ADVANCE CARE PLANNING IN LONG-TERM CARE COMMUNITIES

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Background

Advance Care Plans (ACP) are court supported medical directives that enable individuals to make plans about their future health care. ACP's incorporate personal values, preferences, and can be made proactively with loved ones and healthcare providers. Without ACP's, full life sustaining treatment orders can lead to the administration of potentially unwanted intensive care, a higher burden of unrelieved physical symptoms and emotional distress, and a disproportionate amount of healthcare expenditures. Advance Care Planning (ACP) is a tool that can be used to reach concordance between preferred and delivered health care (Zwakman et al., 2018). Although it is widely accepted as an important method to improve end-of-life communication and quality of life for patients, their relatives, and health care providers; the frequency of ACP conversations in practice remains low (Zwakman et al., 2018).

ALG Senior is the largest provider of senior housing in the southeastern United States with more than 140 communities across 6 states serving over 7,000 residents. Based in Hickory, North Carolina, the vast majority of ALG Senior's portfolio focuses on providing affordable care for the middle market. The average ALG Senior resident is 83 years old, has multiple chronic health conditions, and an average length of stay of 23 months. Forty percent of ALG Senior's residents have an annual income of less than $20,000 and 60% receive government assistance. Due to the socio-economic demographic of the typical ALG resident, the project team determined that ACP was an integral piece of the treatment planning process that was often being overlooked.

At the inception of this project, ALG Senior communities were not routinely addressing ACP as a part of the admissions process. It was estimated that approximately 30% of residents had ACP's in place. Given the average age, length of stay and cost-conscious profile of the typical ALG Senior resident, this team determined that increasing the awareness and utilization of ACP by ALG Senior residents would be beneficial in a number of ways that help to increase the resident's quality of life while decreasing emotional stress on their loved ones.

Project Objective and Methods

The objective of this project was to increase the awareness and utilization of ACP's in long-term care (LTC) communities operated by ALG Senior. The project team consisted of a physician, psychologist, nurse, dementia specialist, and Human Resources representative from ALG Senior as well as a nurse from a local Hospice organization.

The project team began by holding weekly and bi-weekly project team calls. All relevant legal and medical documents pertaining to ACP in the State of North Carolina were collected and reviewed. The documents collected were the North Carolina Living Will form, the North Carolina Healthcare Power of Attorney (HPOA) form, the North Carolina Medical Orders for Scope of Treatment (MOST) form, and the North Carolina Do Not Resuscitate (DNR) form *(see appendices A – D).* Each form is unique in value for the person in which they are drafted. A living Will is a written statement detailing a person's desires regarding their medical treatment in circumstances in which they are no longer able to express informed consent. A MOST form is designated by its hot pink color in North Carolina to distinguish a doctor's order which helps the individuals maintain control over their medical care at end of life. The DNR form,

designated by its golden yellow color in North Carolina, is a medical document that instructs medical personnel to cease performing life-sustaining treatments such as cardiopulmonary resuscitation (CPR), endotracheal intubation and defibrillation. These forms are not entirely exclusive of each other. Both the MOST form and the Living Will are inclusive of elections for life-sustaining measures as well as medically administered fluids and nutrition. The MOST form also addresses antibiotic administration as well as hospital transfer and level of hospital care elections while the Living Will addresses an individual's acceptable quality of life as it pertains to life support measures and has an open-ended space for additional wishes. Because of the unique qualities of each of the forms, the project team determined that, for purposes of the project, Living Wills, NC MOST forms, and DNR forms would be counted as ACP's. HPOA forms were not counted as an ACP.

Three LTC communities operated by ALG Senior were identified for participation in the project based on their geographic location and a shared primary care provider for many of the residents. A Chair and Co-Chair were identified at each of the communities to ensure compliance with the projects procedures and maintain momentum by ensuring that new employees were educated on the importance of ACP. In addition to the identified key staff at the community level, the project team sought sponsorship from the Corporate Executive Team as well as the Divisional Vice President of Operations and Area Directors of Operations.

The local palliative care teams relevant to each community were identified. The Palliative Care teams were contacted and informed about the project. The project team invited the participation of the Palliative care teams who were eager to become involved. They were invited to the educational events, and their subsequent involvement was requested. All palliative care teams were supportive of the project and actively engaged in 1:1 consults with referred residents following the outreach events.

