Rotary Club of Portage Bulletin
Porta-Rota-Call

Date: July 24, 2019 by: Christy Klien

The meeting was called to order at 12:00 p.m. by President Tom Welsh.

President Tom led us in the Four-Way Test,

Of the things we think, say or do

1. Is it the TRUTH?
2. Is it FAIR to all concerned?
3. Will it build GOODWILL and BETTER FRIENDSHIPS?
4. Will it be BENEFICIAL to all concerned?

Chaplain Dave Jewell gave our invocation.

The Pledge of Allegiance was recited.

Greeter Nancy Card welcomed Rotarians and guests, including Jacob Maxson, Ted Watson, and Erica McCulley.

PROGRAM: Hilary Kerr from Bronson Hospital presenting on "Advance Care Planning and Completing an Advance Directive."

Hillary Kerr works at Bronson Hospital as well as being a teacher of gerontology at Western Michigan University. Hillary is a Rotarian at the Rotary Club of Kalamazoo. She asked us to think

about the "what if's?" that happen in life. What if I am in an accident? What if I have a heart attack? Are we prepared for when the "what ifs" happen?

70 % of all adults will need help making a health decision during their life. We need to have a plan in place. Hillary provided participants with tools to help with the decision making.

Advanced care planning lets people know what kinds of health and personal care you want if in the future you are not able to speak for yourself. An advance directive is a legal document that records who you would like to make medical decisions on your behalf and also documents your end of life wishes. There are five steps to advance care planning.

Step 1: Decide who you want to be your Patient Advocate.

Step 2: Decide what life sustaining treatments you would want, if any. Consider how far you want life support to go.

Be knowledgeable of statistics when you are making your decisions. Your age, overall health condition, and location all make a difference. Did you know that you only have a 12% chance of surviving if you collapse and need CPR out in the community? In the hospital, you have a 25% chance of survival.

Document your wishes in an advance directive.

Hillary encouraged us not to put off creating an advance directive. Every adult should have one done, because you never know when you will need it.

Step 3: Talk with your patient advocate about your decisions and values.

Step 4: Make copies of your advance directive. Give copies to your doctors, put one in your glove box, scan it and email to family members and friends also give them a print copy. You can also put it on the Michigan Peace of Mind registry: https://www.mipeaceofmind.org. Save a copy on your phone in your In Case of an Emergency (ICE) or Medical ID.

The advance directive only needs two witnesses that are not family, medical providers, or people who would receive inheritance from you. It does not need to be notarized.

Step 5: Update your advance directive every year or two and make sure you have new conversations with your advocate.

Hillary also shared information about the Four Pillars of Planning. They have workshops on Healthcare, aging safely, financial planning, and death/funeral planning. In her presentation, Hillary also highlighted MMAP. MMAP volunteers are certified counselors trained in health care benefits. Their service is free and they are not connected to any insurance company. Our own Jim Martin is a MMAP volunteer.

Make sure you are prepared for all types of emergencies. Have an emergency preparedness kit at the ready. Place copies of all of your important documents in one folder to be able to grab

and take with you. The U.S. Department of Homeland Security has suggestions for being ready. Visit their website at www.ready.gov

Copies of My Medical Wishes Care Planning Workbook and Making Choices Michigan's Advance Directive can be found at the end of this document.

ANNOUNCEMENTS:

- Remember no lunch meeting on July 31, 2019.
- Adopt a Park clean-up activity at North Celery Flats on July 31 at 5:01 PM followed by Jac's Pizza social time. Spouses and children are welcome to attend.
- Golf Outing- Still need 11 teams ($500 for a foursome) , need tee sponsors ($75) , major sponsor ($300) and volunteers.
- Kalamazoo Free Store- donations of in good condition business attire are needed. Donations can be given to Ben Barber.

PRESENTATION: Shirley Johnson received her +3 Paul Harris.

ANNIVERSARIES: We celebrated the anniversaries of Dennis Berkebile and Chad Schuring.

