Respecting Choices® at Beaumont

ADVANCE DIRECTIVE

Beaumont

CONTENTS

INTRODUCTION

RESPECTING CHOICES AT BEAUMONT ADVANCE DIRECTIVE

LEGAL SECTION

RECOMMENDED INFORMATION FOR YOUR PATIENT ADVOCATE AND HEALTH CARE TEAM

OPTIONAL SECTION

These forms may be scanned into your electronic health record to assist your patient advocate and physician in understanding your health care wishes and values.

Let's Have A Conversation

Advance care planning begins with a conversation. Respecting Choices at Beaumont certified facilitators are available to guide you through the process. It involves sharing your values and beliefs with your chosen patient advocate and doctor. Successful completion results in an advance directive legal document.

It may not be easy to complete an advance directive but millions of people have done it successfully and you can too.

WHAT IS ADVANCE CARE PLANNING?

Beaumont Health has partnered with Respecting Choices, an internationally recognized, evidence-based model of advance care planning that creates a health care culture of person-centered care that honors an individual's goals and values for current and future health care.

Respecting Choices at Beaumont certified facilitators are available to assist you in the completion and review of your advance directive. Discussing your preferences is part of good healthcare so your physician can always be guided by your known wishes and beliefs. We encourage you to learn more about this important topic.

This approach to conversations recognizes that advance care planning is not a "one size fits all" process. You may also choose to complete additional documents which provide insight to your values and additional instructions for your designated patient advocate and health care team.

At your request, your advance directive document will be entered into Beaumont's electronic health record system so it is available at any campus or practice location that shares the same electronic health record.

As you consider your advance care plan, we know that the conversation and process may take some time. Your Respecting Choices at Beaumont facilitator can be with you every step of the way.

Respecting Choices®
PERSON-CENTERED CARE

WHAT IS AN ADVANCE DIRECTIVE?

The advance directive is a legal document that describes your specific preferences for medical treatments in case you are unable to do this. Your advance directive, also called a Durable Power of Attorney for Health Care, will only be used if you become so sick or injured you cannot communicate your wishes yourself. The advance directive starts with listing a patient advocate to make decisions for you when you are no longer able and includes additional documentation regarding preferences for cardiopulmonary resuscitation (CPR), life support and organ donation.

You will name a legal representative for yourself, also known as a patient advocate. Your patient advocate should be someone you trust, who is available when you call, and will be comfortable making medical decisions for you when you are unable to make them for yourself. You and your patient advocate should have a conversation on your wishes outlined in your advance directive. Your patient advocate should be expected to follow your instructions even if they do not agree with those instructions.

By describing your general goals of care and your treatment preferences in your own words, the advance directive document helps your health care team and patient advocate better provide the type of care that you truly want. You can change this document at any time.

Reviewing your advance directive annually with your doctor, health care team and patient advocate, as well as every time you enter a health care facility will keep it up to date with your values. You can update or cancel it at any time.

Additional online worksheets that provide guidance to your patient advocate and healthcare team can be found at **beaumont.org/respecting-choices**.

Additional online worksheets:

- What Makes Life Worth Living
- Breathing Tubes/Intubation
- Feeding Tubes/Nutrition
- Wakefulness versus Comfort
- Blood Transfusion

SHARING YOUR WISHES AND CHOICES

DISCUSS, DISTRIBUTE AND REVIEW AFTER COMPLETING YOUR ADVANCE DIRECTIVE:

- Let your family and close friends know you have completed this document. Let them know who your patient advocate(s) are and what your health care wishes are. Let them know these are your decisions and not merely your requests.

- Give copies of your completed advance directive to the people you listed on the information page of your advance directive (page one of your advance directive).

- Take a copy of your advance directive with you whenever you are admitted to a hospital or skilled nursing facility (nursing home or rehabilitation center). Ask that your advance directive be entered into your electronic health record. You can also upload your document to your electronic health record through MyChart, email advancedirectivefax@beaumont.org or fax 947-522-0473.

- Keep a copy of your advance directive where it can be easily found.

- Your advance directive can be updated anytime by completing and dating a new one. You can update or change this document yourself or contact Respecting Choices at Beaumont to assist you. If changed, the advance directive must be witnessed and signed again, then give new copies to everyone who has an old copy.

- You can always change your mind about the care you want and about who your patient advocate is. Let your healthcare team know if you want to change your advance directive. You can also contact Respecting Choices at Beaumont.

Respecting Choices® at Beaumont Wallet Card

Please complete the wallet card. Write the names and phone numbers of your advocate(s).

