Minnesota Health Care Directive Planning Toolkit

This planning toolkit contains information to help you:

- Plan Ahead
- Understand Common Terms
- Know the Facts
- Complete a Health Care Directive: Step-by-Step Suggestions
- Distribute Copies
- Keep a Planning Record
- Review and Update

It also contains suggested user-friendly forms to use for a Health Care Directive that complies with Minnesota law:

- Minnesota Health Care Directive (Parts I and III)
- Health Care Instructions Worksheet (Part II)

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These materials were developed by a group of professionals with expertise in law, health care, life and death health care decision making, and plain language materials development with the leadership of Marlene S. Stum, Ph.D., University of Minnesota. Revised August 2015.

Plan Ahead

Medical decision making is a patient's right. Adults have the right to control their own medical care by consenting to or refusing medical treatment. Patients have the right to understand their health problems, potential care options, and what effect accepting or rejecting various treatments might have on their quality of life.

A person's right to control one's health care decisions does not end if he/she becomes incapable. There are times when health care decisions may need to be made when an individual is no longer able to decide or communicate his/her preferences. Adults of all ages are at risk of incapacity as a result of an injury or illness.

Putting your wishes in writing is the best way to help make sure your wishes will be known and followed by family, friends, health care providers, and others. A Health Care Directive is a tool which allows you to:

- Appoint another person (called an agent) to make health care decisions for you if you become unable to make or communicate decisions for yourself (Part I).
- Leave written instructions so that others can make decisions based on your wishes and preferences (Part II).
- Do both — appoint a health care agent and leave instructions. (Part I and Part II).

You are encouraged, but not required, to complete both Part's I and II of the Health Care Directive form. Knowing whom you want to make decisions for you *and* providing instructions to your decision-makers helps reduce future questions and conflicts.

Understand Common Terms

Advance directive: A written tool used to guide health care decisions when an individual is unable to do so because of incapacity. Most people are familiar with the terms "living will" or "Durable Power of Attorney for Health Care" as different types of advance directives. In Minnesota, an advance directive is called a "health care directive."

Health care directive: This is what an advance directive is called in Minnesota. It combines the general purposes of the living will and durable power of attorney for health care. Health care directives are governed in Minnesota by Statutes chapter 145c.

Health care agent: One or more persons legally authorized to make health care decisions for another who does not have decision making capacity.

POLST Form: POLST stands for "Provider Orders for Life Sustaining Treatment." Health care providers complete this medical order based on their understanding of a patient's wishes (based on in-person conversation or wishes expressed in a health care directive). A POLST communicates end-of-life treatment wishes to other health care providers during an emergency.

Beware of confusing a health care directive with other estate planning tools!

Will: A legal document written to have control over what happens to one's property and assets when one dies. This does not involve health care decisions.

Power of Attorney: A legal document in which one person gives another the authority to make specific *financial* decisions. Unless specifically written to do so, this does not cover health care decisions.

Know the Facts

Did you know…

- Once a health care directive is written, it can be changed or revoked as long as you have capacity. This means living wills, power of attorney for health care and other written health care directives signed in the past no longer apply.
- It is just as important for an individual who wants to initiate or continue medical treatment to leave written instructions as it is for individuals who have other preferences.
- A health care directive does not require an attorney to complete. Suggested forms and suggestions for completing are included with this toolkit to help you put your wishes in writing.
- It is illegal for a health care provider to require you to complete an advance directive. Health care providers *are* required to tell you about advance directive laws in Minnesota and note whether or not you have an advance directive in your medical file.
- Laws regarding advance directives are not the same in all fifty states in the United States. If you spend a great deal of time in another state, or move to another state, be sure you understand the laws.

Complete a Health Care Directive: Step-by-Step Suggestions

Part I: Name an Agent

Go to Form

Review the Agent's Duties

When naming a health care agent, select someone who is at least 18 years of age and, when possible, someone who:

- You trust.
- Has similar beliefs and values about medical care and death or dying OR is willing to carry out your wishes even if they are different from his or her own.
- Is not easily intimidated by family members, friends, or health care providers.
- Will be an advocate for your interests.

- Can cope with making difficult life and death decisions including making decisions which would allow you to die.
- Can make decisions under stress.

