. There are different kinds of Advance Directives.

| Name of document | Important information |
|---|---|
| **Health Care Power of Attorney (HCPOA)** | A legal document where you state who you want to be your Health Care Agent if you can't speak for yourself.<br>*Must be signed in front of two witnesses and a notary.* |
| **Living Will (LW)** | A legal document where you give instructions on care you would or would not want at the end of life.<br>*Must be signed in front of two witnesses and a notary.* |
| **Advance Instructions for Mental Health Treatment (AIMHT) or Psychiatric Advance Directive (PAD)** | A legal document where you give instructions about Mental Health Care if you should need it.<br>*Must be signed in front of two witnesses and a notary.* |
| **Medical Orders for the Scope of Treatment (MOST)** | A medical order that you and your provider sign where you give instructions on care you would not want for a life limiting illness.<br>*Keep an original with you at all times* |
| **Do Not Resuscitate Order (DNR)** | A medical order that your provider signs upon your request to state you do not want CPR if you stop breathing or your heart stops.<br>*Keep an original with you at all times.* |

## Where to get the forms you need

Attached to this toolkit is ***An Advance Directive for North Carolina: A Practical Form for All Adults***. This form combines the two most common types of Advance Directives ***(Healthcare Power of Attorney* and *Living Will***) into one document in simple language that is legally acceptable across North Carolina

Additional forms and more information is available at **ECUHealth.org/AdvanceCare**. MOST and DNR forms must be provided by your health care provider. ECU Health also offers free services to assist you in the completion of Advance Directives.

## A few more things to consider about your Advance Directives

- **Original documents:** Keep your original documents in a safe place but quickly accessible by you and your health care agent or others who might be involved in your care for the future. For MOST and DNR, original documents must be present for Emergency or Health Care Personnel to honor them, so keep an original with you such as in your purse or glove box of your car as well as visible in your home such as on the refrigerator or bedroom door.
- **Copies:** Keep a copy of your Advance Directives with you such as in the glove box of your car. When you travel, the Advance Directives will be available to emergency personnel or your health care providers.
- **Changes:** If you update your documents, be sure to discard the old ones and replace with the new ones.
- **Validity of Advance Directives:** A valid North Carolina Advance Directive (HCPOA, Living Will, Advance Directive for Mental Health Treatment) ***must*** follow the guidelines listed below:
    - Documents ***must*** be notarized by Notary Public and include an official stamp.
    - Documents are signed and dated by you and two witnesses in the presence of a Notary Public.
    - **Witnesses *must*:**
        - Be 18 years or older
        - Not be related to the person by blood or marriage
        - Not be the person's attending physician or mental health provider
        - Not be an employee of a healthcare facility, nursing home or any adult care facility where the person is a patient or resides.
        - Not be entitled to any portion of the estate under any existing will or as an heir under the law.
        - Not have any claim against the person or the estate of the person.
    - Documents must be notarized by a NC Notary Public.
        - Notary ***cannot*** act as a witness.
        - Notary ***cannot*** be named as Health care agent **and** notarize said Advance Directive.
    - Ensure that all pages are present and documents have not been altered. Altered documents would require that they be re-notarized.
    - If any part of these guidelines are not followed, the Advance Directive is considered invalid.

## STEP 4 – Share

Now that you have completed your Advance Directive, share copies of your signed documents and discuss your choices to make sure each person involved in your future care understands your decisions. Keep a list of everyone you give a copy to so you will know who to notify if you make any changes in the future. Also be sure they are able to locate your original documents, or that they have a valid copy.

