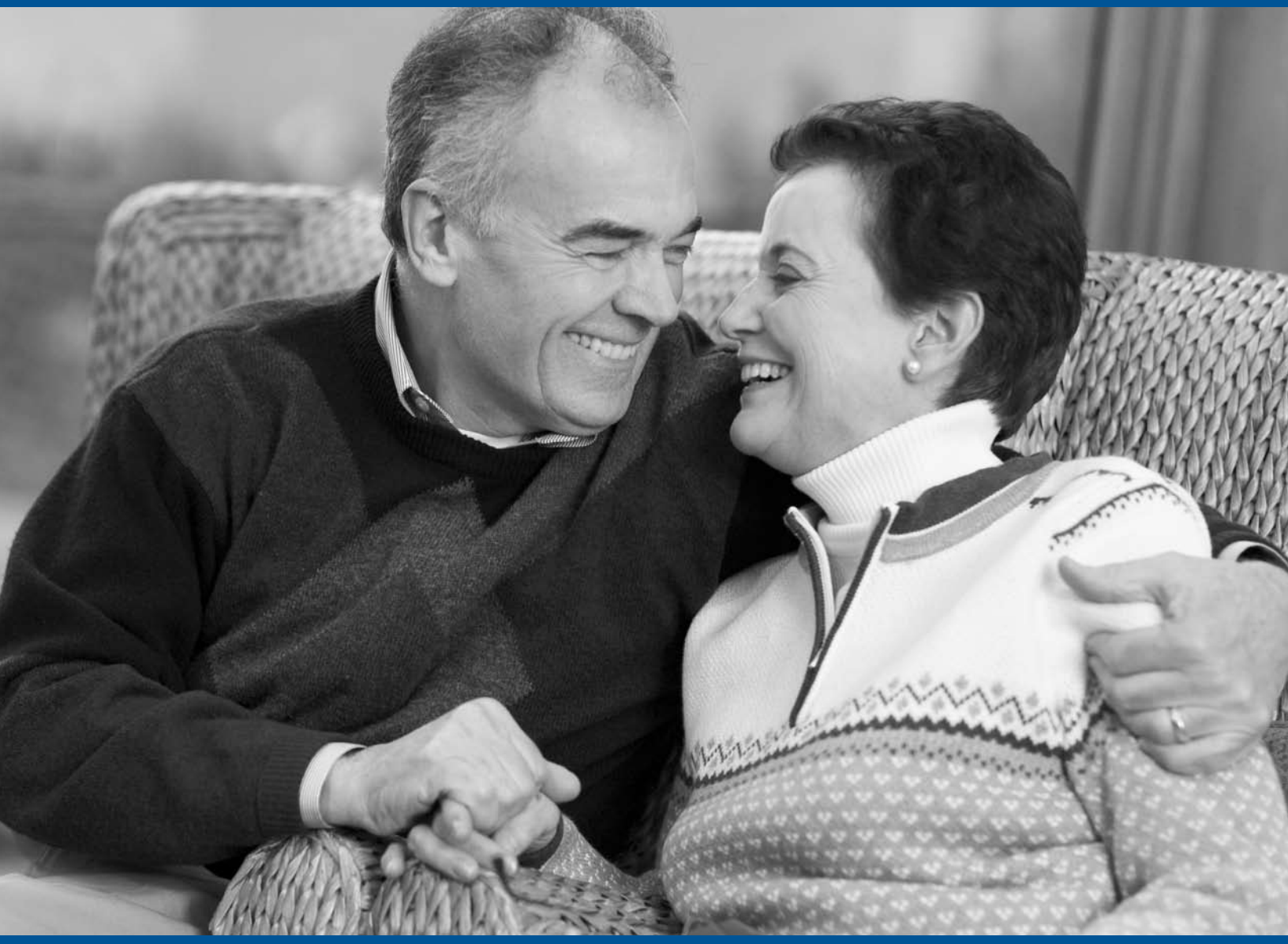
ADVANCE DIRECTIVES IN OREGON

Important information for Kaiser Permanente members and their families



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All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Ste. 100, Portland, OR 97232.

Like many people, you value your independence and ability to make decisions for yourself. No one ever wants to think he or she may someday be unable to make his or her own decisions—especially when it comes to health care. But sometimes medical situations arise that prevent people from communicating their wishes about medical intervention and/or life-prolonging care.

This brochure has been prepared to assist you in making end-of-life decisions. Your decisions can be communicated in written documents called "advance directives." Your chosen decision-maker on your advance directive can speak for you if you are ever unable to communicate your medical wishes.

