Conversations Before the Crisis

Here's what you should know about my care choices...

YOUR NAME:_____

DATE:_____

IN PARTNERSHIP WITH THE CONVERSATION PROJECT AND
THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

How to use this workbook

This workbook was created to help you think about what you would want if you were very sick and could not communicate with your care providers. Not only is it important for you to express your wishes, it is a ***gift*** for your family because it takes the emotional burden off of them.

Did you know illnesses like COPD, CHF (heart disease), chronic kidney or liver disease and dementia are **treatable but incurable?** People with these illnesses will have them for the rest of their lives and they may lead to death.

Have you asked your doctor if you have an incurable or serious illness?

Family Matters

Think about who you would choose to make healthcare decisions for you if you aren't able to speak for yourself. This person will be your "legal representative," also known as your healthcare power of attorney (POA). If you don't make your wishes known, and if you can't speak for yourself, your care team turns to your legal representative to make medical decisions. Your legal representative is determined by Mississippi law in the following order:

1. Person designated by you (does not have to be related to you)
2. Spouse
3. Adult child/children over the age of 18 (All children are considered equal; majority rules. The oldest child does not legally have more decision-making weight.)
4. Parent
5. Adult sibling (All siblings are considered equal; majority rules.)
6. Any next closest relative if none of the above apply
7. Any competent adult who has been known to care for you

A conservator or guardian by court order overrides any of the above

Do you have step-children or have you remarried?
Will your children and new spouse agree on your care?
Will your step-children agree with your choices for their parent?

Have the Conversation!

Step 1 Get Ready

Remember:

- Talking with friends and family about your wishes may reveal you disagree. ***Stick with it!*** The most important thing is that you're talking about it now instead of during a ***medical crisis***.
- ***Every*** attempt at making your wishes known is ***valuable***. One conversation can make all the difference.
- ***Nothing is set in stone.*** As your health changes, your wishes for care may change. That's OK! Just be sure to let your loved ones know so they can tell your health care team if you aren't able.

Step 2 Get Set

Even though it may feel scary or awkward to think about these things, knowing what you want can help you figure out what you don't want.

What are you NOT willing to give up? What makes your life worth living?
Many of our patients say they are not willing to give up being able to:

- go to the bathroom or bathe by themselves
- feed themselves or eat foods they enjoy
- Talking with friends and family
- Living at home

Are there things you would not be willing to give up?

- _____
- _____
- _____
- _____
- _____
- _____

Here's what you should know about me…

Use the scales below to figure out how you want your care to be. Select the number that best represents your feelings on the given situation.

As a patient, I'd like to know...

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Only the basics about my condition and my treatment				All the details about my condition and my treatment

As doctors treat me, I would like...

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My doctors to do what they think is best				To have a say in every decision

If I had a **terminal** illness, I would prefer to...

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Not know how quickly it is progressing				Know my doctors' best estimation for how long I have to live

Especially, if you chose mostly 4s or 5s on these questions, it is even more important to make your wishes known so your care team can honor them!

What concerns do you have about your health?

- ☐ My doctor says I have a serious illness. _____
- ☐ I can't do things I enjoy anymore. _____
- ☐ I have to take a lot of medications most days. _____
- ☐ My breathing or pain is getting worse. _____

What matters most about your medical care?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I want to be kept alive, no matter how uncomfortable I am				The quality of my life is more important to me than quantity

What are your concerns about treatment?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I'm worried that I won't get enough care				I'm worried that I'll get overly aggressive care

What are you worried may happen? Are there kinds of treatment you would or would not want like resuscitation/CPR, a long-term feeding tube or life support?

_____

_____

_____

What are your preferences about where you want to be?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I wouldn't mind spending my last days in a health care facility

I want to spend my last days at home

How closely do you want your wishes followed?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable

I want my loved ones to do what brings them peace, even if it goes against what I've said

Who do you trust to honor your wishes or make decisions for you if you could not?
(This is not legally binding, just a list of people you would consider.)

- _____
- _____
- _____
- _____
- _____
- _____

What do you feel are the three most important things that you want your friends, family and doctors to understand about your wishes and preferences for care?

1. _____
2. _____
3. _____

It always seems too early until it's too late.