The project team also solicited the involvement of the primary care providers at each community but, despite palliative care consults being a billable service, were not successful in securing the involvement of any primary care providers.

Education regarding ACP was chosen as the intervention for the project. The project team explored various methods of educating residents, their relatives (or contact persons), and staff about ACP and determined that group education sessions were the most practical method. Group education was the chosen method for outreach as the project team hailed from various geographic regions and in person outreach required out of town travel. The project team did not believe that virtual education sessions would be accessible or embraced by the majority of the target audience as the identified LTC communities were located in rural areas of Western North Carolina.

The project question was identified as "Will group education sessions provided to residents, their relatives and staff increase the utilization of Advance Care Planning in the three identified LTC communities?"

Enhancement Activities

The project team met with key staff at the 3 identified LTC communities. The identified Chair and Co-Chair at each community were provided with a detailed description of the material that would

be presented to the residents, their relatives, and the remaining staff at the community, as they would be responsible for project implementation following the departure of the project team.

The project team held weekly conference calls with the chairs and co-chairs from the three pilot communities to review the progress of the project and plan the group education sessions. The chairs and co-chairs at all three communities believed that attendance at the group education events would be increased if refreshments were offered. As such, the project team secured funding from the corporate office budget to provide refreshments.

The project team designed an informational flier for the LTC communities to distribute to residents, their relatives and other relevant contact persons (*See appendix E*). The chair and co-chair at each community posted the flier on the community bulletin boards, social media pages, as well as mailed a hard copy of the flier to all relatives and contact persons of residents.

A PowerPoint presentation was created to introduce ACP and its benefits. The DNR form, MOST form, and Living Will were also introduced. An informational toolkit explaining each of the aforementioned documents was also provided by the project team's Hospice representative. A representative from the local palliative care team was present at each group education event and offered various education materials to participants. The project team also made various educational materials from the National Institutes for Health (NIH) available to attendees.

Educational outreach was provided to both community staff and families of residents. Residents were invited to participate in the educational outreach event with their relatives. Staff education events were held in the afternoon during shift change at each pilot community so both first and second shift staff has the opportunity to attend. The project team determined that for the purpose of the project, it was not necessary to provide the training to third shift staff as they have less involvement in care planning for residents. Family outreach events were held at 6pm in the form of "Family Nights" at each pilot community.

Light snacks and refreshments were provided at staff education events and heavy hors d'oeuvres and refreshments were provided at family education events. An assortment of deserts was also provided.

The educational outreach events were held on January 28-30, 2020. While conducting the first staff training, the project team realized that staff had experiences and questions unique to their role and the presentation would be more effective if it was separated into a staff version and a resident/family version. Due to the tight scheduling of the outreach events the project team was not able to create separate presentations. However, the team deviated as necessary from the presentation during the staff trainings to address their unique questions and concerns.

Though the primary metric for the project was the number of ACPs, the project team also wanted to get a pulse on the quality of the education sessions. A survey was created to track overall quality of the presentation, how informative and engaging participants perceived it to be, participants familiarity with ACP prior to the presentation, and the reported likelihood that a participant would create an ACP following the presentation.

Following the educational outreach events, each community committed to including ACP as a component of the admissions and treatment planning processes. Although residents and their contact

persons maintained choice as to whether they wished to take part in ACP, the introduction to and conversation regarding the process was included in each admission. Educational materials regarding ACP were also included in each admissions packet. ACP planning was also integrated into regularly scheduled care plan meetings as well as care plan meetings that were scheduled due to a change in resident health status.

The palliative care teams were an integral component of the project. They continued to offer educational services to the residents and their relatives and were actively engaged by conducting 1:1 consultation with interested residents and their relatives and the palliative care nurse practitioner.

Evaluation Method

The census, as well as number of ACP's on file in November 2019 were recorded for each pilot community. To determine the number of ACP's needed to achieve a 30% increase, the project team used the following formula:

census November 2019 (-) # ACP November 2019 = # (x) .30 = target number for 30% increase

Results

The goal for this project was to increase utilization of ACP's by 30% in each pilot community. The number of ACP's on file for each community on May 11, 2020 were compared to those from November 2019. The percentage increase was calculated using the following formula:

new # of ACP (-) original # of ACP (=) difference (÷) original # of ACP (=) percentage increase.

