



Your Advance Care Planning Resource Kit

We plan for college, marriage, a baby & retirement...
but we don't prepare for the end of life.

Let's change that!

It's as simple as 1, 2, 3

gotplans123.org



A Basic Guide to Advance Care Planning

Advance care planning is a **process** where you reflect upon and plan for the healthcare you would want if you are unable to make decisions or speak for yourself. You should talk about your goals and wishes with loved ones and put them in writing.

Advance care planning isn't just for those who are sick or dying. It is important that you plan for your care early so that your wishes can be honored if you are in an accident, undergo surgery, or get a serious illness. Don't wait! Making your wishes known helps your loved ones and healthcare providers know and honor your goals and wishes if you are unable to speak for yourself.

Our guide gives you 3 steps to advance care planning. Keep in mind that this is a **process** and should be revisited as your goals, wishes, and health status change throughout your life.

In this kit:

- Got Plans? It's as simple as 1, 2, 3
- Roles and Responsibilities of a Health Care Agent
- Next Steps – what to do with your advance directives
- Information about the MOST form

*Advance Care Planning documents provided separately.



We plan for college, marriage,
a baby & retirement...
but we don't prepare
for the end of life.
Let's change that!

Advance Care Planning

It's as simple as 1, 2, 3!

1

Decide *what kind of healthcare you would want and who you would want to speak for you if you cannot.*

Ask yourself questions like: *What makes life worth living? What would I consider a good (or bad) death? Who would I trust to speak for me?*

2

Discuss *your wishes with your loved ones and healthcare providers.*

After reflecting on some of your wishes, ***spark some conversation*** with the important people in your life. Make sure to include the person who you would like to speak for you if you cannot. Ask him or her if they would be willing and able to do this for you. You want to pick someone that you will trust to honor your wishes. This person does not have to be your next of kin.

Be sure to ***discuss your wishes with your healthcare provider***. If you have a serious illness or are planning to undergo surgery, he or she can help put your wishes into context. Once you document your wishes, make sure your healthcare provider has a copy of your most current documents on file!

3

Document *your wishes in the form of advance directives.*

Advance directives are legal documents that record your wishes in writing and help ensure your wishes are known & honored.

- ***Health Care Power of Attorney***: a document that allows you to name your ***Health Care Agent***, the individual you would like to speak for you if you are unable to speak for yourself.
- ***Living Will***: a document that describes your preferences related to life-prolonging treatment.

Remember, advance care planning is an ***ongoing process***. Your wishes may change and that's okay! ***Re-visit your documents on a regular basis*** and make any changes necessary to ensure they are up-to-date with your wishes. Keep your loved ones and healthcare providers informed any time your wishes change so they can help honor your wishes!

Roles & Responsibilities of a Healthcare Agent

1. Your role is to make healthcare choices for me if and when I am not able to make those decisions for myself. My doctor will decide when I have lost the ability to make my own healthcare decisions.
2. I will give you a copy of my advance directive documents. I will list any special instructions on this document. I am counting on you to follow those instructions and respect my wishes. I know this may not be easy since my choices may be different from the choices you might make for yourself or what you think is best for me.
3. As my healthcare agent, you will be able to make many healthcare decisions for me. This includes the ability to:
 - talk with my doctors about my medical condition and treatment options;
 - look at my medical information;
 - make decisions about who provides my medical care;
 - admit or discharge me from a healthcare facility. This includes a hospital, mental health facility, assisted living facility, or nursing home;
 - begin or stop life-prolonging measures;
 - consent to or refuse any tests, procedures or surgeries;
 - give permission for an autopsy; and
 - direct what will happen to my body after death.If I do not want you to have the authority for any of these duties, I have stated so in my advance directive documents.
4. I ask that you make treatment choices for me based upon my goals and desires about what kind of care I should receive. It is very important that we take time to talk about these issues so you will understand my goals and preferences.
5. If I need medical care and cannot make my own treatment decisions, please discuss my medical condition and treatment options with my healthcare providers. Please ask them for any medical information you need, and ask them to explain anything you don't understand. The information they provide will help you make informed decisions about my treatment.
6. If, at any time, you decide that you can no longer serve as my healthcare agent, please let me know. Likewise, if I decide at some future time to name another person as my healthcare agent, I will let you know. Either decision will release you from any further responsibilities as my healthcare agent.



Next Steps

What do I do after I have completed my advance directive (Health Care Power of Attorney and/or Living Will) documents?

Once you have completed these documents, there are a few steps to take to be sure your choices are honored by your doctors and loved ones.