Please review this brochure. We encourage you to talk with your physician about these issues. While advance directives don't require an attorney's involvement, you may want to discuss any legal questions you have with your personal attorney.

Advance planning reduces uncertainty about how you want to be cared for at the end of your life. We hope you will discuss your decisions with those closest to you and that you will put your wishes in writing. By making choices in advance, many patients find peace of mind and assurance knowing their desires will be carried out in the event of a medical crisis. Family and friends appreciate the guidance your decisions provide.

For general information about Health Care Directives, contact Kaiser Permanente's Ethics Service. Call 503-813-2657, Monday through Friday, 8 a.m. to 5 p.m. You can talk with a representative or leave a message.

Health Education Services also offers a two-hour class, "Your Life, Your Choices," free to Kaiser Permanente members and one guest. The class talks about how you can make your wishes known to your family and health care providers when you cannot speak for yourself.

To register, contact Health Education Services at 503-286-6816 in the Portland area or 1-866-301-3866 from all other areas. Representatives are available Monday through Friday, 8 a.m. to 5 p.m.

Filling out your advance directive form

A copy of the Oregon advance directive is included in this brochure. For additional copies, call Kaiser Permanente's Membership Services at 503-813-2000 or pick up copies at the Membership Services desk at your medical office.

Your health care provider can discuss this form with you. Social workers at our medical offices can help you complete it, or you can complete the form yourself. Be sure to read the instructions in Part A.

It is important to fill out the form completely and correctly. Be sure to include all the required signatures.

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You may consult a legal advisor about this form. An attorney can help if you need legal advice to make your decisions.

You don't have to have an attorney help you with your advance directive form. Your form will be legal even if you fill it out by yourself.

Instructions

a. Choose a health care representative. Your health care representative should be someone you can trust to make your wishes known. He or she will speak on your behalf. Unless you are related by birth, adoption, or marriage, your health care representative cannot be:
   - Your primary health care provider.
   - An employee of your health care insurer.
   - The owner or employee of a health care facility where you are a patient.

b. Ask someone to be your health care representative. If this person agrees, place his or her contact information on the form.

c. You can appoint an alternate in the event your health care representative can't complete his or her duties. Follow the same guidelines as for your health care representative. If you don't choose an alternate, please write "no alternate" on the form.

d. Write down on the form any special instructions you may have. Your health care representative can then make your wishes known when speaking on your behalf. If you need more room, you can write on a separate piece of paper and attach it to the form.

e. Two adults must witness your signature.
   - Your witnesses cannot be your primary health care provider, an employee of Kaiser Permanente, your health care representative, or your alternate.
   - You need at least one witness who cannot inherit from your estate. This means that you need a witness who is not a relative by blood, marriage, or adoption.

f. Sign your form in front of your witness and date it. Then have your witnesses sign and date the "Declaration of Witnesses."

g. Your health care representative and alternate (if you are appointing one) must sign and date the advance directive. They do not have to sign in front of witnesses.

For more information

Here are several options for help with or information about advance directives:

Social Services department

Our Social Services representatives can tell you about advance directives. Please give us a call. You don't need a referral. We're located at various medical offices in the service area and at Kaiser Sunnyside Medical Center. For locations and telephone numbers, see your *Medical Directory*.

Kaiser Permanente Ethics Service

Our Ethics Service can help you, your family, and your doctors with difficult health care choices. We can also help resolve differences about how advance directives are followed.

To ask for a consultation, call 503-813-2657. If you are a patient at Kaiser Sunnyside Medical Center, call the operator at 503-652-2880. For TTY, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010.

For general information about advance directives, call 503-813-2657, Monday through Friday, 8 a.m. to 5 p.m. You can talk to a representative or leave a message.

Health Education Services also offers a class, "Your Life, Your Choices," free to Kaiser Permanente members and one guest (see listing at the end of this brochure.)

Your health care provider

Your physician, nurse practitioner, or physician assistant can talk with you about advance directives and about your care options.

An attorney

It is not necessary to have an attorney to complete your advance directive. You may contact an attorney for legal help with your advance directive if you wish.

Kaiser Permanente's policy about advance directives

You have a right to be told about your medical care. You can consent to treatment or refuse it.

You have a right to tell us in advance how you want to be treated if you become ill or injured and cannot speak for yourself. You may give us instructions in an advance directive.

You have a right to change your advance directive whenever you would like.

We recognize your rights and will seek to honor your wishes.

Filling out the form is your choice. You do not need to complete an advance directive. You will still be covered by your health plan. You may still be treated at a Kaiser Permanente facility.

