STATE OF CALIFORNIA
ADVANCE HEALTH CARE DIRECTIVE ACT
Also Known as the Health Care Decisions Law

FACT SHEET

Purpose of the Law
It combines California's previous advance directive laws to make it easier for you to make your wishes known for health care. You can appoint a power of attorney for health care, and/or state instructions for future health care decisions.

What is a Power of Attorney?
Someone known as your agent or proxy who has legal authority in all your health care matters if you become unconscious or too ill to communicate your wishes.

Effective Date
The law became effective on July 1, 2000.

Is It A Simple Form?
Yes. There are some simple forms you can use. You can do it without an attorney or a notary.

Who Can Complete This Form?
You must be over 18 years of age, complete and sign the form correctly, and have it witnessed by two people.

The Duties of Your Physician or Health Care Professional
Your health care professional must follow your instructions or those of your agent.

Special Issues for Chronic Dialysis Patients
Dialysis treatment keeps you alive, so you need to be very clear when you state your wishes for care.

More Information?
Talk to your physician or social worker for more detailed information on this very important issue.

Prepared by

Western Pacific Renal Network, LLC
Southern California Renal Disease Council, Inc.

Reviewed: 4/2007

The Advance Health Care Directive Act

Also Known as the Health Care Decisions Law

A Guide for Chronic Dialysis Patients

Prepared by

Western Pacific Renal Network, LLC
Southern California Renal Disease Council, Inc.

Originated: 1/2002
Reviewed: 4/2007

Acknowledgements

Thanks to the following participants whose knowledge contributed greatly to the preparation of this document.

Task Force - The Advance Health Care Directives Act

Co-Chairpersons

Doug Marsh, Executive Director
Southern California Renal Disease Council

Arlene Sukolsky, Executive Director
TransPacific Renal Network

Members

Gregory L. Adams, NREMT-P
EMS Education Manager
MedicAlert Foundation

Joan Brenta, RN
Patient Services Coordinator
TransPacific Renal Network

Cherie Morrison Davis, MPA
Advance Care Planning Program Director
MedicAlert Foundation

Karen Dyer, MS, RD
Regulatory Affairs Coordinator
Innovative Dialysis Systems Inc.

Alicia Hugg, MA, RN
Professional Programs Manager
MedicAlert California Emergency
Medical Services

Greg Monta, MSW
Modesto Kidney Center

Sang Mi Oh
Patient Services Program Director
National Kidney Foundation of
Northern California

Nancy Polley, RN, CNN
Director of Nursing
Modesto Kidney Center and
OakdaleKidney Center

Melissa Reyes, RN
Health Facilities Evaluator
California Department of Health
Services

Charles P. Sabatino, JD
Assistant Director, Commission
on Legal Problems of the Elderly
American Bar Association

Lois Williams, RN
Health Program Manager
State of California Emergency
Medical Services

Table of Contents

This material was prepared by Western Pacific Renal Network, LLC under contract #HHSM-500-2006-NW017C and Southern California Renal Disease Council, Inc. under contract #HHS500-2006-NW018C with the Centers for Medicare and Medicaid Services (CMS). The contents do not necessarily relfect CMS policy.

I. What is an Advance Health Care Directive?

An Advance Health Care Directive (AHCD) allows you to tell health care professionals and those close to you the health care you would like to receive, or not receive, should you ever become unconscious or too ill to communicate. If you are able to express your own wishes, your advance directives will not be used, and you can accept or refuse any medical treatment. But if you become unable to communicate due to serious illness or injury, others may be required or called upon to make health care decisions based on their views rather than yours.

II. A Description of the Laws Concerning Health Care Decisions

Chronic dialysis patients in California are affected by two laws concerning their legal rights to make their treatment preferences known in the event that they become unconscious or too ill to communicate.

The California Advance Health Care Decisions Law (Assembly Bill 891)

This law, which became effective July 2, 2000, consolidates California's previous advance directive laws to make it easier for individuals to make their health care preferences known through written and oral communication. Previous laws were the Natural Death Act Declaration, the Directives to Physicians, and the Durable Power of Attorney for Health Care. Forms executed under these previous laws are still valid, as are any forms that were legal before July 1, 2000. The new law allows a person to do either or both of the following:

- Appoint a Power of Attorney for Health Care
- State instructions for future health care decisions

The Omnibus Budget Reconciliation Act of 1990 (OBRA)

This federal law encourages communication between patients, families, physicians and professional staff on the issue of advance directives. It applies to hospitals, nursing facilities, hospices and most other health care providers and requires that they give patients information concerning their legal rights to make decisions about the medical care and treatment they are about to receive. Although outpatient chronic dialysis facilities are not specifically named in this federal law, it requires that most other health care providers:

- Provide all adults under their care with written information about patients' rights under state law, which ensures the patients their right to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives.
- Inform all patients of their institution's policy on implementing advance directives.

