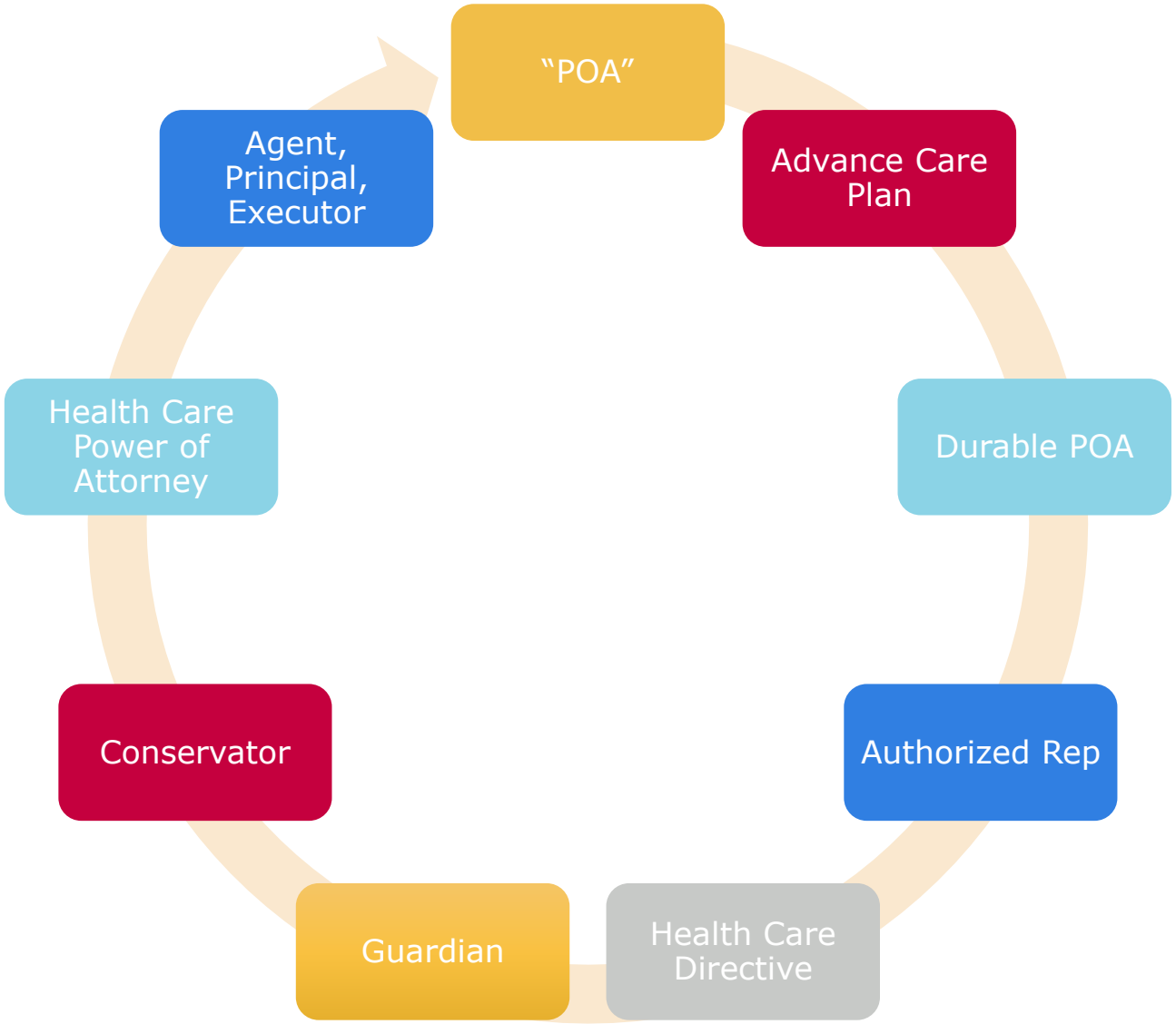
Alternative Decision Makers and Health Care Directives

Agenda and Objectives

By participating in this training, you will:

- Understand the differences in Financial and Health Care alternative decision makers
- Gain understanding of the least restrictive to most restrictive alternative financial and health care decision makers
- Understand the importance of viewing documents to know the potential limitations of alternative decision makers
- Know the requirements to complete a MN Health Care Directive
- Have knowledge of best practices when completing and updating POLST and Health Care Directives

Common Terminology



Financial Helpers

Least Restrictive to Most Restrictive

Alternative Decision Makers - Financial

Least Restrictive

- Authorized Rep – for MA purposes
- Joint Checking (Informal Caregiver)

More Restrictive

- Representative Payee (fiduciary)
- Power of Attorney/Durable POA
- Special Needs Trust

Most Restrictive

- Conservatorship

Alternative Decision Makers - Rep Payee

- Use the beneficiary's Social Security or SSI payments to meet essential needs, such as food, shelter, household bills and medical care. The money can also be used for personal needs like clothing and recreation.
- Keep any remaining money from benefit payments in an interest-bearing bank account or savings bonds for the beneficiary's future needs.
- Keep records of benefit payments received and how the money was spent or saved.
- Report to Social Security any changes or events that could affect the beneficiary's payments (for example, a move, marriage, divorce or death).
- Report any circumstances that affect the payee's ability to serve in the role.

To Learn More: Social Security Rep Payee

Alternative Decision Makers - POA

Ch. 523 MN Statutes

FIRST: To act for me in any way that I could act with respect to the following matters, as each of them is defined in Minnesota Statutes, section 523.24:

(A) real property transactions;

(B) tangible personal property transactions;

(C) bond, share, and commodity transactions;

(D) banking transactions;

(E) business operating transactions;

(F) insurance transactions;

(G) beneficiary transactions;

(H) gift transactions;

(I) fiduciary transactions;

(J) claims and litigation;

(K) family maintenance;

(L) benefits from military service;

(M) records, reports, and statements;

(N) All of the powers listed in:

(A) through (M) above and all other matters, ***other than health care decisions*** under a health care directive that complies with Minnesota Statutes, chapter 145C.

Alternative Decision Makers - DPOA

SECOND: (You must indicate below whether or not this power of attorney will be effective if you become incapacitated or incompetent. Make a check or "x" on the line in front of the statement that expresses your intent.) ---


_This power of attorney shall continue to be effective if I become incapacitated or incompetent.

___ This power of attorney shall not be effective if I become incapacitated or incompetent.

“Now it’s Durable”

Special Needs Trust

A self-funded special needs trust allows people with disabilities to place their own money into a special needs trust and still be eligible for certain benefits under SSI and Medicaid programs. These trusts only hold assets that belonged to the beneficiary with disabilities before the funds are placed into the trust.

Any funds that remain in a SNT at the beneficiary's death must be used to reimburse the State for all medical benefits provided during the beneficiary's lifetime. (payback provision)

Conservator

Persons subject to conservatorship are individuals that lack capacity and have demonstrated an inability to make decisions regarding their financial affairs or estate.

- Court appointed:
  - Power over the person's property, financial, and business affairs
  - May be full or partial power
  - May be time limited

To Learn More: Mn State Law; Sec. 524.5-417 MN Statutes

Health Care Decision Makers

Least Restrictive to Most Restrictive

Alternative Decision Makers – Health Care

Least Restrictive

- Informal Caregivers (Spouse/children etc.)

More Restrictive

- Health Care Directive
- Supported Decision Making

Most Restrictive

- Limited/Temporary Guardianship
- Full Guardianship

Informal Caregivers

- **Technical definition**: An unpaid relative, partner, friend or neighbor who routinely provides support that may include direct care, chore, arranging medical appointments, medication administrations, transportation, shopping, and help with paying bills, balancing checkbook, or assistance with paperwork.

Supported Decision Makers

- “Supported decision making" means assistance from one or more persons of an individual's choosing in understanding the nature and consequences of potential personal and financial decisions which enables the individual to make the decisions and, when consistent with the individual's wishes, in communicating a decision once made.
- Less restrictive alternative to Guardianship.

