



TO HELP EASE

DECISION MAKING

IN THE FUTURE

ADVANCE CARE PLANNING TOOLKIT



VIDANT HEALTH™

Your health care decisions are important.

Providing Patient Centered Care is the guiding principle of Vidant Health's focus on advance care planning. 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:

VidantHealth.com/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.

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
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 and how that influences your choices about 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.
- Writing in a journal or a letter may help you organize your thoughts.
- You can 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.

Think About....think about the questions in the rest of this section and write down your thoughts. This can help you sort out your feelings about what matters most to you.

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. How have those experiences influenced your choices for future health 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 treatments just to keep you alive longer and only use *comfort measures* to keep you as comfortable as possible in the time you have left?

Where would you prefer to spend your last few months, weeks, or days?
In your 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? Do you have instructions about what should happen to your body after you die?

STEP 2 – Talk About

You have thought about your end of life care choices and what matters most to you. You are ready to begin sharing 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.

It is important to remember this is probably something you will discuss more than one time. The more you talk about your choices for care at the end of life, the more comfortable you and your family will become. So keep talking.

Here are some ideas for starting your conversation:

- *“There’s something I’ve been thinking about for a while that I want to share. I really need you to listen carefully.”*
- *“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 power of attorney 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?”*
- *“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 my choices are 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.”*

You have now completed a very important step in the advance care planning process. You have had the difficult, and sometimes very emotional, conversations about your end of life care choices. Now you will want to complete the process by putting it in writing.

STEP 3 - Put it in Writing

Now you need to record your choices in an Advance Directive document or form. By taking this step, you give your loved ones and your medical team the information they need to be able to honor your choices.

There are different kinds of Advance Directives.

The ones you need may include some or all of the following:

Name of document	Important information
Health Care Power of Attorney	Must be signed in front of two witnesses and a notary
Living Will	Must be signed in front of two witnesses and a notary
Advance Instructions for Mental Health Treatment	Must be signed in front of two witnesses and a notary
Medical Orders for the Scope of Treatment (MOST)	A doctor's order that you and your doctor sign <i>Keep it with you at all times</i>
Do Not Resuscitate Order (DNR)	A doctor's order that doctor signs <i>Keep it with you at all times.</i>

How to get the forms you need

- **Healthcare Power of Attorney and Living Will (combined)**

Attached you will find a document called ***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.

Using the *Practical Form for All Adults* form, fill it in, and then sign it when you are in front of two witnesses and a notary.

- **Advance Instruction for Mental Health Treatment**

Visit the North Carolina Secretary of State website to download a form. www.secretary.state.nc.us/ahcdr/Forms

- **MOST or DNR Orders**

If you would like a MOST or DNR, talk with your doctor. Only a doctor, nurse practitioner or physician assistant can fill these out. These doctor's orders are typically completed when a person has an advanced illness or life limiting condition with a life expectancy of one year or less.

STEP 4 – Share

Now that you have completed your Advance Directive, you need to share copies of your signed documents with your health care provider(s) and your family or those closest to you. Be sure to talk about your choices with them.

You should be sure that your family, health care power of attorney and health care providers know and understand your decisions. Some families can do this in one conversation, and others will need more. There is no right or wrong way to have these conversations. They also need to have access to your documents and be able to find them.

Who should get a copy of your Advance Directives?

- **Vidant Health:** Provide a copy to Vidant Health for your Vidant Electronic Health Record. Use the enclosed Cover Sheet to send a copy of your completed Advance Directive documents to the Vidant Health Information Management Services (HIMS) department, or take a copy to your next appointment with your Vidant provider or to your local Vidant hospital patient access services. Vidant will scan your documents into your health record.
- **Other Health Care Providers:** Give a copy to any providers who are not a part of Vidant 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: www.secretary.state.nc.us/ahcdr *(there may be a fee)*
 - Federal registry: www.uslivingwillregistry.com *(there may be a fee)*
- **Family and/or Health Care Power of Attorney:** Share a copy of your documents with your family and/or designated Health Care Power of Attorney(s).

Make sure you give copies of your completed document to anyone likely to play a role in your future health care. That could include family or loved ones, friends, your health care provider(s), attorney, pastor, or clergy.

- Discuss your choices with them to make sure they understand what matters to you.
- Discuss your choices with your health care providers to assure they know what you want. You should talk about this more than one time.

Other things to consider about your Advance Directives

- **Original documents:** Keep your original documents in a safe place. Make sure you can get the documents quickly if you need them.
- **Copies:** Keep a copy of your Advance Directives in a place that is easy to get to, such as the glove box of your car. When you travel, the Advance Directives will be available to emergency personnel or your health care providers.
- **Keep a list:** Keep a list of everyone who got a copy of your Advance Directives. Then, you will know who to notify if you make any changes to your documents.

STEP 5 – Review your decisions

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

- **What you want now:** It is important to make sure these documents reflect your current preferences about end of life choice and any changes in your health.
- **Your agent:** Make sure that the agent(s) you selected is still your best choice.
- **Any big changes since the last review?** A good guideline is to re-examine your Advance Directive when there are major changes in your life (marriage, birth of a child, significant illness, divorce, death of a family member, etc.) or at least once a year.

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



Instructions to Add Your Advance Directive to Your Vidant Health Medical Record

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

Your Advance Directive will go in to your Vidant 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 a Vidant patient before**, we will create a Vidant Health record for you. Your Advance Directive will be the first entry in your record.
- **If you are already a Vidant 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 Vidant hospital or Vidant Medical Group practice can check your Vidant 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 a Vidant patient before (Hospital or Physician Practice), so I have a Vidant Health Record:
Vidant Medical Record Number (*if known*): _____

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

**Send a copy of your completed, signed and notarized Advance Directive(s) to Vidant Health.
Be sure to include all pages of the document.**

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

2) Take a copy to:
Your Vidant Medical Group practice
or
Patient Access Services at a Vidant 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

street address city state zip code

home phone work phone cell 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

street address city state zip code

home phone work phone cell 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.)

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)