See Table A for results.

Table A

	ACP's November 2019	**ACP's May 2020**	**Target Increase ACP's**	**Actual Increase ACP's**	**Percent Increase**
Community 1	26	33	14	7	27%
Community 2	25	34	4	9	36%
Community 3	47	73	6	26	55%
Overall	140	98	24	42	43%

Discussion

The target outcome of a 30% increase in ACP's was achieved for two of the three pilot communities. Although the goal was not met for community 1, the goal was exceeded for community 2 and almost doubled for community 3. The project team believes that the difference in outcomes between communities, at least partially, can be attributed to the level of commitment by key staff at each community. Attendance was lowest at the outreach event for community 1. The project team also observed that while communities 2 and 3 posted the flier for the outreach event on social media about a month prior to the event as well as several times thereafter, community 1 only posted the event flier once, with no reminders in the month preceding the event.

Survey results indicate that, on average, participants arrived to our information sessions Moderately Informed on the topic of advanced care planning (average was 3.06, on a 1-5 rating where 1 indicated not at all familiar with topic and 5 indicated extremely familiar), but left with a high likelihood of taking action as a result of the session (Avg 4.67 on a 1-5 rating where 1 indicated very unlikely and 5 indicated the very likely to create an advanced care plan or make updates to an existing plan based on the information session).

A retrospective review revealed several factors that the project team believes could have affected the outcomes across the three communities. First and foremost, the project team believes that the global pandemic, Covid-19, negatively affected the outcomes for this project. The pilot communities and palliative care teams were actively engaged in the initial outreach events as well as follow up outreach and 1:1 consults the first month following the initial event. However, the Covid-19 pandemic drastically changed the daily operations of LTC communities across the globe. Face to face visits were no longer allowed for family and most healthcare appointments were conducted virtually as well. The project team understands that despite efforts made by the community staff to address ACP at admission and during the care planning process, it is likely to have been overlooked more often that it would have been had the communities not been faced with a pandemic. Paradoxically, although Covid-19 has resulted in an insurmountable amount of regulatory modifications and time-consuming responsibilities for LTC communities, the project team believes that, in light of the pandemic, ACP is more salient now than ever before. With this in mind, it is the opinion of the project team that, in the long-term, the global pandemic may actually prompt an increased focus on ACP in LTC settings.

In addition to the effects of Covid-19 on the pilot communities, the project team was also drastically affected by the pandemic. Sadly, two of the five members of the project team were furloughed at the end of March 2020 and the remaining team members assumed additional responsibilities following the furloughs. This caused considerable strain on the momentum of the project as remaining team members were now overwhelmed with additional responsibilities. One team member who was furloughed maintained commitment to the project on a volunteer basis.

The Covid-19 pandemic also affected the level of involvement the local palliative care organizations as opportunities for face to face contact were limited. 1:1 consults with palliative care teams are typically held in person and ACP's are often created during these appointments. Although palliative care consults were made available through telehealth, the project team believes that given the sensitive nature of the topic, as well as the rural locations of the pilot communities, engagement was lower than it would have been had face to face appointments been continued.

The project team also recognizes that the decision to use a group format for educational outreach may have affected participation. However, although some may have been deterred by the group education format, the project team also believes that those who attended the educational sessions may have benefited from the group setting by normalizing the ACP process and learning from others' questions and comments. In hindsight, the project team feels that the normalization of the ACP process is an integral component to increasing utilization of ACP. In fact, Zwakman et al., 2018, identified 'Readiness' as one of 3 themes in patients' experiences with ACP. While 'Readiness' for ACP was identified as a necessary prerequisite for experiencing the benefits from ACP, it was also noted that readiness can be promoted by the process of ACP itself.

Conclusions

The objective of this project was to increase the awareness and utilization of ACP's in long-term care (LTC) communities operated by ALG Senior. Although a quantitative goal was set for purposes of measurability, the project team believes that the increase in awareness surrounding ACP's also brings great value. While increasing the number of ACP's is an important goal, the project team hopes that those residents who do not have ACP's made an informed choice not to create one.