- Document in the patient's medical record whether they have executed an advance directive.
- Not discriminate against patients because they have or have not executed an advance directive.
- Provide staff and patients with education on advance directives.

III. Benefits of an Advance Health Care Directive—It's Simple!

An Advance Health Care Directive (AHCD) allows you to state your wishes for medical care or to name an agent to make those choices if you cannot. The AHCD is now the legally recognized format for appointing a health care agent in California, and allows you to do more than a living will. A traditional living will states your desire not to receive life-sustaining treatment only if you are terminally ill or permanently unconscious. An AHCD allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation. You do not need a lawyer to assist you to complete an AHCD, and there are excellent kits and forms available to guide you through the process (see "Additional Resources"). You can revoke or change it at any time. *Special note for residents in skilled nursing facilities: You must have a patient advocate or ombudsman sign as your witness.*

IV. If You Select an Agent

Talk to your family, friends, spiritual adviser, doctor and your health care team before making your decisions. Your agent should be someone you are comfortable with, someone who knows you well, and someone with whom you have discussed your views on these matters. This person should be able to be there when needed. Your agent should also be strong enough to advocate for you in the face of doctors or institutions that may disagree with your choices. This person will have legal authority to make decisions about your medical care if you are unable to do so. The agent is immune from liability so long as he or she acts in good faith.

The law does not allow you to choose an agent who is your doctor, or who is a person who operates a community care facility (board and care home) or a residential care facility where you receive care. You may not appoint anyone who works for the health facility in which you receive your care unless the person is related to you. You may only name one agent, but you may have an alternate if your agent is unavailable or unable to carry out your wishes.

Your instructions might also include preferences such as appointment of a conservator if ever needed, and your wishes regarding autopsy, funeral arrangements, and organ and tissue donation.

V. Record Keeping

Make sure your document is properly signed, dated, witnessed correctly, or notarized if required. Keep the original in a safe place where it can be found quickly. Give a copy to your agent, your alternate agents, your doctor, your dialysis facility, health plan if appropriate, and family members or anyone else who might be contacted if you have an emergency. If you are admitted to a hospital, take a copy with you. Keep a list of those persons who should be contacted in an emergency situation. Include names, addresses, and phone numbers, and make this list available to everyone who has a copy of your Advance Health Care Directive.

VI. Special Issues and Considerations for Dialysis Patients

Dialysis is a life-sustaining treatment, so you should be very precise when you state your preferences for care, and you should understand all the implications. Complications may arise during your treatment, which are actually caused by the treatment itself, such as blood pressure changes, allergic reactions, or heart rhythm changes. The dialysis staff are trained to react to these complications. The staff may place you flat on your back, give you fluids, return your blood, and give you oxygen. These events are considered treatable, and are not Do Not Resuscitate (DNR) situations. See Section VII for a detailed description of DNR.

VII. What About Do Not Resuscitate Orders (DNR)?

Cardio-Pulmonary Resuscitation (CPR) is only used in an emergency situation when a person's breathing and/or heart stops. It can prolong life for certain patients, but complications can arise. After considering the possible benefits or burdens of CPR, you may decide that you do not want to be resuscitated. If you do not want CPR, you can receive other kinds of "comfort care" such as clearing the airway, administering oxygen, controlling bleeding, providing pain medication, and providing emotional support.

If you have stated clearly in your instructions that you do not wish to be resuscitated, your wishes should be respected. California pre-hospital emergency medical services personnel (paramedics and emergency medical technicians) have been trained to recognize DNR orders, which require them to withhold chest compressions (CPR), defibrillation, endotracheal intubation, assisted ventilation, or cardiotonic drugs. You should complete a state recognized DNR form. California law requires that the DNR form be signed by your doctor to indicate that you have been counseled, and that you wish to refuse CPR during out of hospital emergencies. Emergency responders are required by law to administer CPR unless they see a patient's completed, state-recognized DNR form. Sometimes these forms are not available during emergencies. In California, patients with completed out-of-hospital DNR forms may obtain a DNR bracelet or medallion that can be worn on the body from the MedicAlert Foundation to ensure that emergency responders do not

administer unwanted CPR. The MedicAlert Foundation, a nonprofit organization, is the only state-approved provider of such medallions that California EMS personnel are authorized and trained to recognize (see "Additional Resources"). Emergency responders can honor the DNR order on the medallion without having to locate the actual written DNR order.