HAPPY BUCKS were collected from R. Orwig, A. Maher, C. Schuring, and M. Semelbauer.

Sergeant Matt Semelbauer did a Paul Harris quiz and another trivia game and fined tables with wrong answers.

50/50: Bill Crown was the winner of $ 12.00.

ACE OF SPADES: Chris Cole drew from a deck of 40 cards for the chance to win the pot of $157.50. Luck was not on his side today.

Next week's program features Adopt a Park clean-up activity at North Celery Flats on July 31 at 5:01 PM followed by Jac's Pizza social time.

Meeting adjourned at 12:46 p.m. by President Tom Welsh.

The Portage Rotary Club provides financial support for youth education, families in need and other local charitable causes. We are part of Rotary International. A service organization of business and professional leaders that provide humanitarian services and help build goodwill and peace in the world.

My Medical Wishes Care Planning Workbook

Make your medical wishes known now

A serious accident or change in health could affect your ability to make your wishes known. Have you chosen somebody who could make medical decisions for you if you are ever unable to speak for yourself? Does your family know the types of treatments you would or would not want? We encourage people of all ages to start advance care planning before there is a need. This workbook will help you and your loved ones know what you want.

Advance care planning is the process of understanding your values and wishes. It lets people know what kind of health and personal care you would want in the future if you were unable to speak for yourself. It involves talking with your loved ones about your healthcare choices. Then, writing down your wishes in an advance directive document.

> An **advance directive** or durable power of attorney for healthcare is a legal document. In this form, you write down who you want to make medical decisions and your end-of-life wishes. It will be used only if you are unable to make medical decisions on your own. An advanced directive is free to complete. You may never need to use the plan -- but if you do, you'll be glad it's there for you.

My notes from the advance care planning workshop:

The best time to make healthcare decisions is before you need emergency care or your health declines.

Why don't people make their medical decisions known?

Here are some common reasons:

- I am not sick enough.
- I don't think I will ever need help making decisions.
- I am not sure what to say, or how to start the conversation with my family.
- It's too upsetting to think about.
- I am not sure where to begin.
- I am young and healthy.

Why making your medical wishes known is important:

- No one can honor your wishes if they do not know what they are.
- Knowing your wishes takes a heavy burden off your loved ones and medical providers. They will not have to make tough choices while trying to guess what you would want.
- Family members do not always agree, especially in stressful situations.
- You can take the time to talk to your family about what is most important to you. You can explain the type of care you want to receive.

There are five steps involved in advance care planning:

1. **Decide**
   Think about who you would want to make medical decisions if you could not. Carefully consider your values to determine the end-of-life treatments you would or would not want.

2. **Document**
   Complete an advance directive document.

3. **Discuss**
   Talk to your patient advocate(s) about your personal values.

4. **Distribute**
   Make the document available to both family and your healthcare providers.

5. **Update**
   Review your advance directive and have a new conversation with any life changes.

Give your loved ones the gift of your choices today before a crisis.

♡ DECIDE

A) Choose your patient advocates

These are the people you most trust to make medical decisions if you could not. It is best to choose two to three people as someone may not be available. Only one person can act as your patient advocate at a time.

A patient advocate:

- Must agree to perform the role.
- Only directs your healthcare after two doctors agree you lack decision-making ability.
- Discusses with your health care team about what your answers to medical questions would be if you could give them.
- Agrees to or refuses medical treatments for you, including life-sustaining treatments.
- Allows your transfer to other facilities if needed (nursing home, other providers, another hospital).

Choose the right person to be your patient advocate. Select someone who:

- Is 18 years of age or older who you fully trust (does not have to be family).
- Knows you well and understands what is important to you.
- Is willing to follow your wishes.
- Is strong enough to act on your wishes, separate from his or her own feelings.
- Would ask key questions about treatment choices.
- Can handle different opinions that may arise with family members, friends, and medical providers regarding your choices.