Before naming an agent or alternate agent, talk with each person to be sure he or she is willing to:

- Serve as your health care agent
- Take time to understand and talk about your wishes
- Follow your instructions or act in your best interest

Go to Form

Decide if Agents Will Act Alone or Act Together

If you want the individuals you name to act alone when making health care decisions:

- Check the box by the first statement (page 1).
- Name your primary health care agent (page 2).
- You are encouraged to name at least two alternate agents to speak for you if the agent you name is unable, unwilling, or unavailable when needed (page 2).

If you want to name more than one person — a spouse, adult children, or other family or friends — to act together and agree on what health care decisions should be made:

- Check the box by the second statement (page 1).
- List the names using the spaces provided for primary agent and alternate agents (page 2). Attach additional pages if more than three individuals are named.

Keep in mind that a group of people may find it difficult to be available, to agree, or to understand or carry out a patient's preferences or wishes. If you appoint two or more persons as your health care agent, you need to:

- Say how you want decisions made.
- Offer suggestions on what should be done if there are disagreements. Additional instructions beyond the statement you checked on page 1 can be attached.

Go to Form

How to Name a Health Care Provider as your Agent

You cannot appoint a health care provider or employee of a provider giving direct care to you when you complete this form or when decisions need to be made unless you meet one of these requirements:

- You are related to that person by blood, marriage, adoption, or registered domestic partnership.
- You state *why* you want that person to serve as your health care agent. (Complete the section on page 2).

Powers of Agent

Go to Form

Minnesota law allows your agent to make the same types of health care decisions that you would be able to make.

Go to Form

In addition, you may want to give your agent power over some related health care decisions. Check the box in front of each statement if you want your agent to have the power explained. Your health care agent is NOT automatically given these powers. Please note:

- You may prefer to have someone else make your health care decisions. In Minnesota, you can have your agent make decisions for you even when you are able to make and communicate your own health care decisions. If you want to do this, check the appropriate box in the "Additional Powers of My Agent" section.
- In Minnesota, if you name your spouse or registered domestic partner as an agent, it is assumed that you would NOT want that individual to continue as your health care agent if a dissolution, annulment, or termination of the relationship is in process or has been completed.

Go to Form

You may limit the powers you want your agent to have. Use the space provided (page 3). You should carefully consider the effect of limiting your agent's powers on his/her ability to make informed decisions regarding your care.

Part II: Leave Health Care Instructions

Why Leave Instructions?

If you did not appoint an agent in Part I, you MUST leave some instructions in Part II for your health care directive to be valid.

Leaving instructions helps make sure that decisions are based on your values, preferences, and wishes. While making health care decisions is never easy, knowing what a person does or does not want helps decision makers feel as if they are making the "right" decisions.

How to Leave Instructions

DO leave instructions which help others understand your health care goals, fears, concerns, and what you want as well as do not want. It is impossible to predict what specific types of health care decisions might be needed.

Go to Form

You may leave health care instructions by doing any of the following:

- Fill in the space provided in the Health Care Directive (page 3 on our form).
- Write out your wishes on a piece of paper.

Go to Form

- Use and attach the Health Care Instruction Worksheet provided with this toolkit.

DO NOT leave instructions asking for illegal practices in Minnesota. This includes:

- Assisted suicide, mercy killing, or euthanasia.
- Health care treatment that is outside of reasonable medical practice.

Go to Form

Completing the Health Care Instructions Worksheet

If you choose to use the worksheet provided with this toolkit, it will ask you specific questions about your health care values and preferences including:

- What is most important for others to consider.
- What are your feelings about specific medical treatments.
- How should your religious or spiritual beliefs influence your care.
- What are your beliefs about quality and length of life.
- What are your wishes for care when dying.
- What are your preferences regarding organ and tissue donation. (For more information about organ donations, visit www.organdonor.gov/.)

You do not have to complete all of the questions or blanks on the worksheet. Complete only those you feel will help others understand your personal wishes.

Do not be surprised if you find some of the questions hard to answer at first. Take time to think about and complete the worksheet. Try out your answers by talking about them with family and friends. If needed, gather more information from clergy, a religious or spiritual adviser, or health care providers until you feel comfortable with your answers. Remember that there are no right or wrong answers. What is right for someone else may not be right for you.

Part III: Making the Document Legal

Go to Form

To make the document legal:

- Print a copy if needed and proof. All signatures and dates need to be added "by hand" on your final copy.
- Talk with the agent and alternate agents to make sure they are willing to serve.
- Check to make sure you have completed either Part I or Part II, or both Parts I and II.