### Who should get a copy:

- **Family and/or Health Care Power of Attorney:** Give a copy to anyone likely to play a role in your future health care. Talk about your choices with them and make sure they understand what matters to you.
- **ECU Health:** Provide a copy to ECU Health for your ECU Health Electronic Health Record. Use the enclosed Cover Sheet to send a **copy** of your completed signed Advance Directive documents to ECU Health to scan into your health record. Be sure to discuss your choices with your providers.
- **Other Health Care Providers**: Give a copy to any of your providers who are not a part of ECU Health.
- **Register on Websites:** Consider uploading your documents to the North Carolina registry and/or the Federal registry so they are available to other health care providers and institutions if needed.
    - North Carolina registry: *sosnc.gov/ahcdr (fee may apply)*
    - Federal registry: *usacpr.net (fee may apply)*
- **Store and Share it on an App**: An app on your phone keeps your documents with you electronically and many apps allow you to share access with family or designated health care agents.
    - American Bar Association: *mindyour-lovedones.com (fee may apply)*
    - Mind My Health: *mindmyhealth.org*

## STEP 5 – Review your decisions

Review your Advance Directive documents at least once a year, any time your health condition changes or you have major life changes. Your thoughts, perspectives, and viewpoints can also change over time.

- **What you want now:** Things change over time so it is important to make sure these documents reflect your current preferences about end of life choices and any changes in your health.
- **Your agent:** Make sure that the agent(s) you selected is still your best choice, and is still willing and able to serve in that capacity.
- **Health or life changes:** Re-examine your Advance Directives when there are major changes in your health or your life such as a marriage, birth of a child, significant illness, divorce, or death of a family member.
- **Review yearly:** As part of your annual health check-up, review your documents.

# Advance Directive – Cover Sheet
# To File In Your ECU Health Medical Record

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## Instructions to Add Your Advance Directive to Your ECU Health Medical Record

After you complete your Advance Directive, give a **COPY** of your document with this cover sheet to ECU Health. You can send a copy to the Health Information Management Services (HIMS) department **or** take it to your ECU Health provider or hospital.

Your Advance Directive will go in to your ECU Health Electronic Health Record (EHR) so it is available if you are not able to communicate your choices for yourself.

- **If you have never been an ECU Health patient before**, we will create an ECU Health medical record for you. Your Advance Directive will be the first entry in your record.
- **If you are already an ECU Health patient**, we will scan your Advance Directive into your record.
- Your documents will be available in your record within five business days after we receive them.
- Any ECU Health hospital or medical practice can check your ECU Health record. You DO NOT have to send your documents to each separately.

**Please complete the following information:**

Full Name: _____

Address: _____

_____

Phone Number: _____ Alternate Phone Number: _____

Date of Birth: ____/____/____ (Month/Day/Year) Gender: ☐ Male ☐ Female

Last 4 Digits of Social Security Number: _____

Patient Status:

☐ I have been an ECU Health patient before (hospital or medical practice), so I have an ECU Health Record:
ECU Health Medical Record Number *(not required)*: _____

☐ I have never been an ECU Health patient and need a new ECU Health Record created for me.

**Send a copy (not the original) of your completed, signed and notarized Advance Directive(s) to ECU Health. Be sure to include all pages of the document.**

**1) Mail a copy to:**
ECU Health Medical Center
Attn: Health Information Management Services
2300 Beasley Drive, Doctors Park 8
Greenville, NC 27834

**OR**

**2) Take a copy to:**
Your ECU Health Physicians medical practice
or
Patient Access Services at an ECU Health hospital

# An Advance Directive
# For North Carolina

## A Practical Form for All Adults

## Introduction

This form allows you to express your choices for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form is intended to comply with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

## Part A: Health Care Power of Attorney

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.
2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your choices. It is very important to talk with your health care agent about your goals and preferences for your future health care, so that he or she will know what care you want.
4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make all health care decisions for you, including:
    - starting or stopping life-prolonging measures
    - decisions about mental health treatment
    - choosing your doctors and facilities
    - reviewing and sharing your medical information
    - autopsies and disposition of your body after death
5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial in Section 3 of Part A.
6. **When will this health care power of attorney be effective?** This document will only become effective if your doctor determines that you have lost the ability to make your own health care decisions.