People I fully trust who might be good healthcare patient advocates.

_____ _____

_____ _____

B) Consider your life-sustaining treatment preferences

Planning ahead will help you and your loved ones make hard decisions in the event of a serious accident or illness. It is important to decide ahead of time what types of medical treatments you would or would not want to extend your life.

♡ DOCUMENT

Complete an advance directive document

One advance directive option is the *Making Choice Michigan* document. Another term used for this type of legal document is a durable power of attorney for healthcare. There are also other types of advance directive forms available.

There are two main components that make the document legal in Michigan.

1. Be certain that your signature is witnessed by two people who are not related to you and are not directly serving as your medical healthcare providers.
2. Your patient advocates must sign they are willing to perform the role if they are ever needed. These signatures do not have to match the same date as your signature and witnesses.

When completing the treatment preferences or goals of care on pages (pgs. 6&7) there are some statistics that are important to make an informed choice.

- CPR success rate is 25% if your heart stops while in the hospital. It decreases to 12% if received outside of the hospital.
- CPR success rates decrease for people who have more medical issues. Older individuals or those with more than one chronic illness generally have less than 5% chance of surviving CPR.
- Ribs are broken in up to 97% of CPR attempts.
- A breathing tube is placed during CPR. Those who survive CPR are usually monitored in the intensive care unit (ICU). The person may need a ventilator for days, weeks, months or longer to support their breathing.
- Permanent brain damage may occur from lack of oxygen in up to half of those who have CPR attempted. Damage can occur after 3-6 minutes without oxygen.

Questions I have about life-sustaining treatments:

Things I want to talk through with my doctor or clergy/spiritual leader:

DISCUSS

Talk to your family about your choices and share the document

This is one of the most important steps in advance care planning. You have to talk to your patient advocates and explain your preferences and personal values fully.

Plan the conversation with your chosen patient advocates and family

Who: Invite your patient advocate and other close family members

Where & When: Choose a quiet, private place where you can talk openly

How to start the conversation: "Even though I am OK right now, I want to be prepared. I need to think about the future, will you help me?"

What to share: Bring your completed advance directive document so they can read about their role on page 4 and then sign the document on page 5. Bring this workbook to help guide the discussion, especially the quality of life worksheet on page 7. Please also consider using the questions below to help you express your feelings to your loved ones.

1) What are some of the things you really enjoy doing? What gives your life special meaning? How would you like to live until you can't?

2) What fears or worries do you have about death? What fears do you have about getting sick or needing medical care?

3) What problems do you think you may have in the future from your illness? What are your most important goals if your health situation worsens?

4) If you were very ill, how much are you willing to go through for the possibility of gaining more time? Are there specific medical treatments that might be too much for you?

5) What abilities are so critical to your life that you can't imagine living without them?

6) Who or what helps you when you face serious challenges in your life? Do you have any beliefs that guide you when you make medical decisions?

♡ DISTRIBUTE

It is very important once you have carefully put your feelings onto paper and discussed your preferences with your loved ones, that you place copies in several places so that it can be located in the event of an emergency.

Places you could store your advance directive document:

- Bring a copy to your doctor's office to scan into your medical record
- Give a copy to your patient advocate and close family members
- Place a copy where you keep important papers
- File-of-Life red refrigerator magnet so EMS can have quick access
- Vehicle glove box
- E-mail as attachment so family can easily retrieve on their smart phones
- MI Peace of Mind registry: https://www.mipeaceofmind.org/

♡ UPDATE

You can make changes to your advance medical directive at any time. You can do this by making a note on the bottom of the document that you reviewed it with signature and date. We recommend you update your document every few years, or follow the 5D rule:

- Every new decade of your life
- After the death of a loved one
- After a divorce
- After any significant diagnosis
- After any significant decline in functioning

More Resources

- https://www.bronsonhealth.com/services/advance-care-planning/
- Talk with your doctor with specific questions particular to your health status
- For more information or help, call: **1-269-341-8778**

Notes on next steps to complete my advance care planning:

- _____
- _____
- _____
- _____
- _____

Quality of Life Worksheet to Supplement an Advance Directive/Healthcare DPOA

Below are questions for thought and discussion to help you plan for future healthcare. Circle one number for each statement. A rating of 4 indicates something that is very important to you. A rating of 0 indicates something that is not important.

