Instructions to add your Advance Care Planning document (ACP) to your Cone Health Medical Record

What type of ACP documents do we accept?

Advance Directives: This can include a Healthcare Power of Attorney (HCPOA), Living Will, or a combination of both.
PLEASE NOTE:

1. A Power of Attorney (financial or durable POA) is not the same as a HCPOA.
2. In the state of North Carolina, these documents need to be signed by the patient, notary, and two witnesses. We also accept out of state Advance Directives.
   - **Medical Order for Scope of Treatment (MOST):** This is document created by you and your doctor and is on bright pink paper.
   - **Do Not Resuscitate Order (DNR):** This document is signed by a physician, nurse practitioner or other APP and is on yellow paper with a stop sign on it.
   - **Other types of ACP documents:** There are many resources that can help you create ACP documents. Other documents accepted include, Five Wishes and PREPARE for your Care.

What do I do with my completed document?

After you complete your Advance Care Planning, **keep the original in a safe but easily accessible place**.

Send a **CLEAR COPY** of your completed document(s) to Cone Health. (Be sure to include all pages of the document.)

Take a copy to:	**OR**	**Mail**:	**OR**	**Email**:
Cone Health provider/office		HIM Scanning Center 4411 W. Market St., 2nd Floor Greensboro, NC 27407		ACP_Documents@conehealth.com

Your ACP document(s) will go into your Cone Health Electronic Health Record (EHR) so it is available if you are not able to communicate your wishes for yourself.

- If you have never been a Cone Health patient before, we will create a Cone Health record for you. Your ACP document(s) will be the first entry in your record.
- If you are already a Cone Health patient, we will scan your documents into your record.
- Your documents will be available in your record within five business days after we receive them.
- Any Cone Health hospital or Cone Health Medical Group practice can check your Cone Health record. You DO NOT have to send your documents to each separately.

Please complete the following information:

Full Name:

Address:

Phone Number: _____ Alternate Phone Number: _____

Date of Birth: (Month/Day/Year): ____/____/_____

Last 4 Digits of Social Security Number: _____

Who can help me if I have questions?

If you need assistance, please reach out to your Cone Health provider **OR** AdvanceCarePlanning@conehealth.com

Triad HealthCare Network

CONE HEALTH
we're w/you

ADVANCE CARE PLANNING

It's your choice, and you're not alone. We're right here w/you, from start to finish.

When you make your health care preferences known today, you're planning for your future. Making those future plans – with input from your family, loved ones and physician as needed – will mean your medical care will continue to look the way YOU want it to look, from start to finish. It will also take the pressure off your family or other health care decision makers, because they'll be clear on your medical wishes.

This document has everything you need to navigate the process of planning for your future when it comes to your medical wishes. We'll walk you through what advance care planning includes, how to determine your medical priorities and values, tips on communicating your wishes to your family, physician and caregivers, and give you the paperwork you need to document your wishes.

Table of Contents

In this document, we'll walk you through:

EXPLORE

What is advance care planning?

Advance care planning (ACP) is the process of helping you, as our patient, and your family understand, reflect and communicate your health care goals and values. These will be important in the event of an accident, sudden illness or chronic condition that prevents you from speaking for yourself. ACP does not require a formal document to be created, but is the first step in thinking about what medical treatment you would want.

Advance care planning is important for any adult – regardless of age – to spend time considering. After all, you never know when an unexpected accident or medical issue will arise that could leave you unable to communicate your wishes. With advance care planning in place, your loved ones will know exactly what you want your care to include.

How can I determine my health care values and priorities?

These questions might help you uncover some of those values and priorities:

1. Who would you want to communicate your health care decisions if you weren't able to do so yourself?

2. If the situation were to arise, would you want doctors to use any and all lifesaving measures to treat you, including things like a feeding tube, a ventilator or resuscitation?

3. What fears or concerns do you have about your future health?

4. What does "quality of life" mean to you? For example, does it mean being independent and being able to care for yourself, or does it mean having others help you but extending your lifetime as a result?

5. If you have a serious, chronic or life-threatening condition, have you spoken with your provider about what to expect as your condition progresses?

6. Do your religious beliefs affect the type of interventions you'd want to receive or avoid?

7. Have you witnessed a family member or loved one lose the ability to communicate their health care wishes? If so, do you feel like that situation was planned for and handled well, or would you want it to be different if it were you?

Consider these treatments as you think about what you would want to receive as far as care in an end-of-life or medical emergency scenario: CRP/resuscitation, breathing machine/ventilator, IV fluids, kidney dialysis, tube feeding. If so, have you shared your wishes with friends, family and/or your health care provider?

DISCUSS

Once you have an idea of the kind of care you'd like to receive in an end-of-life or medical emergency, it's time to share those wishes with:

- Your family
- Your health care provider(s)
- Your caregiver (if not a family member)

These conversations with loved ones can be hard, so consider these as a way to initiate them:

"I want you to know my medical wishes so that if something happens to me, you'll be confident in making decisions you know I'd want."

"I was reading recently about preparing for end-of-life wishes, and it prompted me to get my own in place. I'd like to share those with you."

"My doctor shared information with me about planning for my long-term medical care and wishes and suggested I talk with you about them."

If you have any questions after discussing this topic with your family that you'd like to share with your provider for their input, please note those here:

Your health care provider will be happy to help you put your care preferences in place as well, and they're also available to answer any questions you may have about treatments and what those look like, what the outcomes can be, etc.

Note: If you'd like help completing any of the forms in this packet, or in exploring your health care options and values, feel free to reach out to a Cone Health chaplain or clinical social worker for free assistance with this important process.

