

## Health Care Decision Making

### State Advance Directive Registries: A Survey and Assessment

By Allison Hughes

Expanding the use of health care advance directives (ADs)—legal documents indicating one’s desires for care and nominating a personal representative to make health care decisions in one’s behalf—has been a priority goal in health care decision-making policy for over 30 years. Increased use of ADs is still a primary goal despite a substantial amount of research documenting their limitations and availability.<sup>1</sup> One of the critical barriers to the effective use of ADs is the difficulty in ensuring their availability when and where needed. Merely executing an AD does not ensure that one’s end-of-life wishes will be followed. An AD will not serve its purpose if no one knows of its existence or if it cannot be located.

As of mid-2009, twelve states have attempted to ameliorate this problem by enacting statutes that establish a registry where people can store their ADs and they can be accessed by the designated personal representative or health care providers when needed. It is unclear to what extent these registries accomplish their intended purpose because no descriptive or evaluative literature exists that examines their operation and use.

To address this informational void the author surveyed twelve states<sup>2</sup> that have statutes authorizing an AD registry and two states<sup>3</sup> that have statutes suggesting the creation of

*Continued on page 36*



Allison Hughes is the 2009 Borchard Foundation Center on Law and Aging Summer Intern and a third-year law student at Brigham Young University School of Law. Prior to law school, Ms. Hughes attended the University of Nevada, Reno, where she worked with elder law attorneys and her school’s gerontology and health care ethics programs.

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## In Memory of F. William McCalpin

Chair, ABA Commission on Law & Aging, 1996 - 2002

F. William McCalpin, former chair and a long-standing friend of the ABA Commission, died on December 9, 2009. In his lengthy and distinguished career, he was partner and counsel of the St. Louis, Missouri-based law firm Lewis, Rice & Fingersh, L.C. He was also a dedicated advocate for legal services. He was named chair, twice, of the national Legal Services Corporation and served on its board of directors for more than 40 years.

Within the ABA, Mr. McCalpin served in numerous capacities, including: assistant secretary (1975-79), secretary (1979-83); member, House of Delegates (1979-88); chairman, Standing Committee on Lawyer Referral Service (1964-65); chairman, Special Committee on Prepaid Legal Services (1970-73); chairman (1973-76 and 1983-85) and

member (1985-89), Standing Committee on Legal Aid and Indigent Defendants; member (1988-93) and chairman (1990-93), Consortium on Legal Services and the Public; and chairman, Senior Lawyers Division (1991-92). He also served as chairman of the Fellows of the American Bar Foundation and ex-officio director of the foundation (1976-77); and director and member of the executive committee of the American Bar Foundation (1977-87). In 1982 -84, he served as vice president, followed by president (1984-86) of the National Conference of Bar Presidents.

Mr. McCalpin was recognized numerous times for his leadership and excellence in service over the course of his lifetime. In 1988, he was awarded the American Bar Association Medal of Honor for "exceptionally distinguished service . . . to the cause of American jurisprudence."

Memorial contributions would be appreciated to Legal Services of Eastern Missouri, 4232 Forest Park Avenue, St. Louis, Mo. 63108, [www.lsem.org](http://www.lsem.org).

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Save the Date



## EQUAL JUSTICE CONFERENCE

May 13-15, 2010

Pointe Hilton Tapatio Cliffs Resort  
Phoenix, Arizona

Every year the **American Bar Association** and the **National Legal Aid and Defender Association** bring together all components of the legal community to discuss equal justice issues as they relate to the delivery of legal services to poor and low-income individuals in need of legal assistance.

Through plenary sessions, workshops, networking opportunities, and special programming, the conference provides a wide range of learning and sharing experiences for all attendees.

*Pro bono* and legal services program staff, judges, corporate counsel, court administrators, private lawyers, paralegals, and many others attend this event. The main conference celebrates the ongoing collaboration between *pro bono* and legal services and explores additional partnerships that must be created, the resources that must be tapped, and the new issues facing clients.

**For more information, visit online:**  
<http://www.abanet.org/legalservices/ejc/>

## *State Bar/Pro Bono/Veterans Benefits*

### **Delaware State Bar Honors Members Who Served, Launches Program to Assist Veterans**

By David Godfrey

On November 9, 2009, Dr. Jill Biden, wife of Vice President Joe Biden, addressed more than 120 guests at a special event presented by the Delaware State Bar Association. The event marked the kickoff celebration of a new veterans advocacy *pro bono* recruitment program and a ceremony to recognize Delaware Bar members who are or who have served in the military.

Dr. Biden spoke of the need to support military families and veterans. Dr. Biden was accompanied at the event by her son Joseph R. "Beau" Biden III, a veteran of the war in Iraq.

The event was held at the Delaware Air National Guard Armory in New Castle, Delaware.