1. **Give a copy to your doctor.** It is very important that your advance directives are added to your medical record. If you send your directives by mail, be sure to include your address, social security number, date of birth and contact information.
2. **Discuss your choices with your doctor(s).** Talk with your doctor about your wishes. Make sure you are both clear about what you want and agree that your wishes will be honored.
3. **Give a copy of your document(s) to your healthcare agent, if you have one.** This is the person you named in your Health Care Power of Attorney.
4. **Give copies to your family and loved ones.** You might also want to give a copy to your clergy.
5. **Keep the original document(s) where they are safe and easy to obtain.** Make an extra copy for yourself, in case you lose your original or it is accidentally destroyed or damaged. Do not put these documents in a safe deposit box.
6. **Label one copy “Hospital” and take it with you if you are admitted to a hospital.** Ask the hospital staff to make a copy of the document and return your copy to you.
7. **Make a list of everyone whom you gave a copy of your document(s).** If you ever change documents, you will have a list of who needs updated copies.
8. **Upload the documents onto your smartphone.** Consider uploading a copy of your advance directives onto your smartphone. The American Bar Association’s “My Health Care Wishes” smartphone app gives you immediate access to your advance directives wherever and whenever you need them.



gotplans123.org

Guide for Patients and Families: Understanding and using Medical Orders for Scope of Treatment (MOST)

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)
This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient's Last Name: _____ Effective Date or Time: _____
 Patient's First Name, Middle Initial: _____ Patient's Date of Birth: _____

Section A
 CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.
 Attempt Resuscitation (CPR) Do Not Attempt Resuscitation (DNR/no CPR)
 What are your preferences about follow orders in B, C, and D?

Section B
MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.
 Full Scope of Treatment: Use whatever advanced emergency interventions, mechanical ventilation, cardiopulmonary resuscitation, and/or treatment of DNR/no CPR you deem appropriate. **Transfer to hospital if indicated.**
 Limited Additional Interventions: Stop advanced emergency interventions, resuscitation, or intubation. Do not use mechanical ventilation. **Transfer to hospital if indicated.**
 Comfort Measures: Keep your family nearby. Use mechanical ventilation, breathing, wound care and other supportive therapies as needed. Do not use mechanical ventilation, intubation, or chest compressions as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**
 Other Interventions: _____

Section C
ANTIBIOTICS
 Antibiotics indicated
 Defer use or limit use of antibiotics when infection is not serious
 No Antibiotics (same as the patient's preference)
 Other Interventions: _____

Section D
MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically possible.
 IV fluids indicated Feeding tube suggested if indicated
 IV fluids for a defined trial period Feeding tube for a defined trial period
 No IV fluids (same as the patient's preference) No feeding tube
 Other Interventions: _____

Section E
DISCUSSED WITH AND AGREED TO BY:
 Patient Majority of patient's reasonably available persons and/or children
 Parent or guardian if patient is a minor Health care proxy Legally designated agent Adult relative
 Next of kin with power of attorney Legally designated agent Adult relative
 Other Interventions: _____
 Base on order made, discussed in medical _____ with the patient who is acting in good faith and is available to receive the wishes of the patient.

MD/DO, PA, or NP Name (Print): _____ MD/DO, PA, or NP Signature and Date (Required): _____ Phone #: _____

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
 Signature is required and must reflect the order on this form on my first. I agree that adequate information has been provided and a judgment thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent. If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact representative for personal representative should be provided on the back of this form. You are not required to sign this form to receive treatment.

Patient or Representative Name (print) _____ Patient or Representative Signature _____ Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Completing MOST
 MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
 MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. Be sure to document the basis for the order in the progress notes of the medical record. Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
 The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
 Use of original form is required. Be sure to send the original form with the patient.
 MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. MOST may supersede any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.
 There is no requirement that a patient have a MOST.
 MOST is recommended under N.C.G.S. Stat. 90-21.17.

Reviewing MOST
 Review of the MOST form is recommended when:
 • The patient is admitted to and/or discharged from a health care facility; or
 • There is a substantial change in the patient's health status.
 This MOST must be reviewed if:
 • The patient's treatment preferences change.
 If a MOST is revised or becomes invalid, draw a line through Sections A - E and write "VOID" in large letters.

Revocation of MOST
 A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST				
Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed
				<input type="checkbox"/> No Change <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed <input type="checkbox"/> CHANGED: new form completed

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED
DO NOT ALTER THIS FORM!

REVISIONS/CHANGES Health Service Department of Health and Human Services, Division of Health Policy and Practice, Office of Emergency Medical Services
 101 North Salisbury Street, Raleigh, NC 27601-1001. For more information, please contact the Division of Health Policy and Practice at 919-733-2000.