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Regarding advance directives, we will:

- Inform you about your rights under state law.
- Provide you with the appropriate forms.
- Include your advance directive in your medical records when you give us a copy and update it whenever you give us changes.

Please send your advance directive to:

Kaiser Permanente Process Center
Medical Records Department
Advance Directive
10220 SE Sunnyside Rd.
Clackamas, OR 97015-9734

If you are unable to speak for yourself

If you are an adult patient and can no longer communicate your wishes or make decisions about your medical care, we will follow these policies:

If you have an advance directive

Your attending physician will treat you according to your wishes, or he or she will transfer your care to another physician who will carry out your wishes.

If you don't have an advance directive formally recognized by Oregon or Washington

We will try to honor statements you have made about treatment.

If we do not know your wishes

We will try to find out what treatment you would have wanted in the current situation.

First, we will ask your health care representative, relatives, or closest friends. If they can't help us find out what you would want, your attending provider will give you care that is in your best interest. State law, a court order, or a guardian may also help determine what your doctor will do.

What you can do

Talk to your health care representative, closest relatives, friends, and your health care provider. Talk with them before you have to go to a hospital. Tell them your wishes about medical treatment.

Make copies of your advance directive. Give copies to your health care representative and relatives. We will usually contact them first if you cannot speak for yourself.

Forms for other circumstances

- First responders and emergency medical technicians must follow certain procedures. They have to follow them unless a doctor orders them not to. This means they may have to give you treatment you don't want, even if you have filled out an advance directive form.

  However, there is a form that gives instructions that emergency personnel can follow. This form is called Physician Orders for Life-Sustaining Treatment (POLST). You or your health care representative (or both) and your health care provider fill it out.

  POLST says what kind of care you want in specific circumstances. Because a health care provider signs it, emergency personnel will follow it. POLST is recognized by both Oregon and Washington.

  POLST forms are only given to members who are receiving end-of-life care. They are valid only when a health care provider signs them.

  Keep the form in a visible location so it can be found in an emergency.

- Oregon also has mental health advance directives. They let you say what you want to happen if you become so incapacitated by mental illness that your judgment is impaired or you are unable to communicate effectively.

  Mental health advance directives tell what treatment you want or don't want. You can name a person whom you want to make decisions for you.

  For more information, contact the Mental Health Department at your medical office.

If you disagree with how we handle your advance directives

You or your health care representative may have concerns. Talk about them first with your physician.

Our ethics consultants can also help resolve disputes. Contact the Kaiser Permanente Ethics Service at the phone numbers listed previously.

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The Oregon Advance Directive, in brief:

What it does

- This form lets you choose a health care representative. This person can make health care decisions for you only if you cannot.
- Your health care representative must agree to represent you. This person must sign the form.
- This form lets you give directions to your health care representative. It gives directions for care if you are found to have specific medical conditions. If you cannot make health care decisions for yourself, your health care representative will.

What it covers

- This form allows you or your health care representative to refuse artificial life support and artificial food and water in the event that:
  - Life support would not benefit you and would cause you permanent and severe pain.
  - You are terminally ill.
  - You are permanently unconscious.
  - You are in an advanced stage of progressive, fatal illness.

  Your wishes are followed even if you have not appointed a health care representative.
- If your form says you want to receive life support for medical conditions that you list, it will not be prevented or stopped.
- You will receive care for cleanliness and comfort no matter what your condition or choices are.

How long is it good for

- Good for your lifetime, unless you state otherwise.
- You may revoke it at any time.
- Older forms signed before November 4, 1993:
  - *Directive to Physicians*. This older form is still good for your lifetime unless you revoke it or sign the Oregon Advance Directive.
  - *Power of Attorney for Health Care*. This form was valid for seven years after you signed it. For most people, this form is no longer valid. However, if you became unable to make decisions before the seven years were up, the form is still valid.

Limits on health care representatives

- Your health care representative must follow what your advance directive says and follow your known wishes. If your wishes are unknown, he or she must act in your best interest. He or she does not have to pay your medical bills.
- Your health care representative can't refuse food or water that you can take in a normal way.
- Your health care representative can't make decisions about mental health treatment, sterilization, abortion, psychosurgery, shock treatments, or physician-assisted death.

For more information

For legal advice

- Contact your legal advisor. Kaiser Permanente cannot give legal advice.

For general questions

- Contact Kaiser Permanente's Ethics Service. Between 8 a.m. and 5 p.m., Monday through Friday, call 503-813-2657 or TTY 1-800-735-2900. For language interpretation services, call 1-800-324-8010.

