

*my*Directives for Clinicians™

Product User Guide

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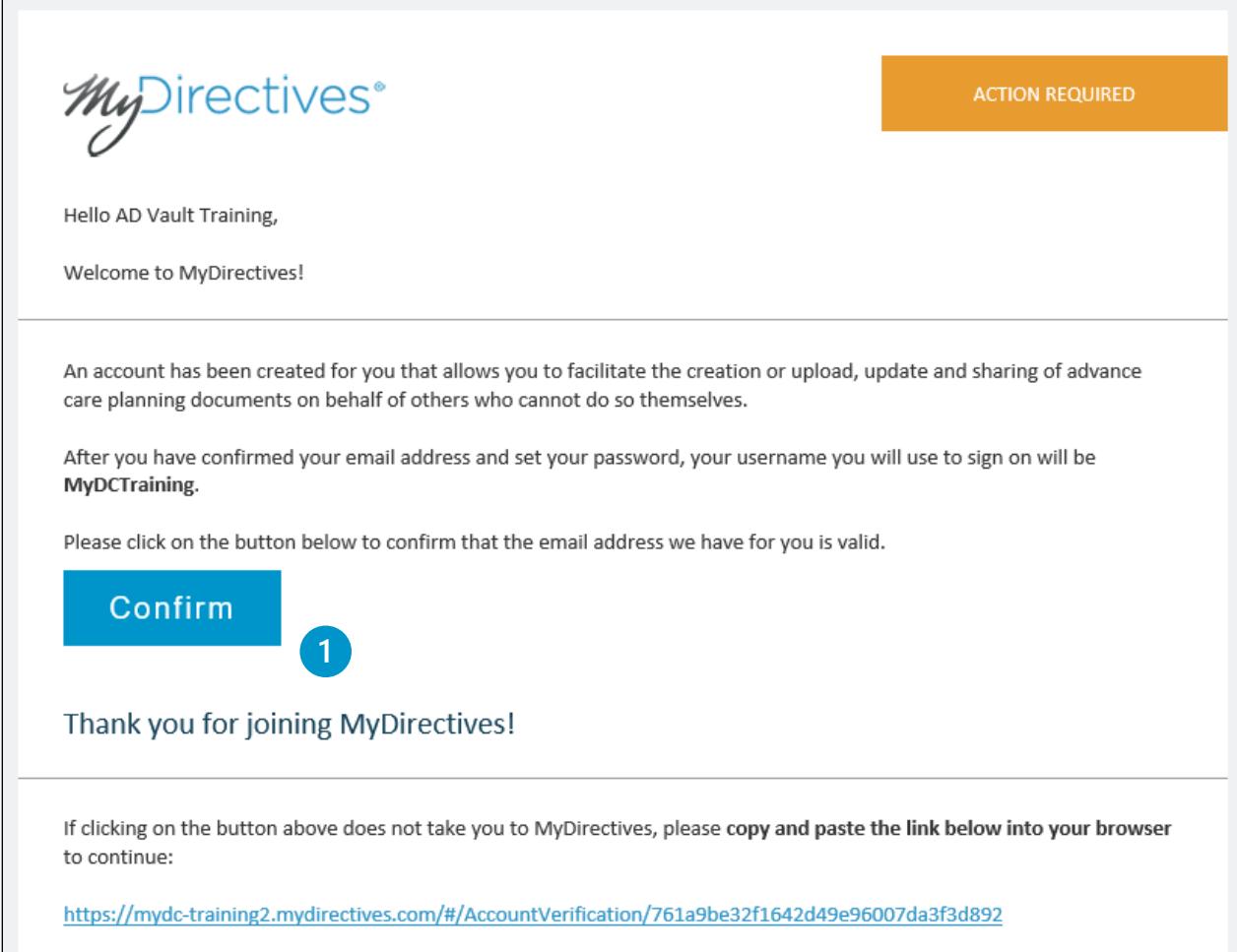
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Register Your Account

Your company program administrator will set up an account for you. Please see the email example below for what to expect to receive after your account has been created.

1. Select the blue “Confirm” box within the email you receive to be redirected to a registration page to complete and confirm your MyDirectives for Clinicians account. This email will also have the associated username.

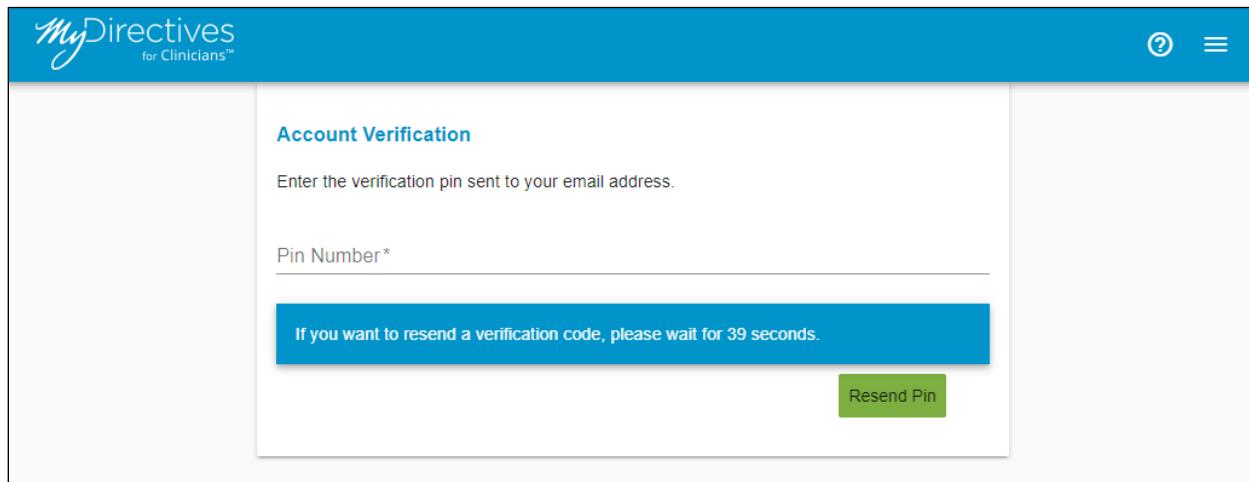
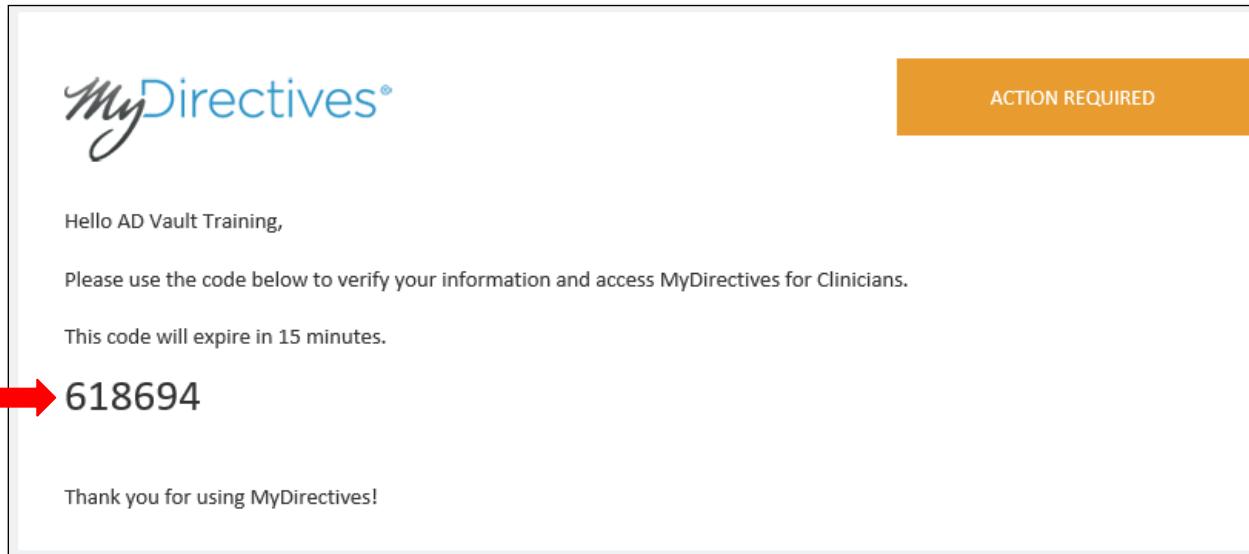
Please do not hesitate to contact your company administrator if you do not receive your login information or email.



The image shows a screenshot of an email from MyDirectives. The subject line is "ACTION REQUIRED". The email body starts with "Hello AD Vault Training," and "Welcome to MyDirectives!". It explains that an account has been created for the user to facilitate advance care planning. It states that after confirming the email address and setting a password, the username will be "MyDCTraining". The user is instructed to click the "Confirm" button to verify the email address. A circled "1" is placed next to the "Confirm" button. The email concludes with "Thank you for joining MyDirectives!" and provides a link for manual entry if the button does not work: <https://mydc-training2.mydirectives.com/#/AccountVerification/761a9be32f1642d49e96007da3f3d892>.

Your Account Verification

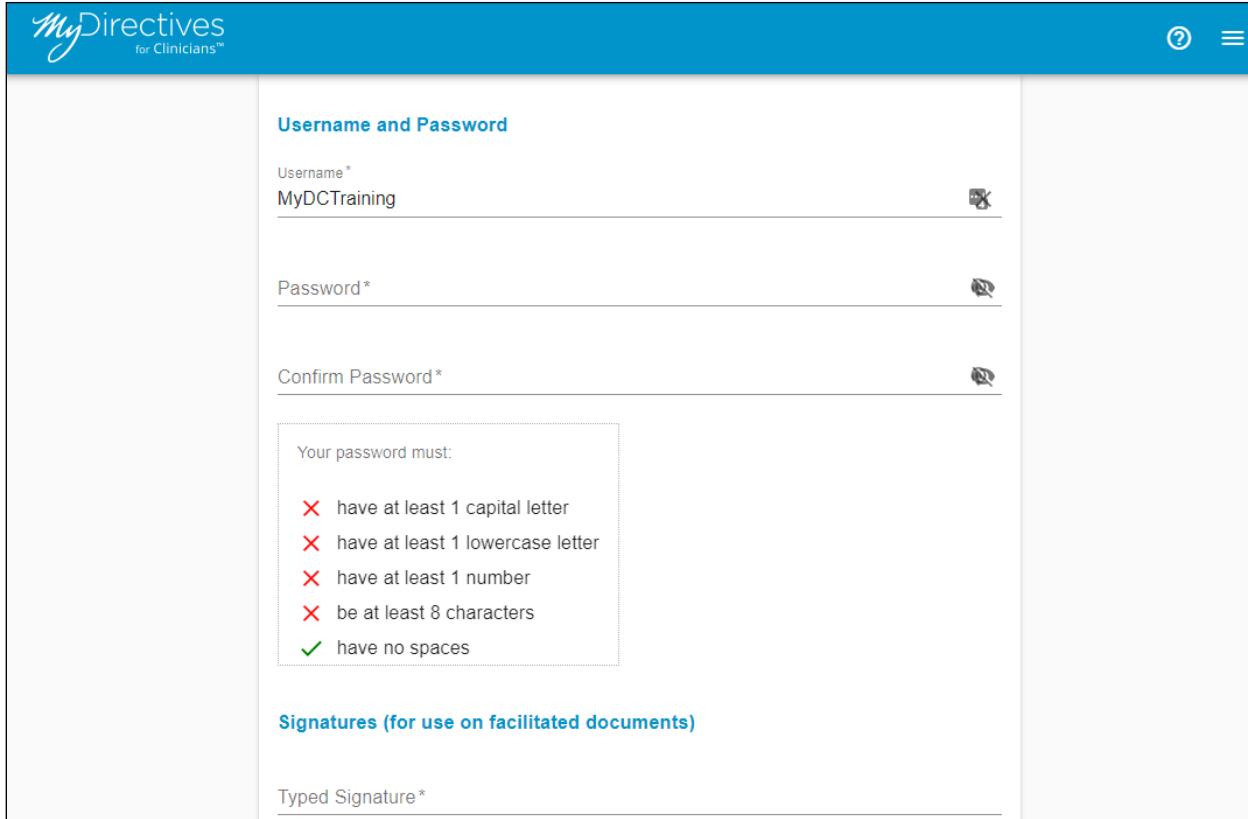
To verify and complete your account setup, you will receive an additional email with a Pin Number attached. Type in the pin number on the account verification screen – see examples below. Please note that this pin will expire within 15 minutes of receiving it.



Username and Password Set Up

To complete your account setup –

- Your username will already be created and automatically filled in.
- Add and confirm your desired password.
- Type and sign your signature below.
- Read and select the Terms and Conditions of Use



The screenshot shows the 'Username and Password' setup page of the MyDirectives for Clinicians™ application. The page has a blue header with the logo and a navigation bar. The main content area is titled 'Username and Password' and contains three input fields: 'Username *' (filled with 'MyDCTraining'), 'Password *', and 'Confirm Password *'. Below these fields is a box titled 'Your password must:' containing the following requirements: 'have at least 1 capital letter' (crossed out), 'have at least 1 lowercase letter' (crossed out), 'have at least 1 number' (crossed out), 'be at least 8 characters' (crossed out), and 'have no spaces' (checkmark). At the bottom is a section for 'Signatures (for use on facilitated documents)' with a 'Typed Signature *' input field.

Username *

MyDCTraining

Password *

Confirm Password *

Your password must:

- ✗ have at least 1 capital letter
- ✗ have at least 1 lowercase letter
- ✗ have at least 1 number
- ✗ be at least 8 characters
- ✓ have no spaces

Signatures (for use on facilitated documents)

Typed Signature *

Registration for MyDirectives for Clinicians

After registering your account, you can now access the website directly from the email or the URL: [MyDirectives for Clinicians](#). Login using the credentials created during your registration process.

You *should* have received login credentials from your company administrator, and you will use those credentials to log in to your account.

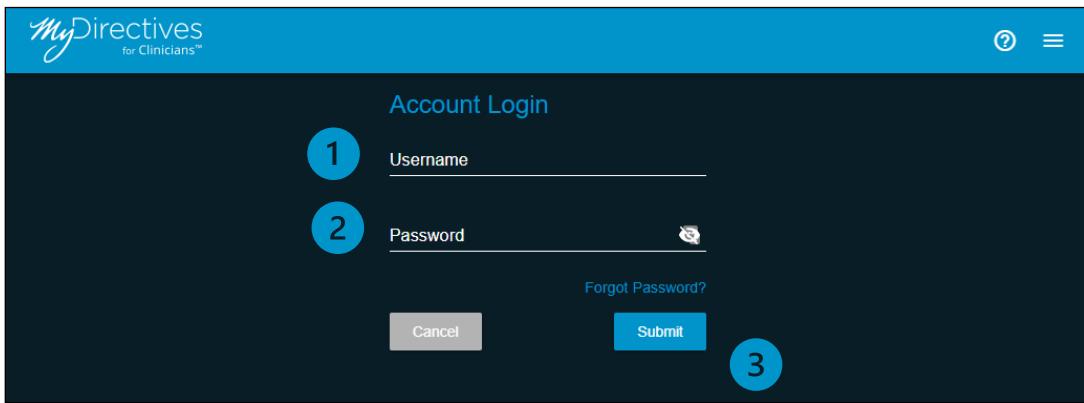
1. Click "Login" to enter your credentials.



Login using your Credentials

Enter your MyDirectives for Clinicians credentials below:

1. Username
2. Enter your password.
3. Click "Submit"



The image shows the 'Account Login' page of the MyDirectives for Clinicians website. The page has a dark blue header with the 'MyDirectives for Clinicians' logo. Below the header, the text 'Account Login' is centered. There are two input fields: 'Username' and 'Password'. The 'Username' field is preceded by a large blue circle containing the number '1'. The 'Password' field is preceded by a large blue circle containing the number '2'. Below the password field is a 'Forgot Password?' link. At the bottom of the form are two buttons: 'Cancel' and 'Submit'. A large blue circle containing the number '3' is positioned to the right of the 'Submit' button.

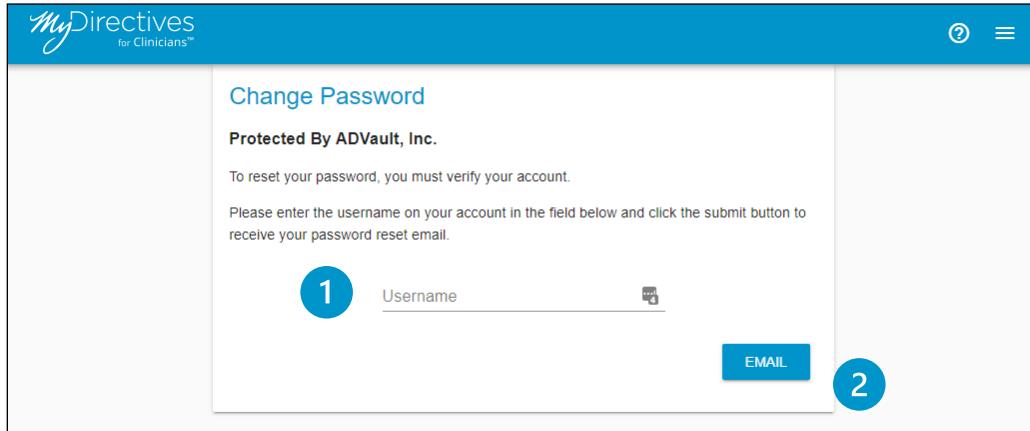
Reset Your Password

To reset your password, select "Forgot Password?" You will be redirected to the page below.

Follow the steps to reset your MyDirectives for Clinician's password:

1. Enter the username you use to log into the MyDirectives for Clinicians portal.
2. Click "Email"

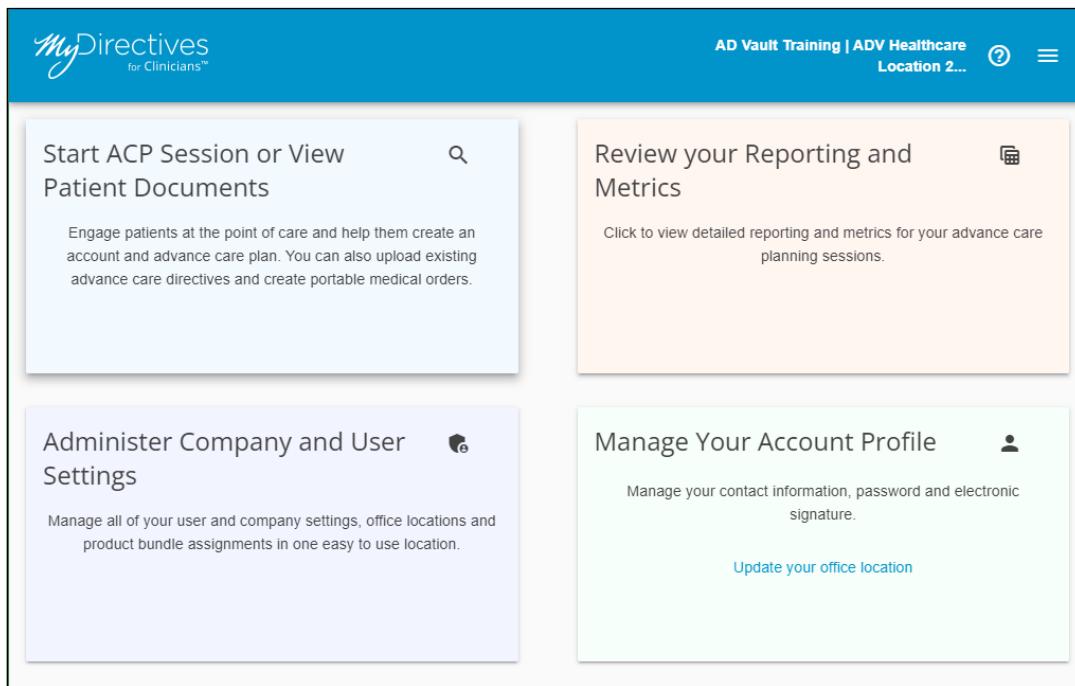
An email will be sent with instructions on how to reset your password.



The image shows the 'Change Password' page of the MyDirectives for Clinicians website. The page has a dark blue header with the 'MyDirectives for Clinicians' logo. Below the header, the text 'Change Password' is centered. A sub-header 'Protected By ADVault, Inc.' is present. Below the sub-header, instructions state: 'To reset your password, you must verify your account.' and 'Please enter the username on your account in the field below and click the submit button to receive your password reset email.' There is a single input field labeled 'Username' with a large blue circle containing the number '1' to its left. To the right of the input field is a 'Submit' button with a small 'EMAIL' icon. A large blue circle containing the number '2' is positioned to the right of the 'EMAIL' button.

User Dashboard

Please note that depending on your responsibilities, you may not have access to all dashboard functionalities.



Start ACP Session or View Patient Documents 🔍
Engage patients at the point of care and help them create an account and advance care plan. You can also upload existing advance care directives and create portable medical orders.

Review your Reporting and Metrics 📊
Click to view detailed reporting and metrics for your advance care planning sessions.

Administer Company and User Settings ⚙️
Manage all of your user and company settings, office locations and product bundle assignments in one easy to use location.

Manage Your Account Profile 👤
Manage your contact information, password and electronic signature.
[Update your office location](#)

Start ACP Session or View Patient Documents

Select this option on your dashboard to create, continue, or review your patient's account within your MyDirectives for Clinician portal.

Start ACP Session or View Patient Documents



Engage patients at the point of care and help them create an account and advance care plan. You can also upload existing advance care directives and create portable medical orders.

Review your Reporting and Metrics

Select this option on your dashboard to review your reporting and metrics needs based on your planning sessions.

Review your Reporting and Metrics



Click to view detailed reporting and metrics for your advance care planning sessions.