How to break the ice

Here are some ways you could break the ice:

- "I was thinking about what happened to_____, and it made me realize…"
- "You know I'm sick, and I've made some choices about my care. I want to let you know what I'm thinking..."
- "Even though I'm okay right now, I'm worried that _____ may happen, and I want to be prepared."
- "I don't want you to be burdened by making hard decisions if something happened to me. Can we talk about what I would want if I couldn't speak for myself?"

Step 3 Go!

Now that you've thought about it and shared your feelings with someone you trust, it's time to complete two important legal documents to make sure your wishes are clearly stated and respected when the time comes. These forms are free and are in the back of this workbook.

Choose a Power of Attorney for Health Care

Durable power of attorney for health care is a legal document in which you appoint another person, called your agent, to express your wishes and make health care decisions for you if you cannot speak for yourself. You can choose someone from the list you made earlier in this workbook, or choose someone new. Choose someone who knows your wishes well – a person you trust to speak for you if you're not able to speak for yourself. There is a free Power of Attorney for Health Care form in the back of this workbook.

Complete an Advance Directive

An Advance Directive, sometimes known as a Living Will, is a legal document in which you state your wishes regarding end-of-life medical care – including the types of treatments you do and do not want – in case you are no longer able to communicate your wishes. (Note: This is different from your Last Will and Testament, which is used to distribute assets.) There is a free Advance Directive form in the back of this workbook.

For additional information about advance care planning in your area, please connect with:
North Mississippi Medical Center
Palliative Care Program
(662) 377-3404
palliative care@nmhs.net
www.nmhs.net/palliative_care.php

Mississippi Advance Directive
Durable Power of Attorney for Health Care and Living Will

This advance directive form is an official document where you can write down your wishes for your healthcare. If you can't make health care decisions for yourself, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, long-term care, or other types of healthcare

If you do not choose a healthcare decision maker and are too sick to make your own decisions, your care team will turn to your family to make decisions for you according to Mississippi law in the following order: (1) spouse; (2) adult children (all are equal, majority rules); (3) parents; (4) adult brothers and sisters (all are equal, majority rules); (5) any next closest relative; (6) any competent adult who has been known to care for you. A conservator or guardian by court order overrides any of the above.

PART 1: YOUR PERSONAL INFORMATION

YOUR NAME *(Last, First, Middle)*:		
YOUR STREET ADDRESS, CITY, STATE, ZIP:		
HOME PHONE:	WORK PHONE:	CELL PHONE:

Primary Care Providers

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

If the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my primary care provider:

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

PART 2: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you if you are too sick to make decisions for yourself. This person will be called your Health Care Agent.

Your Health Care Agent

- Should be someone who you trust, who knows you well, and is familiar with your values and beliefs.
- **CANNOT** be someone who works at a hospital, nursing home or similar facility where you are being treated unless you are related.

HEALTH CARE AGENT		
Place your initials in the box next to your choice.		
Initials	I designate the following individual as my agent to make healthcare decisions for me if I am unable to decide for myself.	
NAME *(Last, First, Middle)*:		Relationship to me:
STREET ADDRESS:	CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:

ALTERNATE HEALTH CARE AGENT		
Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't willing or able to speak for you when the time comes.		
Initials	If I revoke my agent's authority, or if the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my Health Care Agent.	
NAME *(Last, First, Middle)*:		Relationship to me:
STREET ADDRESS:	CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:

My Healthcare Decision Maker's Authority: My healthcare decision maker can make any healthcare decisions for me, but **must** follow my wishes as expressed in Part 3, even if he/she disagrees or thinks this isn't in my best interest. My healthcare decision maker can access my personal health information and medical records, and talk with my care providers about my health. If my medical choices are not clear, he or she must make those decisions in my best interest and based on what is known of my wishes. I can revoke or limit my Agent's authority at any time.

Effective Date: My healthcare decision maker can make healthcare decisions for me **(CHOOSE ONE):**

☐ when my primary care provider or treating physician determines I cannot make my own decisions or

☐ immediately after signing this form until revoked

PART 3: LIVING WILL

This section of the advance directive form is called a Living Will. This section lets you write down how you want to be treated, in case you aren't able to decide for yourself anymore and helps others choose the care you would want.