Cut along dotted line

Patient Advocate
Name: _____
Phone: _____

Successor advocate 1
Name: _____
Phone: _____

Successor advocate 2
Name: _____
Phone: _____

Fold here

Respecting Choices® at Beaumont

I have an advance directive.

See back of this card for my advocate(s) information.

_____
Signature

LEARN MORE ABOUT RESPECTING CHOICES AT BEAUMONT

What is a Respecting Choices at Beaumont certified facilitator?

A Respecting Choices at Beaumont facilitator is someone who can help guide you through advance care planning conversations. You and others you choose to participate can discuss your experiences and what living well means to you. The conversation results in the creation of an advance directive that identifies and reflects your individualized goals of care.

Respecting Choices at Beaumont in your community.

Respecting Choices at Beaumont speakers are available to talk to any size group on advance care planning at no charge throughout the metro area. To request a speaker, please contact us at **respectingchoices@beaumont.org**.

Would you like to have a group facilitation?

Respecting Choices at Beaumont facilitators can guide groups through the advance care planning process and the creation of an advance directive. Please email us at **respectingchoices@beaumont.org**.

Want to volunteer with Respecting Choices at Beaumont?

Learn more about becoming a Certified Respecting Choices at Beaumont facilitator and other volunteer opportunities at **respectingchoices@beaumont.org**.

This document, the durable power of attorney for health care, is for medical decisions only. A different power of attorney form is required if you wish to designate someone to make financial decisions for you. A financial power of attorney document does not allow that advocate to make medical decisions for you. Be sure you understand the difference between a medical power of attorney and a financial power of attorney.

IF YOU NEED ADDITIONAL INFORMATION, or would like a certified facilitator to call you, please contact us at:

Phone: 947-522-1948

Email: respectingchoices@beaumont.org

Website: beaumont.org/respecting-choices

KEEP WITH LEGAL DOCUMENT

RESPECTING CHOICES AT BEAUMONT – ADVANCE DIRECTIVE

Information Page

Patient's Full Name *(please print)*:_____

Today's date:_____

Date of birth:_____

Mailing address:_____

Phone(s) Home: _____Cell: _____Work: _____

Email:_____

I have given copies of my advance directive to:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Be sure to include your patient advocate, alternate patient advocates and physician. Consider including your healthcare organization, as well as other friends and family. Remember to keep a copy for yourself.

You can make changes to your advance directive at any time.
We recommend you update your document every few years, or follow the 5D rule:

- Every new *decade* of your life.
- After the *death* of a loved one.
- After a *divorce.*
- After any significant *diagnosis.*
- After any significant *decline* in functioning.

LEGAL DOCUMENT

Durable Power of Attorney for Health Care – Patient Advocate Designation

This is a legal document. I am naming a patient advocate who will speak on my behalf only if I cannot speak for myself or become unable to participate in making medical (as determined by my physician and one other physician or licensed psychologist) or mental health (as determined by my physician and mental health practitioner) decisions. My patient advocate has no authority to make decisions on my behalf at any time that I am able to participate in these decisions for myself. I authorize this document to be included as part of my medical record and given to my patient advocate and my health care provider as well as to successor advocates and health care systems where I receive care.

Patient Advocate Designation

I _____, living at _____
(patient's full name) *(patient's address)*

am over the age of 18, of sound mind and I voluntarily choose the following as my patient advocate or successor advocate to make health and care decisions for me if, and only if, I am unable to participate in these decisions myself. I understand I can change my mind at any time by communicating in any manner that this choice no longer reflects my wishes.

I choose the following person as my patient advocate

Name:_____ Relationship:_____

Address:_____ City:_____ State:____Zip: _____

Phone(s) Home:_____ Cell: _____ Work:_____

Email: _____

If my Patient Advocate does not accept the appointment, is unwilling, unavailable or unable to act as my Patient Advocate then I want this person to be my:

First alternate (successor) patient advocate:

Name: _____ Relationship:_____

Address: _____ City:_____ State:____Zip: _____

Phone(s) Home: _____ Cell: _____ Work:_____

Email: _____

Second alternate (successor) patient advocate:

Name: _____ Relationship:_____

Address: _____ City:_____ State:____Zip: _____

Phone(s) Home: _____ Cell: _____ Work:_____

Email: _____

**You may choose to name additional alternate (successor) patient advocates.*

LEGAL DOCUMENT

Patient Signature

Must be signed and dated in the presence of two witnesses

My signature below applies to all pages of this document, including 'Acceptance by patient advocate/ successor patient advocate' found on page 5. I want the people selected in this document to be my patient advocate and successor patient advocate(s). I am making this decision because this is what I want, NOT because I am being forced by anyone in anyway. I understand that I may revoke this patient advocate designation at anytime and in any manner that communicates my intent to revoke.