The project team believes that we may pivot the project to be more successful in a company-wide launch by embedding more community team members to champion the change, drive adoption, and sustain momentum. As a result of the project, ALG Senior also plans to build ACP into the admission and care planning process, with routine checks to drive accountability. In light of the Covid-19 pandemic, virtual education solutions will be explored. The project team remains committed to securing the cooperation and commitment of primary care providers to the ACP process.

Some limitations of this project should be taken into consideration. First, the review of the literature was completed by a team member who was furloughed and eventually laid off. The remaining team members were not successful in obtaining the articles from this team member and were only able to locate the titles for two of the articles. Of the two titles, only one was able to be located. It is thought that the second article title may not have been accurate as it was unable to be located, even via paid sources. In light of the pandemic-related time restrictions of the remaining team members, it was determined that conducting a new literature review, after the project had been completed, was not a justifiable use of time.

Additionally, the project team believes that should this project be replicated, inclusion of third shift staff in the training sessions would be valuable. Although the stated goal of the project was to increase the number of ACP's by 30% in each community; and third shift staff are unlikely to be instrumental in increasing the number of ACP's, the project team realized additional needs related to the project as it was implemented. During staff trainings, it was revealed that staff members were often uncomfortable with following ACP's, especially when those plans consisted of inactions such as DNR orders. Information and feedback gathered during staff trainings also revealed systemic issues such as some Emergency Medical Services (EMS) failing to recognize MOST forms and as a result providing life sustaining measures that the individual had elected not to receive. In one instance, staff reported that

EMS performed cardiopulmonary resuscitation on an individual for an extended period of time until the Executive Director of the community was able to make contact with the county's attorney via phone to instruct EMS to follow the physicians orders stated on the MOST form.

Though the COVID-19 pandemic resulted in numerous disruptions to the project, ACP is more salient now than ever before. With this in mind, it is the opinion of the project team that, in the long-term, the global pandemic may actually prompt an increased focus on ACP in LTC settings. This pilot project has highlighted the importance of ACP and led to the determination that ACP will have a role in the integrated system of care ALG Senior is building.

References

Zwakman, M. Et al. (2018). Advance care planning: A systemic review about experiences of patients with a life-threatening or life-limiting illness. *Palliative Medicine,* 32(8) 1305-1321.

Appendix A

LIVING WILL (ADVANCE DIRECTIVE)

This document contains two parts. Both parts are for use when you can no longer communicate your health care wishes to your doctors. You may choose to sign one or the other or both.

The first form is called a Health Care Directive, also known as a living will. The Health Care Directive allows you to tell your health care providers your preferences for end of life treatment.

The second form is called a Health Care Power of Attorney. This Health Care Power of Attorney allows you to appoint another person to make health care decisions on your behalf taking into account your wishes.

This form was completed and signed on ____ day of _____,20____.

I. HEALTH CARE DIRECTIVE (LIVING WILL)

(If you do not wish to fill out this form and just wish to designate a health care agent, draw an "X" through the following section)

I, _____, with a street address of _____, City

of _____, County of _____, State of

_____, with the last four (4) digits of my social security number

(SSN) being xxx-xx-_____ (Hereinafter may be referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

A. LIFE SUPPORT

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

_____ ☐ - Chronic coma or persistent vegetative state

_____ ☐ - no longer able to communicate my needs

_____ ☐ - no longer able to recognize family or friends

_____ ☐ - total dependence on others for daily care

_____ ☐ - Other: _____

Initial and check only one:

_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

_____ ☐ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

B. **CERTAIN LIFE-SUSTAINING TREATMENT**: (You do not have to initial and check any of these if you do not wish to)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you do not wish to have under any circumstances:

_____ ☐ - Cardiopulmonary Resuscitation (CPR)

_____ ☐ - Ventilation (breathing machine)

_____ ☐ - Feeding tube

_____ ☐ - Dialysis

_____ ☐ - Other: _____

C. **END OF LIFE WISHES** (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that:

_____

_____

_____

_____

II. **HEALTH CARE (MEDICAL) POWER OF ATTORNEY WITH MENTAL HEALTH AUTHORITY**

It provides peace of mind to be able to choose someone you know and who knows you to make healthcare decisions on your behalf when you no longer can communicate your wishes. It is important that you discuss your wishes with your health care agent so they can be sure to make sure your wishes are carried out by the health care providers. If you DO NOT, however, choose someone to make decisions for you, write NONE in the line for the agent's name.