Go to Form

- Have the document signing witnessed by a notary public or two individuals.
  - Neither of the witnesses or the Notary Public can be named as your agent or alternate agents.
  - Only one of the witnesses can be someone who is a direct care provider or employee of a provider on the day this form is signed.
  - A signature can also be any mark you choose (such as an "X"). If you are unable to write, the document can be signed for you by someone you ask.

Distribute Copies

Give copies of your health care directive to family, friends, and health care providers so that your preferences will be known when needed. Copies (as well as originals) of the form are valid. Copies should be placed:

- In your medical record where you receive care. Ask your physician to make sure your health care directive is on file.
- With health care providers such as physicians, hospitals, home care, hospice. Start a discussion with your physician and share your preferences. Are your care providers willing and able to carry out your wishes?
- With named health care agents and alternate agents. Help your decision makers understand their responsibilities and powers.
- With family members and close friends. Inform those important to you that you have completed a health care directive, where it is, and who you have chosen as your decision makers.

DO NOT keep your health care directive in a safe deposit box where it would not be available in an emergency.

Indicate you have a health care directive on your Minnesota driver's license or other sources of identification in your wallet or billfold.

Keep Planning Record

Keep a master list of who has copies of your health care directive. It will be easier to make sure everyone is kept up-to-date if and when changes are made.

Copies of my Health Care Directive have been given to:

_____	_____
_____	_____
_____	_____

Review and Update

You can change or revoke your Health Care Directive as long as you are able to make and communicate your own health care decisions. Your most recently dated directive should be followed.

My most recent Health Care Directive was completed on _____
(month/day/year)

It is not uncommon for individuals to change their opinions about who they want as agents or about specific health care instructions. Review your Health Care Directive on a regular basis, especially when there are changes in:

- Your health status.
- Your state of residence given differences in state laws.
- The availability of individuals named as health care agent or alternate agents.

Additional copies of the Minnesota Health Care Directive Planning Toolkit and related forms can be found at http://z.umn.edu/mnhcdirective/. Users can choose to print the toolkit and complete by hand, OR download a fillable PDF and complete electronically and keep it on your personal computer for future updating.
In accordance with the Americans with Disabilities Act, this resource is available in alternative formats upon request. Direct requests to 612-626-6602.

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Minnesota Health Care Directive

Purpose

This form contains the following parts:

- Part I Allows you to appoint another person (an "agent") to make health care decisions if a doctor decides you are unable.
- Part II Allows you to give written instructions about your wishes.
- Part III Requires you and others to sign and date to make this legal.

This form revokes all past living wills, Durable Powers of Attorney for Health Care, and other advance health care directives you have signed.

My Personal Information

My name: _____
Address: _____
_____
Preferred phone: _____
Alternate phone: _____
Date of birth: _____

Part I: Name an Agent

Agent Duties

Go to Instructions

My health care agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions in Part II of this document or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

Agent Roles

Go to Instructions

When naming my health care agent, I must choose one of the following. *Check the box by the statement you prefer.*

Act alone

☐ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.

Act together

☐ I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

Agent Contact Information

My primary health care agent

I appoint:
Agent's name: _____
Address: _____
_____
Preferred phone: _____
Alternate phone: _____

My first alternate health care agent

Agent's name: _____
Address: _____
_____
Preferred phone: _____
Alternate phone: _____

My second alternate health care agent

Agent's name: _____
Address: _____
_____
Preferred phone: _____
Alternate phone: _____

(If needed) Reasons for Naming Health Care Provider

Go to Instructions

I have named as my agent a health care provider, or employee of a health care provider, who is currently (or may in the future) be providing direct care to me when decisions are needed. *Check the statement that applies.*

☐ That person is related to me by blood, marriage, registered domestic partnership, or adoption.

☐ My reasons for wanting to appoint that person as my agent are *(fill below):*

Powers of My Agent

Go to Instructions

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure.
- Stop or not start health care which is keeping or might keep me alive.
- Choose my health care providers.
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.

Additional Powers of My Agent

Go to Instructions

If I WANT my agent to have any of the following powers, I must check the box by the statement.

