



A University of Hawai'i Cooperative Extension Service Project

www.ctahr.hawaii.edu/tcym

Course Objectives



- Increase your knowledge about financial planning
- Improve your ability to make informed decisions



Incapacity Planning

Goodsill Anderson Quinn & Stifel

A Limited Liability Law Partnership

Presenter



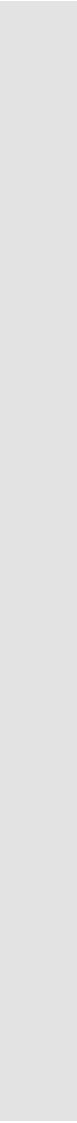
Judy Yuriko Lee,
Esq., CFP®, Partner

Lesson Objectives



- Identify the purpose and need for proper estate planning
- Gain awareness of documents for incapacity planning

Incapacity Planning



Society is Changing



Demographics

- Large elderly population needing assistance in living and managing finances
- Younger family members living outside of state

Two Areas of Concern



- Decision-making for the property and finances
- Decision-making over one's person and medical care

Avoid Need
For



Court-Supervised Proceedings

- Conservatorship of the property
- Guardianship of the person



Execution of Special Documents



- Revocable Living Trust
- Power of Attorney

Advanced Health Care Directive



- Health Care Power of Attorney
- Living Will

POLST

Provider Order for Life Sustaining Treatment



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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider. This Provider Order Form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name: _____ Date of Birth: _____ Sex: M F

First Name: _____ State Form Prepared: _____

A **CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing ****
 Attempt Resuscitation/CPR Do Not Attempt Resuscitation (DNR) (Allow Natural Death)
 (Section B: Full Treatment required)
 If the patient has a pulse, then follow orders in B and C.

B **MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing ****
 Comfort Measures Only 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. Transfer if comfort needs cannot be met in current location.
 Limited Additional Interventions Includes care described below. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway options (e.g., endotracheal or nasal positive airway pressure). Transfer to hospital if indicated. Avoid intensive care.
 Full Treatment Includes care described above, plus ventilation, advanced airway interventions, mechanical ventilation, and sedation/analgesia as indicated. Transfer to hospital if indicated. Includes intensive care.
 Additional Orders: _____

C **ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired.**
 No artificial nutrition by tube Limited time period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
 Additional Orders: _____

D **SIGNATURES AND SUMMARY OF MEDICAL CONDITION** (Discussed with: _____)
 Patient or Legally Authorized Representative (LAR). If LAR is checked, you must check 1 of the boxes below:
 Guardian Agent designated in Power of Attorney for Healthcare Patient-designated surrogate
 Surrogate selected by consensus of interested persons (See section E) Patient of a Minor
 Signature of Provider (Physician/APRN licensed in the state of Hawaii)
 My signature below indicates that to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.
 First Name: _____ Provider Phone Number: _____ Date: _____
 Last Name: _____ Provider License #: _____
 Signature of Patient or Legally Authorized Representative
 My signature below indicates that these orders are consistent with the wishes of (if signed by LAR) the person whose wishes are in the best interests of the patient who is the subject of this form.
 Signature (Required): _____ Relationship to Patient (if not patient)
 Name (Required): _____
 Signature of Health Care Provider: _____ Date of Last Order: _____

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Patient Name (Last, First, Middle): _____ Date of Birth: _____ Sex: M F

Section A: Patient's Preferred Emergency Contact or Legally Authorized Representative
 Name: _____ Address: _____ Phone Number: _____
 Health Care Professional Preparing Form: _____ Provider Title: _____ Phone Number: _____ Date Form Prepared: _____

Section E: SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)
 I have this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable who are interested in the patient's care. The patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawaii Revised Statutes §421C-3. Please read section C below and understand the limitations regarding decisions to withdraw or to withhold artificial and/or mechanical ventilation.
 Signature (Required): _____ Name: _____ Relationship: _____

DIRECTIONS FOR HEALTH CARE PROFESSIONAL
Completing POLST
 • Must be obtained by health care professional based on patient preferences and medical indications.
 • POLST must be signed by a Physician or Advanced Practice Registered Nurse (ARNP) licensed in the state of Hawaii and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
 • Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are legal and valid.
Using POLST
 • Any incomplete section of POLST implies full treatment for that section.
Section A:
 • The declaration including information to name emergency contact should be used on a person who has chosen "Do Not Attempt Resuscitation."
Section B:
 • When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only" should be transferred to a setting able to provide comfort (e.g., treatment of a hot fever).
 • If medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
 • A person who desires to have "Limited Interventions" or "Full Treatment."
Section C:
 • A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate should be designated for the patient (surrogate selected by consensus of interested persons) may also make a decision to withhold or provide artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the end-of-life and the patient is highly unlikely to have any volitional response in the future. HRS §421C-3.
Reviewing POLST
 It is recommended that POLST be reviewed periodically. Review is recommended when:
 • The person is transferred from one care setting to care level or another, or
 • There is a significant change in the person's health status, or
 • The person's treatment preferences change.
Modifying and Voiding POLST
 • A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that constitutes an intention as to this change.
 • To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
 • The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health, status and goals of care.

KiKou Mau - Hawaii Hospice and Palliative Care Organization
 KiKou Mau is the lead agency for implementation of POLST in Hawaii. Visit www.kikoumau.org to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014.
 KiKou Mau • PO Box 92155 • Honolulu HI 96894 • kou@kikoumau.org • www.kikoumau.org

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Credits



We would like to thank the following for their support:

- University of Hawai'i at Mānoa
 - College of Tropical Agriculture & Human Resources, Cooperative Extension Service, Department of Family & Consumer Sciences
 - Information Technology Services-Academic Technologies
- Judy Yuriko Lee, Esq., CFP®, Partner
Goodsill Anderson Quinn & Stifel
A Limited Liability Law Partnership LLP

Mahalo Special Guests



Actors & Actresses in Skits

- Susan Pang as Mrs. Kai
- Travis Agustin as Kimo
- Judy Lee as Estate Attorney