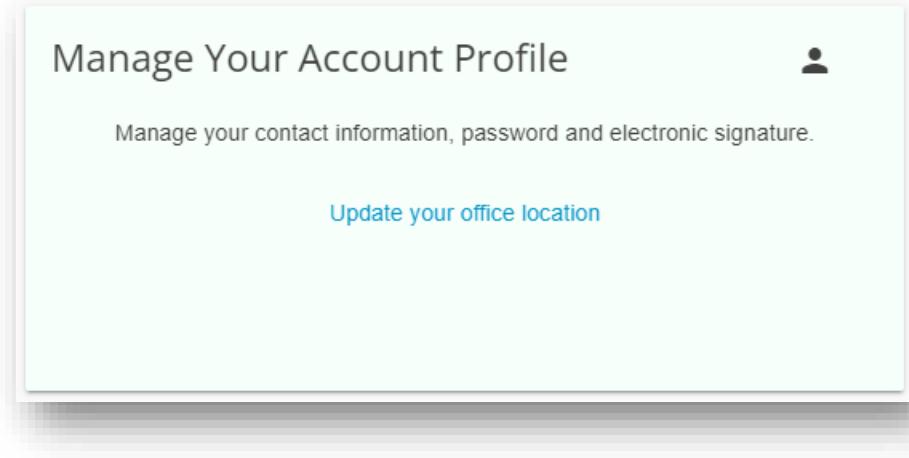
Administer Company and User Settings

Administrators for your company will have selected this option to manage any user and company settings, adding/deleting office locations, bundles, etc.



Manage Your Account Profile

Select this option on your dashboard to manage your account profile. If you are associated with more than one office location, you can update your location here by selecting Update your office location.

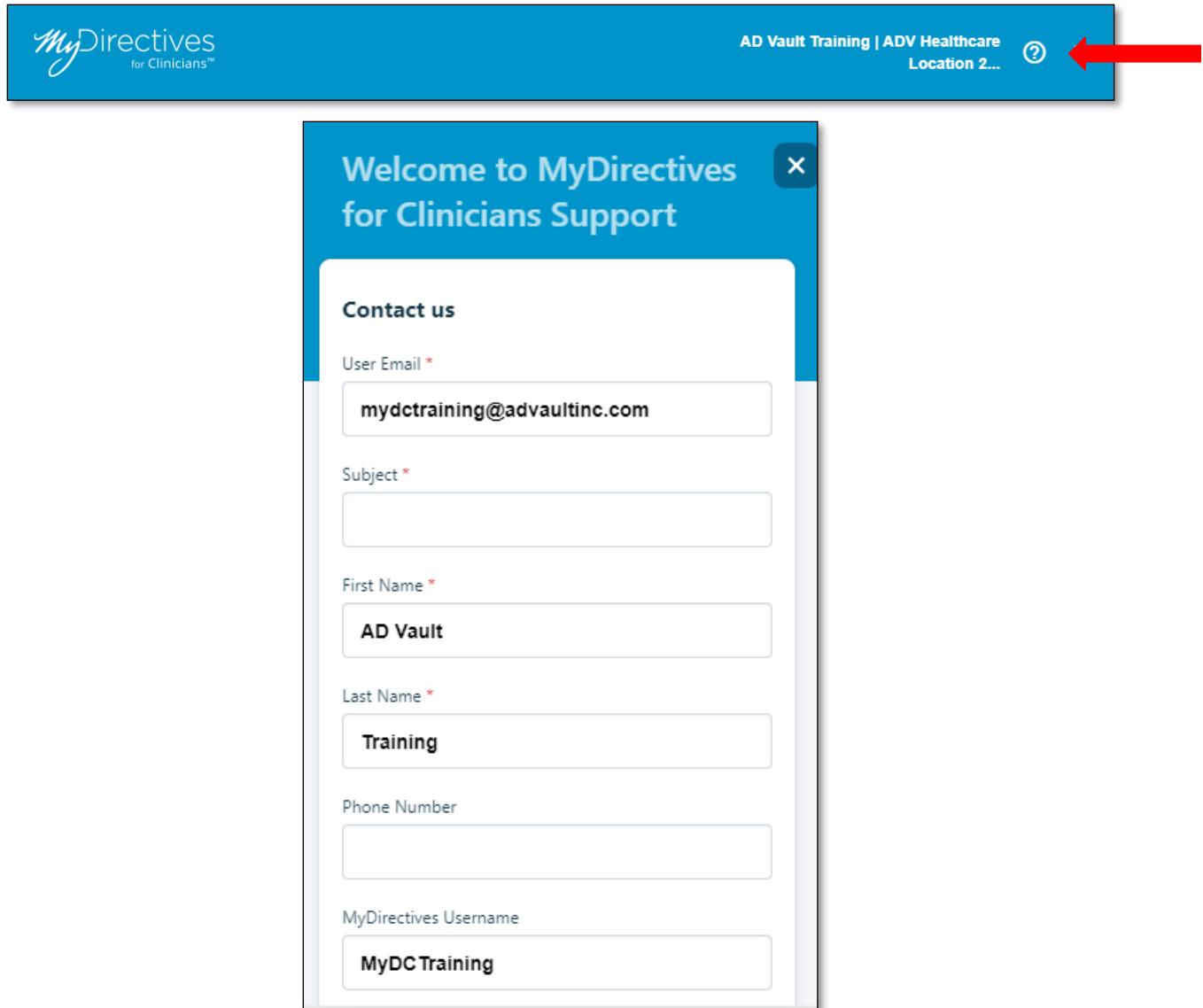


Need Help?

If you have questions, please select the (?) icon, as shown below. Enter required fields –

- User Email Address
- Subject
- First Name
- Last Name
- Description of the issue

You can also add a screenshot or upload a file if needed.



The screenshot shows a support contact form for MyDirectives for Clinicians. The form fields are as follows:

- User Email: mydctraining@advaultinc.com
- Subject: (empty)
- First Name: AD Vault
- Last Name: Training
- Phone Number: (empty)
- MyDirectives Username: MyDCTraining

The browser header includes the MyDirectives logo, the text "AD Vault Training | ADV Healthcare Location 2...", and a question mark icon with a red arrow pointing to it.

Patient Search

When you log in to the MyDirectives for Clinicians portal, search for existing patients by entering the patient's information in the Patient Search fields. The required fields to search for an existing patient include the following:

1. First Name
2. Last Name
3. DOB
4. Gender

Click "Search" to populate results. If a patient is found, select the tile with the patient's name to launch the patient data.

5. There are four (4) options at the bottom of the page if the patient is not found:

- Select "Send ACP Invite" to send an invitation to your patient to create their MyDirectives account.
- Select "Create a New Patient" and follow the steps to assist your patient in creating their account.
- Select "Patient Declines ACP" if the patient does not want to participate in creating their advanced care plan.
- Select "New Search" to start from the beginning.

1

2

3

4

5

MyDirectives
for Clinicians™

AD Vault Training | ADV Healthcare

Patient Search

First Name
John

Last Name
Smith

Date of Birth
12-12-1990

Gender
Male

more...

Clear

Search

Patient Search Results

No results found...

Patient Declines ACP

Create New Patient

Send ACP Invite

Select Patient from Recent Patient Activity

1. Located under Patient Search, you will have the option to choose from Recent Activity or Recent Invitations.
 - Recent Activity: patients you have already begun to assist.
 - Recent Invitations: view invitations and their status

First Name

Last Name

Date of Birth

Gender

more...

Clear Search

RECENT ACTIVITY RECENT INVITATIONS

1

| Name | Date of Birth | Document Count | ACP Status | Last Viewed |
|------------|---------------|----------------|------------|-------------|
| John Smith | 12/12/1990 | 0 | Not Signed | 10/13/2022 |

Hide

AD Vault Training | ADV Healthcare Location 2...
Update your office location

Creating a New Patient

If your patient does not appear under Patient Search Results, the patient does not exist in the MyDirectives database, and you will need to create an account for them.

1. After you have searched the database for your patient, if they did not appear in the search results - Select "Create a New Patient" to complete the required new patient account details.
2. For advanced searches, select "more..." under the required fields. Select "less..." to return to the search fields necessary

MyDirectives for Clinicians™

AD Vault Training | ADV Healthcare ? ≡

Patient Search

First Name
John X

Last Name
Smith X

Date of Birth
12-12-1990 X

Gender
Male ▼

more...

Clear Search

Patient Search Results

No results found... 1

Patient Declines ACP Create New Patient Send ACP Invite

Create a new patient by selecting “Create New Patient” at the bottom of the page after you have searched the database for the patient’s information. You must complete all required fields on the form to create a new patient in the MyDirectives database.

1. Required fields:

- First & Last name
- DOB
- Gender
- Username (the username is autogenerated but can be changed)
- Address1
- City/State/ Zip/Country

2. Note that a username will auto-populate. You can change this at the patient’s request.

3. Click the “Add” button to create a new patient.

You will be taken to the Advance Care Plan for new patients. If you are selecting an existing patient, then you will be taken to the patient’s dashboard.

Add Patient Account

1

First Name
John

Last Name
Smith

Date of Birth
12-12-1990

Gender
Male

Mobile Phone

Email

Username
johnsmith385

2

Address 1

Address 2

City

State

Zip Code

Country
USA

SSN

DL State

Drivers License

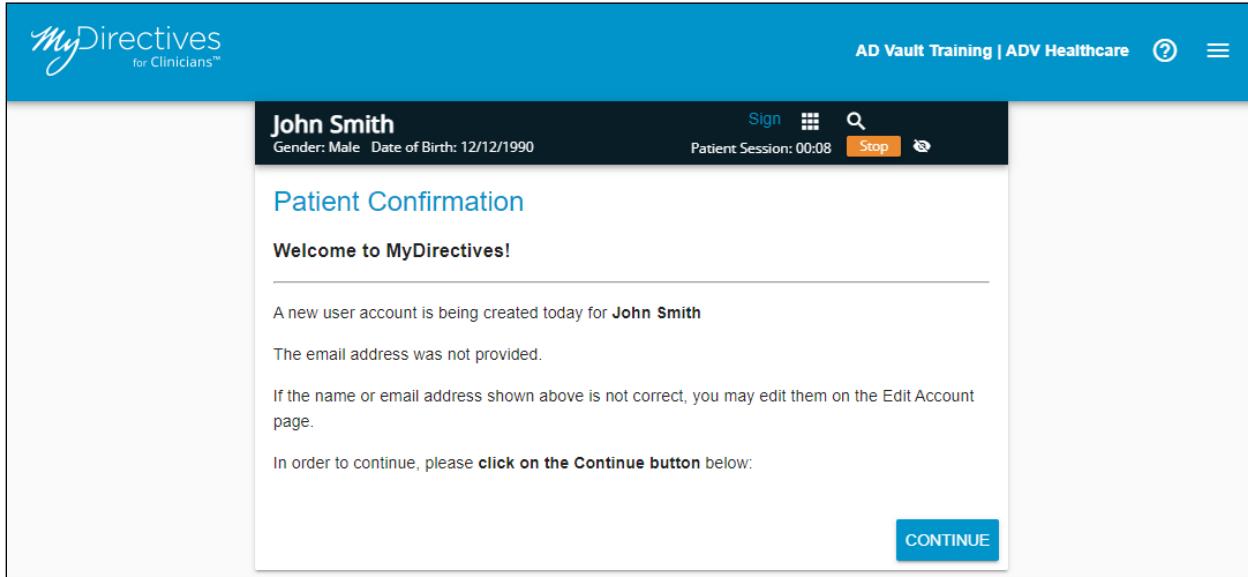
Cancel

Add

3

Patient Account Confirmation

When you create an account for a patient, you will receive this notification on your screen. This confirms the patient's username, whether they provided an email address or not, and lets you know that if either is incorrect, you can edit that information.



The screenshot shows a web interface for 'MyDirectives for Clinicians™'. At the top, the logo is on the left, and 'AD Vault Training | ADV Healthcare' with a help icon and a menu icon are on the right. The main header 'Patient Confirmation' is in blue. Below it, a bold header 'Welcome to MyDirectives!' is followed by a horizontal line. The text 'A new user account is being created today for **John Smith**' is displayed. Underneath, it says 'The email address was not provided.' and 'If the name or email address shown above is not correct, you may edit them on the Edit Account page.' At the bottom, a note says 'In order to continue, please **click on the Continue button** below:' followed by a blue 'CONTINUE' button.

Invite New Patient

You can invite new patients to create their own MyDirectives account by selecting “Invite New Patient.” An invitation is sent to the patient instructing them how to create their account. The patient can click on the link in their email, which will take them to the MyDirectives portal, where they can create their account. You can search their patient record just like you would if you assisted with their account setup. If your patient has additional questions, you can help them through their advanced care plan, uploading documents, creating healthcare agents, etc.

1. Complete the required fields for an invitation to be sent to the patient, which include:

- First name
- Last name
- DOB
- Email
- Gender
- Username (the username is autogenerated, but allowed to change)
- Address1
- City/State/ Zip/Country

2. Select Send Invitation to send the invitation to your patient.

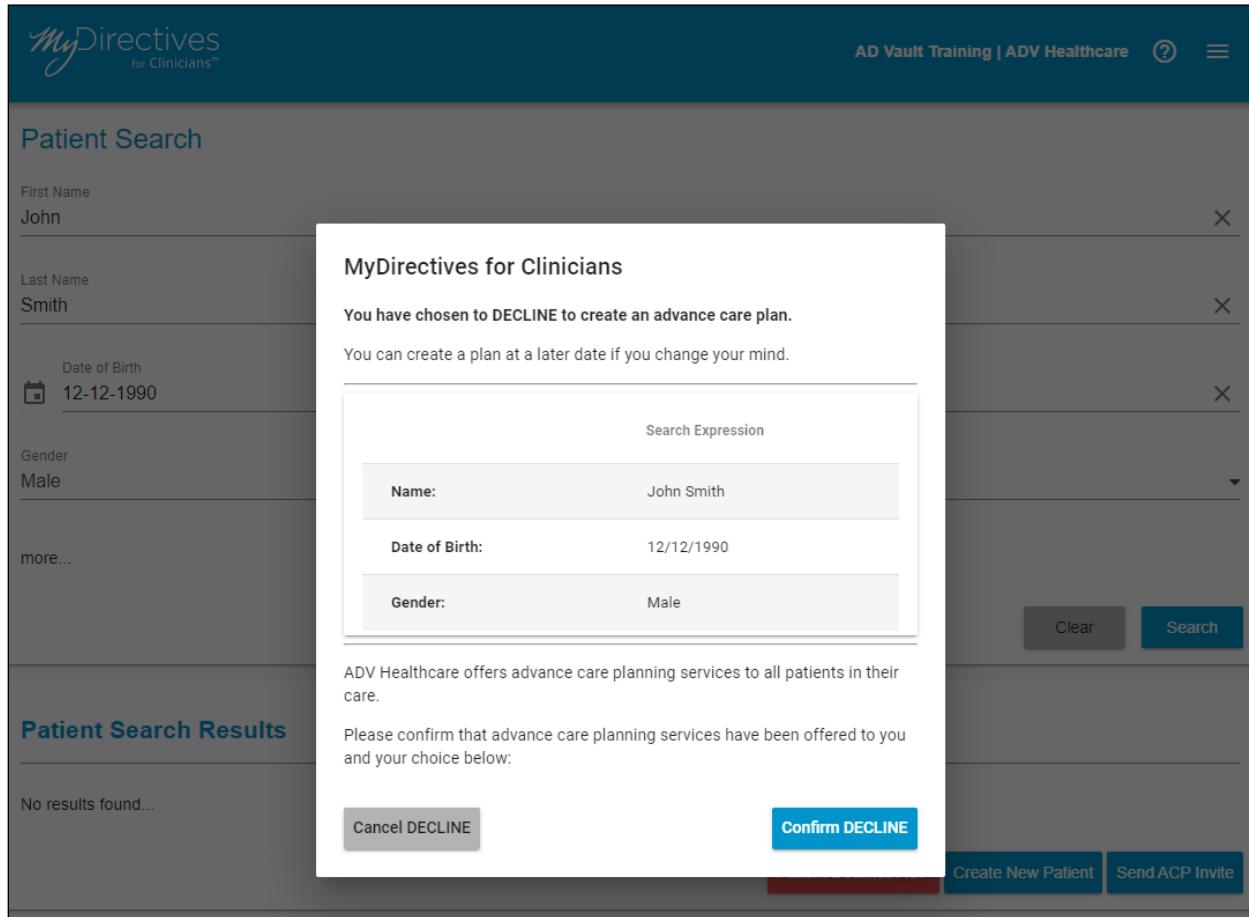
Invite Patient

1

| | |
|--|-------------------------|
| First Name John | X |
| Last Name Smith | X |
| Date of Birth 12-12-1990 | X |
| Gender Male | ▼ |
| Email | Mobile Phone (optional) |
| Address 1 (optional) | Address 2 (optional) |
| City (optional) | |
| State (optional) | ▼ |
| Zip Code (optional) | |
| Country (optional) USA | ▼ |
| <input type="button" value="Cancel"/> <input type="button" value="Send Invitation"/> 2 | |

Patient Declined to Create an Advance Care Plan

If your patient chooses not to create an Advance Care Plan, they can decline. When you choose Decline, you will receive the following message. The patient will have the option to create an ACP later. Select Confirm or Cancel Decline.



Patient Dashboard

The patient dashboard provides tiles to help you navigate and manage the patient's data. You will click on the tile you need to access. The tile icon is on the top of the page next to the sign icon. You can click that icon and be taken back to the dashboard page. You can also access the dashboard from the burger menu at the top right of the logo header.

Patient Summary

Overview of patient account activity.

Edit Patient

If any information needs to be changed or updated on your patient's account.

Digital Advance Care Plan

Paperless document that captures the wishes of the patient's care.

Document Upload

Upload and manage the patient's documents.

Name a Healthcare Agent

Add a primary and alternate healthcare agent(s) for the patient and select access to the patient's documents.

Record a New Video

Record videos of the patient or the healthcare agent. These video files can be uploaded or recorded from your device.

Contacts

Add additional contacts to the patient's record and select access to the patient's documents.

Portable Medical Order

Paperless document MOST, MOLST, POLST options

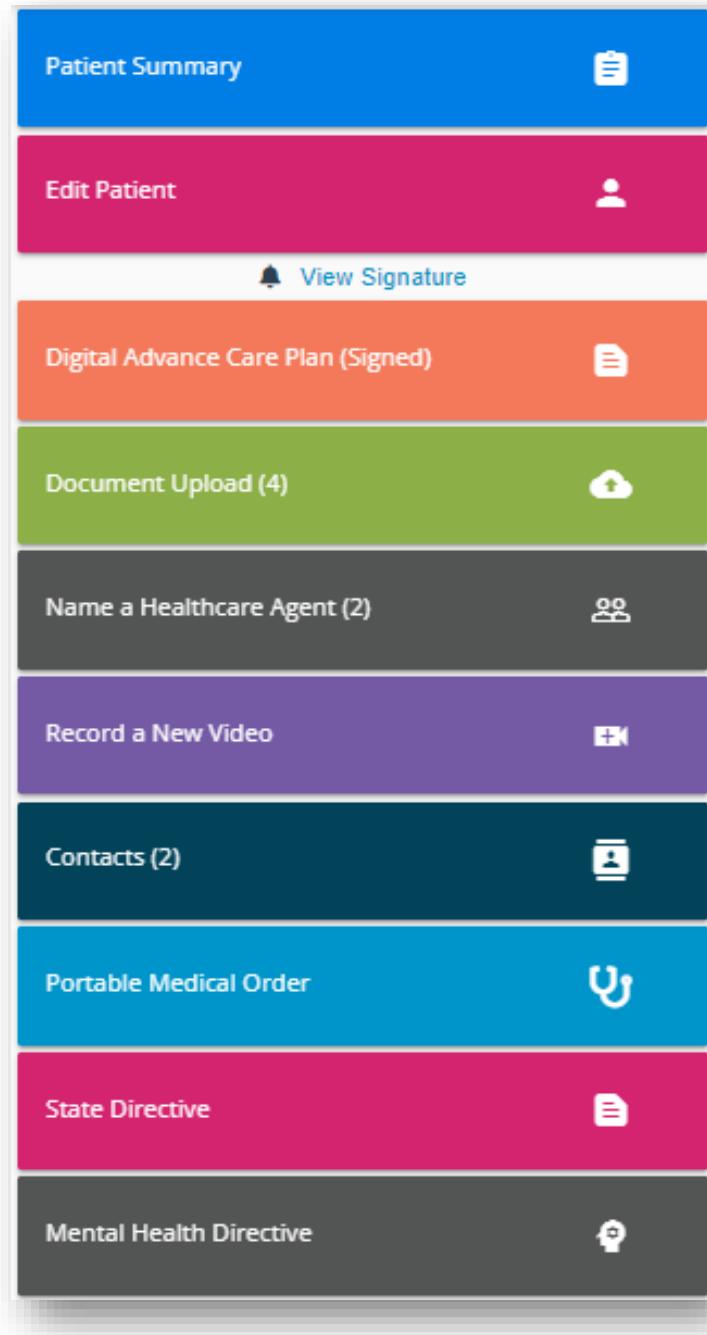
State Advance Directive

Paperless state specific directive

Mental Health Directive

Paperless Psychiatric Advance Directive

Patient Account Module's



Patient Summary

Patient Summary

Name John Smith
Address 123 Main St., Dallas, TX 75204
Email
Username johnsmith385

ACP Documents

 uADD
MyDirectives® Universal Advance
Digital Directive @    Updated: 02/23/2023

Uploaded Documents

| | |
|---|--|
|  DC Psychiatric Advance Directive Advance Statements And Decisions @    Updated: 11/17/2022 |  DC MOST MOST @    Updated: 11/17/2022 |
|  HIPAA HIPAA @    Updated: 10/06/2022 |  Johns Five Wishes Five Wishes® @    Updated: 12/12/2022 |
|  Johns Living Will Living Will @    Updated: 12/12/2022 |  Johns Caring Conversations Caring Conversations® @    Updated: 12/12/2022 |

Healthcare Agents

| | |
|--------------------------------------|---|
| Jane Doe Primary Healthcare Agent | Steve Smith First Alternate Healthcare Agent |
|--------------------------------------|---|

Video Files

None

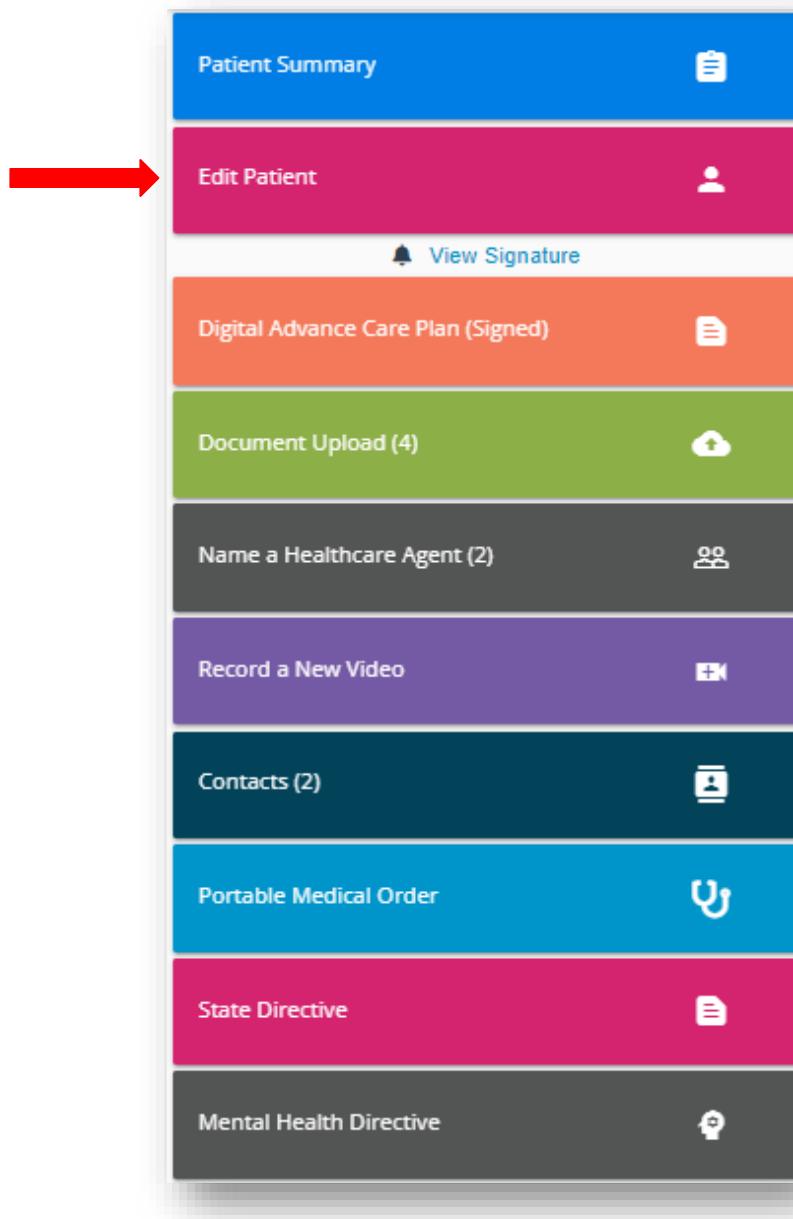
Contacts

| | |
|---|---|
| Jane Doe jdoe@gmail.com (815) 555-5555 Primary HCA | Steve Smith steve.smith@hotmail.com (815) 555-5555 Alternate HCA |
|---|---|

Edit Patient Information

Select Edit Patient if any information needs to be changed or updated on your patient's account.