I also authorize my agent to:

- ☐ Make health care decisions for me even if I am able to decide or speak for myself.
- ☐ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.
- ☐ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.
- ☐ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.
- ☐ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

Limiting the Powers of My Agent

Go to Instructions

I wish to limit the powers of my health care agent in the following way(s):

Go to Instructions

Part II: Give Health Care Instructions

I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments, concerns, fears, etc.):

Go to Form

I am attaching additional instructions concerning my health care values and preferences.
Check one: ☐ Yes ☐ No

I authorize donation of organs, tissue, or other body parts after my death.
Check one: ☐ Yes ☐ No

Part III: Make this Document Legal

My Signature/ Mark and Date

Go to Instructions

I agree with everything in this document and have made this document willingly:

My signature: _____

Date: _____

(month/day/year)

Notary Public OR Witnesses

Notary Public

NOTE: Must not be named as agent or alternate agent.

Go to Instructions

STATE OF MINNESOTA

County of _____

This document was signed or acknowledged before me this _____ (day)

of _____, _____by the above named principal.

(month) (year)

_____

Signature of Notary Public

Two Witnesses

NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.

Witness 1 Signature: _____

Address: _____

_____

Date: _____

(month/day/year)

Witness 2 Signature: _____

Address: _____

_____

Date: _____

(month/day/year)

Health Care Instructions Worksheet

This worksheet fulfills Part II of Minnesota Health Care Directive.

My Health Care Goals

Go to Instructions

Having a sense of what is important to you can help your decisionmakers make health care decisions under different and complex circumstances. Read each statement below and on a scale of "0" to "4," rate and select how important each of the health care goals are to you. In this case, "4" means "Extremely Important and "0" means "Not Important At All." Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

My Health Care Goals	Not Important	Somewhat Important			Very Important
	0	1	2	3	4
How Important Is Pain Control?					
Being as comfortable and free from pain as possible					
Having pain controlled, even if my ability to think clearly is reduced					
Having pain controlled, even if it shortens my life					
How Important Is the Use of Life Prolonging Treatment When:					
I have a reasonable chance of recovering both physically and mentally (50/50+)					
I have some physical limitations but can socially relate to those I care about					
I can live a longer life no matter what my physical or mental health					
I have little or no chance of doing everyday activities I enjoy					
I am not able to socially relate to those I care about					
I have a terminal illness and treatment will only prolong when I die					
I have severe and permanent brain injury and there is little chance of regaining consciousness					
I have severe dementia or confusion and my condition will only get worse					
How Important Are Finances and Health Care?					
Having my wishes followed regardless of whether or not my finances are exhausted					
Not being a financial burden to those around me					
Not having my health care costs affect the financial situations of those I care about					

My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you, given your current as well as future health conditions.

Medical Procedure	When this is Used	My Feelings About this Procedure
Intubation A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure	You are intubated when you cannot breathe on your own. A breathing tube is placed in your mouth – to your lungs – and is attached to a ventilator. You cannot talk or eat by mouth if you are intubated. For long term needs, a tracheostomy (a breathing tube placed in your neck) may be needed.	
Nutrition support and hydration	If you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR) A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	CPR is used if your heart and lungs stop working. CPR can include chest compressions, defibrillation (electric shock), medications, and/or a tube in your throat.	
Dialysis	If your kidneys are not working, a dialysis machine can be used to clean your blood. You may need to be hooked up to this machine several hours a day.	

My Additional Health Care Goals and Instructions

My decision makers should also know these things about me to help them make decisions about my health care.

I am concerned about…

I have a fear of…

I hope that my end of life care will…

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious/spiritual beliefs should affect my health care:

My religion/spirituality is: _____

My congregation/spiritual community is (name, city, state): _____

_____

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. ☐ Yes ☐ No

Contact Information (name/phone number): _____

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

- ☐ At home.
- ☐ At a hospital. Which one? _____
- ☐ At a nursing home. Which one? _____
- ☐ Through hospice services/care. Which one? _____
- ☐ From other health care providers. Which ones? _____

Other wishes I have about my care if I am dying:

My Feelings about Quality and Length of Life

I have the following beliefs about whether life should be preserved as long as possible:

The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

My Wishes about Donating Organs, Tissues, or Other Body Parts

Check the statements that apply to you:

☐ I DO NOT wish to donate organs, tissue, or other body parts when I die.

☐ I DO wish to donate organs, tissue, or other body parts when I die.

- ☐ Any needed organs, tissue, or other body parts.
- ☐ Only the following listed organs, tissue, or body parts: _____

_____

Limitations or special wishes I have include:

My Signature

I agree that these are my health care instructions and have completed this willingly.

My signature: _____

Date completed: _____
(month/day/year)

This worksheet is an attachment to my Health Care Directive:

Check one box: ☐ Yes ☐ No