PATIENT SIGNATURE:_____ **Date:**_____

Address:_____ City:_____ State: ____ Zip: _____

Power Regarding Life Sustaining Treatment-Optional:

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my natural death.

PATIENT SIGNATURE:_____ **Date:**_____

(sign your name if you wish to give your patient advocate this authority)

Witness Statement

I declare that the person who signed this document signed it in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence.

I am NOT:

- The person appointed as the patient advocate by this document.
- Under the age of 18 years.
- Related to the patient by blood, marriage or adoption.
- The patient's physician or health care provider.
- An employee of a healthcare facility or community mental health program that is treating or caring for the patient.
- An employee of a life or health insurance provider for the patient.
- To the best of my knowledge, a creditor of the patient or entitled to any part of his/her estate under a will now existing or by operation of law.

WITNESS ONE SIGNATURE:_____ **Date:** _____

Name *(please print)*:_____

Address: _____ City:_____ State: ____ Zip: _____

WITNESS TWO SIGNATURE:_____ **Date:** _____

Name *(please print)*:_____

Address: _____ City:_____ State: ____ Zip: _____

LEGAL DOCUMENT

Mental Health Treatment Decisions – Optional

☐ I choose not to complete this section.

Complete this section to authorize your patient advocate to make treatment decisions if a physician and a mental health professional determine that you cannot give informed consent to mental health care.

My preference of physician and mental health practitioner to evaluate my ability to make my own mental health treatment decisions are the following:

Physician name: _____

Office address: _____ Phone: _____

Mental health practitioner name: _____

Office address: _____ Phone: _____

I understand if the above designated individuals are not available to make the determination, my treatment team will identify other practitioners who are able to do so. Whenever possible, my preference and that of my patient advocate will be considered.

What follows is a list of treatment options. I can choose one or more choices, by initialing next to the options that I want to give my patient advocate power to consent to:

_____ Outpatient therapy.
initials

_____ My admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days' notice of my intent to leave the hospital.
initials

_____ My admission to a hospital to receive inpatient mental health services.
initials

_____ Psychotropic medication.
initials

_____ Electro-convulsive therapy (ECT).
initials

Power Regarding Mental Health Treatment-Optional:

I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

PATIENT SIGNATURE:_____ **Date:**_____
(sign your name if you wish to give your patient advocate this authority)

PATIENT SIGNATURE:_____ **Date:**_____

LEGAL DOCUMENT

Acceptance by Patient Advocate and Alternate (Successor) Patient Advocates

I agree to be the patient advocate for_____, I accept the responsibility
(patient's name)
and agree to take reasonable steps to follow the desires and instructions of the patient as outlined in this document and as I may have discussed verbally with the patient. If I am unable to act after reasonable efforts to contact me, a successor patient advocate, in the order designated by the patient, shall act until I become available.

By signing this acceptance, I acknowledge that I am accepting the responsibility to act on behalf of the patient and make decisions consistent with the patient's expressed wishes and best interests. I also understand that signing this acceptance does not obligate me to become financially responsible for the patient or for the cost of the patient's care. Further, I understand and agree that as patient advocate:

A. My authority shall not become effective unless the patient is declared by physicians to be unable to make medical and/or mental health treatment decisions.

B. I cannot exercise any powers concerning the patient's care, custody, medical or mental health treatment that the patient could not have exercised for himself/herself.

C. I cannot make a decision to withhold or withdraw care from a patient who is pregnant if that decision would result in the patient's death.

D. I may make a decision to withhold or withdraw treatment which would allow the patient to die only if the patient has expressed in a clear and convincing manner that I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

E. I cannot receive compensation for serving as patient advocate, but I may be reimbursed for any actual and necessary expenses incurred on behalf of the patient.

F. The patient can revoke my authority to act as patient advocate at any time and in any manner sufficient to communicate an intent to revoke.

G. If the patient has waived his or her right to revoke my authority to make mental health treatment decisions, then revocation as to any mental health treatment will be delayed for 30 days after the patient expresses his or her intent to revoke.

H. I may revoke this acceptance at any time and in any manner sufficient to communicate my intent to stop acting as patient advocate.

I. I must act in accordance with medical and legal standards that require me to make decisions in the best interests and for the benefit of the patient. The known desires of the patient expressed or evidenced while the patient is able to participate in making his or her medical and/or mental health treatment decisions are presumed to be in his or her best interests.