I, _____, as Principal, designate _____, as my agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations and related health care. This power of attorney is effective at the point when I am not longer able to communicate my health care wishes. My agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees and personal representatives.

I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician. (Initial if this is your choice)

This Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated. (Initial if this is your choice)

My agent's address and phone number are as follows:

_____

Address Phone Number

If my agent is unwilling or unable to serve, I hereby appoint,

_____, as my successor agent.

My successor agent's address and phone number are as follows:

_____

Address Phone Number

I intend for my agent to receive any and all of my health records and information as if I were the one requesting such information. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

I have signed this document on this ____ day of _____, 20____.

_____ _____

Principal's Signature Print Name

_____

Address Phone Number

You may either choose two witnesses or a notary to witness and acknowledge your signature.

WITNESS ACKNOWLEDGMENT

On the date set forth above, I hereby state as follows:

The above named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an agent or successor agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness 1

_____ _____

Signature Print Name

_____

Address Phone Number

Witness 2

_____ _____

Signature Print Name

_____

Address Phone Number

NOTARY ACKNOWLEDGMENT

State of _____ }

County of _____ }

Signed and sworn to me on the ___ day of _____, in the year 20___.

I, the undersigned authority in and for said County in said State, hereby certify that the

Principal _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this ___ day of _____, 20___.

Notary Public Signature _____ State of _____.

Printed Name: _____.

My commission expires: _____

(Notary Seal)

Appendix B

STATE OF NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

EXPLANATION: *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

This document gives the person you designate as your health care agent ***broad powers*** *to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.sosnc.gov.

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ *(Physician)*
2. _____ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations to your agent's authority.)

A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent:	
_____ (Initial)	Shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
_____ (Initial)	Shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.	

_____ (Initial)	B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)
NOTE: DO NOT initial unless you insert a limitation.	
_____ (Initial)	C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only

	mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)
NOTE: DO NOT initial unless you insert a limitation.	
_____ (Initial)	D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):
NOTE: DO NOT initial unless you insert a limitation.	
_____ (Initial)	E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):

NOTE: DO NOT initial unless you insert a limitation.	

6. Organ Donation.
To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ (Initial)	donate any needed organs or parts; or
_____ (Initial)	donate only the following organs or parts:
NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.	
_____ (Initial)	donate my body for anatomical study if needed.
_____ (Initial)	In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)
NOTE: DO NOT initial unless you insert a limitation.	

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the

powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this

document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____(SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____

(type/print name of signer)

_____

(type/print name of witness)

_____

(type/print name of witness)

Date: _____ _____

(Official Seal) Signature of Notary Public

_____, Notary Public

Printed or typed name

My commission expires: _____

Appendix C

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	**Patient's Date of Birth:**

Section A *Check One Box Only*

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

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C, and D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

☐ Patient	☐ Majority of patient's reasonably available parents and adult children
☐ Parent or guardian if patient is a minor	☐ Majority of patient's reasonably available adult siblings
☐ Health care agent	☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient
☐ Legal guardian of the patient	
☐ Attorney-in-fact with power to make health care decisions	
☐ Spouse	