Dialysis patients also wear the medallion to identify their medical conditions, such as "hemodialysis patient", as well as to note any allergies or special medications. In case of emergency, the medallion alerts the paramedics or other emergency responders about your renal disease and other important medical information. Because you never know when a health emergency may arise, it's a good idea to wear the medallion at all times. This way, you are more likely to receive the right kind of care for your particular situation.

VIII. The Role of the Health Care Provider

A health care provider or institution (including your dialysis facility) must comply with your advance directive or instructions from an agent to the same extent as if you had made the decision.

Your primary physician must document all the information about the advance directive or oral communication about your preferences in your health care record. If your health care provider and/or physician feel they cannot comply with your directive because of conscience, or because the care would be medically ineffective or contrary to generally accepted health care standards, you and your agent must be immediately informed. All reasonable efforts to assist in transferring you to a setting where your wishes will be honored must be made, and continuing care must be provided until the transfer can be accomplished.

Remember, it's your choice — make it wisely

Questions To Consider Before You Complete Your Advance Health Care Directive

- What are my most important dialysis treatment goals?
- Would I want to continue dialysis if it is just delays death?
- Under what circumstances would I want dialysis to be stopped?
- How much treatment would I want if there were little chance of recovery from a serious side effect?
- Would I want dialysis to continue if I was permanently unconscious?
- Other issues to think about include pain relief, ability to think and communicate, finances, suffering and anxiety to others, control of body functions, mobility, and religious beliefs.

Some Sample Statements That Might Serve As Models For You

- If you have any doubts, err on the side of my life.
- I want only those treatments that offer reasonable hope to restore me to a condition that my agent thinks I would find acceptable.
- I do not want treatment that might postpone my death, but not restore me to an acceptable quality of life.
- I want treatment if there is even a small, remote chance that it might help me.
- I want enough pain medication to keep me free of pain, even if the dosage might shorten my life or lessen my mental or physical ability.
- I want the cost of treatment and its financial impact on my family to be considered by my agent when making decisions.
- If I lose consciousness with no reasonable hope of ever regaining it, I want all medical treatment stopped.
- If I lose consciousness with no reasonable hope of ever regaining it, I want food and fluids to be withheld.

If you include statements like these, review your directions carefully to make sure they are consistent. You don't want to give contradictory directions.

IX. Additional Resources

- California Hospital Association (CHA) Consent Manual 2000 contains a copy of a suggested form in both English and Spanish. Call 1-800-494-2001 or visit www.calhealth.org
- California Medical Association (CMA) has an Advance Health Care Directive Kit, including a new form. Call 1-800-882-1CMA or visit www.cmanet.org
- 10 Myths About Advance Directives www.abanet.org/elderly/myths.html
- Partnership for Caring. Visit www.choices.org/ad.html. Forms can be ordered by calling 1-800-989-9455.
- About DNR Orders, Channing L. Bete Co., 1-800-628-7733, Item 396938-10-97.
- MedicAlert Foundation, 1-800-432-5378, or visit www.medicalert.org
- Guidelines for EMS Personnel Regarding DNR Directives (EMSA #111) www.emsa.ca.gov

This project has been funded at least in part with federal funds from the Department of Health and Human Services under Contracts #HHSM-500-2006-NW017C and #HHSM-500-2006NW018C.

SAMPLE

California Advance Health Care Directive

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

AGENTS AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **except** as I state here:

(Add additional sheets if needed)

WHEN AGENTS AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

AGENTS OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENTS POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here:

NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: **(Initial only one box)**

☐ **(a) Choice NOT To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

☐ **(b) Choice TO Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death

_____

_____

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed)

SIGNATURE OF PERSON COMPLETING THIS FORM:

_____ _____ _____
(sign your name) (print your name) (date)

_____
(address)

_____
(city) (state) (zip code)

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence, (4) that I am not a person appointed as an agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

First Witness:

_____	_____	_____
(sign your name)	(print your name)	(date)

_____

(address)

_____	_____	_____
(city)	(state)	(zip code)

Second Witness:

_____	_____	_____
(sign your name)	(print your name)	(date)

_____

(address)

_____	_____	_____
(city)	(state)	(zip code)