1. As stated previously, the username is automatically generated. If your patient would like to select their username or change their current username, they can do this at any time.



Edit Patient

| | | | |
|---------------------------|--------------------|-----------------------------|----------------|
| First Name John | Last Name Smith | Date of Birth 12-12-1990 | Gender Male |
| Mobile Phone | Email | Username johnsmith385 | |
| Address 1 123 Main St. | | Address 2 | |
| City Dallas | State TX | Zip Code 75204 | Country USA |
| SSN | DL State | Drivers License | |

Cancel **Save**

Patient's Advance Care Plan

Access the advance care plan by clicking on the Digital Advance Care Plan tile. The Digital Advance Care Plan (ACP) will guide you through creating the ACP for your patient.

Advance Care Plan Status

The tile will show you the status of the patient's ACP. The status shows "Not Completed," meaning the patient's ACP has not been completed. The statuses for the patient's ACP include:

- No status shown: The ACP has not been started.
- Complete: The ACP has been completed and signed.
- Not Complete: The ACP is incomplete and is not signed.
- Not Signed: The ACP is complete but has not been signed.

Create or Update the Patient's ACP

If you or the patient have previously completed an ACP from MyDirectives or MyDirectives for Clinician portal, those choices will appear in the plan. If the patient does not have an existing plan with MyDirectives, you will go through each of the questions in the ACP.

Questions will auto-save, so you do not have to click Save for the question to update. If you make any changes to the ACP, then you and the patient must sign the ACP.

You will click on each tile in the ACP and complete all required questions. All required questions must be completed before you and the patient can sign the ACP.

My Advance Care Goals Questions

Each question in this section requires a minimum of one response to complete. Some questions will require a follow-up selection to the question.

What is important to you?

1. The “what is important to you question” requires at least one response to complete. You will drag the tiles the patient selects to the rectangular box area, and you can prioritize the responses by the patient’s wishes in the rectangular box area by dragging the tile up or down.

1

▼ My Advance Care Goals

1. **What is important to you?**

If you're seriously ill and can't make your wishes known, you would obviously want your doctors to try to improve your condition. But, in case they can't, you might want them to know the things about your life and health that you value most.

(Select all that apply. Your selections can be prioritized by clicking and dragging to adjust the order.)

Select (drag) one or more items listed below to this section

Being free from pain

Being with my family

Being able to feed, bathe, and take care of myself

Not being a financial burden to my family

Not being a physical burden to my family

Being at peace with my God

Resolving conflicts

Avoiding prolonged dependence on machines

Avoiding prolonged dependence on artificial or assisted nutrition through tubes

Dying at home

Other things that are very important to me about life and health...

Patient is not of sound mind.

If the patient is no longer of sound mind, how do they want their care managed? Please select one of the answers by clicking on the corresponding space.

Q If in the future your doctors determine you no longer have sound decision-making capacity or you are declared incompetent, do you want your doctors to follow the preferences you're expressing now, or do you want to be allowed to change these preferences in the future regardless of your mental state?

- If I am declared incompetent, follow this document.
- If I am declared incompetent, let me override this document regardless of my mental state.

Religion, Faith & Spirituality

The patient can provide information to the care team about the role religion, faith, or spirituality play a role in the patient's life. Please select one of the answers by clicking on the corresponding space

Answering yes will open a section to allow for the patient to expand on their answer and provide more detail as to their wishes.

Q Do you want doctors and nurses to know about the role religion, faith, or spirituality play in your life?

Yes...

Use this text box to tell them about any beliefs and observances you would like them to know about.

Please enter your thoughts.

Type here...

No

Suffering Significant Pain

Please select one of the answers by clicking on the corresponding space.

Q If you are having significant pain or suffering, would you like your doctors to consult a Supportive and Palliative Care Team to help treat your physical, emotional, and spiritual discomfort, and to support your family?

Yes

No

My Preferences in Specific Circumstances Questions

Each question in this section requires a minimum of one response to complete. Some questions will require a follow-up selection to the question.

Terminal Illness

The patient will answer the question that pertains to terminal illness. Please select one of the answers by clicking on the corresponding space:

You will click the first option if the patient stops all life-sustaining treatments.

Additional information is required to complete the question if the patient requests life-sustaining treatments.

1. Select the "For" option, and the patient will determine the period, and you will enter that information by adding the number the patient stated, then select from the dropdown menu choose either day(s), week(s), month(s), or year(s).
2. The patient may want life-sustaining treatments indefinitely, which can be selected by selecting the Indefinitely circle box.
3. The patient may want the Healthcare Agent to determine the time to stop life-sustaining efforts, which can be selected by clicking the Until my healthcare decides circle box.
4. The patient can choose Neither if the patient is not satisfied with the options.

Q Imagine you have a terminal illness that doctors believe will prevent you from meaningfully interacting with your family, friends or surroundings. Based on your priorities, how would you prefer to be treated?

I prefer that they stop all life-sustaining treatments and let me die as gently as possible. I realize that I would not receive life-sustaining treatments including but not limited to breathing machines, blood transfusions, dialysis, heart machines, and IV drugs to keep my heart working. Also, I realize that cardiopulmonary resuscitation (CPR) would not be attempted, and I would be allowed to die naturally.

I would like them to keep trying life-sustaining treatments...

| | | |
|---|--|---|
| 1 | <input type="radio"/> For <input type="text"/> <input type="button" value="▼"/> | <input checked="" type="radio"/> day(s) |
| 2 | <input type="radio"/> Indefinitely. | <input type="radio"/> week(s) |
| 3 | <input checked="" type="checkbox"/> Until my healthcare agent decides it is time to stop life-sustaining treatments and let me die gently. | <input type="radio"/> month(s) |
| 4 | <input type="radio"/> Neither of the choices above reflects my preference, and I have additional thoughts on this... | <input type="radio"/> year(s) |

If the patient wants all life-sustaining treatments stopped, additional information is required to complete the question.

1. The patient can select the following:
 - No, I do not want additional nutrition and hydration.
 - Yes, I do want additional nutrition and hydration.
 - I do not know.

Q In the situation described above, would you want artificial nutrition and hydration?

1

No, I do not want artificial nutrition and hydration.

Yes, I do want artificial nutrition and hydration.

I do not know if I want artificial nutrition and hydration. I would like to talk with my doctor or someone else before I make that decision. I understand that my uADD will not include a statement on artificial nutrition and hydration, which means I could receive those treatments even if I do not want them.

Brain Injury

How the patient wants to be treated in the event of life-sustaining treatments after a severe and irreversible brain injury. Please select one of the answers by clicking on the corresponding space:

1. Select the "For" option, and the patient will determine the period you will enter that information by adding the number the patient stated, then select from the dropdown menu choose either day(s), week(s), month(s), or year(s)
2. The patient may want the life-sustaining treatments indefinitely, which can be selected by selecting the Indefinitely circle box.
3. The patient may want the Healthcare Agent to determine the time to stop life-sustaining efforts, which can be selected by clicking the Until my healthcare decides circle box
4. The patient can choose Neither if the patient is not satisfied with the options

Q Now imagine that you have a severe, irreversible brain injury. You can't feed or bathe yourself, and you can't communicate with others, but doctors can keep you alive for a long time. Based on your priorities, how would you prefer to be treated?

I prefer that they stop all life-sustaining treatments and let me die as gently as possible. I realize that I would not receive life-sustaining treatments including but not limited to breathing machines, blood transfusions, dialysis, heart machines, and IV drugs to keep my heart working. Also, I realize that cardiopulmonary resuscitation (CPR) would not be attempted, and I would be allowed to die naturally.

I would like them to keep trying life-sustaining treatments...

1

For

Please enter reasonable period and amount of periods.

2

Indefinitely.

3

Until my healthcare agent decides it is time to stop life-sustaining treatments and let me die gently.

4

Neither of the choices above reflects my preference, and I have additional thoughts on this...

If the patient wants all life-sustaining treatments stopped, additional information is required to complete the question.

1. The patient can select the following:

- No, I do not want additional nutrition and hydration
- Yes, I do want additional nutrition and hydration
- I do not know

1. In the situation described above, would you want artificial nutrition and hydration?

No, I do not want artificial nutrition and hydration.

Yes, I do want artificial nutrition and hydration.

I do not know if I want artificial nutrition and hydration. I would like to talk with my doctor or someone else before I make that decision. **I understand that my uADD will not include a statement on artificial nutrition and hydration, which means I could receive those treatments even if I do not want them.**

CPR

You will guide the patient through their thoughts on CPR. Please select one of the answers by clicking on the corresponding space

1. Which of the following statements best describes your thoughts on CPR?

I want CPR attempted unless my doctor says any of the following...

- I have a terminal illness or a severe, irreversible brain injury; OR
- I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering; OR
- It simply will not work in my condition.

I do not want CPR attempted.

Without knowing the future facts, it is hard to make this statement today, so I will rely on my healthcare agent to decide for me.

I want CPR attempted if my heart or breathing stops.

If you would like to provide additional thoughts, click on *I have additional thoughts on this...* and a text box will be displayed, and you may share your thoughts in the text box.

Q I have additional thoughts on this...

Type here...

My End-of-Life Preferences Questions

Please select one of the answers by clicking on the corresponding space.

Where to spend final days

The patient can select where they choose to spend their last days.

Please select one of the answers by clicking on the corresponding space:

1. The At home option will add an additional option that must be selected:
 - a. The patient can select the option to have hospice care if available
2. In the hospital selection, adds an option (Example in the second picture below):
 - a. The patient can request a consultation with a Supportive & Palliative Care Team, if possible
3. In a hospice facility
4. Select "I am not sure." If the patient is not ready to answer this question

Q If it were possible to choose, where would you like to spend your final days?

1

At home...

I want hospice care at home if possible.

3

In the hospital...

4

In a hospice facility.

I'm not sure.

Q If it were possible to choose, where would you like to spend your final days?

2

At home...

In the hospital...

I want a consultation with a Supportive and Palliative Care team, if possible.

In a hospice facility.

I'm not sure.

If you would like to provide additional thoughts, click on *I have additional thoughts on this...* and a text box will be displayed, and you may share your thoughts in the text box.

Q I have additional thoughts on this...

Type here...

Tissue Donation

You will guide the patient through the set of questions.

Please select one of the answers by clicking on the corresponding space:

Q What are your thoughts on organ and tissue donations?

1

I want to donate my organs to help save someone else's life...

I want to donate my entire body.

I don't want to donate my organs.

I'd like my healthcare agent to decide that after I die.

I'm not sure.

2. If the patient selects to donate my organs, then the patient will need to make one of the following decisions:

- All organs
- The patient can list which organs they wish to donate in the text box that appears when this option's selected.
- The patient can opt to donate the whole body.
- The patient can opt not to donate their organs.
- The patient can select to let the healthcare agent decide.
- Or select the box I am not sure if the patient is undecided.

Q What are your thoughts on organ and tissue donations?

I want to donate my organs to help save someone else's life...

Which organs do you want to donate?

Please make a choice.

All organs

I choose to donate only the following...

I want to donate my entire body.

I don't want to donate my organs.

I'd like my healthcare agent to decide that after I die.

I'm not sure.

If you would like to provide additional thoughts, click on *I have additional thoughts on this...* and a text box will be displayed, and you may share your thoughts in the text box.

Q I have additional thoughts on this...

Type here...

Thoughts on Autopsy

You will guide the patient through their thoughts regarding an autopsy.

1. Please select one of the answers by clicking on the corresponding space

Q What are your thoughts regarding autopsy?

1

- I want an autopsy if my doctor thinks it will help others.
- I want an autopsy only if there are questions about my death.
- I don't want an autopsy.
- I want the person who's designated by law to make this decision to decide after I die.
- I'm not sure.

If you would like to provide additional thoughts, click on *I have additional thoughts on this...* and a text box will be displayed, and you may share your thoughts in the text box.

Q I have additional thoughts on this...

Type here...

My Thoughts

My Likes/Joys

In the text box, the patient can share their likes and dislikes. These are the patient's wishes and are not required to complete the ACP.

Q My Likes / Joys

Describe the things that bring you joy. Photographs or other items you would like to have nearby, or music you'd like to hear. A favorite pillow, a night light or your favorite flowers.

Type here...

Follow the same process for each of the sections in My Thoughts:

- My Dislikes/Fears
- How to Care for Me
- My Religion
- My Unfinished Business
- If I Were to Pass Away
- Laughter
- Message to People Who Matter to Me
- Information People may need to know

My Dislikes/Fears

Q My Dislikes / Fears

Describe the things you fear, like being left alone or being in the dark. Maybe you don't like needles. Perhaps there are visitors you don't want to see, or maybe you fear a family member or pet won't be cared for.

Type here...

How to care for me

Q How to Care for Me

Describe how you want people to care for you. When do you want to be bathed, and how do you want your appearance to be maintained? Do you like to be kept warm or cool? Maybe you like sunlight and fresh air.

Type here...

My Religion

Q My Religion

Do you identify with a particular religion or faith? Would you like the people treating you to contact someone from your faith? Do you have any special religious rituals, dietary issues or other observances you'd like caregivers to know about?

Type here...

Q My Religion

My Unfinished Business

Q My Unfinished Business

Describe any unfinished emotional business that needs to be addressed. Record any thoughts, comments or wishes you'd like to express to anyone you choose.

Type here...

If I Were to Pass Away

Q If I Were to Pass Away

Record any pre-arranged funeral or burial plans, or express any wishes that you'd like healthcare providers, family or friends to follow.

Type here...

Laughter

Q Laughter

Use this space to tell caregivers what makes you laugh. There's growing evidence of the role laughter can play in healing and grieving. Just knowing what makes you laugh may be comforting to others.

Type here...

Messages to People Who Matter to Me

Q Messages to People Who Matter to Me

If you cannot express yourself, use this space to say something to your healthcare agent, family, and friends.

Type here...

Information People May Need to Know

Information People May Need to Know

Provide information about where others can find your important documents or information they may need.

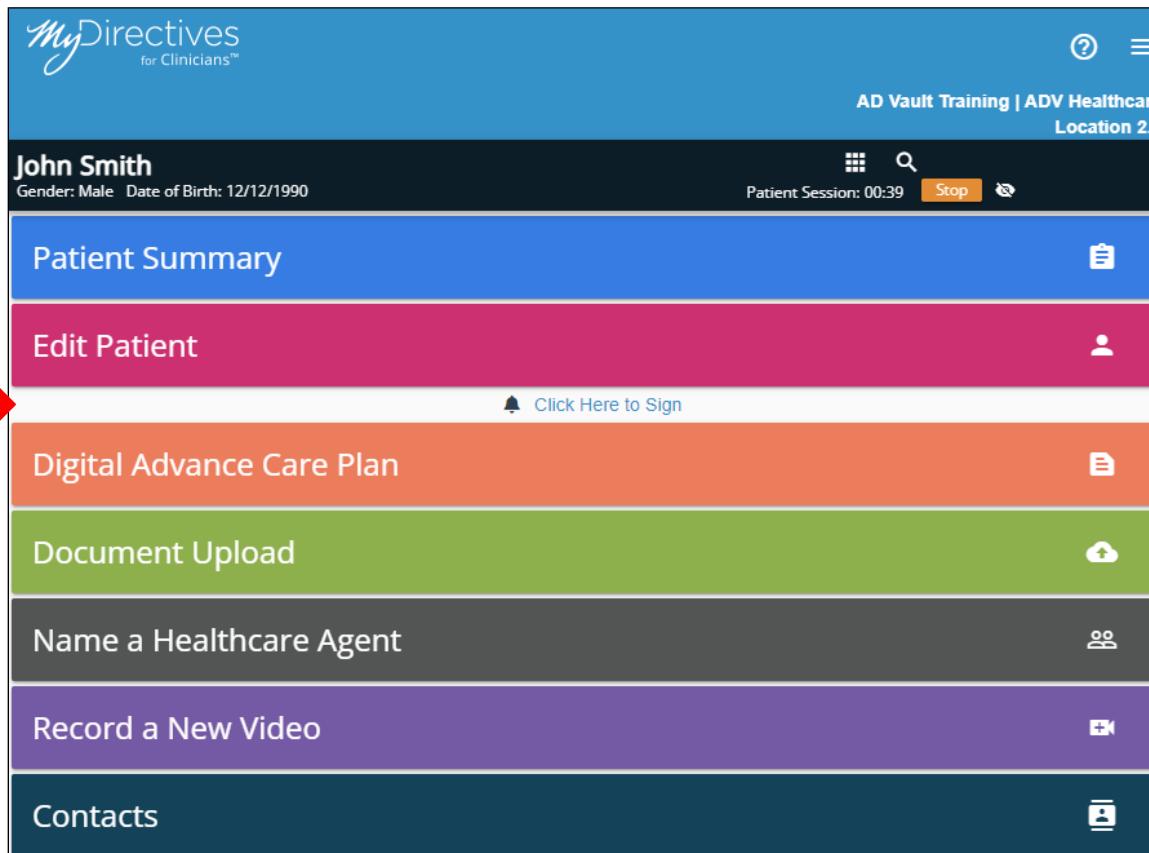
Type here...

Signature

You and the patient can sign the ACP once you have completed all required fields in the ACP documents.

How do you know the ACP is ready to be signed?

You will know the document is ready to be signed when you see *the documents that need to be signed listed* in the Digital Advance Care Plan tile. You will click on the tile to launch the signature module.



The screenshot shows the MyDirectives for Clinicians software interface. At the top, it displays the logo and the text "AD Vault Training | ADV Healthcare Location 2.". Below this, the patient information "John Smith" and "Gender: Male Date of Birth: 12/12/1990" is shown. The interface is divided into several colored tiles: a blue "Patient Summary" tile, a red "Edit Patient" tile with a "Click Here to Sign" button, an orange "Digital Advance Care Plan" tile (which has a red arrow pointing to it), a green "Document Upload" tile, a grey "Name a Healthcare Agent" tile, a purple "Record a New Video" tile, and a dark blue "Contacts" tile.

Sign the ACP

Once the ACP is completed and you have clicked on the Sign link, a document signature page will appear.

1. If the patient cannot sign the ACP, you will click the check box next to the patient's name, which is located above the patient's signature. Checking this box allows the patient to consent to execute the ACP digitally verbally, and you will sign your name below.
2. If the patient is not present, you will click the Request Remove Signature button, allowing the patient to sign on their own device. They will receive a request via text message or email; whichever they prefer.
3. If the patient is present and can sign, then the patient and you will both sign and click submit. Your signature should automatically appear in the facilitator box.
4. If the patient needs the signature redone, click on the Clear button to remove the signature and sign again.
5. Click submit when finished to complete the patient's ACP.