The program included an overview of the military justice system presented by Col. John Ewers, U.S.M.C. Col. Ewers serves as a circuit military judge for the Western Judicial Circuit. He explained the purpose, structure, and procedure of the military criminal justice system. He provided an insightful look into the unique legal system that operates inside all branches of the U.S. armed forces.

R. Craig Martin, the chair of the Delaware State Bar Association Veterans Committee, also provided remarks to the assembled guests. Mr. Martin had organized the Veterans Committee of the Delaware State Bar Association. He also is responsible for administering a grant from the ABA's Enterprise Fund to launch the veterans advocacy *pro bono* recruitment program.

The Veterans Committee is the recipient of a capacity building mini-grant made possible by the ABA's Enterprise Fund and overseen by the **Commission on Law and Aging**. This event was made possible, in part, by that grant and served as the kick-off for a planned program to recruit and train *pro bono* attorneys, with an emphasis on emeritus attorneys, to assist veterans and their families. More than a dozen attorneys joined the growing list of *pro bono* volunteers at the event.

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*\*Photographs courtesy of David Godfrey.*



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Dr. Jill Biden addresses guests at the special event presented by the Delaware State Bar Association.



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R. Craig Martin, chair, Delaware State Bar Association Veterans Committee, addresses the crowd.



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Col. John Ewers provides an overview of the military justice system.

## Pro Bono/Veterans Benefits

# To Help Veterans with Claims, Lawyers Must Be Accredited by U.S. Department of Veterans Affairs

By David Godfrey

Lawyers must be “accredited” by the U.S. Department of Veterans Affairs (VA)<sup>1</sup> before assisting with the “preparation, presentation, and prosecution” of claims. The accreditation process applies to all attorneys, including legal aid attorneys and *pro bono* volunteers assisting veterans.

Accreditation is a fairly simple five-step process:

- File an application for accreditation with the VA office of general counsel.
- Receive “initial accreditation” notice from VA.
- Within 12 months of “initial accreditation,” complete a three-hour continuing legal education (CLE) course in compliance with the rules.
- Send a letter certifying completion of the CLE.
- Complete and certify to the VA office of general counsel at least three hours of ongoing CLE on veterans benefits and procedure every two years thereafter.

The application for accreditation is filed on VA form 21a, available online at <http://www4.va.gov/ogc/accreditation.asp>.

To complete the form you need name, address, phone numbers, e-mail address, employer, date and place of birth, military service information (if any), employment history for the past five or more years, education back to high school, state and federal bar admission information, including dates and bar numbers.<sup>2</sup> The form requires that you complete a series of questions about character, fitness, and past history as a representative before federal agencies.<sup>3</sup> The information in the application is self-certifying as to completeness and accuracy.<sup>4</sup> You can complete the form using an Adobe software “fillable form” and print it for signature. The “fillable form” can not be saved, so it helps to have all of the information need-

ed to complete the form when you start the process. Completing and printing the form is estimated to take 45 minutes or less.<sup>5</sup> The completed and signed form is mailed to the VA office of general counsel (mailing instructions are on the form.)

Once the form has been reviewed, the office of general counsel will send the attorney notice of “initial accreditation.”

Following the initial accreditation, the attorney has 12 months to complete a qualifying three-hour CLE program and send certification to the VA office of general counsel detailing the title of the program, date and time of attendance, and identity of the CLE provider.<sup>6</sup> The CLE must, at a minimum, cover representation and claims procedures, basics of VA benefits eligibility, appeals rights, disability compensation, dependence and indemnity compensation, and basic pensions.<sup>7</sup> The **ABA Commission on Law and Aging** is collaborating with Paralyzed Veterans of America to distribute free of charge a video CLE that will meet the basic accreditation requirement. Check for upcoming Elderbar posts and the February issue of *Bifocal* for more information.<sup>8</sup>

To remain qualified to represent claimants before the VA attorneys must receive ongoing CLE on VA rules and procedures. Starting not less than three years after the initial accreditation, an attorney must certify in writing to the VA office of general counsel completion every two years of at least an additional three hours of CLE on veterans benefits, law, and procedure.<sup>9</sup>



## Notes

1. 2 C.F.R. 38-14.629(b)(1)(i).
2. VA form 21a.
3. C.F.R. 38-14.629 (b)(2)(iii).
4. C.F.R. 38-14.629(b)(1)(ii).
5. VA form 21a and the experience of the author.
6. C.F.R. 38-14.629 (b)(1)(iii).
7. *Id.*
8. For more information, contact David Godfrey at [godfreyd@staff.abanet.org](mailto:godfreyd@staff.abanet.org).
9. C.F.R. 38-14-629 (b)(1)(iv).