For advance care planning

"Your Life, Your Choices" is a two-hour class that is free for Kaiser Permanente members and one guest. We will give you advance directive forms and other documents. These will help you make decisions about the care you want in case you cannot speak for yourself. The class will talk about how you can make your wishes known to your family and health care providers.

To register, contact Health Education Services. Call 503-286-6816 in the Portland area or 1-866-301-3866 from all other areas. Representatives are available Monday through Friday, 8 a.m. to 5 p.m.

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500 NE Multnomah St., Ste. 100, Portland, OR 97232.

Name: _____

Health Record Number: _____

Advance directive [1]

You do not have to fill out and sign this form.

Part A: Important information about this advance directive

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts about Part B (Appointing a health care representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts about Part C (Giving health care instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts about completing this form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign Part B, Part C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign Part D.

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[1] This form is contained in section 8 Oregon Senate Bill 286, which was enacted by the Legislature on August 3, 1993, and signed into law on September 1, 1993. The law became effective November 4, 1993.

Advance directive

Print your name, birth date, and address here:

Name: _____

Birth date: _____

Address: _____

Unless revoked or suspended, this advance directive will continue for:

Initial One:

_____ My entire life

_____ Other period (_____ years)

Part B: Appointment of health care representative

I appoint _____ as my health care representative.

My representative's address is _____

_____

and telephone number is _____.

I appoint _____ as my alternate health care representative.

My alternate's address is _____

_____

and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator, or employee of your health care facility, unless that person is related to you by blood, marriage, or adoption or that person was appointed before your admission into the health care facility.

1. **Limits**

   Special conditions or instructions:

   Initial if this applies:

   _____ I have executed a Health Care Instruction or Directive to Physicians.

   My representative is to honor it.

2. Life support

"Life support" refers to any medical means for maintaining life, including procedures, devices, and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

Initial if this applies:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube feeding

One sort of life support is food and water supplied artificially by a medical device, known as tube feeding.

Initial if this applies:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

(Signature of person making appointment)

Part C: Health care instructions

Note: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if he or she believes it could be helpful and then discontinue it if it is not helping your health condition or systems.
- "Life support" and "tube feeding" are defined in part B.
- If you refuse tube feeding, you should understand that malnutrition, dehydration, and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out items 1 to 4 below, or you may use the general instruction provided by item 5.

1. Close to death

If I am close to death and life support would only postpone the moment of my death:

a. Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

b. Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

2. Permanently unconscious

If I am unconscious and it is very unlikely that I will ever become conscious again:

a. Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

b. Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

3. Advanced progressive illness

If I have a progressive illness that will be fatal and is in an advanced stage, and if I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

a. Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

b. Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

4. Extraordinary suffering

If life support would not help my medical condition and would make me suffer permanent and severe pain:

a. Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

b. Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

5. General instruction

Initial if this applies:

_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor or another knowledgeable doctor confirms I am in any of the medical conditions listed in items 1 to 4.

6. Additional conditions or instructions:

(Insert a description of what you want done.)

7. Dementia

Here are my desires about short-term hospitalization if my physician recommends that I receive short-term hospitalization to treat behavior caused by dementia:

Initial one:

_____ I want short-term hospitalization for behavior caused by dementia.

_____ I want short-term hospitalization for behavior caused by dementia only as my physician recommends.

_____ I DO NOT WANT short-term hospitalization for behavior caused by dementia.

8. Other documents

A health care power of attorney is a document you may have signed to appoint a representative to make health care decisions for you.

Initial one:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ I DO NOT have a health care power of attorney.

(Date)

Sign here to give instructions.

(Signature)

Part D: Declaration of witnesses

We declare that the person signing this advance directive

(a) Is personally known to us or has provided proof of identity,

(b) Signed or acknowledged that person's signature on this advance directive in our presence,

(c) Appears to be of sound mind and not under duress, fraud, or undue influence,

(d) Has not appointed either of us as health care representative or alternative representative, and

(e) Is not a patient for whom either of us is attending physician.

Witnessed by:

(Signature of Witness/Date)	(Printed name of Witness)
(Signature of Witness/Date)	(Printed name of Witness)

NOTE: One witness must not be a relative (by blood, marriage, or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate, or be employed at a health care facility where the person is a patient or resident.

Part E: Acceptance by health care representative

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider, if known to me.

(Signature of Health Care Representative/Date)

(Printed name)

(Signature of Alternate Health Care Representative/Date)

(Printed name)

When you have completed your form, please mail a copy to:
Kaiser Permanente Process Center
Medical Records Department, Advance Directive
10220 SE Sunnyside Rd., Clackamas, OR 97015-9734

Notes

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