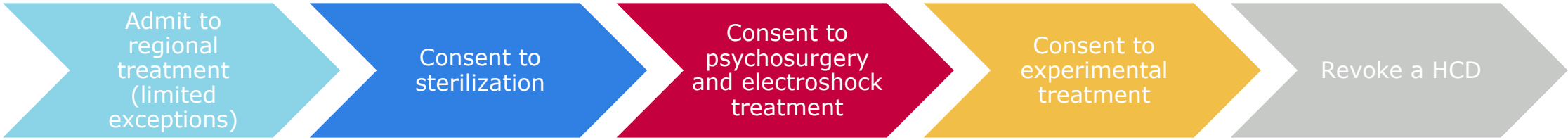
To Learn More: Volunteers of America

Guardianship

- **Persons subject to guardianship** are minors or incapacitated adults who have a court appointed **guardian**, lack sufficient understanding or capacity to make or communicate responsible personal decisions, and who have an inability to meet personal needs for medical care, nutrition, clothing, shelter, or safety
- If a person who had capacity completed a HCD, then is presented to the court in need of guardianship, the judge may allow the HCD decision makers to remain in place. This would be outlined in the guardianship documents.
- A guardian with medical powers cannot consent to any medical care which violates the known conscientious, religious, or moral belief of the person subject to guardianship.

To Learn More: Mn Judicial Branch

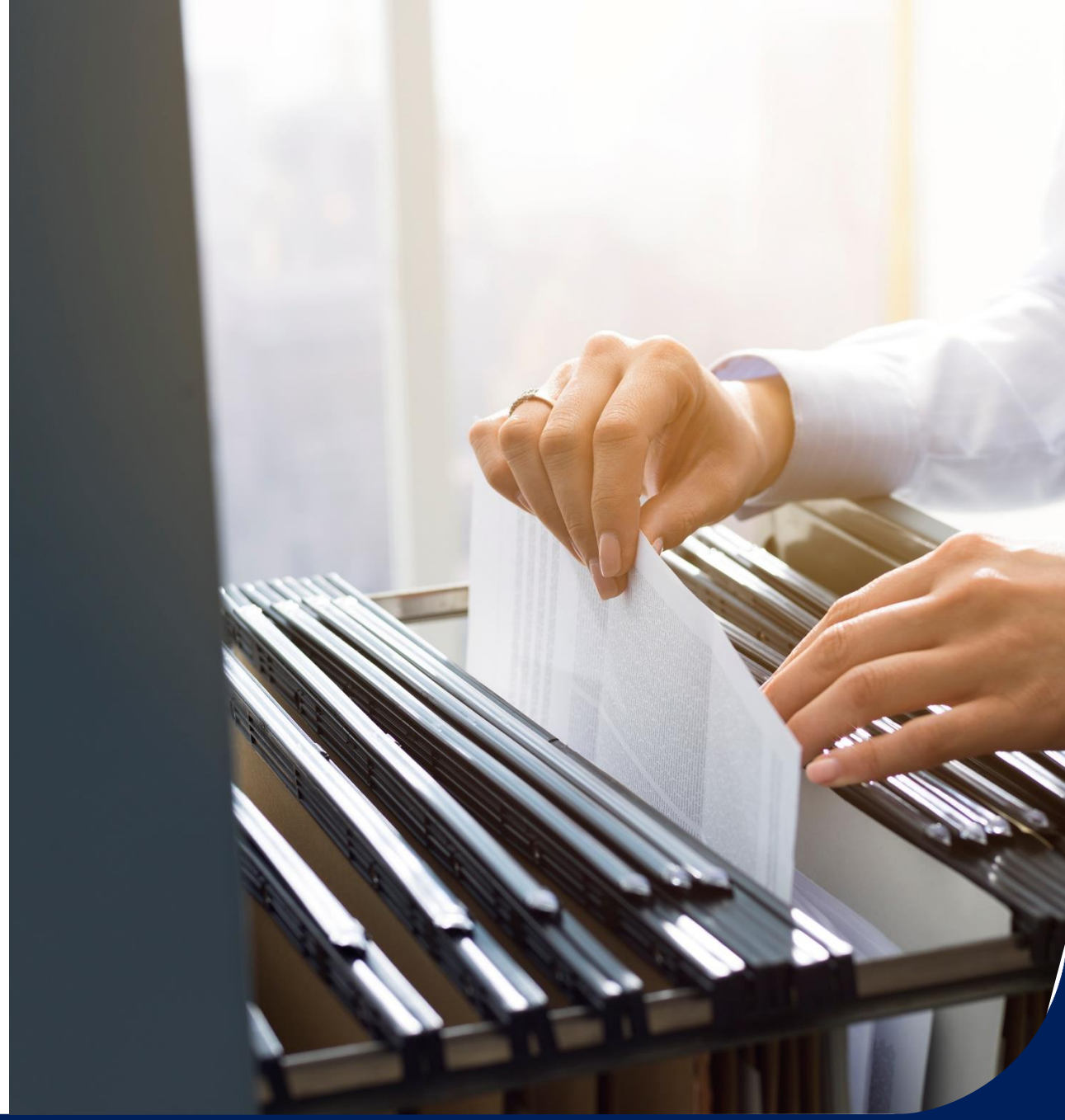
Things a Guardian May Not Do Without Court Approval