Digital Document Signature

1 **John Smith** has given verbal consent to digitally execute this Advance Care Plan (no signature required)

2 **X**

3 **Patient Name:** John Smith
Patient DOB: 12/12/1990

4 **Request Remote Signature** **Clear**

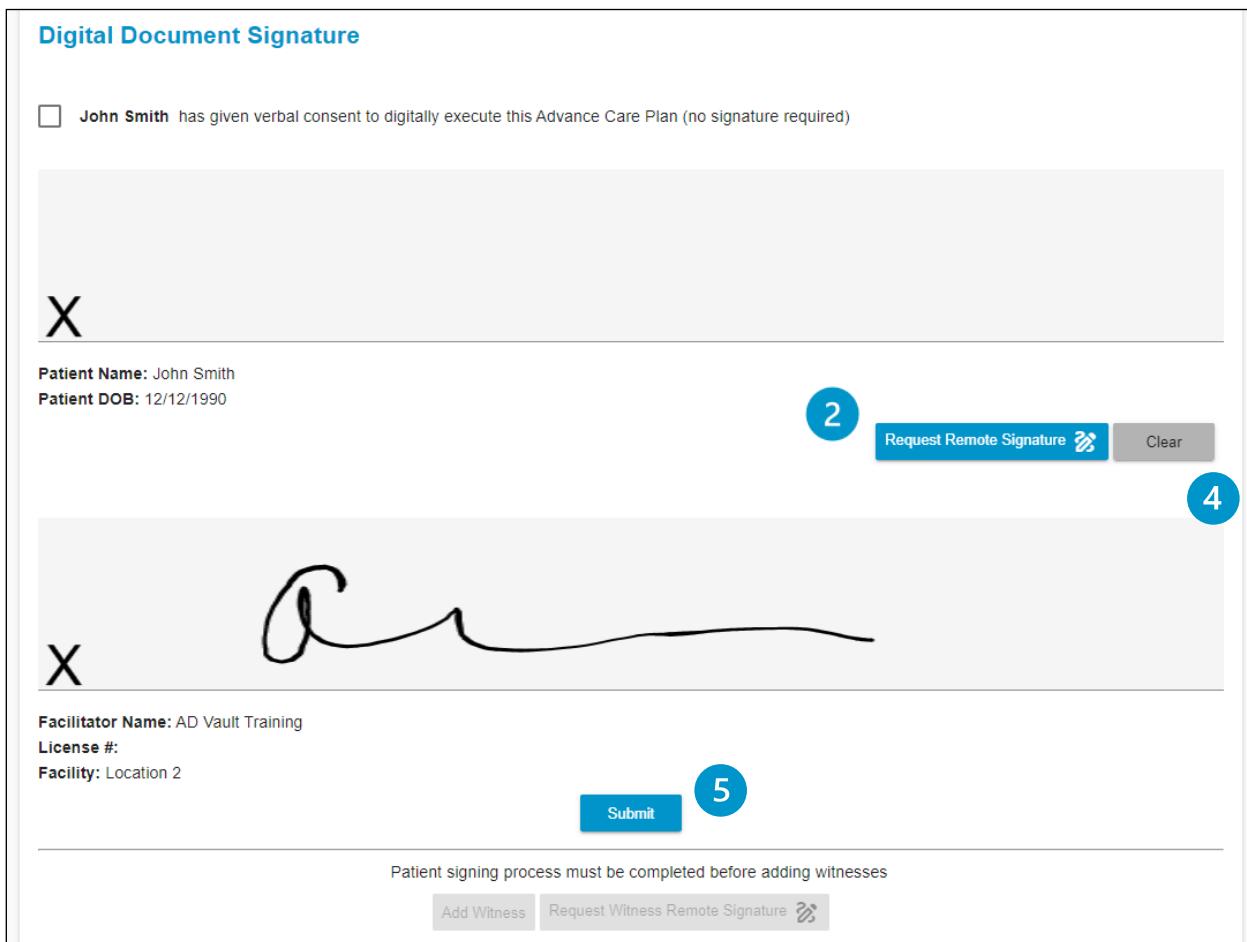
5 **X** 

Facilitator Name: AD Vault Training
License #:
Facility: Location 2

Submit

Patient signing process must be completed before adding witnesses

Add Witness **Request Witness Remote Signature**



Request Remote Signature

The first and last name of the patient will automatically populate in the popup window. Depending on the patient's preferences, they have the option to receive a text message or email allowing them to click a link to sign their documents.

Request Remote Signature from:

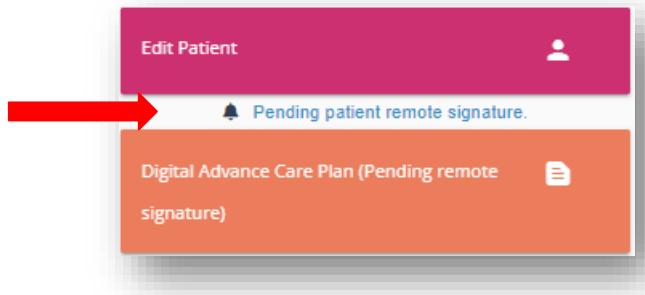
You are requesting a remote signature from ADV Healthcare. Upon receipt of this request, ADV Healthcare will be able to review and sign their ACP.

The signature request is being sent to:

| | |
|---|--|
| First Name ADV | >Last Name Healthcare |
| <input type="text"/> X 3 / 50 | <input type="text"/> X 10 / 50 |
| Mobile Phone | Email |
| <input type="text"/> 0 / 100 | |

SEND **CANCEL**

Note that the module will say pending remote signature until the patient has signed his or her documents and clicked submit.

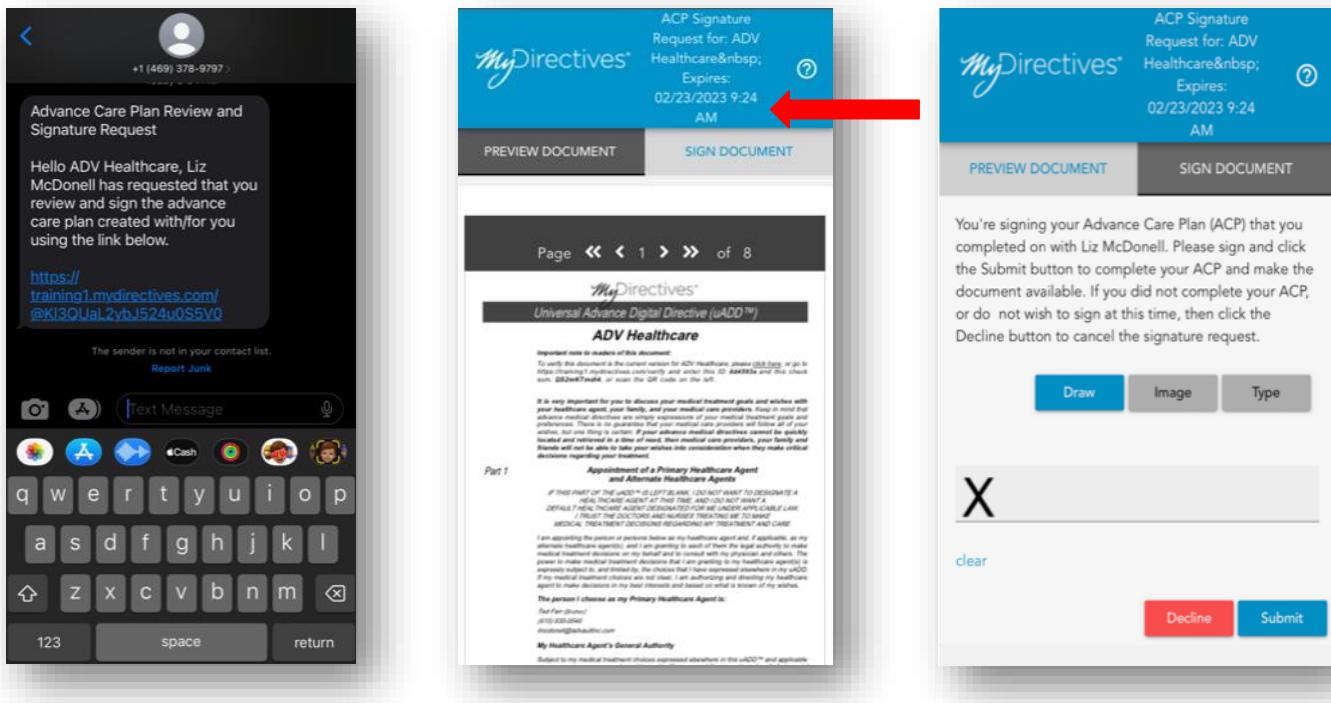


Request Remote Signature – Text Message

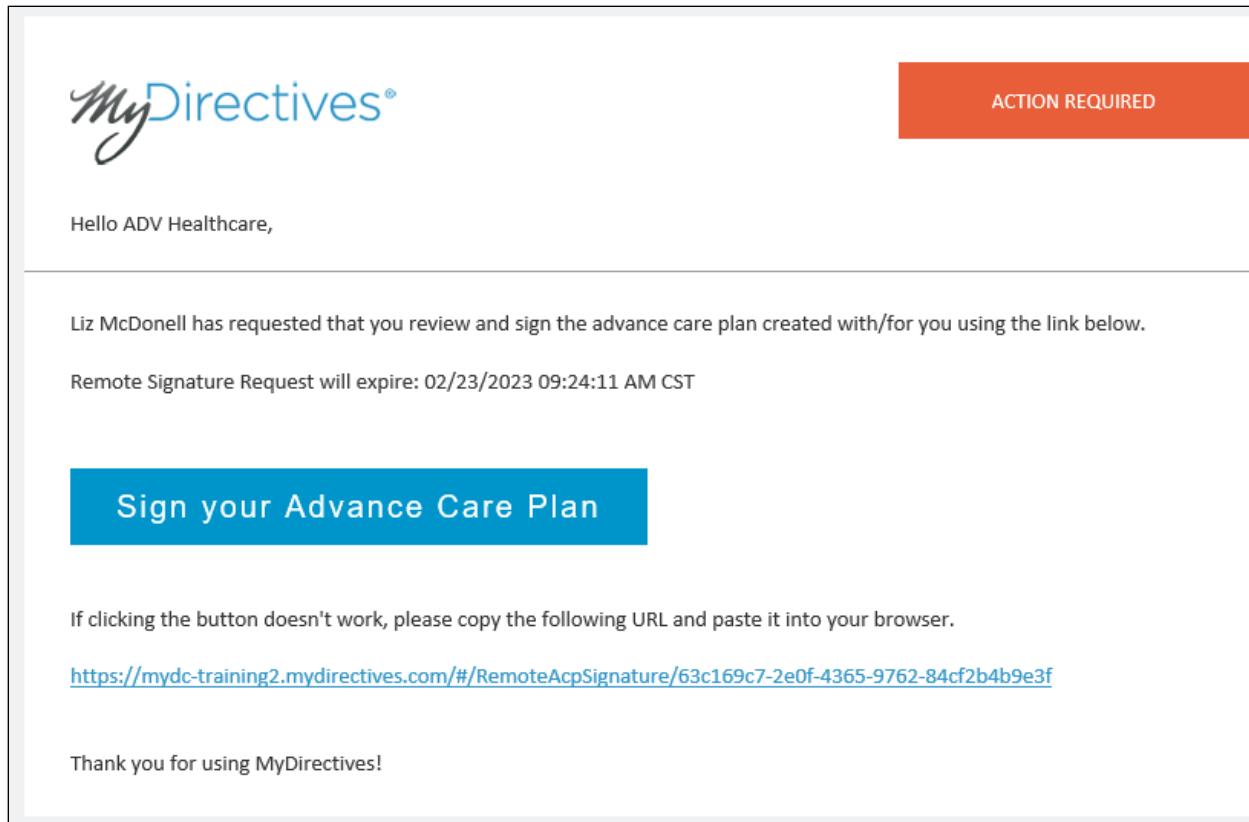
An example of the text message the patient will receive from you with the link to submit their signature from their own device.

After the patient selects the link provided via text message. Their documents will appear for them to review and sign. They will have to sign and submit within the allocated time frame, as shown below.

After the patient has reviewed their documents, they will select Sign Document. They will have the option to draw their signature with their finger, select an image, or type their signature – they will then select submit, allowing the provider to see their signature on their end.



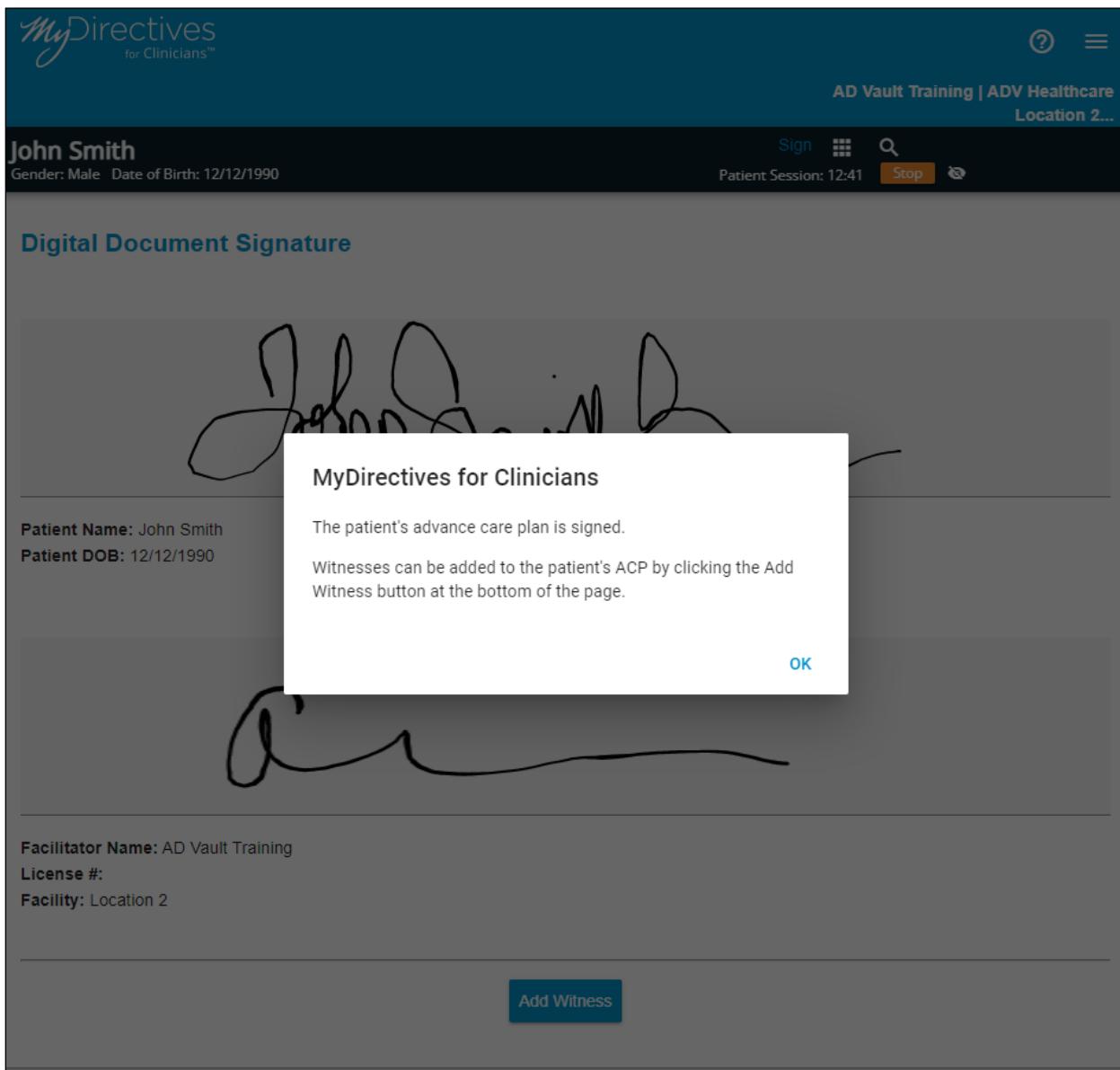
If their patient would like to receive an email, like the example below – they will select Sign your Advance Care Plan to be taken to the signature page.



The image shows an email from MyDirectives. The subject line is "ACTION REQUIRED". The body of the email reads: "Hello ADV Healthcare, Liz McDonell has requested that you review and sign the advance care plan created with/for you using the link below. Remote Signature Request will expire: 02/23/2023 09:24:11 AM CST". A large blue button with the text "Sign your Advance Care Plan" is prominently displayed. Below the button, a note says "If clicking the button doesn't work, please copy the following URL and paste it into your browser." followed by a link: <https://mydc-training2.mydirectives.com/#/RemoteAcpSignature/63c169c7-2e0f-4365-9762-84cf2b4b9e3f>. The email concludes with "Thank you for using MyDirectives!"

Confirmation the ACP is Signed

You will see a message confirming the ACP is signed after you and the patient have fully executed the signature. You can add witnesses to the patient's ACP once the ACP is complete.



Add Witnesses to the patient's ACP.

You will see that the Witness button is now on, and you can add a witness to the patient's ACP.

1. Select Add Witness to add one or more witnesses to the patient's ACP if they are present.
2. If the witness is not present, select Request Witness Remote Signature. They will have the same option of receiving a text message or email, just as the remote patient signature explained above.

The screenshot shows the MyDirectives for Clinicians software interface. At the top, the logo 'MyDirectives for Clinicians™' is on the left, and 'AD Vault Training | ADV Healthcare Location 2...' is on the right. Below the header, the patient's name 'John Smith' is displayed, along with 'Gender: Male' and 'Date of Birth: 12/12/1990'. On the right, there are buttons for 'Sign', 'Patient Session: 13:56', 'Stop', and a search icon. The main content area is titled 'Digital Document Signature' and shows a handwritten signature of 'John Smith'. Below the signature, the patient's details are listed: 'Patient Name: John Smith' and 'Patient DOB: 12/12/1990'. Further down, another handwritten signature is shown. At the bottom, there are two buttons: 'Add Witness' (circled with a blue '1') and 'Request Witness Remote Signature' (circled with a blue '2').

Witness to ACP

You will click the Add Witness button to open the witness page. You can add one or more witnesses to the patient's ACP.

1. If the patient witness is present, you will have the witness read the declaration, sign it, and enter their information in the data field.
2. Click the Submit button after the witness has signed and entered their information and you have verified all fields are complete.

A confirmation message on the screen that verifies the witness has been added to the patient's ACP.

Witness Signature

1

Remote Witness: The witness participated in a remote interaction and authenticated the patient's identity. The witness also confirms that the declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

I declare that the person who signed this advance care plan, or who asked another to sign this advance care plan on his/her behalf, is the individual identified in the document, and he/she did so in my presence. I believe him/her to be of sound mind and at least 18 years of age.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or an parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

X

First Name _____ Last Name _____

Address 1 _____ 0 / 10

Address 2 _____

City _____ State _____ Zip _____

2

Remote Witness to ACP

Add a remote witness if the witness is not present when the patient signs the ACP. A witness can be added up to 24 hours after the patient's signature.

1. Select the check box next to Remote Witness. By selecting the remote witness, you will confirm the remote witness declares the patient signed or had another sign on the patient's behalf, using electronic audio-visual means.
 - You will add witness audio or visual recording.
 - You will enter the remote witness information in the data fields.
 - You will click the Submit button to add the witness to the patient's ACP.
 - You can add additional witnesses to the patient ACP by clicking the Add Witness button.

Witness Signature

1

Remote Witness: The witness participated in a remote interaction and authenticated the patient's identity. The witness also confirms that the declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

I declare that the person who signed this advance care plan, or who asked another to sign this advance care plan on his/her behalf, is the individual identified in the document, and he/she did so in real time using electronic audio-visual means to the same extent as if we were physically present with one another, or otherwise provided satisfactory proof to me of his/her identity. I believe him/her to be of sound mind and at least 18 years of age.

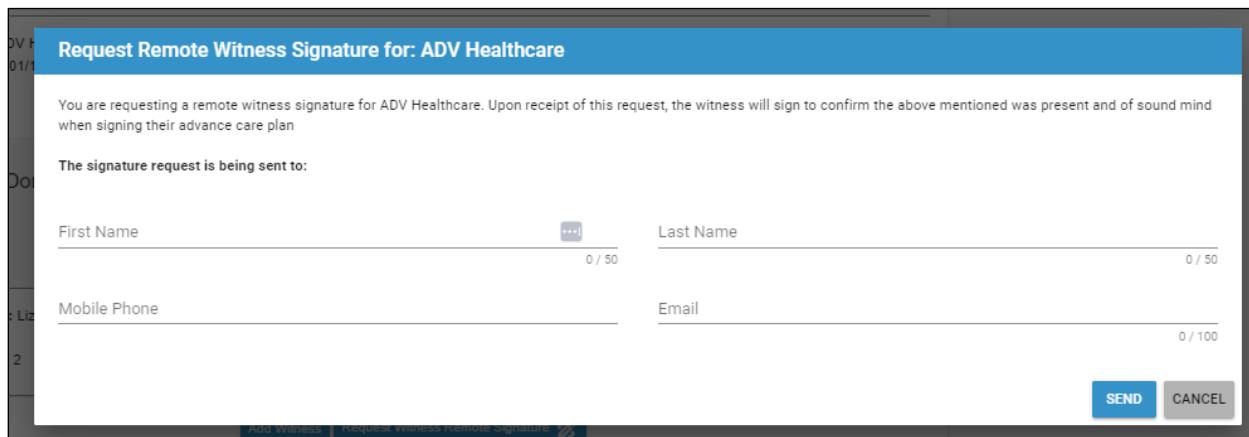
By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Select the witness recording

Request Remote Witness Signature

Enter the requested witness's first and last name, mobile number, and/ or email address, click send.