Important information about MOST forms:

- This bright pink form will help your doctor know and honor your healthcare wishes
- MOST should:
 - make it easier to talk to your doctor about difficult decisions;
 - travel with you from location to location (home, hospital, facility, etc.)
- MOST is designed for people with serious, chronic illness, not for young, healthy adults.
- MOST is a doctor's order.** You must get a copy from your doctor and discuss your wishes together. MOST is NOT a Living Will or Health Care Power of Attorney.
- If you have the form with you, any healthcare provider can follow those orders and honor your wishes.
- If you are at home, the form should be visible and easy to access (above your bed or on your refrigerator door).**

Section A: CPR

- Section A tells the doctor if you do or do not want CPR. You can choose "Attempt" or "Do Not Attempt"
- CPR (Cardiopulmonary Resuscitation) can be used if your heart stops beating and you are not breathing.
- CPR can be helpful or harmful depending upon your condition. Talk to your doctor about what it might mean for you and what results you may expect based upon your health.
- You should understand that after receiving CPR you might be taken to the ICU (Intensive Care Unit) and put on a breathing machine.

Section B: Medical Interventions

- Section B gives you the chance to say what level of treatment you want based upon your goals of care.
- Comfort measures are provided at all levels of care.
- Check only one box based upon discussion with your doctor and family
 - **Full Scope of Treatment:** If your goal is to live as long as possible using any treatments available (breathing machine, feeding tube, etc.) no matter what your condition, check “Full Scope of Treatment.” If you make this choice, all treatments necessary to prolong life will be utilized.
 - **Limited Additional Interventions:** This box should be checked if you want to improve or maintain your level of function. Checking here means you don’t mind being taken to the hospital but do not want to end up in the ICU on a breathing machine. All comfort measures and other indicated medical treatments will be used.
 - **Comfort Measures:** Check this if you and your doctor have decided that further hospital stays and treatments will not benefit you. This means you would rather stay wherever you call home rather than be sent to the hospital. This helps you avoid unwanted medical treatment, ambulance trips, and hospital admissions.

Section C: Antibiotics

- Section C offers you three options similar to section B. You should select one option based upon your goals and discussions with your doctor and family.

Section D: Medically Administered Fluids and Nutrition

- Check only one box based upon discussions with your doctor and family
- Section D offers you three options as in Section B and C.
- Similar to CPR, a feeding tube can be helpful or harmful depending upon your condition. Talk to your doctor about what it might mean for you and what results you may expect based upon your health.
- Be sure you and your family understand when your body would benefit from artificial nutrition and hydration and when it would not.

Section E: Discussion & Signatures

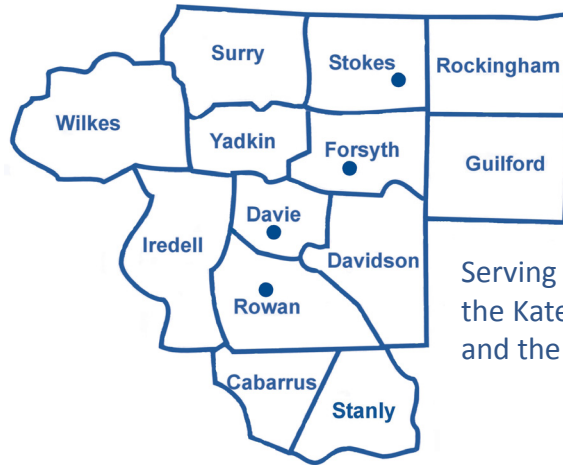
- This section indicates to whom the doctor spoke about your choices. If you are unable to speak for yourself, your doctor will talk to your legal representative.
- If you and your doctor agree with your decisions, you will both sign the form to make it valid.



Hospice & Palliative
CARECENTER



Rowan
Hospice & Palliative CARE



Serving 13 counties from 4 offices,
the Kate B. Reynolds Hospice Home
and the Glenn A. Kiser Hospice House

Hospice & Palliative CareCenter - Mocksville PH: (336) 753-0212

Hospice & Palliative CareCenter - Walnut Cove PH: (336) 591-1124

Hospice & Palliative CareCenter - Winston-Salem PH: (336) 768-3972

Kate B. Reynolds Hospice Home PH: (336) 760-1114

Rowan Hospice & Palliative Care - Salisbury PH: (704) 637-7645

Glenn A. Kiser Hospice House PH: (704) 603-3900

In Partnership with:



® 2014. The Community Partnership for Compassionate Care.

With support from our community partners:

From Hospice & Palliative CareCenter: Christine Brown Ann Gauthreaux
Courtney Whicker Mary Taylor Mann Judy Swain

From Novant Health: Reba Teeter Dee Leahman

From Wake Forest Baptist Health: F. Keith Stirewalt