To Learn More: Mn Judicial Branch

One Document is One Document

- Because each person's situation is unique, each person's documents will also be unique.
- Examining the documents will help in understanding the actual authority/power the alternative decision maker may have.



Health Care Directives

What Care Coordinators Need to Know

What is a Health Care Directive

The term for the MN advance directive that combines a Living Will and a Health Care POA that informs others of your health care wishes.

- It is a legal document that allows a person to appoint someone they trust to make decisions for them, if they become unable to do so.
- Under Minnesota law, a competent person over age 18 can make a Health Care Directive.
- A health care directive becomes “active” when a person is no longer able to speak for themselves or has indicated on their HCD that their “agent” may speak on their behalf even if the person may speak for themselves.

Did U Know?

A health care directive does not require an attorney to complete.

Health Care Directives – A Little History

- Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.
- The law changed so people can use one form for all their health care instructions.
- Forms created before August 1, 1998, are still legal if they followed the law in effect when written.
- They are also legal if they meet the requirements of the new law.
- If someone has a HCD created before 1998, they may want to review any existing documents to make sure they say what you want and meet all requirements.

To Learn More: Light the Legacy

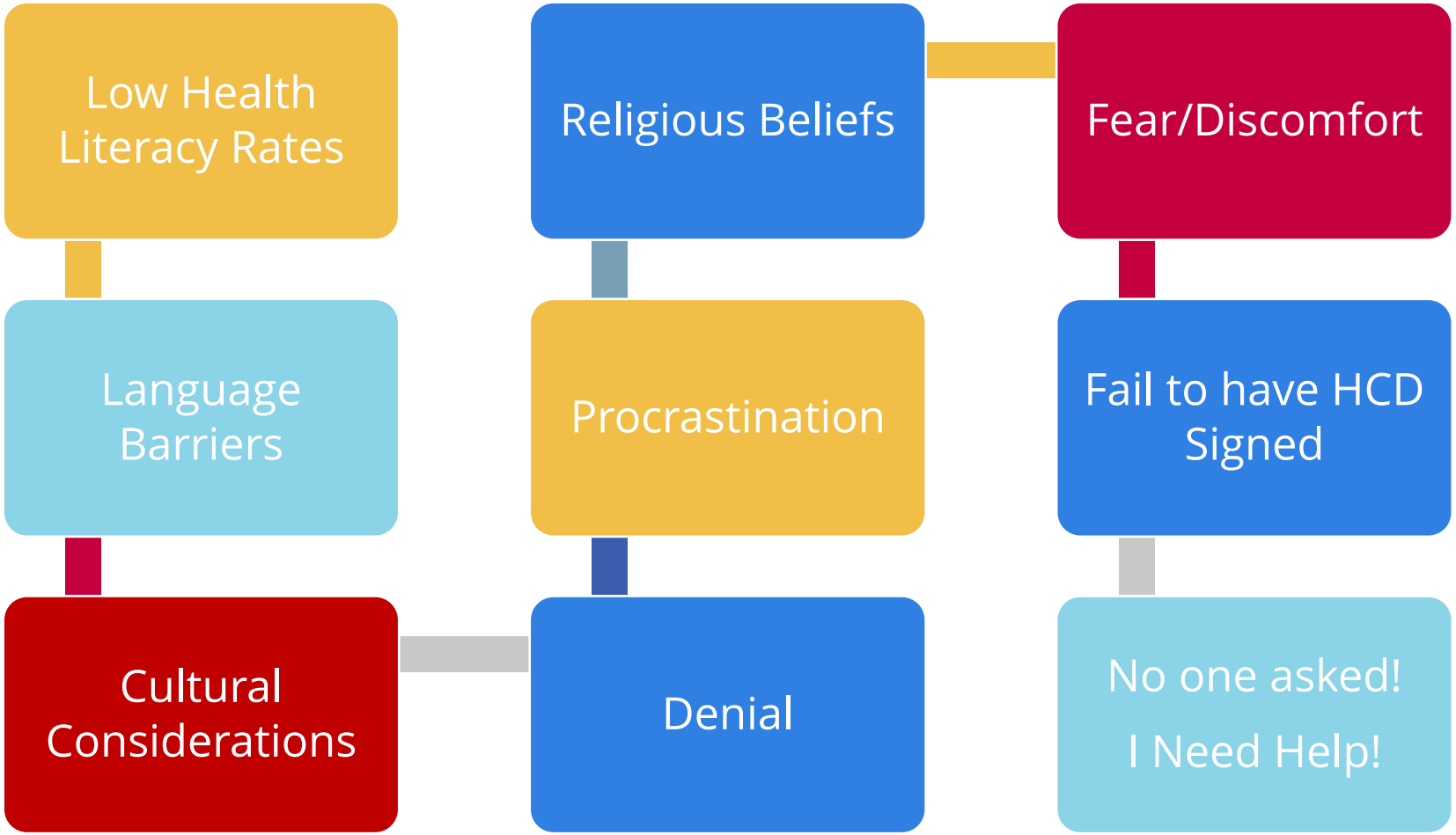
Why Are Health Care Directives Important?