Request Remote Witness Signature for: ADV Healthcare

You are requesting a remote witness signature for ADV Healthcare. Upon receipt of this request, the witness will sign to confirm the above mentioned was present and of sound mind when signing their advance care plan

The signature request is being sent to:

First Name _____ 0 / 50

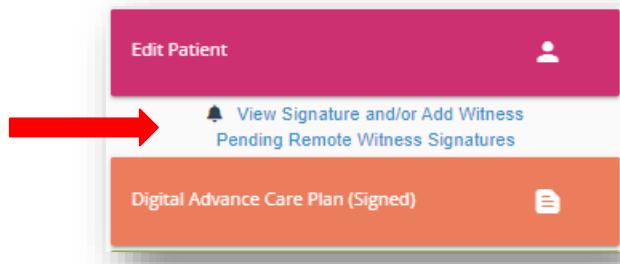
Last Name _____ 0 / 50

Mobile Phone _____

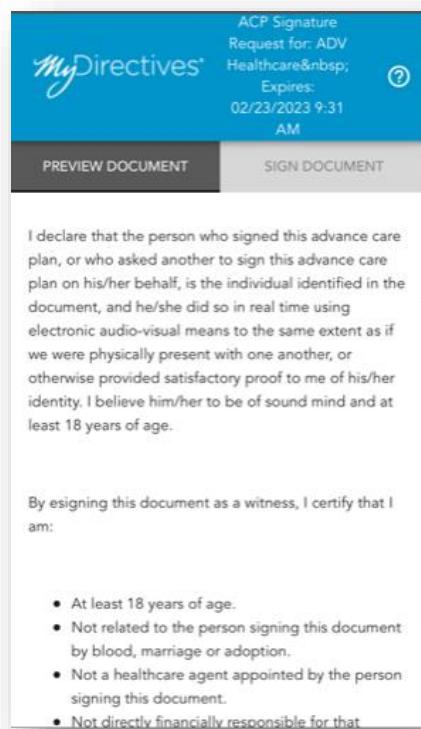
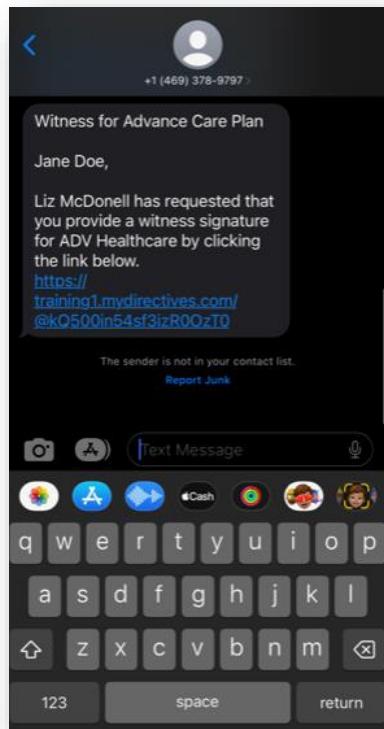
Email _____ 0 / 100

SEND **CANCEL**

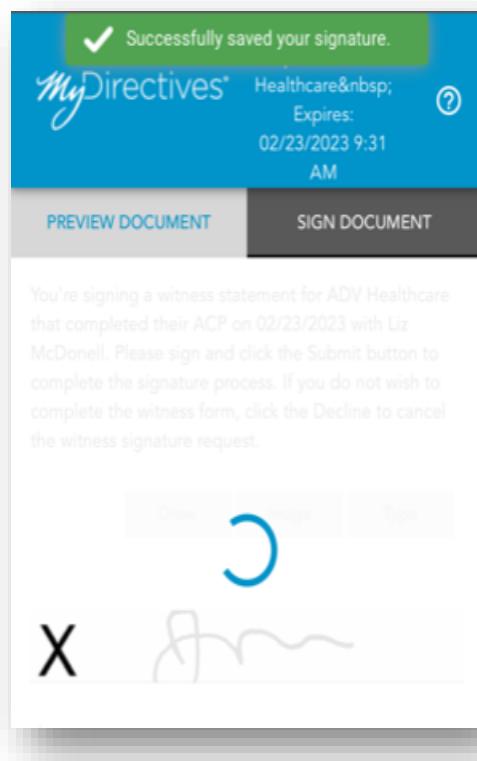
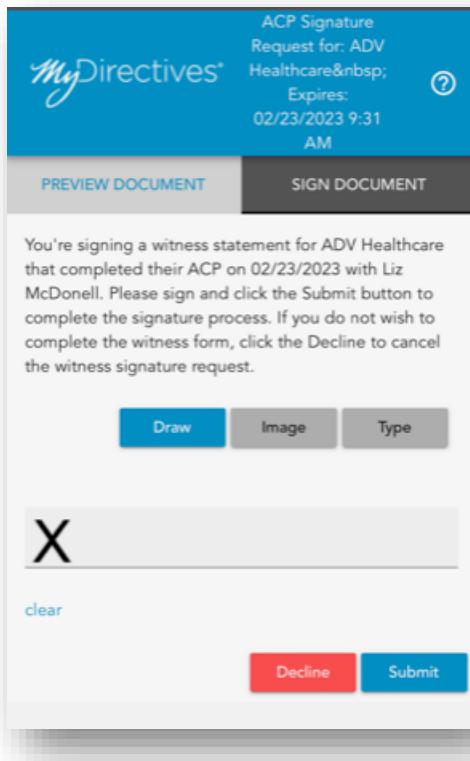
Please note that the signature notification on the side panel will update when the remote witness signature is pending.

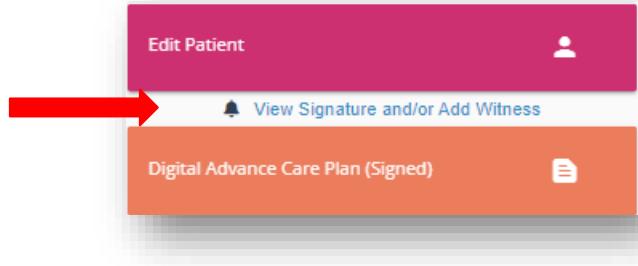


Remote Witness – Text Message and Document Link



Remote Witness - Text Message Link Signature and Confirmation





Remote Witness – Email

Below is an example of the email the desired witness will receive to sign your patient's document.

MyDirectives®

Hello Jane,

Liz McDonell has requested a witness signature for ADV Healthcare. Please click the "Sign Document" button below to provide your information and witness signature to the document.

Sign Document

If clicking the button doesn't work, please copy the following URL and paste it into your browser.

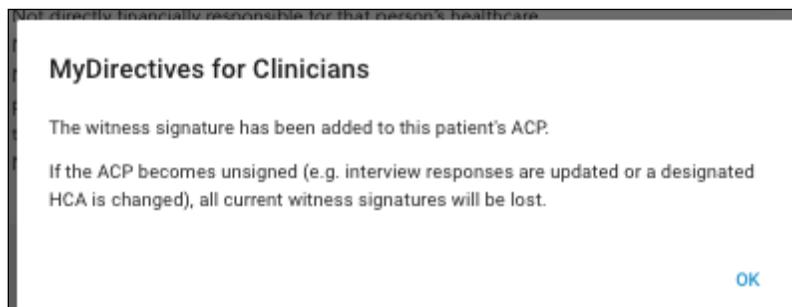
<https://mydc-training2.mydirectives.com/#/RemoteWitnessSignature/4e6ec801-fc02-43c0-825a-3e9139a5b017>

Thank you for using MyDirectives!

Confirmation of the witness was added to the ACP.

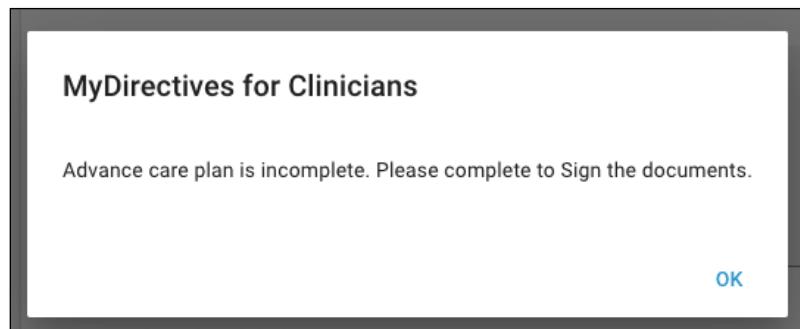
You will receive a confirmation message that the witness's signature was added to the patient's ACP.

All witness signatures are removed from the Patient's ACP if the ACP is changed. The patient's witness(es) must sign the patient's ACP again.



Pop-up message

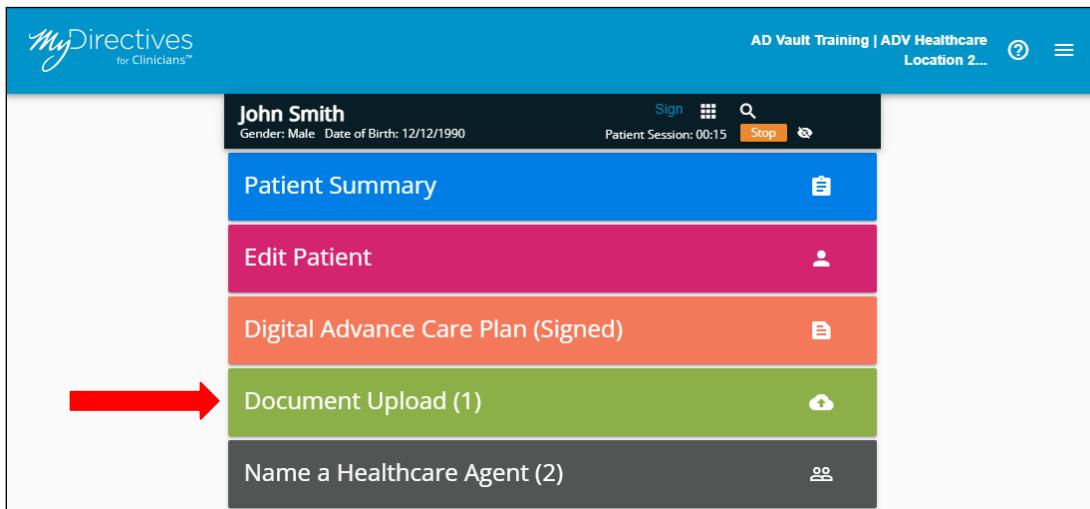
You will see the pop-up warning message if you attempt to sign the ACP before all documents are complete.



Document Upload

You can access and manage the patient's existing documents - Upload, download, view, or delete patient documents as needed and requested.

Select Document Upload to access the patient's documents.



Patient Document's

Manage the patient's current documents. The uADD, also known as an Advance Care Plan (ACP), is the digital ACP created in the MyDirectives for Clinicians portal. The HIPAA form is autogenerated when the patient's account is created, and other documents may be uploaded to the patient's account (See examples below).

All documents can be viewed and downloaded. The uploaded documents to the portal can be viewed, downloaded, deleted, or replaced. The icons next to each document will allow you to manage these documents.

1. Select Upload New Document to add a new document to the patient's record.
2. Select Refresh List to update the documents if changes have been made when you are on this page.

The screenshot shows the 'Document List' page. At the top, the title 'Document List' is displayed. Below it, a card shows a 'HIPAA' document with a download icon, an 'Updated: 10/06/2022' timestamp, and a refresh icon. A blue button labeled '1 + Upload New Document' is located at the bottom right of the card. To the right of the card, a blue circle with the number '2' contains a 'Refresh List' button.

Complete the fields below to upload a document.

- What do you want to call this document?
- What type of document is this?
- When was this document created?
- Select a file.

Document Upload

Complete the fields below to upload a document

What do you want to call this document? _____

What type of document is this? _____

When was this document created? _____

Select a File _____

CANCEL **SKIP** **UPLOAD**

Document List

After you have completed a document upload, it will appear under the document list, just like the example you see below.

John Smith
Gender: Male Date of Birth: 12/12/1990

Sign   Patient Session: 00:09 **Stop** 

Document List

| | |
|--|--|
|  uADD MyDirectives® Universal Advance Digital Directive |   Updated: 10/31/2022 |
|  HIPAA HIPAA |   Updated: 10/06/2022 |
|  John's Five Wishes Five Wishes® |     Updated: 10/31/2022 |
|  John's Living Will Living Will |     Updated: 10/31/2022 |

Upload New Document **Refresh List**

Document Upload

Click the Upload New Document button to add a new document to the patient's record.

1. Complete the required fields to upload a new document to the patient's record.
 - What does the patient want to call this document? Enter the document name that will appear on the document list.
 - What type of document is this? There will be a selection of document types that your organization approves of.
 - When was this document created? Please note: Do not enter today's current date; future dates will not be accepted.
 - Select a file. Click on the icon to open your computer browser and select the file to upload
2. When you have completed the required fields and are ready to upload the file, click Upload, and a document preview will display below.

The screenshot shows the 'Document Upload' interface for patient John Smith. The top bar displays patient information: John Smith, Male, Date of Birth: 12/12/1990, and a Patient Session timer. The main area is titled 'Document Upload' and contains the following fields:

- What do you want to call this document?** (Input field: John's Five Wishes)
- What type of document is this?** (Input field: Five Wishes®)
- When was this document created?** (Input field: 11-05-2021)
- File Selection:** (Input field: FiveWishes.pdf)

At the bottom are 'CANCEL' and 'UPLOAD' buttons. The number '1' is circled in blue next to the first input field, and the number '2' is circled in blue next to the 'UPLOAD' button.

Document Upload Preview

Once you have clicked the Upload button, you will see a preview of your document. You can verify the document is the correct documentation before uploading the document.

1. If the document has multiple pages, click the arrows to verify each page.
2. After verifying the document, select Upload to add the document to the patient's record.

You will have access to the document from the Document Upload page.

MyDirectives
for Clinicians™

AD Vault Training | ADV Healthcare
Location 2...

John Smith
Gender: Male Date of Birth: 12/12/1990

Sign Patient Session: 05:39 Stop

Document Upload

Complete the fields below to upload a document

What do you want to call this document?
John's Five Wishes

What type of document is this?
Five Wishes®

When was this document created?
11-05-2021

FiveWishes.pdf

CANCEL UPLOAD

1

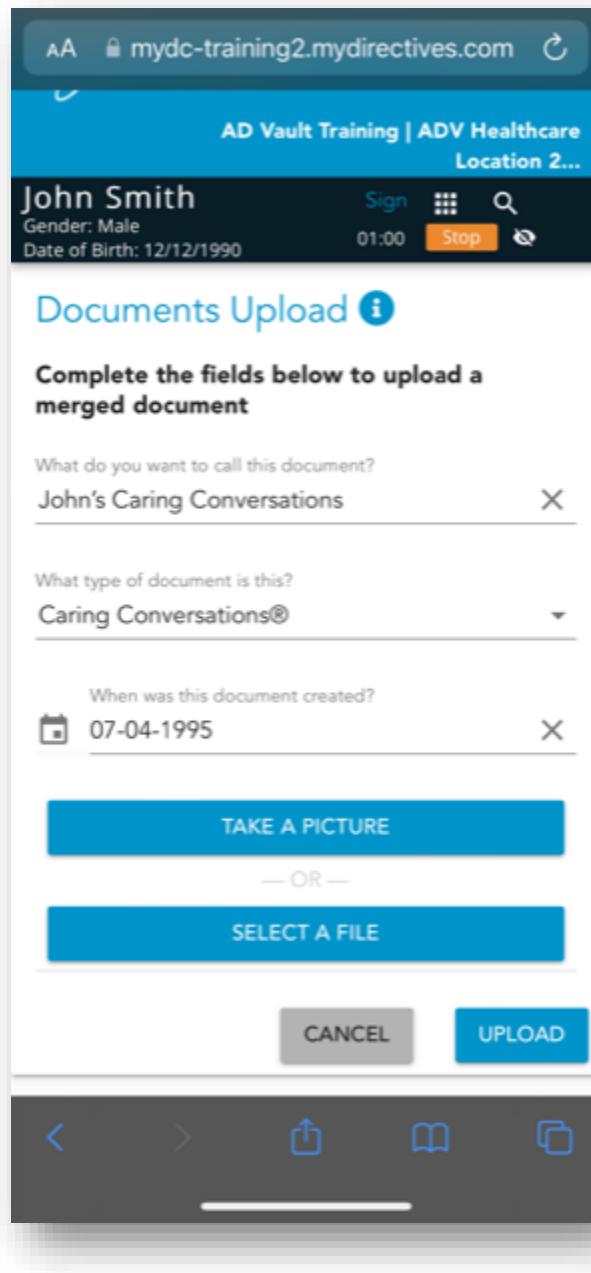
Page << < 1 > >> of 13

FIVE
WISHES®

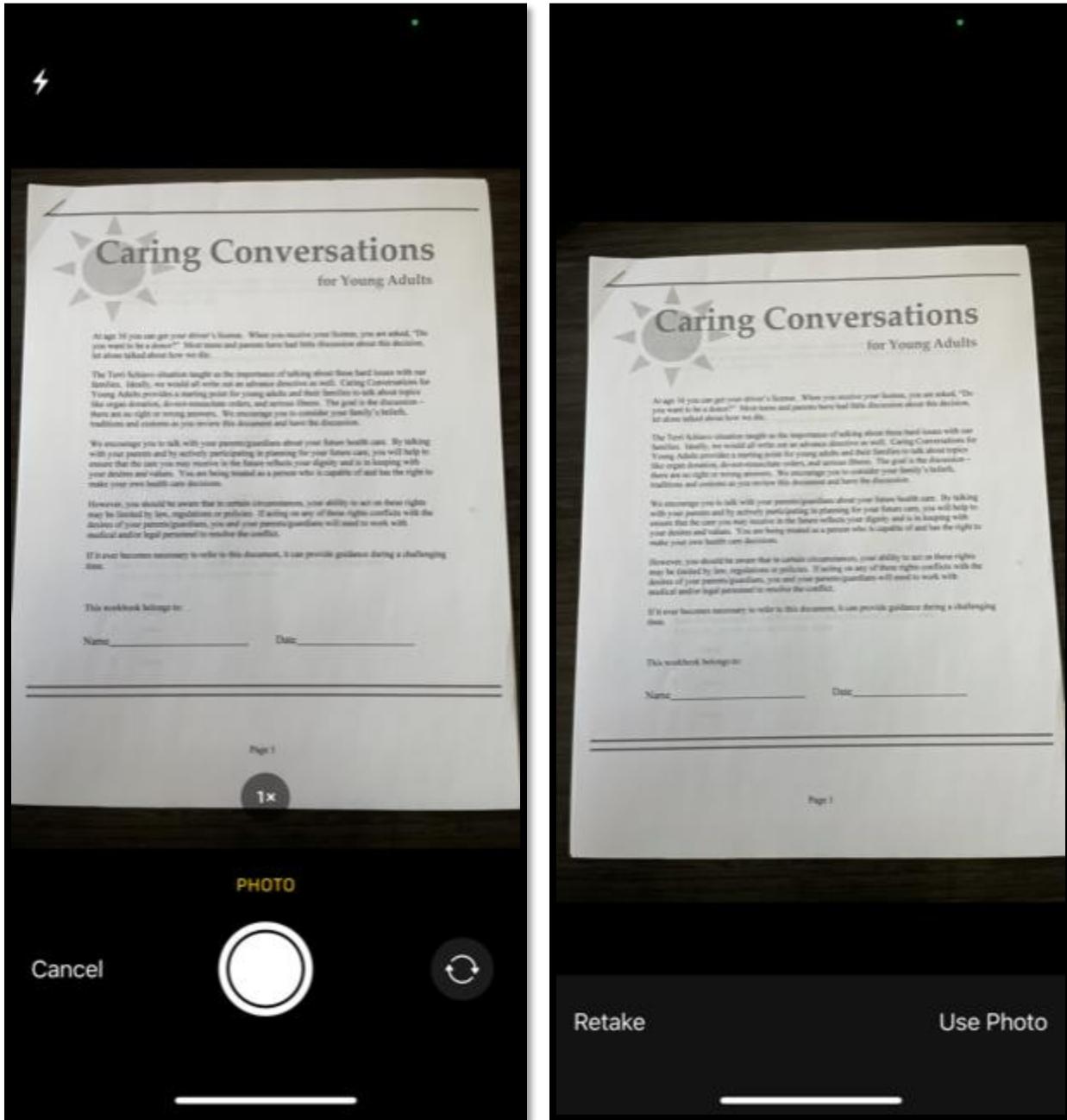
Document Upload Preview – Mobile Phone

Once you have clicked the Upload New Document button using your mobile device, you will be asked to complete the fields below to upload a merged document.

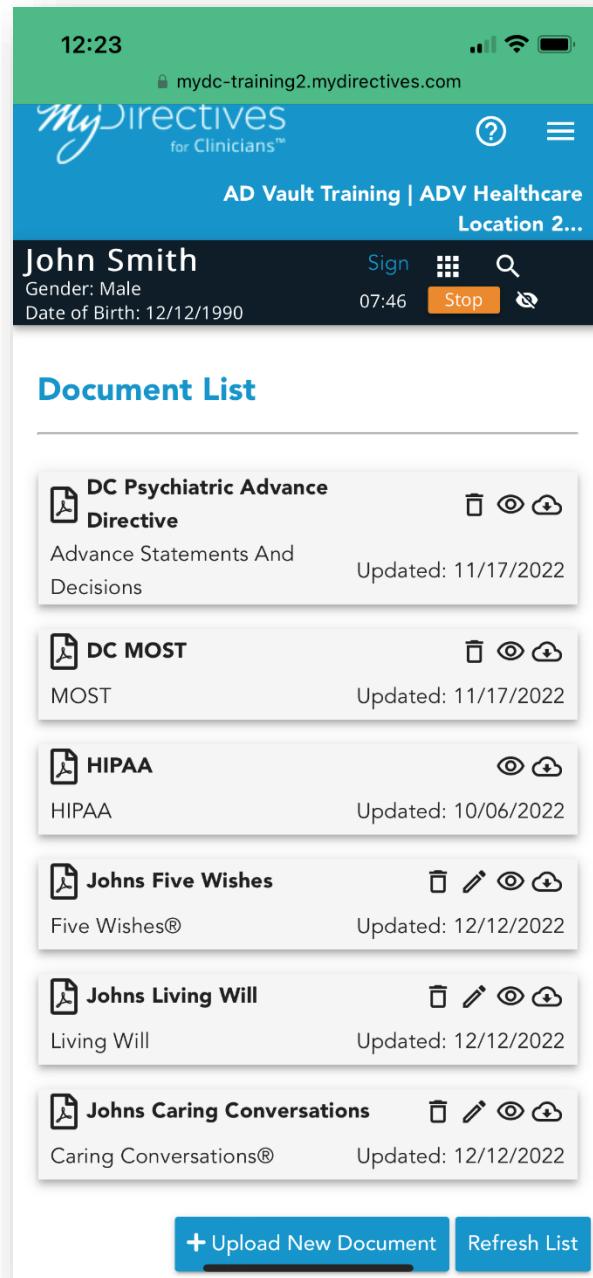
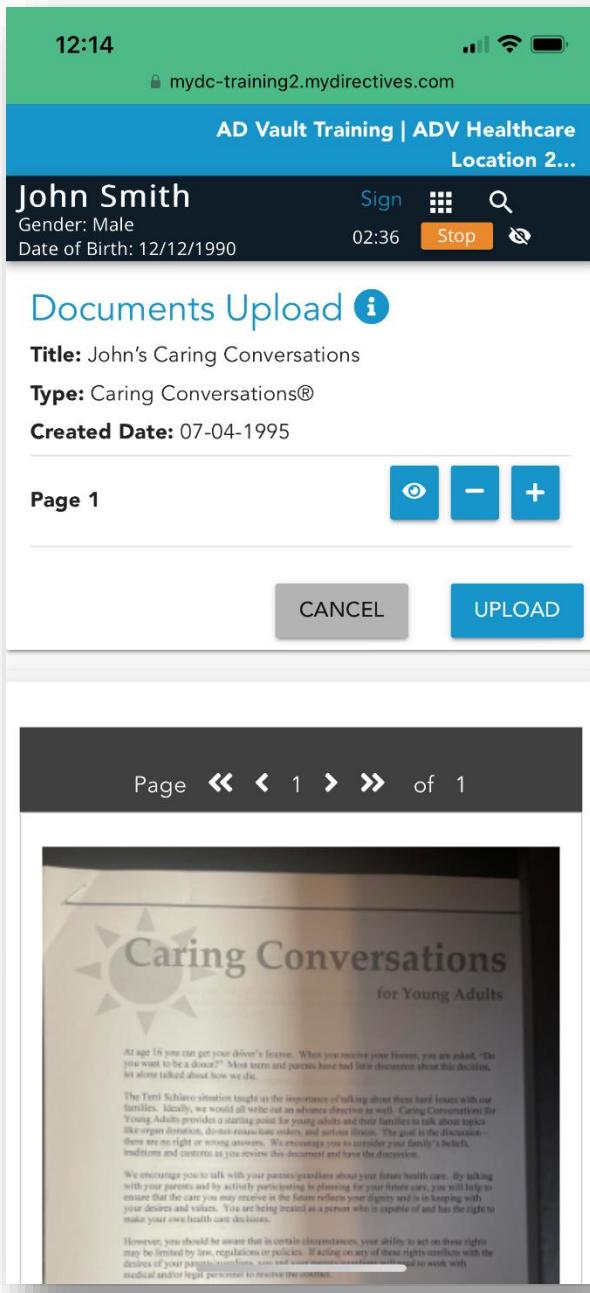
- What do you want to call this document?
- What type of document is this?
- When was this document created?
- Choose between selecting a file or taking a picture of the documents (example below).