LIFE SUPPORT MEASURES

If I am so sick that I might die soon (CHOOSE ONE):

☐ ***I do not want to receive life support treatments***. I want to focus on being comfortable.

☐ ***Try all life support treatments that my doctors think might help***.

If the treatments do not work and there is little hope of getting better (CHOOSE ONE):

☐ I want to stop life support treatments if they are not working.
☐ I want to stay on life support treatments *unless* it looks like I am suffering.
☐ I want to stay on life support treatments *even* if I look like I am suffering.

☐ Other (use additional sheets if needed):

_____
_____
_____
_____
_____

COMFORT AND PAIN RELIEF

In this section, you can indicate your preferences for comfort and pain relief. Place your initials in the box next to the statements that reflect your wishes for comfort and pain relief. **Initial all that apply.**

Initials	I want to receive maximum pain relief even if it may unintentionally cause me to die sooner.
Initials	I want to receive maximum pain relief medication even if it may result in temporary dependence if I survive, recover or rebound from my current conditions and/or hospital stay.
Initials	I want a voluntary non-opioid directive. I am refusing, at my own insistence, the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself.

CONSENT TO DONATE

☐ I want to give away as many of my organs, eyes, and tissues as possible for the purpose of donation.

☐ I only want to give away the following organs, eyes, and/or tissues for the purpose of donation:
_____

☐ I do not want to give away my organs, eyes, or tissues.

Complete this sentence if it is true. *I am already a body donor and have filled out the required consent forms with the following facility*: _____

SPECIFIC PREFERENCES ABOUT END-OF-LIFE TREATMENTS (OPTIONAL)

CPR (Cardiopulmonary Resuscitation)	
CPR is a group of procedures used when the heart stops or breathing stops as a result of a serious illness or injury.	☐ **Yes.** I would want CPR attempted at the end of life, even if the burden may outweigh the benefits. ☐ **No.** I do not want CPR attempted

Kidney Dialysis	
Kidney dialysis uses machines to remove waste products and excess fluid from the body when the kidneys are not working well enough for a person to survive.	☐ **Yes.** I would want kidney dialysis at the end of life, even if the burden may outweigh the benefits. ☐ **No.** I do not want my life prolonged with dialysis machines.

SPECIFIC PREFERENCES ABOUT LIFE-SUPPORT TREATMENTS (OPTIONAL)

In this section, you can indicate your preferences for life support treatments in certain situations. Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-support treatments?" Place your initials in the box that best describes your treatment preference. **You may complete some, all, or none of this section. Choose only one box for each statement.**

	Yes. I would want life-support treatments	**No.** I would not want life-support treatments.
If I need to use a breathing machine to survive for the rest of my life.	Initials	Initials
If I cannot eat or drink by mouth and depend on artificial feeding/hydration through a tube or IV.	Initials	Initials
If I am unconscious, in a coma, or in a vegetative state, and there is little or no chance of recovery.	Initials	Initials
If I have permanent, severe, brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials
OTHER:	Initials	Initials

ADDITIONAL PREFERENCES

This section is optional. In this space you can write other important preferences for your health care that aren't described somewhere else in this document. If you need more space, you may attach extra pages and use this space to refer to the attached pages. **Be sure to initial and date every page you attach.**

_____

_____

_____

_____

_____

_____

_____

PART 4: SIGNATURES

YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	

WITNESSES SIGNATURES

WITNESS #1

I declare under penalty of perjury that I personally witnessed the person signing this advance directive, that the person is known to me, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not appointed as Health Care Agent in this advance directive or an employee at this hospital. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

WITNESS #2

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will. I am not related to the person by blood, marriage, or adoption.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

PART 5: SIGNATURE AND SEAL OF NOTARY PUBLIC *(OPTIONAL)*

This Advance Directive form is valid in NMHS facilities without being notarized. However, you may need to have it notarized to be legally binding outside the NMHS health care setting. Space for a Notary's signature and seal is included below.

STATE OF _____

COUNTY OF _____

On this date, _____, the Declarant, _____, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the advocate, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

WITNESS my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____ (seal)
(Date)