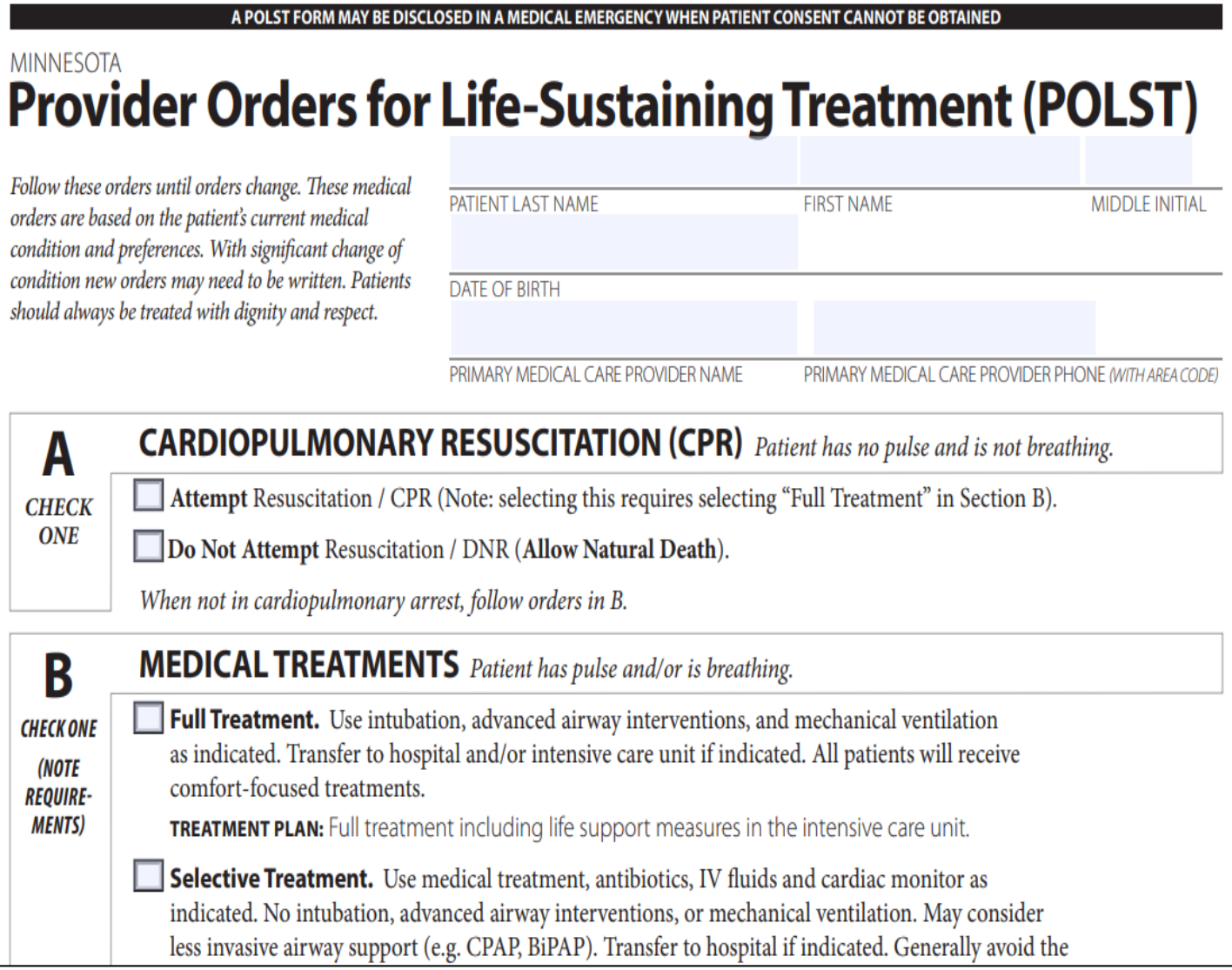
- Aging population – but are important for everyone who wants to have their wishes known.
- People are seeking health care alone. The directive guides your physician, family and friends regarding your care at a time when you are not able to provide that information.
- Health crises are unpredictable. It can be difficult to make health care decisions in midst of crisis.
- Eases burden for family members/providers.
- Reduces fear and worry about health care decisions.
- Communicates your wishes when you are not able to.