- Take a picture of the documents you would like to upload.
- You can retake or use the photo'd documents.

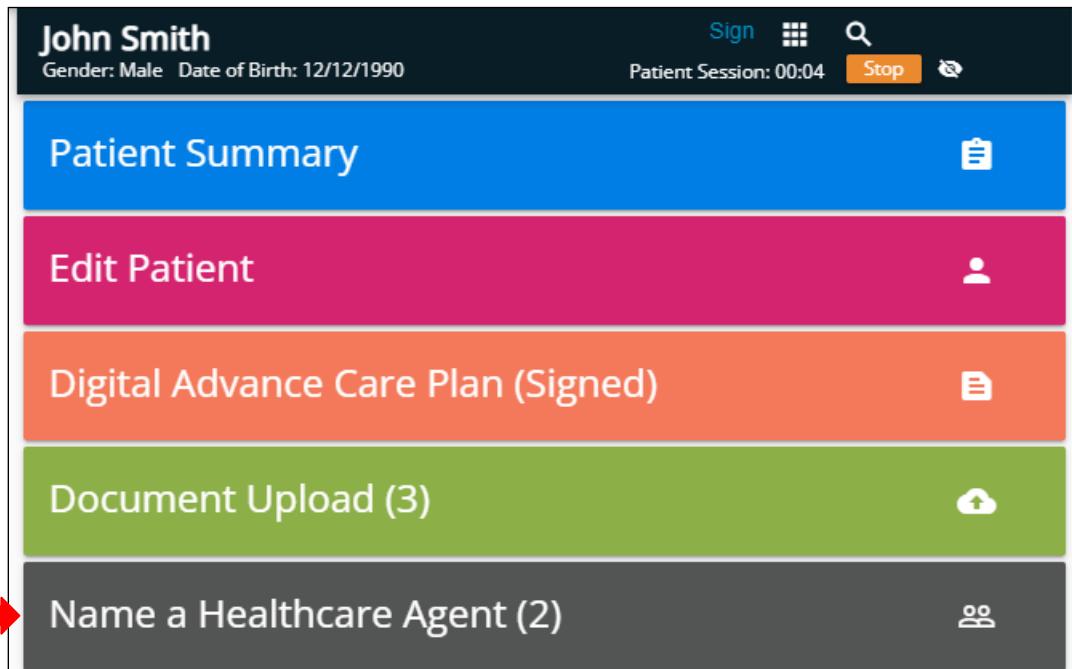


- After selecting the photo'd document, you can view the document, add, or delete the page(s), or upload the patient's documents when ready.
- After you have uploaded your patient's documents, you will be sent back to the Document List – where a list of all uploaded documents should appear.



Healthcare Agent

Select + Add a Healthcare Agent to name the Primary Healthcare Agent your patient would like. After the Primary HCA is listed, you can add a first and second alternate healthcare agent if your patient desires. When finished, a list of all named healthcare agents will appear, as you see below.



John Smith
Gender: Male Date of Birth: 12/12/1990

Patient Summary

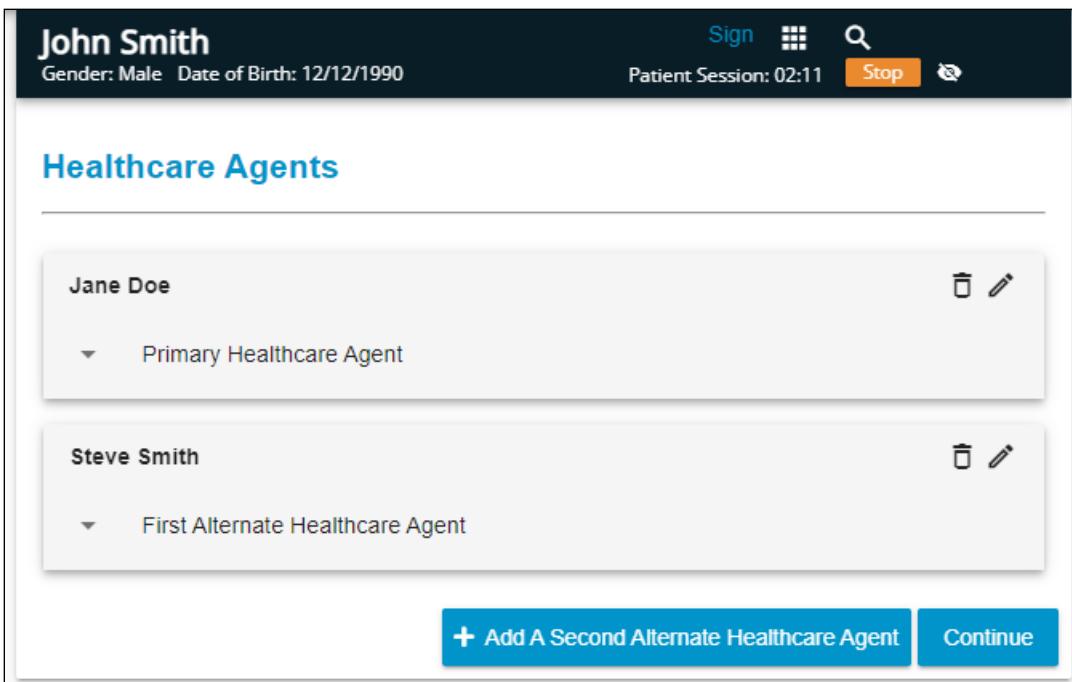
Edit Patient

Digital Advance Care Plan (Signed)

Document Upload (3)

Name a Healthcare Agent (2)

A red arrow points to the "Name a Healthcare Agent (2)" button.



John Smith
Gender: Male Date of Birth: 12/12/1990

Patient Session: 02:11 Stop

Healthcare Agents

| | | |
|------------------------------------|--------|------|
| Jane Doe | Delete | Edit |
| ▼ Primary Healthcare Agent | | |
| Steve Smith | Delete | Edit |
| ▼ First Alternate Healthcare Agent | | |

+ Add A Second Alternate Healthcare Agent **Continue**

Name or update Your Primary Healthcare Agent

1. Enter the patient's healthcare agent information in the required fields, which include:
 - First Name
 - Last Name
 - Email and phone (the HCA will not be notified if an email address is not given)
2. Please note that the "Notify this person that you have chosen him or her to be your healthcare agent" is automatically selected and will notify the named healthcare agent unless you uncheck the selected box. We strongly recommend that this person is notified that they were chosen to make decisions on behalf of your patient.

If you elect to notify the healthcare agent, an email is sent to the agent requesting the agent to go online and respond to the request and give consent to function as the patient's healthcare agent.
3. Powers I wish to give my healthcare agent... The patient can grant their appointed healthcare agent all or limited responsibilities. If the patient has questions regarding what these responsibilities may be, click the list of powers usually given above the all or limited responsibilities section.

Name Your Primary Healthcare Agent

1 Who does the patient want to speak for them if they can't?

Select from existing contacts or Add New
Jane Doe

Title: First Name *
Jane

Middle Name: Last Name *
Doe

Suffix: Relationship

Email: Mobile Phone
jdoe@gmail.com (615) 555-5555

2 Notify this person that you have chosen him or her to be your healthcare agent.
We strongly recommend that this person is notified that they are chosen to make decisions.

3 Powers I wish to give to my healthcare agent...

Here is a list of powers normally given. [Click here to read the list.](#)

I want to grant these responsibilities to my healthcare agent.
 I want to limit the responsibilities of my healthcare agent.

Cancel **Continue**

Powers to Give to Healthcare Agents

Your patient will decide the powers to grant their healthcare agent.

Select the link for a complete description of powers often given to a patient's healthcare agent. *Click here to read the list.*

If your patient wishes to grant their healthcare agent all powers listed, without limitation, select *I want to grant these responsibilities to my healthcare agent.*

Your patient may want to limit the responsibilities of their selected healthcare agent. Select *I want to limit the responsibilities of my healthcare agent.* A free-form menu will populate, allowing your patient to note any added information they would like to include responsibilities, wishes, and thoughts they have for their named healthcare agent.

Powers I wish to give to my healthcare agent...

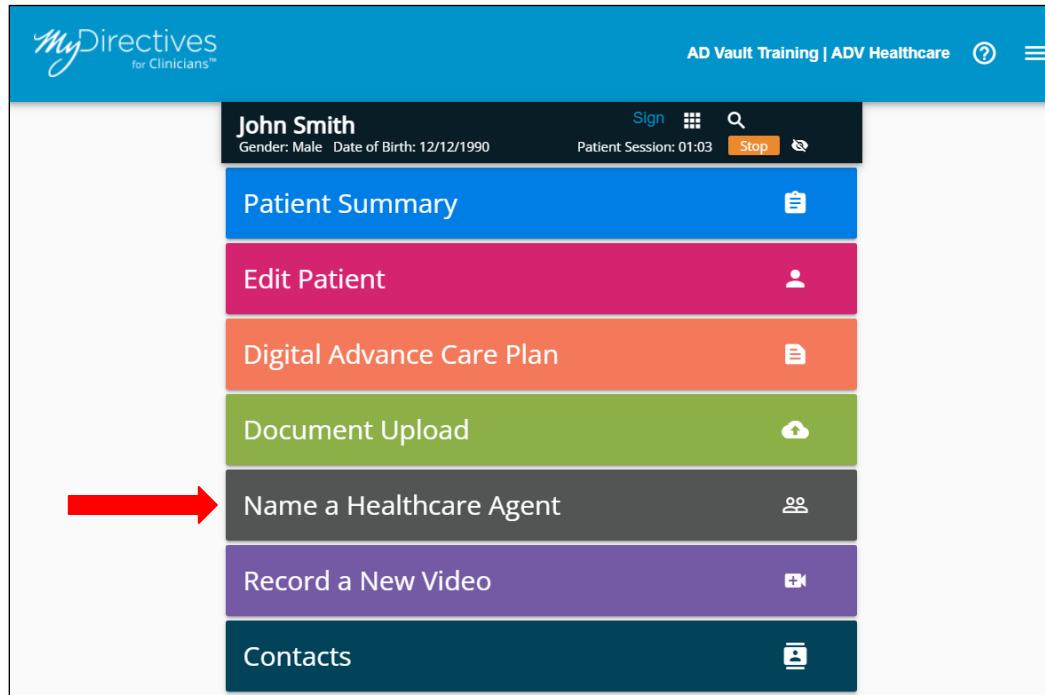
Here is a list of powers normally given. [Click here to read the list.](#)

Powers normally given to healthcare agents:

- Help choose the overall goal of treatment including:
 - Whether or not to try to maintain life at all costs, or
 - Allow a gentle or peaceful death
- Help choose treatments that may be offered by your doctors such as:
 - Breathing machines (that pump air in and out of your lungs)
 - Dialysis (that cleans your blood when the kidneys stop working)
 - Heart machines (that support or replace your heart when it no longer works)
 - Stomach tubes (for artificial nutrition)
 - Blood transfusions
 - Surgery
- Help choose where you die:
 - At home without hospice
 - At home with hospice
 - At a nursing home
 - In a hospice facility
 - In a hospital
- Help choose doctors/hospitals
- Arrange for your healthcare in any country or state
- Release your medical records
- Talk to your family
- Talk to your spiritual advisor
- Interpret your wishes and anything not covered by the above, including but not limited to palliative care, organ and tissue donation, etc.

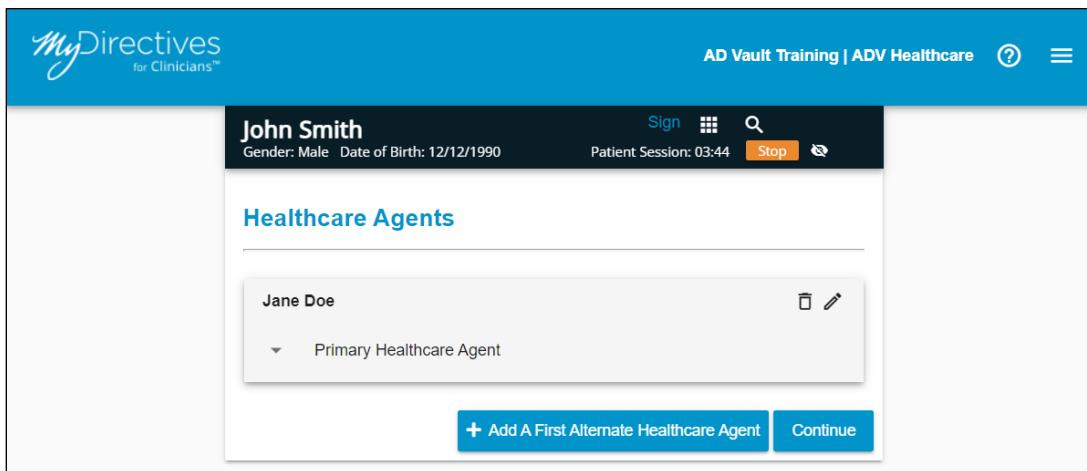
Accessing the Patient's Healthcare Agent

Access your patient's healthcare agent by selecting the Name a Healthcare Agent tile from the dashboard. This will bring you to a list of your patients named Healthcare and Alternate Healthcare Agents.



Managing the Patient's Healthcare Agent

Manage the patient's Healthcare Agents from this page. Edit, delete, or add a healthcare agent if a healthcare agent is not assigned to the patient and add an alternate healthcare agent to the patient record.



Add Alternate Healthcare Agent

Add an Alternate Healthcare Agent to the patient's record by clicking the Add a First Alternate Healthcare Agent option. The screen below will appear, allowing you to select an alternate agent from the dropdown list or the Add New Contact and enter the agent's information in the fields.

1. Select the alternate agent from the dropdown list of current contacts added to the patient's record or select Add New Contact to create a new contact for the patient.
2. Enter the contact's information in the fields.

Select Save to remain on the current page or select Continue to save the agent as the Alternate Healthcare agent and move to the manage the healthcare agent's page.

John Smith
Gender: Male Date of Birth: 12/12/1990

Sign Patient Session: 06:59

Name Your First Alternate Healthcare Agent

Who does the patient want to speak for them if they can't?

Select from existing contacts or Add New

Steve Smith

[Add New Contact]

Steve Smith

1

First Name *
Steve

Middle Name

Last Name *
Smith

Suffix

Relationship

2

Email
steve.smith@hotmail.com

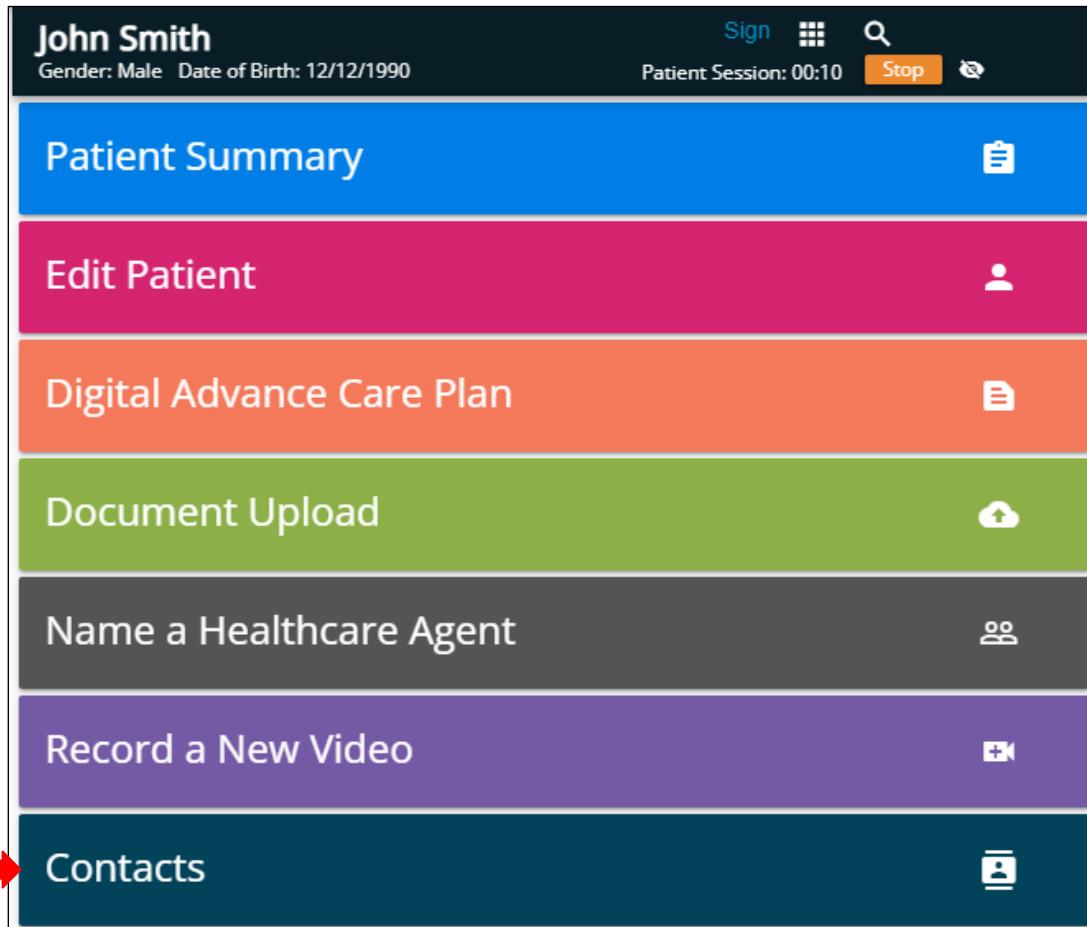
Mobile Phone
(615) 555-5555

Notify this person that you have chosen him or her to be your healthcare agent.
We strongly recommend that this person is notified that they are chosen to make decisions.

Cancel Save Continue

Contacts

Add contacts to the patient's record. Select the Contacts tile on the patient dashboard to add new contacts for the patient.



Add New Contacts

Enter the required information for the patient's contact.

1. The required fields include the following:
 - First name
 - Last name
 - Email and/or Mobile phone
2. Select:
 - Save and Finish when all contacts have been added to the patient's account.
 - Save and Add Another for additional contacts.
 - Skip to return to the list of contacts.

John Smith
Gender: Male Date of Birth: 12/12/1990
Patient Session: 01:04 Stop

Contacts

Patient Contacts

Add contact information for anyone that receive access to the patient's files.

1

First Name _____

Last Name _____

Email _____

Mobile Phone _____

2

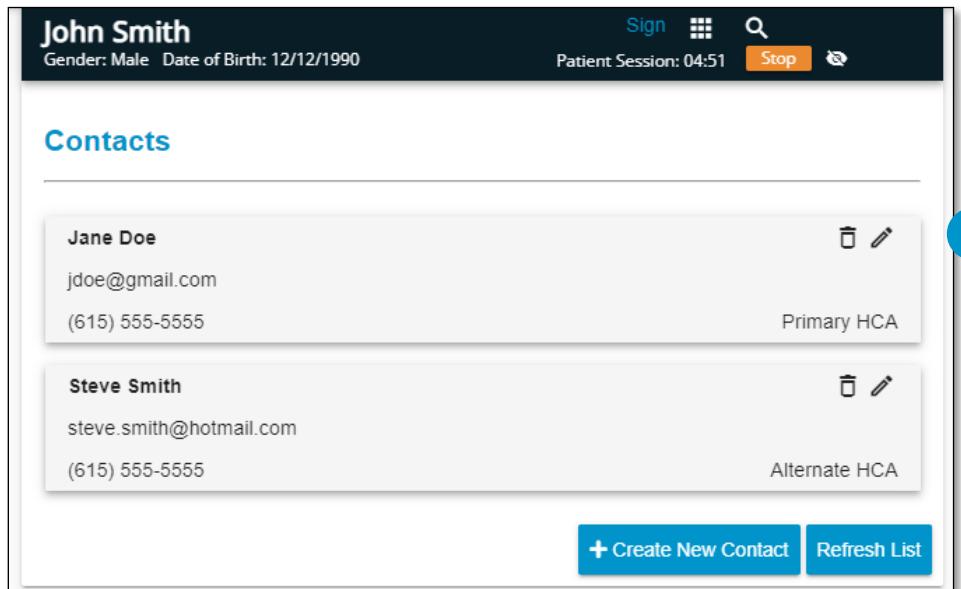
SAVE AND ADD ANOTHER

CANCEL **SKIP** **SAVE AND FINISH**

Managing Patient Contacts

1. Select the delete or edit icon to change the contact's information.

Changes made to contacts will not require the ACP to be resigned.