How important are the following items?

	Very Important → Not Important				
Preserving my quality of life	4	3	2	1	0
Being mentally alert and competent	4	3	2	1	0
Being independent	4	3	2	1	0
Letting nature take its course	4	3	2	1	0
Being comfortable and as pain-free as possible	4	3	2	1	0
Leaving good memories for family and friends	4	3	2	1	0
Being free of physical limitations	4	3	2	1	0
Dying in a short time rather than lingering	4	3	2	1	0
Being able to relate to my family and friends	4	3	2	1	0
Living as long as possible, regardless of quality of life	4	3	2	1	0
Avoiding expensive care	4	3	2	1	0
Staying true to my spiritual beliefs and traditions	4	3	2	1	0
Being able to leave money to family, friends, charity	4	3	2	1	0
Making a contribution to medical research or teaching	4	3	2	1	0

What will be important to you when you are dying? Describe what you would want for your end-of-life care.

Printed Name _____ Signature _____ Date _____

You can attach this page to your advance directive document to offer additional information to your patient advocates. You may want to give copies to your family and healthcare providers.

MakingChoicesMichigan

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This document provides a way for an individual to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state.

This **Advance Directive** allows you to appoint a person (and alternates) to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions *only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist.*

It *does not* give your Patient Advocate any authority to make your financial or other business decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your Patient Advocate.** If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

This is an Advance Directive for *(print legibly)*:

Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Where I would like to receive hospital care (whenever possible): _____

Advance Directive: My Patient Advocate

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Patient Advocate. This person will make my health care decisions when I am determined, by either two physicians or a physician and licensed psychologist, to be incapable of making health care decisions. I understand that it is important to have ongoing discussions with my Patient Advocate about my health and health care choices. I hereby give my Patient Advocate permission to send a copy of this document to other doctors, hospitals and health care providers that provide my medical care.
(NOTE: If your wishes change**, you may revoke your Patient Advocate Designation at any time and in any manner sufficient to communicate an intent to revoke.* ***It is recommended that you complete a new Advance Directive and give it to everyone who has a previous copy.)

The person I choose as my Patient Advocate is

Name: _____ Relationship (if any):_____

Telephone (Day): _____ (Evening): _____(Cell): _____

Address: _____

City/State/Zip Code: _____

First Alternate (Successor) Patient Advocate (strongly advised)

*If Patient Advocate above is not capable or willing to make these choices for me, **OR** is divorced or legally separated from me, then I designate thefollowing person to serve as my Patient Advocate.*

Name: _____ Relationship (if any):_____

Telephone (Day): _____ (Evening): _____(Cell): _____

Address: _____

City/State/Zip Code: _____

Second Alternate (Successor) Patient Advocate (strongly advised)

*If the Patient Advocates named above are not capable or willing to make these choices for me, **OR** is divorced or legally separated from me, then I designate the following person to serve as my Patient Advocate.*

Name: _____ Relationship (if any):_____

Telephone (Day): _____ (Evening): _____(Cell): _____

Address: _____

City/State/Zip Code: _____

Advance Directive Signature Page

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life-sustaining treatment - such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous hydration, kidney dialysis, blood pressure or antibiotic medications — and hereby give my Patient Advocate(s) express permission to withhold or withdraw any treatment that would not help me achieve my goals of care. I understand that such decisions could or would allow my death. ***Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.***

Signature of the Individual in the Presence of the Following Witnesses

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

Signature: _____ Date: _____

Address: _____

City/State/Zip Code: _____

Signatures of Witnesses

I know this person to be the individual identified as the "Individual" signing this form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternate Patient Advocate appointed by the person signing this document.
- Not the patient's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the patient's estate.
- Not directly financially responsible for the patient's health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care or insurance provider directly serving the patient at this time.