Did U Know?

Health care directives allow individuals to say what they **want** for treatment as well as indicating what they **do not want** for treatment.

Why Do Some People Not Have a Completed HCD?





A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

A *CHECK ONE*

CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B *CHECK ONE (NOTE REQUIRE-MENTS)*

MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the

POLST

Is a medical order.

Is one part of advance care planning but is NOT the same as a health care directive.

Identifies what types of treatment a patient wishes to receive at end of life or in medical emergency.

Helps convey those wishes to emergency services and other medical providers.

Used and recognized by hospitals, LTC facilities, medical professionals, and EMS throughout MN.

Must be signed by a licensed provider to be valid.

Standardized form is used in MN.

To Learn More: Mn Medical Association

When Would A POLST Be Appropriate?

- Often used with people with serious progressive illness and/or frailty who are near end of life.
- Involves a conversation with the person and their health care provider.
- EMS can only follow signed medical orders, thus they can follow a POLST but not a health care directive. So people living in assisted living or other shared living setting may want to have a HCD and a POLST.

- **Interesting Fact**: Not all states use the same version of a provider order for treatment. MOST, POST, DMOST, IPOST, LaPOST, TPOPP, MOLST etc!

To Learn More: National POLST Map

Required Elements of Health Care Directives

Person executing HCD must be over the age of 18	Must be in writing	Must be dated	Must state person's name
Must be executed by a **person with capacity** to do so	Stated goals, values, and preferences about health care	Must be signed by the person executing the HCD	Must be verified and signed by a notary or two witnesses

Other Elements of Health Care Directives

- May or may not designate an “Agent” – one or two individuals who may make decisions for you when you can no longer make decisions for oneself
- If naming agent – state their duties.
- Choose how agent(s) can make decisions:
  - Act alone, together,
  - Primary agent, secondary
- Powers of agent - extended or limited.

Completing a Health Care Directive

Name an agent who is:

- 18 years old and competent
- trustworthy
- shares your values
- close to you
- advocate for you
- Be aware that a spouse or domestic partners will be automatically revoked if partnership or marriage dissolved, unless otherwise stated in Health Care Directive

TIP: Be sure that designated agent(s) are willing and able to honor wishes. Review the HCD with them. It may also be important to share the HCD with family members who are not agents to ensure they are aware of wishes and to prevent possible friction in a time of crisis.