CHOOSE

Now it's time to finalize your wishes by putting them in writing. Below are three forms to complete:

1) Living will
2) Health care power of attorney
3) Advance instruction for mental health treatment

Once you have completed document(s), be sure to store your completed, signed advance directive forms where they can be found when needed, such as in your medical records at home, as well as in your hospice, home health care or nursing records if applicable.

Give copies to your spouse and next of kin, and have conversations with them about your wishes, too. You also may wish to give copies to your adult children, close friends, clergy or pastor, or other caregivers. Bring a copy to your next visit with your physician to include in your medical record so your wishes are readily accessible to your health care providers..

You'll be able to change your advance care planning forms at any time. Just complete this process again or talk with your doctor whenever you'd like to make updates to these documents.

RESOURCES

Here are a few additional resources you might find helpful as you navigate this process.

The Conversation Project
Center to Advance Palliative Care (Cone Health employees have free access using their Cone Health email)
Prepare for Your Care
Begin the Conversation
NC Division of Medical Assistance

An Advance Directive
For North Carolina

A Practical Form for All Adults

Introduction

This form allows you to express your choices for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form is intended to comply with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

This form allows you to express your choices for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.

2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.

3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your choices. It is very important to talk with your health care agent about your goals and preferences for your future health care, so that he or she will know what care you want.

4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make all health care decisions for you, including:
   - starting or stopping life-prolonging measures
   - decisions about mental health treatment
   - choosing your doctors and facilities
   - reviewing and sharing your medical information
   - autopsies and disposition of your body after death

5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial in Section 3 of Part A.

6. **When will this health care power of attorney be effective?** This document will only become effective if your doctor determines that you have lost the ability to make your own health care decisions.

7. **How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy

this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.

8. **Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions?** If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Part B: Living Will

1. **What is a living will?** In North Carolina, a living will lets you state your desire not to receive lifeprolonging measures in any or all of the following situations:

    - You have a condition that is incurable that will result in your death within a short period of time.
    - You are unconscious, and your doctors are confident that you cannot regain consciousness.
    - You have advanced dementia or other substantial and irreversible loss of mental function.

2. **What are life-prolonging measures?** Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.

3. **Can life-prolonging measures be withheld or stopped without a living will?** Yes, in certain circumstances. If you are able to express your choices, you may refuse life-prolonging measures. If you are not able to express your choices, then permission must be obtained from those individuals who are making decisions on your behalf.

4. **What if you want to receive tube feeding (artificial nutrition and hydration)?** You may express your choice to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.

5. **How can you revoke this living will?** You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write "void" across the document, tell your doctor that you are revoking the document, or complete a new living will.

Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

1. Wait until two witnesses and a notary public are present, then sign and date the document.

2. Two witnesses must sign and date the document in Section 2 of Part C. These witnesses cannot be:

    - related to you by blood or marriage,
    - your heir, or a person named to receive a portion of your estate in your will,
    - someone who has a claim against you or against your estate, or
    - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.

3. A notary public must witness these signatures and notarize the document in Section 3 of Part C

Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

If you do not wish to appoint a Health Care Agent, strike through this entire part and initial here _____.

My name is:_____ **My birth date is:** _____/_____/_____
(Please Print)

1. The person I choose as my health care agent is:

_____ _____ _____
first name middle name last name

_____ _____ _____ _____
street address city state zip code

_____ _____ _____ _____
home phone work phone cell phone e-mail address

If this person is unable or unwilling to serve as my health care agent, my next choice is:

_____ _____ _____
first name middle name last name

_____ _____ _____ _____
street address city state zip code

_____ _____ _____ _____
home phone work phone cell phone e-mail address

2. Special Instructions: In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding (artificial nutrition and hydration), other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation.

(Note: If you **DO NOT** have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.)

3. Organ Donation:

_____ **(initial)** My health care agent may donate my organs or parts after my death.

(Note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

This form is not complete until notarized in Part C.

Part B: Living Will

If you DO NOT wish to prepare a Living Will, strike through this entire part and initial here .

My name is:_____ **My birth date is:** _____/_____/_____
(Please Print)

1. **If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations:**

   (Note: you may initial **ANY or ALL** of these choices.)

   _____ **(initial)** I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

   _____ **(initial)** I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

   _____ **(initial)** I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

2. **Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, I DO want to receive tube feeding (artificial nutrition and/or hydration) in those situations, as stated below.** (Note: Initial only if you **DO WANT** tube feeding in those situations.)

   _____ **(initial)** **I DO want to receive artificial nutrition.**

   _____ **(initial)** **I DO want to receive artificial hydration.**

3. **I wish to be made as comfortable as possible**. I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may not prolong my life.

4. **My health care providers may rely on this Living Will to withhold or discontinue life-prolonging measures in the situations I have initialed above.**

5. **If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then:**

   (NOTE: Initial **ONLY ONE** of the two choices below.)

   _____ **(initial)** **Follow this living will**. My health care agent cannot make decisions that are different from what I have stated in this living will

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   _____ **(initial)** **Follow health care agent**: My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

This form is not complete until notarized in Part C.

Part C: Completing this Document

My name is:_____ **My birth date is:** _____/_____/_____
(Please Print)

1. Your Signature - STOP

(Note: Wait until two witnesses and a notary public are present before you sign.)

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____ Signature: _____

2. Signatures of Witnesses

I hereby state that the person named above, _____, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

3. Notarization

_____ 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: _____ Signature of Notary Public: _____
(Official Seal)

_____
(type/print name of Notary Public)

My commission expires: _____ __(date)