***It Always Seems Too Early***

***Until It's Too Late:***

***Conversations That Matter***

***About Being Mortal***

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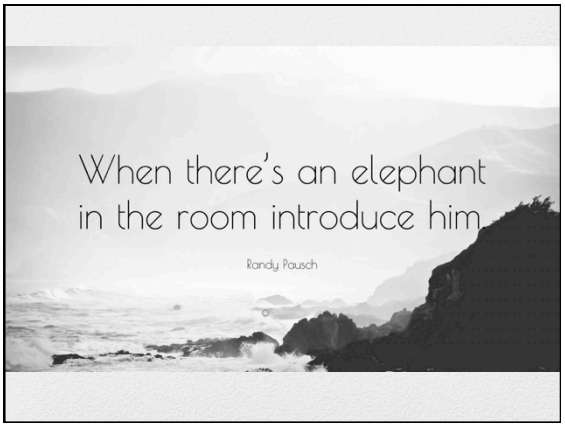

## Four Most Common End of Life Decisions (the "Hard Choices")

- 1. Should CPR be attempted?
- 2. Should artificial nutrition/hydration be utilized ?
- 3. Where do I prefer to receive care (LTCF, hospital, hospice) & by whom?
- 4. Is it time to shift goals of care from curative to comfort care (Allow Natural Death, aka AND)?

## Three Specific Issues for Basic Advance Care Planning

- Who would you want to make decisions if you couldn't?
- What would be the goals of treatment if you permanently lost the ability to meaningfully know who you were, who you were with, or where you were?
- Do you have any religious, personal, or cultural views that would affect treatment choices?

Respecting Choices®



## Why is Advance Care Planning Important?

Efforts to prolong life can create experiences of suffering

The more treatments we use, the greater the risk of complications

Indecision is costly both to families & to society

Feelings of trust & security can increase

Support resources can be identified & utilized

Families involved in care planning can become closer & may adjust to change - & eventual loss - more easily

## The Value of Advanced Care Planning

Involves thinking about, discussing, and documenting the **"what ifs"** (the possibilities we'd prefer to avoid thinking about):

- **What if** I develop a terminal illness or I'm critically injured?
- **What if** I'm told I have a short time to live?
- **What if** I can't communicate what I want and don't want?
- Whom do I trust to be my advocate?

## Advanced Care Planning & Health Care Directives

**A process of shared decision making**

- Advance care planning can help to assure that decisions continue to be made consistent with your values & preferences.
- A Health Care Directive is a tool to communicate your values, preferences, goals & wishes at End of Life (EoL).
- A Health Care Directive is a statement of your personal preferences for future treatment & care which is to be used in the event of your inability to make decisions &/or communicate your decisions.
- **About 80% of Americans think that completing a Health Care Directive is a good idea; less than 20% have completed one.**

## Most People Don't Complete a Health Care Directive

### Why?

- reluctant to discuss EoL (superstitions)
- reluctant to "upset" or "burden" loved ones with "depressing" conversation
- cultural and ethic differences re. Health Care Directives
- indecision about one's own wishes and preferences
- concern that "I might change my mind! Then what?"

**The conversations may be more important than the plan itself. Decision-making is more of a journey than a destination.**

## Denial Springs Eternal?


## Common Elements of a Good Death

- Adequate pain and symptom management
- Avoiding a prolonged dying process
- Clear communication about decisions by me, my family and my physician
- Adequate preparation for death, for both me and my loved ones
- Feeling a sense of control
- Finding a spiritual or emotional sense of life completion
- Affirming and supporting me as a unique and worthy person
- Strengthening relationships with loved ones
- Not being alone

**The Hastings Center Report**

## Minnesota's Health Care Directive

- Established August 1, 1998
- Eliminated "living wills" & "durable powers of attorney for health care"
- Prior documents continue to be valid
- Eliminated "terminal condition" requirement

## Minnesota's HCD

- Forms: none required
- Documents from other states valid if valid there or here
- MN document may or may not be valid in other states
- Can incorporate other instructions
  - Funeral directive
  - Organ donation
  - Nomination of guardian
  - Psychiatric directions

## MN's Health Care Directive: Six Required Elements

- In writing
- Dated
- States your name
- Completed by you when you have the decisional capacity to do so
- Your signature is verified by notary or witnesses
- Allows for either health care instructions or designation of agent or both

## Minnesota's HCD

- May have two or more agents simultaneously, but not recommended
- Should have alternate agents
- May make effective even when you retain health care decision making capacity
- Addresses decisions about where care will be provided (Home, IP, LTCF, Hospice, etc.)
- Give copies to MD, agent(s), & other significant persons

## Questions that Loving People Need to Ask

- What is the goal of my medical care at this time and in this phase of my life?
- What do I want? ("Living well" & "good death"?)
- What is the prognosis and probable consequence of treatments (risks and benefits)?
- **Can I let go & let it be?**

***The future depends upon what we do in the present.***

*Mahatma Gandhi*