John Smith
Gender: Male Date of Birth: 12/12/1990

Sign Grid Search Patient Session: 04:51 Stop

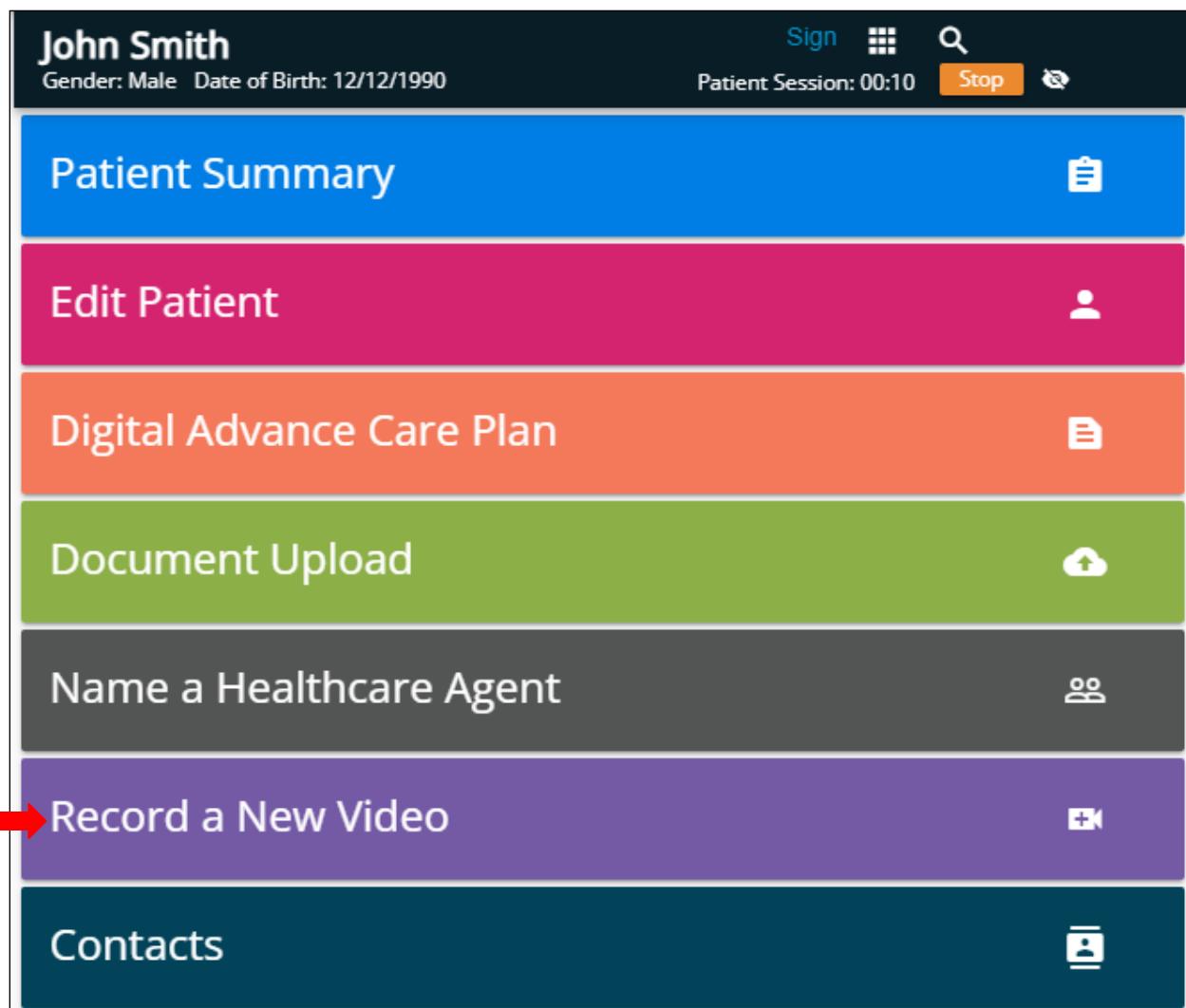
Contacts

| Contact | Role | Actions |
|---|---------------|-------------|
| Jane Doe jdoe@gmail.com (615) 555-5555 | Primary HCA | Delete Edit |
| Steve Smith steve.smith@hotmail.com (615) 555-5555 | Alternate HCA | Delete Edit |

Create New Contact **Refresh List**

Record a Video

- You can record a video of the patient or for the patient's healthcare agent. The video is created from your device using your camera and microphone. The video is saved to the patient's documents and can be accessed from the Document Upload page



Record A Patient Video

1. Your patient can choose between recording a video themselves or having their named healthcare agent do so on their behalf.
2. Your patient can choose between the following recording options below.

Record a video

Who will you be Recording?

1 Patient Healthcare Agent

Video Selection

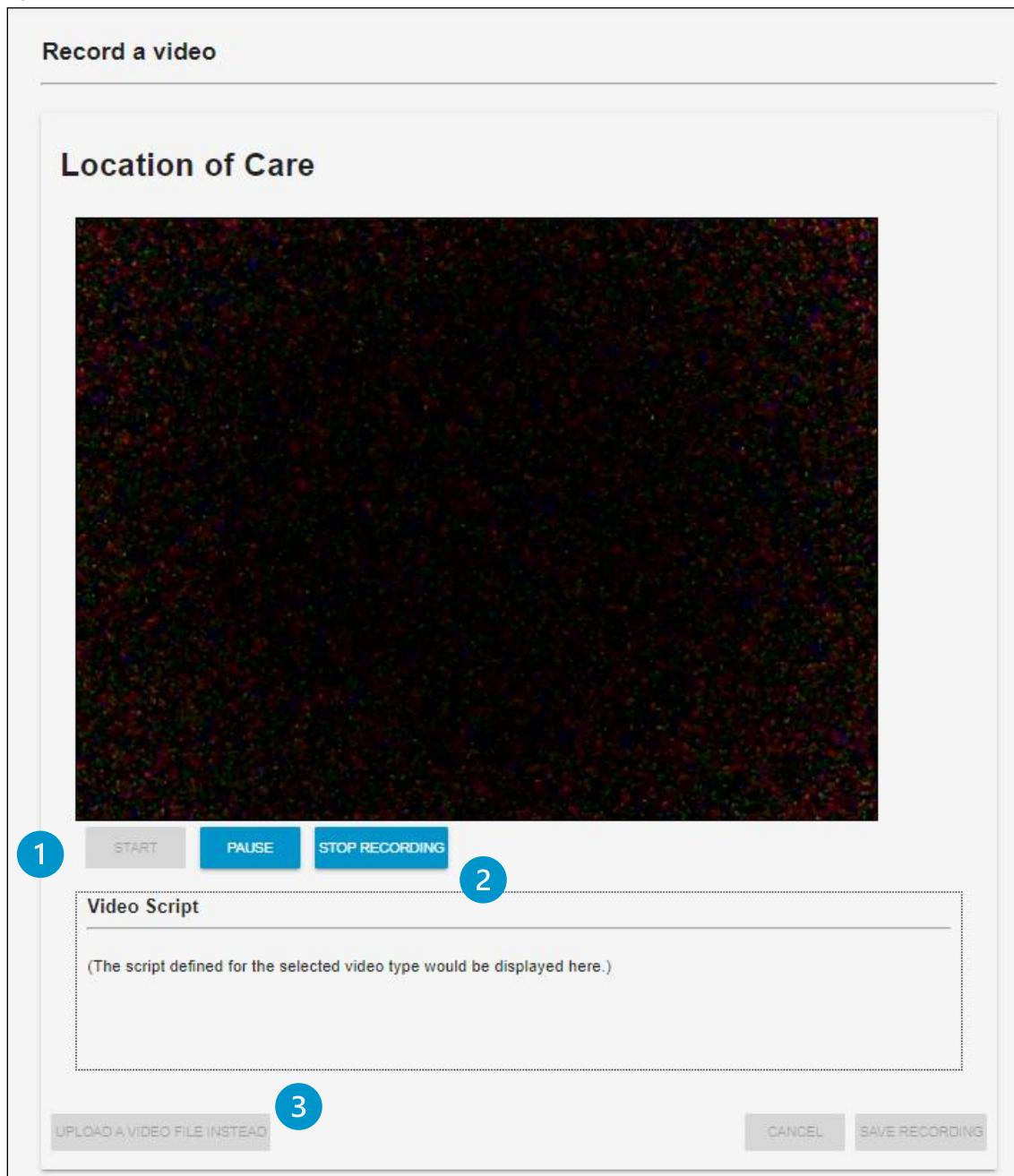
Please select the type of video you would like to record:

2

| | |
|---------------------------|---|
| Location of Care |  |
| Healthcare Proxy |  |
| Life Sustaining Treatment |  |
| Organ Donation |  |
| CPR Preferences |  |
| Advance Care Directive |  |

Record a Video

1. Select the Start button to start recording the video. The screen will display what the camera is pointing towards, and the video will begin recording. Press Pause if the patient or healthcare agent is not ready, and click Resume when you are ready to continue recording.
2. Once the recording is finished, click Stop Recording. Click Save Recording to save the recording file to the patient's document page, or if the patient would like to start over, select Cancel to delete and start recording again.
3. Existing video files can be uploaded by clicking the Upload a Video File Instead button. Select the video file from your documents.



Record Video for Healthcare Agent

1. Click the Healthcare Agent button, select an agent from the dropdown menu, and follow the same steps to record the video:
 - Select the Start button to start recording the video. The screen will display the camera pointed toward, and the video will now begin recording. Press Pause if the patient or healthcare agent is not ready and click Resume when you are ready to continue recording.
 - Once the recording is finished, click Stop Recording. Click Save Recording to save the recording file to the patient's document page, or if the patient would like to start over, select Cancel to delete and start recording again.
 - Existing video files can be uploaded by clicking the Upload a Video File Instead button. Select the video file from your documents.

Record a video

Who will you be Recording? 1

Patient Healthcare Agent

Select a Healthcare Agent

Cancel Add A Healthcare Agent

Video Selection

Please select the type of video you would like to record:

| | |
|---------------------------|---|
| Location of Care |  |
| Healthcare Proxy |  |
| Life Sustaining Treatment |  |
| Organ Donation |  |
| CPR Preferences |  |
| Advance Care Directive |  |

Patient Summary

The patient summary gives you and your patient an overview of their record. Use the subject tiles to navigate the patient record.



The screenshot shows the MyDirectives for Clinicians patient summary page. The top navigation bar includes the MyDirectives logo, a search bar, and session information (Patient Session: 03:03, Stop, and a refresh icon). The left sidebar features a vertical list of tiles with icons and labels: Patient Summary (selected, highlighted in blue), Edit Patient, Digital Advance Care Plan (Not Started), Document Upload (0), Name a Healthcare Agent (0), Record a New Video, Contacts (0), Portable Medical Order, and Mental Health Directive. The main content area is titled 'Patient Summary' and displays basic patient information: Name (John Smith), Address (123 Main St, Dallas, TX 75204), Email, and Username (johnsmith385). Below this are sections for 'ACP Documents' (None), 'Uploaded Documents' (a single item named 'HIPAA' with a download icon and updated on 10/06/2022), 'Healthcare Agents' (None), and 'Video Files' (None).

Full Patient Summary

This page will give you and your patient a brief overview of everything that is and has been created within their account under each section.

Patient Summary

Name John Smith
Address 123 Main St., Dallas, TX 75204
Email
Username johnsmith385

ACP Documents

None

Uploaded Documents

 **HIPAA** eye icon cloud icon
HIPAA Updated: 10/06/2022

Healthcare Agents

None

Video Files

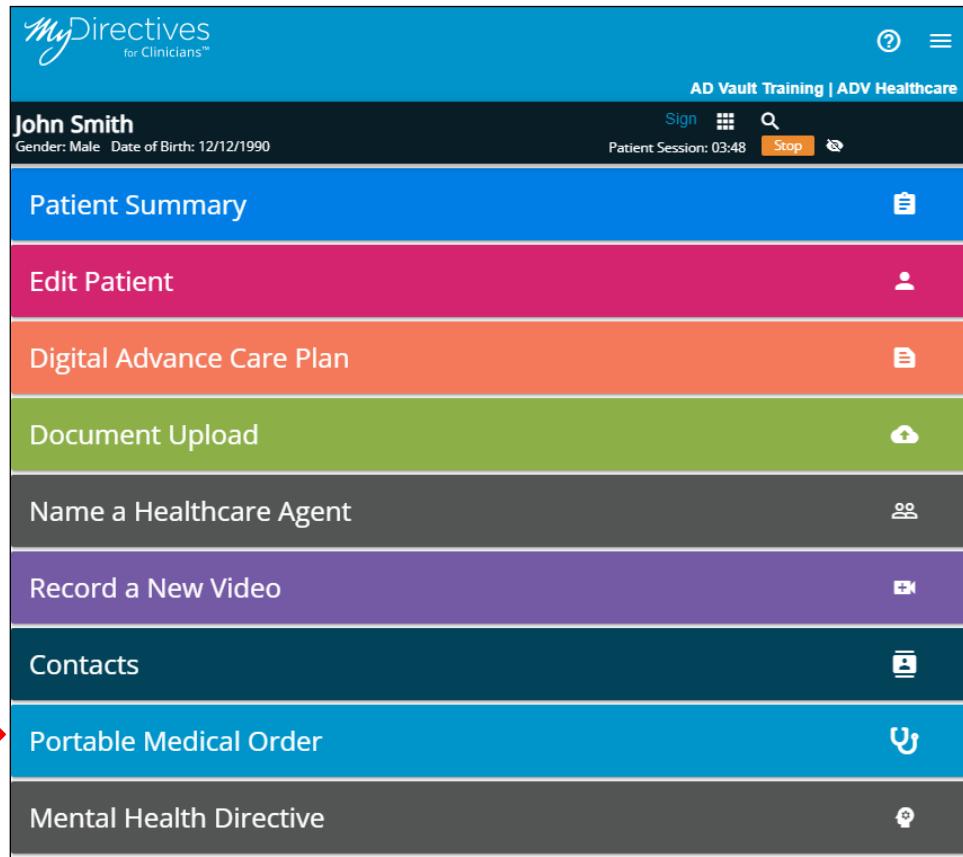
None

Contacts

None

Portable Medical Order

A licensed Physician is the only person allowed to create, fill out, and sign a Portable Medical Order at this time.



Select which Portable Medical Order form you are filling out from the dropdown menu.



After selecting which Portable Medical Order you are filling out with your patient, click the select button for the form to auto-populate.

Portable Medical Order

Select Document
DC - MOST

CANCEL **SELECT**

Complete each section of the Portable Medical Order with your patient.

Portable Medical Order

DC Medical Orders for Scope of Treatment (MOST)

① Medical Conditions/Patient Goals

② Cardio-Pulmonary Resuscitation (CPR): Person has no pulse and is not breathing. *

Attempt Resuscitation/CPR

Do Not Attempt Resuscitation (DNAR) / Allow Natural Death (AND)
Choosing DNAR will include appropriate comfort measures.

③ Medical Interventions: Person has pulse and/or is breathing. *

FULL TREATMENT - primary goal of prolonging life by all medically effective means.
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.
Includes care described below. Use medical treatment, IV fluids and cardiac care as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.

COMFORT FOCUSED TREATMENT - primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no hospital transfer. EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

④ Additional orders: (e.g. dialysis)

⑤ Medically-assisted Nutrition: *
(Always offer food and liquids by mouth if feasible.)

No medically-assisted nutrition by tube.

Trial period of medically-assisted nutrition by tube.

Long-term medically-assisted nutrition by tube.

⑥ Antibiotics: *

Use antibiotics for prolongation of life.

Do not use antibiotics except when needed for symptom management.

⑦ Additional orders: (e.g. dialysis, blood products, implanted cardiac devices. Attach additional orders if necessary.)

④ Discussed with *

Patient

Parent of Minor

Guardian with Health Care Authority

Spouse/Domestic Partner

Health Care Agent (Durable Power of Attorney for Healthcare)

Adult child of patient

④ MD/DO/APRN Printed Name *

AD Vault Training

④ MD/DO/APRN Phone Number *

④ Practitioner Signature *

X

④ MD/DO/APRN Date signed *

11/17/2022

④ MD/DO/APRN License Number *

④ Patient or Legal Authorized Representative Name *

John Smith

④ Patient Phone Number *

④ Patient Signature *

X

④ Patient Date signed *

11/17/2022

④ Person has

Health Care Directive (Living Will)

Durable Power of Attorney for Health Care

| | |
|---------------------------|--|
| Reviewer Name | AD Vault Training |
| Review Location | Location 2 |
| Review Date | 11/17/2022 |
| Review Outcome | <input type="radio"/> New form completed <input type="radio"/> No change <input type="radio"/> Form voided |
| CANCEL SAVE | |

Completed Portable Medical Order

When a Portable Medical Order is complete, it will appear under the Document List.

Document List

| | |
|--|---|
|  DC Psychiatric Advance Directive Advance Statements And Decisions |    Updated: 11/17/2022 |
|  DC MOST MOST |    Updated: 11/17/2022 |
|  HIPAA HIPAA |   Updated: 10/06/2022 |
|  John's Five Wishes Five Wishes® |    Updated: 10/31/2022 |
|  John's Living Will Living Will |    Updated: 10/31/2022 |

DC MOST CLOSE

Page **<< < 1 > >>** of 2

DC | HEALTH GOVERNMENT OF THE
DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

HIPAA PERMITS DISCLOSURE OF THIS DOCUMENT TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

DC Medical Orders for Scope of Treatment (MOST)

Smith, John
Patient Last Name / First Name / Middle Initial
123 Main St.

Address
Dallas, TX 75204

City/State/Zip Code
12 / 12 / 1990

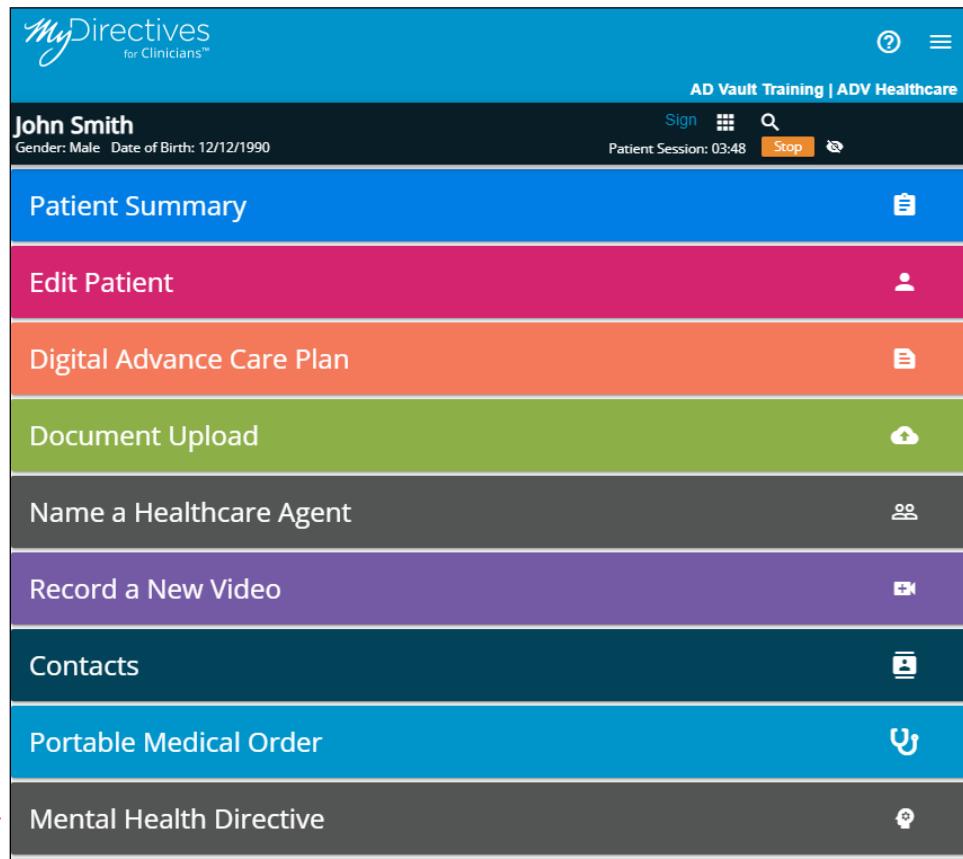
Medical Conditions/Patient Goals:
 Male Female
 Transgender Other

Date of Birth (MM/DD/YYYY) Last 4 Digits of SSN (optional)

Instructions for Responding Providers:
FIRST follow these orders, THEN contact physician or nurse practitioner. The MOST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a MOST form is always voluntary. Everyone shall be treated with dignity and respect. PLEASE keep the original or a copy of this MOST form in the patient's medical record. To print the DC MOST form, go to: dchealth.dc.gov/most

| | |
|-----------------------|---|
| A Check One | Cardio-Pulmonary Resuscitation (CPR): Person has no pulse and is not breathing. <input checked="" type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation (DNAR) / Allow Natural Death (AND) Choosing DNAR will include appropriate comfort measures. |
| B Check One | Medical Interventions: Person has pulse and/or is breathing. <input checked="" type="checkbox"/> FULL TREATMENT - primary goal of prolonging life by all medically effective means. Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. <input type="checkbox"/> SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures. Includes care described below. Use medical treatment, IV fluids and cardiac care as indicated. Do not intubate. May use less invasive |

Mental Health Directive



Select what Mental Health Directive you are filling out with your patient from the dropdown menu.



Part I: Statement of Intent

Mental Health Directive

DC Psychiatric Advance Directive

Part I: Statement of Intent

Q Principal (Consumer) Name
John Smith

I, the Principal named above, being of sound mind, voluntarily create these advance instructions for behavioral health treatment to assure that my choices will be carried out if I am unable to make my own decisions.

By this document, I intend to create a declaration of advance instructions for behavioral health treatment as authorized by District of Columbia law, to indicate my wishes regarding behavioral health treatment. To the extent, if any, that this document is not valid under District of Columbia law, it is my desire that it be considered a statement of my wishes and that it be given the greatest possible legal weight and respect. I understand that this directive will only be used when I cannot make my own behavioral health treatment decisions.

Even if I left blanks on the form or did not complete certain sections, I want all completed sections to be followed. If I have not expressed a choice, then whoever is appointed as my substitute decision maker should make the decision that he or she thinks is the decision I would make if I were able to do so. It is my intention that each part of my advance instructions for behavioral health treatment stand alone. If some parts are invalid under District of Columbia law or ineffective, I desire that all other parts be followed, by whoever is appointed as my substitute decision maker.

I intend this declaration of advance instructions for behavioral health treatment take precedence over any and all living will and/or durable power of attorney for health care documents and/or other advance directives I have previously executed that addresses behavioral health treatment, to the extent that they are inconsistent with this document.