7. **How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.
8. **Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions?** If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

## Part B: Living Will

1. **What is a living will?** In North Carolina, a living will lets you state your desire not to receive life-prolonging measures in any or all of the following situations:
    - You have a condition that is incurable that will result in your death within a short period of time.
    - You are unconscious, and your doctors are confident that you cannot regain consciousness.
    - You have advanced dementia or other substantial and irreversible loss of mental function.
2. **What are life-prolonging measures?** Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.
3. **Can life-prolonging measures be withheld or stopped without a living will?** Yes, in certain circumstances. If you are able to express your choices, you may refuse life-prolonging measures. If you are not able to express your choices, then permission must be obtained from those individuals who are making decisions on your behalf.
4. **What if you want to receive tube feeding (artificial nutrition and hydration)?** You may express your choice to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.
5. **How can you revoke this living will?** You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write "void" across the document, tell your doctor that you are revoking the document, or complete a new living will.

## Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

1. Wait until two witnesses and a notary public are present, then sign and date the document.
2. Two witnesses must sign and date the document in Section 2 of Part C. These witnesses can **NOT** be:
    - related to you by blood or marriage,
    - your heir, or a person named to receive a portion of your estate in your will,
    - someone who has a claim against you or against your estate, or
    - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.
3. A notary public must witness these signatures and notarize the document in Section 3 of Part C.

# Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

**If you do not wish to appoint a Health Care Agent, strike through this entire part and initial here _____.**

**My name is: _____ My birth date is: _____/_____/_____**
(Please Print)

## 1. The person I choose as my health care agent is:

| first name | middle name | last name | relationship |
|---|---|---|---|

| street address | city | state | zip code |
|---|---|---|---|

| cell phone | work phone | home phone | e-mail address |
|---|---|---|---|

**If this person is unable or unwilling to serve as my health care agent, my next choice is:**

| first name | middle name | last name | relationship |
|---|---|---|---|

| street address | city | state | zip code |
|---|---|---|---|

| cell phone | work phone | home phone | e-mail address |
|---|---|---|---|

**(Optional) If these persons are unable or unwilling to serve as my health care agent, my 3rd choice is:**

| first name | middle name | last name | relationship |
|---|---|---|---|

| street address | city | state | zip code |
|---|---|---|---|

| cell phone | work phone | home phone | e-mail address |
|---|---|---|---|

## 2. Special Instructions:

In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding (artificial nutrition and hydration), other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation.

(Note: If you **DO NOT** have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section, and/or write NONE and initial.)

_____

_____

## 3. Organ Donation:

_____ **(initial)** My health care agent may donate my organs or parts after my death.

(Note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

**This form is not complete until notarized in Part C.**

# Part B: Living Will

**If you DO NOT wish to prepare a Living Will, strike through this entire part and initial here _____.**

**My name is: _____ My birth date is: ____/_____ /_____**
(Please Print)

1. **If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations:**
   (Note: you may initial **ANY or ALL** of these choices.)

   _____ **(initial)** I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

   _____ **(initial)** I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

   _____ **(initial)** I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

2. **Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, I DO want to receive tube feeding (artificial nutrition and/or hydration) in those situations, as stated below.** (Note: Initial only if you **DO WANT** tube feeding in those situations.)

   _____ **(initial) I DO want to receive artificial nutrition.**

   _____ **(initial) I DO want to receive artificial hydration.**

3. **I wish to be made as comfortable as possible.** I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may not prolong my life.

4. **My health care providers may rely on this Living Will to withhold or discontinue life-prolonging measures in the situations I have initialed above.**

5. **If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then:**
   (NOTE: Initial **ONLY ONE** of the two choices below.)

   _____ **(initial) Follow this living will.** My health care agent cannot make decisions that are different from what I have stated in this living will.

   _____ **(initial) Follow health care agent:** My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

**This form is not complete until notarized in Part C.**

# Part C: Completing this Document

**My name is: _____ My birth date is: _____/_____ /_____**

(Please Print)

## 1. Your Signature - STOP

(Note: Wait until two witnesses and a notary public are present before you sign.)

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____Signature: _____

## 2. Signatures of Witnesses

I hereby state that the person named above, _____, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

## 3. Notarization

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ *(type/print name of Signer)*

_____ *(type/print name of Witness)*

_____ *(type/print name of Witness)*

Date: _____ Signature of Notary Public: _____

*(Official Seal)*

_____

*(type/print name of Notary Public)*

My commission expires: _____ *(date)*