Completing a Health Care Directive

Write instructions:

- Identify considerations for decision making
  - What's important to the person, including preferences for
    - Pain mgt, hydration, and things like where you prefer to receive care
  - Feelings about medical treatment
    - What the person wants and doesn't want for treatment
      - CPR, intubation and tube feeding
    - Preferences on mental health treatments and the use of electroshock therapy or neuroleptic medications
  - Wishes for dying, organ donation, even funeral arrangements

Tools:

- Minnesota Health Care Directive Planning Tool
- Light the Legacy

Did U Know?

In Minnesota, a person cannot request assisted suicide, nor request treatment that is outside of reasonable medical practice.

Completing a Health Care Directive

Make it legal:

- Sign and date it
  - Signed by notary public or two witnesses
  - Limits on who can witness
    - Neither of the two witnesses or the notary can be named as agent or alternate agents
    - Only one of the witnesses can be a direct care provider or employee of provider on day the form is signed

Did U Know?

A care coordinator may be a witness on a member's health care directive. A care coordinator **cannot** be a health care agent for a member.

Completing a Health Care Directive

Inform others and provide copies:

- ***Inform others of the content/wishes***
- Give others a copy, especially health care providers
  - keep record of who has copies
- Keep in a safe place, where easily found,
  - not in safe deposit box or lock box.

NOTE: Copies of the HCD form are valid.

Did U Know?

It is illegal for health care providers to require patients to complete a Health Care Directive.

Updating a Health Care Directive

Review and update it when there are:

- Change in health status – such as a new diagnosis or significant change in condition.
- Change in state of residence.
  - An advance directive from another state must meet requirements of each state.
- Change in Agent(s).
  - The availability of individuals named as health care agent or alternative agents.

Did U Know?

Once written, a health care directive can be changed or revoked if the person has the capacity to do so.

How Long Does a Health Care Directive Last?

Until the person changes or cancels it.

- Writing a statement saying they want to cancel it.
- Destroying it.
- Telling at least two people they want to cancel it.
- Writing a new health care directive.

TIP: Inform those who have copies of the HCD of changes

Care Coordinator’s Role

- Review previous HRA/Support Plan Health Care Directive notes
- Annually ask member if they have a Health Care Directive
- Transition of Care: Inquire if an update is needed if there has been a significant change of condition.

Care Coordinator's Role

If members wish to discuss Health Care Directives

- Provide education and resources/tools
- Ask if they want help completing or need forms/tools
- Encourage talking with family / assigned agents
- Support their ideas or wishes
- Follow up on any planned discussion

Create goals that reflect members desire to complete/update their HCD:

EXAMPLE GOAL:

Joan would like to complete her Health Care Directive within the next year.

EXAMPLE INTERVENTIONS:

Care Coordinator provided copy of Light the Legacy
Joan to review by 6 month check in
Joan will identify 2 trusted people to be her agents
Care Coordinator to make referral to XXX agency to assist Joan with completing directive after 6 month check in
Care Coordinator to assist with providing Dr. Jones a copy once signed

Care Coordinator's Role

If member does NOT wish to discuss Health Care Directives:

Document that the member does not want to discuss.	Assure members that they will still have coverage and receive health care if they choose not to have a Health Care Directive.

Address Health Care Directives annually with all members, and document.

Did U Know?

Care Coordinators may assist members in filling out advance directive.

Cultural Considerations

Address openly

Educate yourself before meeting with members from an unfamiliar culture about cultural beliefs/norms and traditions.

Respect cultural beliefs about death and dying.

Do not require member to discuss.

Document if member does not want to discuss.

Act as a resource when possible.

Questions?

MSC_MSHO_ClinicalLiaison@ucare.org

SNBCClinicalLiaison@ucare.org

Resources

- Questions and Answers About Health Care Directives - MN Dept. of Health (state.mn.us)
- Advance Directives / Minnesota Board on Aging (MBA) (mn.gov)
- Volunteers of America – Supported Decision Making
- MN Judicial Branch