Part II: Statement of My Instructions Regarding My Behavioral Health.

Part III: Appointment of Substitute Decision Maker.

Part IV: Instructions for Notification of Others, Visitors, and Custody of My Children.

Part V: Signature of Principal (Consumer) and Witnesses.

CANCEL **SAVE**

Part II: Statement of My Instructions Regarding My Behavioral Health

Part II: Statement of My Instructions Regarding My Behavioral Health.

In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

| | |
|---------------|--------|
| Hospital Name | Reason |
|---------------|--------|

In the event I am to be admitted to a hospital for 24-hour care, I do **not** wish to go the following hospitals:

| | |
|---------------|--------|
| Hospital Name | Reason |
|---------------|--------|

If, during an admission or commitment to a behavioral health treatment facility, it is determined that I am behaving in a way that requires emergency treatment, my wishes regarding which form of emergency treatment I receive are as follows:

0/400

My choice of doctors are:

| | | |
|------|-------|-------------------|
| Name | Phone | Reason (optional) |
|------|-------|-------------------|

I am taking the following medications as of (date):
11/17/2022

List all medications and dosages:

| | |
|-----------------|--------|
| Medication Name | Dosage |
|-----------------|--------|

I find the administration of the following medications to be helpful (list any special circumstance):
It is recommended that you obtain advice or resources in completing this section

0/150

I prefer not to receive the following medications (list reasons, if possible):

0/150

Pharmacy Name

Pharmacy Phone

Pharmacy Location

Q If I am having a hard time, the following approaches have been helpful in the past
(select all that apply)

| | | |
|--|---|---|
| <input type="checkbox"/> Voluntary time out in my room | <input type="checkbox"/> Listening to music | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Voluntary time out in quiet room | <input type="checkbox"/> Calling my therapist | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Talking to my psychiatrist | <input type="checkbox"/> Punching a pillow | <input type="checkbox"/> Going for a walk |
| <input type="checkbox"/> Talking with a peer | <input type="checkbox"/> Pacing the floor | <input type="checkbox"/> Pounding clay |
| <input type="checkbox"/> Being with certain people (specify) | <input type="checkbox"/> Talking with staff | <input type="checkbox"/> Calling a friend |
| <input type="checkbox"/> Deep breathing exercises | <input type="checkbox"/> Writing in a journal | <input type="checkbox"/> Adjusting diet |
| <input type="checkbox"/> Having cool water available | <input type="checkbox"/> Having my hand held | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Taking a shower/bath | <input type="checkbox"/> Medication as needed | <input type="checkbox"/> Sitting near staff |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Other (specify) | |

Q In the past, I have found that the following actions make me feel worse:
(select all that apply)

| | | |
|---|--|---|
| <input type="checkbox"/> Exposing one's situation to others | <input type="checkbox"/> Seclusion | <input type="checkbox"/> Restraints |
| <input type="checkbox"/> Being touched | <input type="checkbox"/> Lying down | <input type="checkbox"/> Talking with peer(s) |
| <input type="checkbox"/> Sitting near staff | <input type="checkbox"/> Being held | <input type="checkbox"/> Loud talking |
| <input type="checkbox"/> Writing in journal | <input type="checkbox"/> Loud noises | <input type="checkbox"/> Crowds/crowding |
| <input type="checkbox"/> Being compared to others | <input type="checkbox"/> Other (specify) | |

Q Special Instructions Regarding Touch/Body Space Considerations.

| |
|--|
| <input type="checkbox"/> I do not want to be touched |
| <input type="checkbox"/> I want to be asked permission before being touched |
| <input type="checkbox"/> I want to be told reasons why I am being touched |
| <input type="checkbox"/> I want special attention to be given to allowing me extra personal body space |
| <input type="checkbox"/> Other (specify) |

Q Instructions regarding other treatments (counseling, socialization, etc.)

| |
|--|
| |
|--|

0/400

Part III: Appointment of Substitute Decision Maker

Part III: Appointment of Substitute Decision Maker.

In the event that a court decides to appoint a guardian or substitute decision maker to make decisions regarding my behavioral health treatment, I desire that the following person be appointed:

Name

Relationship

Phone

Address (line 1)

Address (line 2)

Address (City, State Zip)

Part IV: Instructions for Notification of Others, Visitors, and Custody of My Children.

Part V: Signature of Principal (Consumer) and Witnesses.

Part IV: Instructions for Notification of Others, Visitors, and Custody of My Children

Part IV: Instructions for Notification of Others, Visitors, and Custody of My Children.

① I want staff to tell the following people that I have been admitted to a hospital when I am unable to tell them myself:

| | | |
|--|--------------------------------------|--|
| Name | Relationship | Phone |
| Address | | |
| May Visit | <input checked="" type="radio"/> Yes | <input type="radio"/> No |
| <input checked="" type="checkbox"/> Remove this person | |  Add another person |

② I do not wish the following people to visit me while I am in the hospital:

| | |
|--|--------------|
| Name | Relationship |
| <input checked="" type="checkbox"/> Remove this person | |
|  Add another person | |

③ In the event that I am unable to care for my child(ren), I want the following person to care for and have temporary custody of my child(ren):

| | | |
|--|--------------|--|
| Name | Relationship | Phone |
| Address | | |
| <input checked="" type="checkbox"/> Remove this person | |  Add another person |

④ I want the following person to care for and have temporary custody of Pets:

| | | |
|---------|--------------|-------|
| Name | Relationship | Phone |
| Address | | |

⑤ I want the following person to care for and have temporary custody of Financial Affairs:

| | | |
|---------|--------------|-------|
| Name | Relationship | Phone |
| Address | | |

⑥ I want the following person to care for and have temporary custody of Other Important Matters and Affairs:

| | | |
|---------|--------------|-------|
| Name | Relationship | Phone |
| Address | | |

Part V: Signature of Principal (Consumer) and Witnesses.

 CANCEL  SAVE

Part V: Signature of Principal (Consumer) and Witnesses

Part V: Signature of Principal (Consumer) and Witnesses.

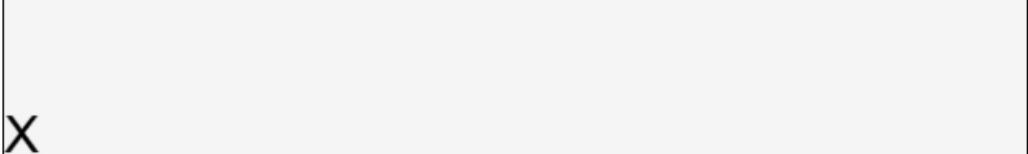
Patient Legal Name
John Smith

Patient Signature Date
11/17/2022

Signature Location (Address Line 1)

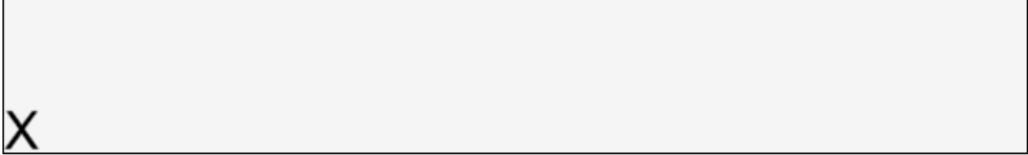
Signature Location (Address Line 2)

Signature Location (City, State Zip)

Patient or representative signature


CLEAR

Legal Guardian Name

Legal Guardian Signature


CLEAR

First Witness Name

First Witness Signature Date
11/17/2022

First Witness Home Address (Street)

First Witness Home Address (City, State Zip)

First Witness Signature

X

CLEAR

Second Witness Name

Second Witness Signature Date

11/17/2022

Second Witness Home Address (Street)

Second Witness Home Address (City, State Zip)

Second Witness Signature

X

CLEAR

At least 1 of the witnesses listed above shall also sign the following declaration:

I further declare that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a current existing will or by operation of law.

Declaring Witness Name

Declaring Witness Signature Date

11/17/2022

Declaring Witness Signature

X

CLEAR

CANCEL

SAVE

Completed Document Upload

After you have completed the Mental Health Directive with your patient, it will appear under the Document list, as you see below. You may download, view, or get rid of this document using the icons you see next to each document below.

Document List

| | |
|--|--|
|  DC Psychiatric Advance Directive Advance Statements And Decisions |    Updated: 11/17/2022 |
|  DC MOST MOST |    Updated: 11/17/2022 |
|  HIPAA HIPAA |   Updated: 10/06/2022 |
|  John's Five Wishes Five Wishes® |    Updated: 10/31/2022 |
|  John's Living Will Living Will |    Updated: 10/31/2022 |

DC Psychiatric Advance Directive

Page **1 of 6**

Principal: John Smith Page 1 of 6

DECLARATION OF ADVANCE INSTRUCTIONS
(for behavioral health treatment for mental illness and/or substance use disorder)

Part I.
Statement of Intent

I, (consumer's name) John Smith (sometimes referred to as the "principal"), being of sound mind, voluntarily create these advance instructions for behavioral health treatment to assure that my choices will be carried out if I am unable to make my own decisions.

By this document, I intend to create a declaration of advance instructions for behavioral health treatment as authorized by District of Columbia law, to indicate my wishes regarding behavioral health treatment. To the extent, if any, that this document is not valid under District of Columbia law, it is my desire that it be considered a statement of my wishes and that it be given the greatest possible legal weight and respect. I understand that this directive will only be used when I cannot make my own behavioral health treatment decisions.

Even if I left blanks on the form or did not complete certain sections, I want all completed sections to be followed. If I have not expressed a choice, then whoever is appointed as my substitute decision maker should make the decision that he or she thinks is the decision I would make if I were able to do so.

State Advance Directive

Select which State Advance Directive from the dropdown menu and click select.

State Advance Directive

Select Document

Tennessee Advance Directive

CANCEL **SELECT**

Tennessee Advance Directive

State Advance Directive

Tennessee Advance Directive

Part 1

Part 2

Part 3

Part 4

Part 5: SIGNATURE

Your signature must either be witnessed by two competent adults ("Block A") or by a notary public ("Block B").

CANCEL **SAVE**

Part 1: Primary and Alternate Healthcare Agent

Part 1

Primary Healthcare Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

| | |
|----------------------|----------------------|
| Name | Relation |
| <input type="text"/> | <input type="text"/> |
| Mobile Phone Number | Work Phone Number |
| <input type="text"/> | <input type="text"/> |
| Home Phone Number | Other Phone Number |
| <input type="text"/> | <input type="text"/> |
| Address | |
| <input type="text"/> | |

Alternate Healthcare Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

| | |
|----------------------|----------------------|
| Name | Relation |
| <input type="text"/> | <input type="text"/> |
| Home Phone Number | Work Phone Number |
| <input type="text"/> | <input type="text"/> |
| Mobile Phone Number | Other Phone Number |
| <input type="text"/> | <input type="text"/> |
| Address | |
| <input type="text"/> | |

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective

I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.

I do not give such permission (this form applies only when I no longer have capacity).

Part 2: Indicate Your Wishes for Quality of Life

Part 2

Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

Q Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma. *

Yes

No

Q Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them. *

Yes

No

Q Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help. *

Yes

No

Q End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation. *

Yes

No

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

Q CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance. *

Yes

No

Part 2: Continued

| | |
|--|---|
| <p>④ Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | * |
| <p>④ Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | * |
| <p>④ Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | * |

Part 3: Other Instructions

| | |
|--|-------|
| <p>Part 3</p> <p>④ Other instructions, such as hospice care, burial arrangements, etc.:</p> <div style="border: 1px solid #ccc; height: 100px; width: 100%;"></div> | 0/400 |
|--|-------|

Part 4: Organ Donation

| | |
|---|---|
| <p>Part 4</p> <p>④ Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):</p> <p><input type="radio"/> Any organ/tissue</p> <p><input type="radio"/> My entire body</p> <p><input type="radio"/> Only the following organs/tissues:</p> <p><input type="radio"/> No organ/tissue donation</p> | * |
|---|---|

Signature: Witnesses by two competent adults or a notary

Part 5: SIGNATURE

Your signature must either be witnessed by two competent adults ("Block A") or by a notary public ("Block B").

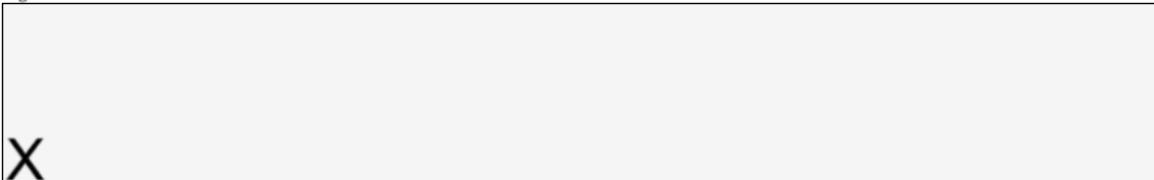
Block A: Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Block B: Notarize Document *

Yes

No

Signature: *



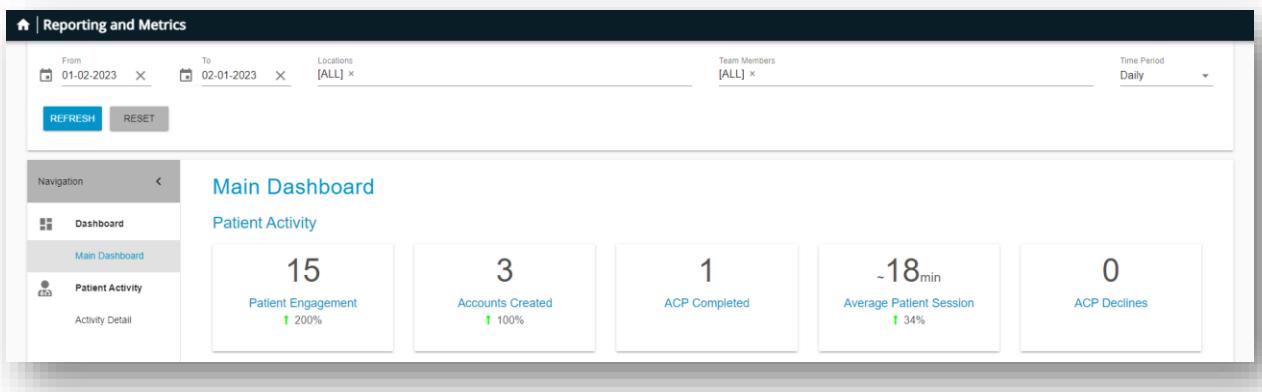
CLEAR

Reporting and Metrics

Main Dashboard

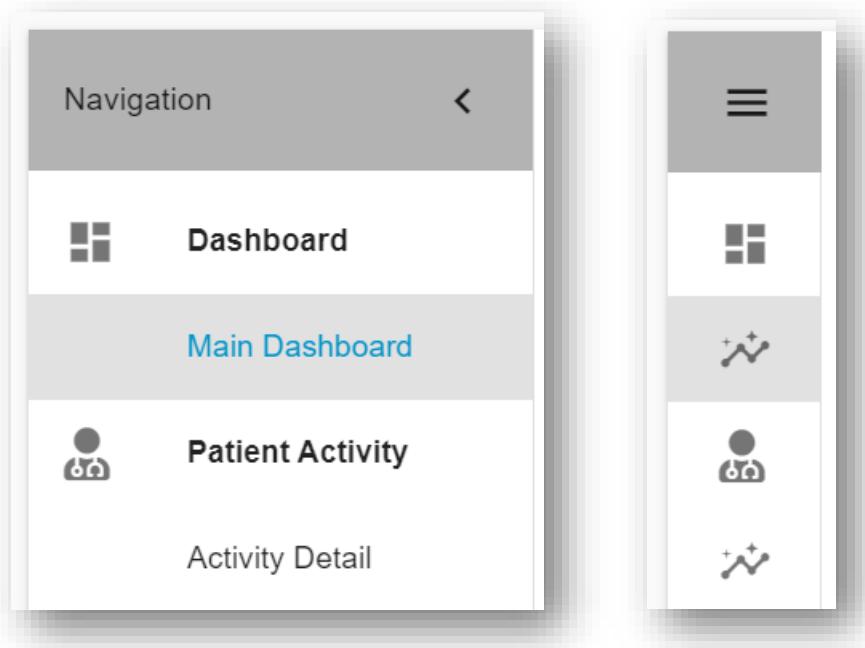
Ops Bundle (Admin User): You will have the option to filter dates, locations, team members, and time period. Dates will automatically filter prior day through the prior month. If there are multiple locations, you can filter to all or specific locations. Team members filter the same as locations. Time period options are weekly, monthly, quarterly, and annually.

Elite and Pro Bundles: You will have the same filter options as the above user, except for filtering team members. You will only be able to view your personal reporting, and locations if applicable.



Dashboard Navigation and Collapsed: Main Dashboard, Patient Activity – Activity Detail

You can filter between the Main Dashboard and Patient Activity Details. If you select the < it will collapse the navigation board.



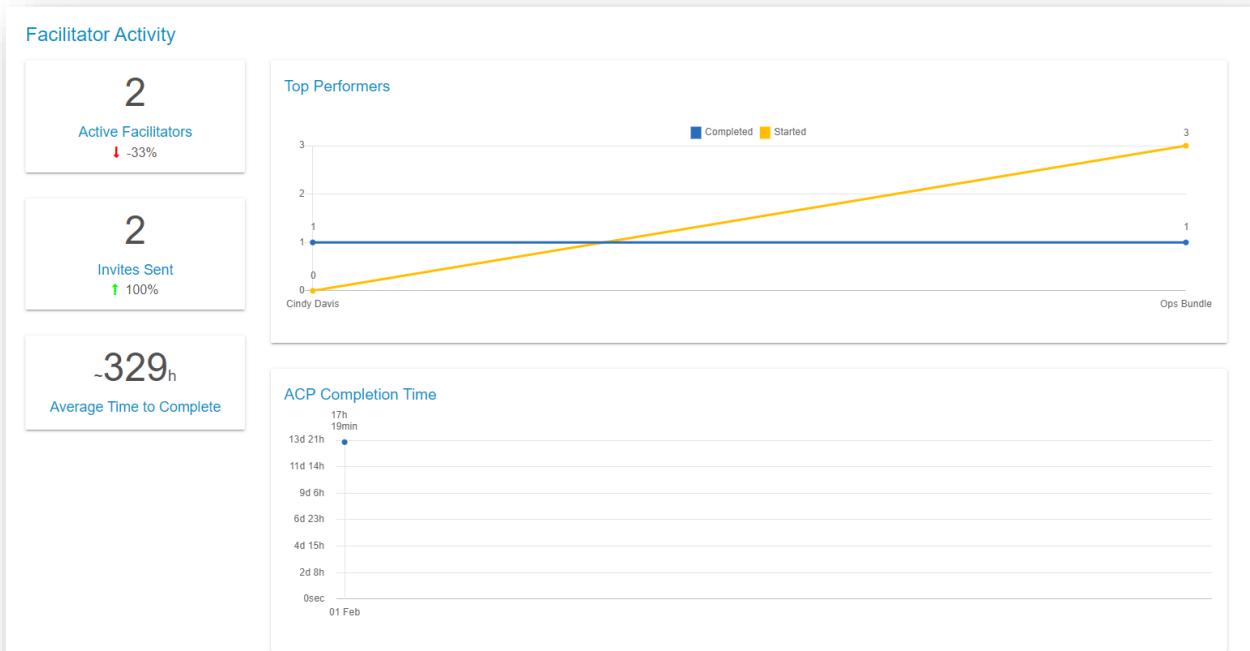
Total Patient Engagements, Total Completed ACP, ACP Status, Document Uploads

The graphs below will show you total patient engagements, total completed ACP's, ACP statuses (complete or incomplete), and how many and which documents have been uploaded. These will adjust depending on the filter information and which bundle you have associated with your user account.



Facilitator Activity: Active Facilitators, Invites Sent, Average Time to Complete, Top Performers, ACP Completion Time

Under this section you will be able to view active facilitators, invites sent, average time to complete, top performers, and ACP Completion Time.



Activity Detail

Under Activity Detail you would be able to view the following: Total Facilitated Sessions, New ACP Accounts Created, Incomplete ACP, Completed ACP Documents, Total Practitioner Reviews, and ACP Declines.

You will be able to filter your search through a specific time frame, location(s), team members, as well as the patient demographics – first/ last name, phone number, etc.

Activity Detail

| | | | | | |
|----------------------------|--------------------------|----------------|-------------------------|----------------------------|--------------|
| 13 | 3 | 4 | 2 | 0 | 0 |
| Total Facilitated Sessions | New ACP Accounts Created | Incomplete ACP | Completed ACP Documents | Total Practitioner Reviews | ACP Declines |

Search by patient first/last name, phone number, etc.

| First Name | Last Name | Age | Activity Date | Total Minutes Spent | Activity Type | ACP Document Status | ACP Document Type | Facilitator/Location |
|------------|-----------|-----|---|---------------------|-----------------|------------------------|-------------------|---------------------------|
| Jane | Doe | 28 | 02/01/2023 1:35 PM 02/01/2023 1:46 PM (Merged 2 sessions) | 11 | ACP Signed | Complete 02/01/2023 | ACP | Ops Bundle Location1 |
| Levi | Strauss | 55 | 02/01/2023 1:34 PM | | ACP Invite Sent | | | Ops Bundle Location1 |
| Stephanie | Sanders | 89 | 02/01/2023 1:33 PM | | ACP Invite Sent | | | Ops Bundle Location1 |
| Debra | Gregory | 67 | 02/01/2023 1:29 PM 02/01/2023 1:29 PM (Merged 2 sessions) | 1 | Acct Created | | | Ops Bundle Location1 |
| Steven | Hill | 73 | 02/01/2023 1:28 PM 02/01/2023 1:28 PM | 1 | Acct Created | | | Ops Bundle Location1 |
| Jennifer | Wright | 59 | 01/31/2023 1:22 PM 01/31/2023 1:43 PM | 21 | ACP Downloaded | Complete 01/27/2023 | ACP | Louis Raya Location 2 |
| Kara | Futura | 75 | 01/19/2023 9:50 AM 01/19/2023 11:09 AM | 72 | ACP/Doc Viewed | Complete 01/12/2023 | ACP & Upload | Cindy Davis Location 2 |
| John | Smith | 32 | 01/18/2023 2:13 PM 01/18/2023 2:43 PM | 30 | | Complete 11/04/2021 | ACP & Upload | Ops Bundle Location1 |

Rows per page: 10 ▾ Displaying 1 to 8 of 8 items < >