J. If authorized by this document to make an anatomical gift, my authority remains exercisable after the patient's death.

K. A patient admitted to the hospital has the rights enumerated in section 20201 of the Michigan Public Health Code (MCL 333.20201).

PATIENT ADVOCATE SIGNATURE: _____ **Date:**_____

ALTERNATE (SUCCESSOR) PATIENT ADVOCATE SIGNATURE (optional):

_____ **Date:**_____

RESPECTING CHOICES® AT BEAUMONT – ADVANCE DIRECTIVE

OPTIONAL PAGE

Recommended Information for Your Patient Advocate and Health Care Team

My Cultural or Spiritual Considerations

☐ I choose not to complete this section.

I want my loved ones and health care team to know the following about my religious, cultural or spiritual beliefs:

My religious, cultural or spiritual beliefs are:

As I am nearing my death, the following is important to me:

Upon my death, the following is important to me:

Additional comments:

PATIENT SIGNATURE: _____ **Date:** _____

OPTIONAL PAGE

Recommended Information for Your Patient Advocate and Health Care Team

Exploring Your Goals of Care for a Severe, Permanent Brain Injury

☐ I choose not to complete this section.

There is one decision every person should think about. Imagine this scenario: a sudden event (such as a car accident or illness) left you unable to communicate. You are receiving all the care needed to keep you alive. The doctors believe there is little chance you will recover the ability to know who you are or who you are with.

In this situation, would you want to continue medical treatment to keep you alive? Or would you want to stop medical treatment? In either case, you would be kept comfortable.

> *It is recommended that a Respecting Choices at Beaumont certified facilitator guide you and others you invite to participate, through your conversation. It is important to explore these questions, your experiences, and what living well means to you. This process allows for a better understanding of your values and decisions made in your advance directive.*

As a result of permanent brain injury, if I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my patient advocate to:

Check the box beside the statement you agree with:

☐ **I want to continue or start treatment** to keep me alive, unless my doctor(s) determines the treatments would be more harmful to me than helpful.

OR

☐ **I want to decline or cease all treatments**, including but not limited to: feeding tubes, including intravenous (IV) hydration, and respirator/ventilator, if I suffer this type of condition. In my view, the potential benefits of supportive medical treatments are outweighed by the burdens of these treatments.

PATIENT SIGNATURE: _____ **Date:** _____

OPTIONAL PAGE

Recommended Information for Your Patient Advocate and Health Care Team

CPR – Cardiopulmonary Resuscitation

☐ I choose not to complete this section.

If my heart stops beating and I am no longer breathing, CPR may be started to try and restart them. CPR includes chest compressions to restart circulation, electrical shocks to restart a heartbeat, and insertion (intubation) of a tube through the mouth and into the trachea to allow for mechanical ventilation and artificial breathing. Without CPR, death will occur naturally.

CPR FACTS:

There may be times when CPR cannot be offered, as it can be unhelpful or even harmful. If my attending physician or other intensive care physician caring for me believes that in keeping with sound medical practice CPR will not help, it will not be offered. In such circumstances my patient advocate will be notified of this decision.

- *CPR is most successful in younger and healthier patients.*
- *In patients who are older with other chronic illnesses, the chance of survival is less than 5%. The chance of surviving to one's previous quality of life is even lower.*
- *In older patients with Alzheimer's disease, Parkinson's disease, end-stage heart, kidney or lung disease, or advanced cancer, survival rate falls to as low as 1% with a dramatic decrease in the quality of life. Going home or living independently is very rarely possible.*

If my heart stops or my breathing stops...

Check the box beside the statement you agree with:

☐ **I want CPR** unless my doctor(s) determines:

- I have a medical condition with no reasonable chance of survival with CPR.

OR

- CPR would be more harmful than helpful.

☐ **I do not want CPR**, instead I wish to allow a natural death.

PATIENT SIGNATURE: _____ **Date:** _____

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RESPECTING CHOICES® AT BEAUMONT – ADVANCE DIRECTIVE

RESPECTING CHOICES® AT BEAUMONT:
OUR PROMISES TO YOU

We will initiate the conversation.

We will provide assistance with advance care planning.

We will make sure plans are clear.

We will maintain and retrieve plans.

We will appropriately follow plans.

To speak with a certified facilitator, request an advance care planning speaker or learn about volunteer opportunities, **please contact us at:**

Phone: 947-522-1948

Email: respectingchoices@beaumont.org

Website: beaumont.org/respecting-choices

Upload your advance directive to your electronic health record through MyChart, fax: 947-522-0473 or email advancedirectivefax@beaumont.org

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