Advance Care Planning

Planning for Future Healthcare Decisions

Advance Care Planning is a process that includes a few key action items: (i) identify your Patient Advocate(s), (ii) discuss your wishes and goals regarding medical care with them, (iii) complete and sign the Patient Advocate Designation form (also called the Durable Power of Attorney for Healthcare) in the presence of two qualified people who sign as witnesses, and (iv) make copies of the completed Patient Advocate Designation form for your Patient Advocate(s), family and healthcare providers.

1. What is an Advance Directive?

An Advance Directive is the document that results from the Advance Care Planning process and includes two parts: communicating your wishes regarding medical treatment with your designated patient advocate and completing a Durable Power of Attorney for Healthcare. The Durable Power of Attorney for Health Care (DPOA-H) is a legally recognized document in Michigan. The DPOA-H allows you to name your Patient Advocate. The DPOA-H is found on page 3 and 4 of this packet.

2. Who should be my Patient Advocate?

Your Patient Advocate is the person who can make medical decisions for you if you are unable to make them yourself. If 2 doctors decide that you cannot make your own medical decisions, they will ask that your Patient Advocate make them for you. Select someone you trust to make the decisions you would want. You may also name an alternate advocate to make the decisions if your first choice cannot. It is very important to have discussions about your wishes with your Patient Advocate.

3. What are my To-Dos?

For the DPOA-H to be legally valid, you must follow the steps in the order below.

- ☐ **1.** Identify a person to serve as your Patient Advocate (and an alternate Patient Advocate). Write these names out on page 3 of this packet (the DPOA-H legal form).
- ☐ **2.** Go through the questions on page 2 with your Patient Advocate and ensure they understand your wishes.
- ☐ **3.** Identify 2 people who can serve as witnesses. Neither witness can be your Patient Advocate, spouse, parent, brother, sister, child, grandchild, heir, physician/APP or employee of the hospital.
- ☐ **4.** Sign the DPOA-H form on page 3 in front of the witnesses.
- ☐ **5.** Have the witnesses sign the form on page 3 on the same date that you sign the form but only after you have signed it in their presence.
- ☐ **6.** Have your selected patient advocate and alternate patient advocate accept and sign the DPOA-H legal form on page 4. Make and give copies to your Patient Advocate, health care provider, family, and friends. Keep copies in an easily accessible place.
- ☐ **7.** If any of the 5 Ds listed below occur, determine if a conversation is needed with your Patient Advocate to re-discuss wishes:
  Decline in health | New Diagnosis | Death of a person close to me or my advocate | Divorce | New Decade of life
- ☐ **8.** Repeat steps 1-6 above if any changes to the DPOA-H document are needed.

4. What is important to me? ***(Information to discuss with your Patient Advocate)***

1. If I no longer am able to make decisions for myself or have a terminal illness, what activities are most important to me to have a good quality of life?
2. Is religion or spirituality important to me? What do I want my advocate to know in regards to this?
3. Do I want to donate my organs?
4. If I am unable to make decisions for myself for any reason, which of the following would I want:

   a. I want doctors to try all treatments that they think might help, including life support even if it may not help me get better (full code). Full code means, if I have a cardiac or respiratory arrest, my health care provider will attempt to perform life-saving measures.

   b. I want doctors to do everything they think might help me, but, if I am very sick and have little hope of getting better, I do not want to stay on life support.

   c. I want to die a natural death. I want no life support treatments. Do not attempt resuscitation. If this is the case, please ensure you have a state-ordered Do-Not-Resuscitate document signed and scanned into your healthcare provider's chart for this to go into effect legally.

   d. I want my Patient Advocate to decide for me with the help of information from my doctors and my thoughts on life.

   e. I am not sure

5. If given a choice, I would prefer to die in the following location:
   - At home
   - At a facility (hospital, hospice, nursing home)
   - I am not sure

The DPOA-H form is found on the following two pages. Please ensure that all sections are completely filled out (including dates and signatures). The only section that is optional (but highly recommended) is the information regarding the Alternate Patient Advocate.

If you have more questions about an Advance Directive
go to the MCM website for resources:

makingchoicesmichigan.org

Trinity Health

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Durable Power of Attorney for Healthcare | **Patient Advocate Designation**

I _____ (YOUR NAME), am of sound mind and voluntarily choose the following person to be my Patient Advocate and make all health care decisions for me:

Patient Advocate:* _____
FIRST NAME LAST NAME

_____
STREET ADDRESS CITY STATE ZIP

_____
HOME PHONE NUMBER WORK PHONE NUMBER CELL PHONE NUMBER

If my first choice cannot serve, I choose the following person to be my Alternate Patient Advocate (optional but recommended):

Alternate Patient Advocate:_____
FIRST NAME LAST NAME

_____
STREET ADDRESS CITY STATE ZIP

_____
HOME PHONE NUMBER WORK PHONE NUMBER CELL PHONE NUMBER

This authority is not effective unless I am unable to participate in decisions regarding my medical or mental health treatment, as determined by my attending physician and another physician. This authority is suspended during any period in which I regain the ability to participate in my own medical treatment decisions. I intend this document to be a durable power of attorney for health care, and it shall survive my disability or incapacity.

In making decisions, my Patient Advocate has authority to consent to or refuse treatment on my behalf, access my medical records, arrange medical and personal services for me, and pay for such services with my funds. This is an option available to me.

Initial here: _____.
(REQUIRED ONLY IF YOU GRANT AUTHORITY TO PATIENT ADVOCATE).

I authorize my Patient Advocate to make decisions to withhold or withdraw treatment which would allow me to die (including a do-not-resuscitate declaration), and I acknowledge such decisions could allow me to die.

I may change my mind at any time by communicating in any manner that this document does not reflect my wishes. I sign this document voluntarily and I understand its purpose and revoke any prior patient advocate designations:

Your Signature:* _____ Date:*_____

_____
STREET ADDRESS CITY STATE ZIP

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother, sister or presumptive heir; who are not my physician or my patient advocate; and who are not an employee of: my life or health insurance company, a home for the aged where I reside, a community mental health program or health care facility providing me services.

Witness Signatures:* We sign below as witnesses. This document was signed in our presence. The individual appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____
WITNESS SIGNATURE WITNESS SIGNATURE

_____ _____
PRINT NAME PRINT NAME

_____ _____
ADDRESS ADDRESS

** REQUIRED*

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ACCEPTANCE OF DESIGNATION AS PATIENT ADVOCATE

I accept the designation as the Patient Advocate for_____.
PATIENT NAME

I understand and agree to take reasonable steps to follow the instructions, both verbal and written, of the patient regarding his or her medical care, custody, and treatment. I also understand and agree to the following:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable.
2. A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.
3. This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.
4. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
5. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.
6. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.
7. A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.
8. A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
9. A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.
10. A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the patient has designated as Alternative Patient Advocate. The Alternative Patient Advocate is authorized to act until I become available.

Patient Advocate:*

_____
PATIENT ADVOCATE SIGNATURE

_____
PRINT NAME

_____
ADDRESS

_____
DATE

Alternate Patient Advocate:

_____
PATIENT ADVOCATE SIGNATURE

_____
PRINT NAME

_____
ADDRESS

_____
DATE

** REQUIRED*