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS 112
North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/ems.htm
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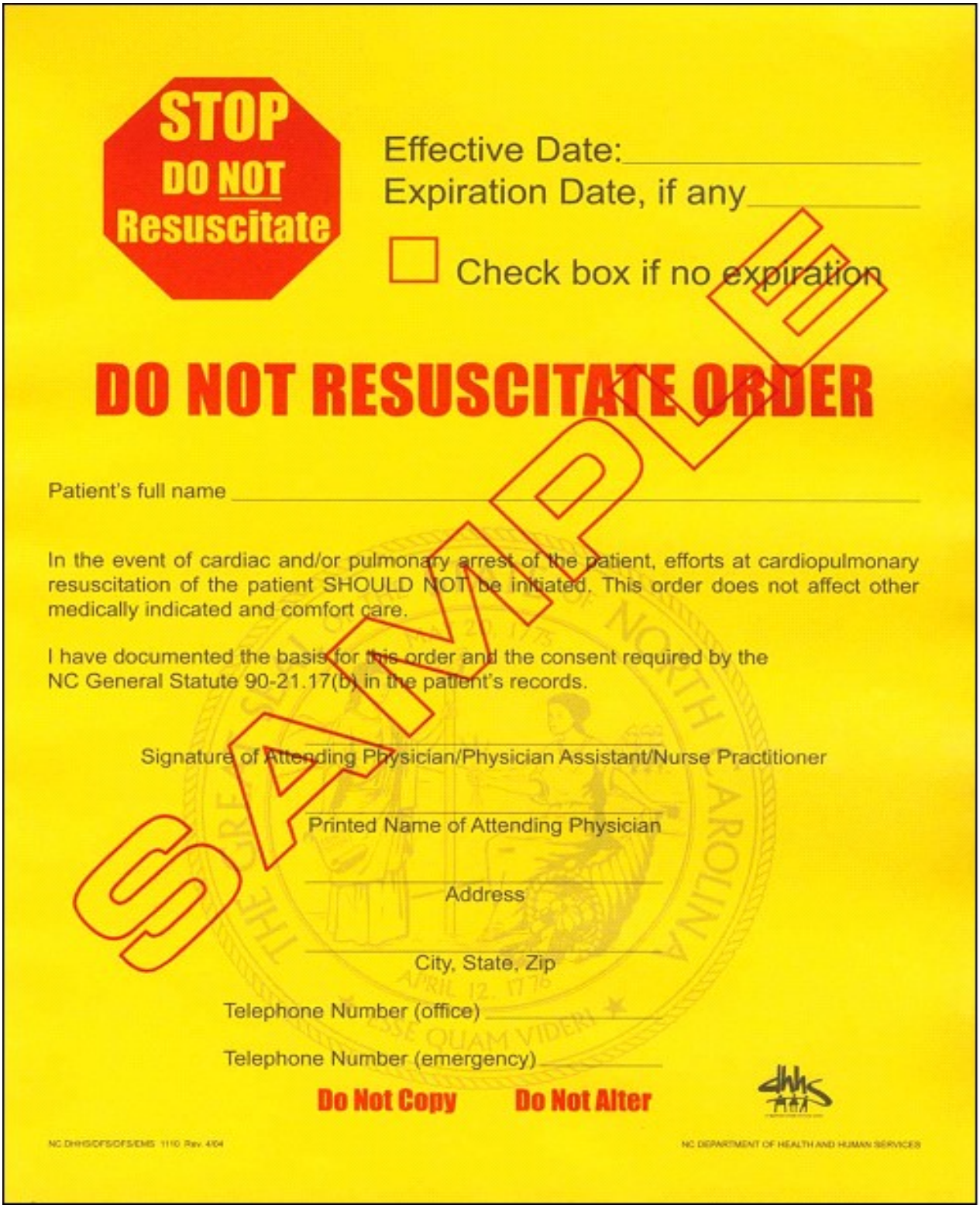
Appendix D



STOP
DO NOT
Resuscitate

Effective Date:_____
Expiration Date, if any_____

☐ Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

_____
Signature of Attending Physician/Physician Assistant/Nurse Practitioner

_____
Printed Name of Attending Physician

_____
Address

_____
City, State, Zip

Telephone Number (office) _____

Telephone Number (emergency) _____

Do Not Copy **Do Not Alter**

NC DHHS/DFS/DFS/EMS 1110 Rev. 4/04

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appendix E


Please join us for
Facts & Snacks
Wednesday, January 29 | 6 p.m.
COME LEARN MORE ABOUT
ADVANCE DIRECTIVES
Please RSVP by calling (828) 276-1004.
Haywood House
MEMORY CARE
(828) 276-1004
27 North Main Street
Canton, NC 28716
AffinityLivingGroup.com/Haywood