Witness Number 1:

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

Witness Number 2:

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

Accepting the Role of Patient Advocate

Acceptance

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate Patient Advocate). Before agreeing to accept the Patient Advocate responsibility and signing this form, please:

1. *Carefully read the **Introduction (1A)**, **Overview** and this completed **Patient Advocate Designation Form**, (including any optional **Preferences** listed on pages 6A-9A). Also, take note of any **Treatment Preferences** (Goals of Care, pages 1B-2B) and/or Statement of Treatment Preferences that may be attached. These documents will provide important information that you will use in discussing the person's preferences and in potentially acting as this person's Patient Advocate.*
2. *Discuss, in detail, the person's values and wishes, so that you can gain the knowledge you need to allow you to make the medical treatment decisions he or she would make, if able.*
3. *If you are at least 18 years of age, and are willing to accept the role of Patient Advocate, read, sign and date the following statement.*

I accept the person's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this "Advance Directive: My Patient Advocate" document or in other written or spoken instructions from the person. I also understand and agree that, according to Michigan law:

a. This appointment shall not become effective unless the patient is unable to participate in medical or mental health treatment decisions, as applicable.

b. I will not exercise powers concerning the patient's care, custody, medical or mental health treatment that the patient – if the patient were able to participate in the decision – could not have exercised on his or her own behalf.

c. I cannot make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant, if that would result in the patient's death, even if these were the patient's wishes.

d. I can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and the patient understands that such a decision could or would allow his or her death.

e. I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.

f. I am required to act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

g. The patient may revoke his or her appointment of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.

h. The patient may waive the right to revoke a designation as to the power to exercise mental health treatment decisions, and if such waiver is made, the patient's ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

i. I may revoke my acceptance of my role as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.

j. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Michigan Public Health Code, (Exercise of Rights by Patient's Representative 1978 PA 368, MCL 333.20201)

Accepting the Role of Patient Advocate *(continued)*
Patient Advocate Signature and Contact Information

This is an advance directive for:

Print Name: _____ Date of Birth: _____

My Patient Advocate(s) will serve in the order listed below:

Patient Advocate

I, _____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone (Day): _____ (Evening): _____ (Cell): _____

First Alternate (Successor) Patient Advocate (Optional)

I, _____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone (Day): _____ (Evening): _____ (Cell): _____

Second Alternate (Successor) Patient Advocate (Optional)

I, _____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone (Day): _____ (Evening): _____ (Cell): _____

Making Changes

If only the contact information for your advocate(s) changes, it may be revised on the original and on the photocopies without replacing the entire form.

Photocopies of this form are acceptable as originals.

Treatment Preferences (Goals of Care)

Print Name: _____ Date of Birth:_____

Specific Instructions to my Patient Advocate -

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*

TREATMENTS TO PROLONG MY LIFE

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

____ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

OR

____ I want my health care providers to try treatments to prolong my life for a period of time. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

OR

____ I want to stop or withhold all treatments to prolong my life.

In all situations, I want to receive treatment and care to keep me comfortable.

____ ***I choose not to complete this section.***

(continues on next page)

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*
- *NOTE: This is NOT a "Do Not Resuscitate" (DNR) Order, which is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.*

CARDIOPULMONARY RESUSCITATION (CPR)

If my heart or breathing stops:

____ I **want** CPR in all cases.

OR

____ I **want** CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving.
- Little chance of surviving long term, and it would be hard and painful for me to recover from CPR.

OR

____ I ***do not want*** CPR but instead want to allow natural death.

Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

_____

_____

_____

_____

____ ***I choose not to complete this section.***

Signature

(If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this section, you need to sign and date the statement below.)

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:

Signature: _____ Date: _____