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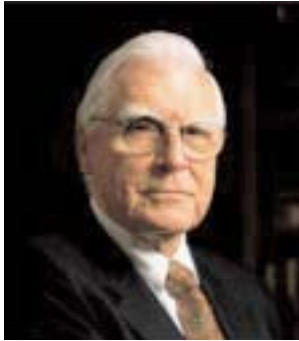
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## Elder Abuse

### The Brooke Astor Case: “An Appalling Set of Circumstances”

Interview Conducted by Lori A. Stiegel, Senior Attorney, ABA Commission on Law and Aging

On October 8, 2009, a New York City jury convicted Anthony Marshall, the 85-year-old son of the late philanthropist Brooke Astor, on 14 of 16 counts for financially exploiting his mother. Charges on which Marshall was convicted included first- and second-degree grand larceny, scheme to defraud, possession of stolen property, offering a false instrument, and conspiracy. Lawyer Francis Morrissey was convicted of 5 of 6 counts, including conspiracy, scheme to defraud, and forgery. To see the *New York*



Alex Forger

*Times'* chart of the verdicts, which specifies each charge against each defendant and the allegation and verdict for each charge, see <http://www.nytimes.com/imagepages/2009/10/08/nyregion/09astorg.ready.html>

Renowned 86-year-old New York lawyer **Alex Forger**, who practiced trusts and estates law for 42 years and who served as **chairman of the Commission on Law and Aging from 1993-1995**, testified as an expert witness for three days of the five-month trial. Assistant district attorney Elizabeth Loewy, head of the elder abuse unit in the Manhattan district attorney's office and one of the three prosecutors in the case, described Mr. Forger as “a lion of the bar” and “incredibly generous with his time.”

Mr. Forger continued his generosity by sharing his thoughts about the case, his role in it, and the lessons that lawyers who represent older persons should learn from it with **ABA Commission Senior Attorney Lori A. Stiegel**. Ms Stiegel has directed all of the Commission's elder abuse activities. In part 1 of this interview, Mr. Forger discusses how he became involved in the case, why he did it *pro bono*, and how he prepared for his testimony.

**Lori Stiegel:** How did you come to be an expert witness in the Astor case?

**Alex Forger:** I met with the three assistant district attorneys in January. I had been aware of the indictment and the sched-

uled trial. They explained that much of the evidence would relate to trusts and estates practice—powers of attorney, wills, codicils, and standards of practice. Not being trusts and estates practitioners they realized that they would need some assistance and thought the jury also would probably need help in understanding the terms, the various documents, and their consequences. I said I would reflect on their request. As I read some of the material relating to the trial, including depositions, I concluded that this presented an appalling set of circumstances, but to reach a full understanding would require considerable interpretation and explanation to enable anyone not familiar with trusts and estates law to comprehend the issues and why what was alleged to have been done was inappropriate. So I agreed to help.

**Stiegel:** Why did you decide to do it *pro bono*?

**Forger:** I believe it was the fact that I've been urging lawyers to do more *pro bono* work. I think it is part of professional responsibility. If the government requests that you give assistance I think that you ought to do that. My motivation wasn't compensation—which I refused—but simply to help in this case, which I thought was important as it affected the legal profession.

**Stiegel:** What did you do to prepare for your testimony?

**Forger:** Mrs. Astor signed her first will in 1952. I read and analyzed the 32 wills that she executed over the ensuing period of nearly 50 years, as well as the seven codicils, the last two being the ones prepared by her new attorney and signed in 2002. These two codicils were at the focal point of the trial. In addition, I read powers of attorney, letters, memos, and thousands of pages of trial testimony preceding my own testimony. I became quite familiar with her estate plan as it evolved over 50 years. Analyzing the various components of the instruments, understanding the nature and extent of her property and the consequence of taxes was part of the basic preparation.

**Stiegel:** Do you have a sense of how much time that took?

**Forger:** I would say many hundreds of hours; I didn't keep track of it. Then, as the testimony went forward, I must have read some 12,000 or 13,000 pages of testimony, particularly focusing on the testimony of the lawyers. [NOTE: Mr. Forger is referring to Henry Christensen, then of Sullivan & Cromwell, who had been Mrs. Astor's trusts and estates lawyer for many years and who prepared the first codicil, and to Warren Whitaker, of Day Pitney, who prepared the second and third codicils after Mr. Christensen was replaced.]

[Part 2 continued in the February issue of *Bifocal*, *Journal of the ABA Commission on Law and Aging*.]

## Why Not Plan a Health Care Decisions Day Event for Your Section's Law Day This Year?

Need help getting started? Check out the free consumer resources on health care decision making available from the ABA Commission (below) and visit the ABA's Law Day Planning Web site at [www.lawday.org](http://www.lawday.org)

## Join the National Health Care Decisions Day Initiative April 16!

All adults can benefit from thinking about what their health care choices would be if they were unable to speak for themselves. These decisions can be written in an advance directive so that others know what they are. Advance directives come in two main forms:

A “**health care power of attorney**” (or “**proxy**” or “**agent**” or “**surrogate**”) documents the person you select to be your voice for your health care decisions if you cannot speak for yourself.

A “**living will**” documents what kinds of medical treatments you would or would not want at the end of life.

Join with lawyers, doctors, and nurses across the country on April 16 to help people understand the benefits of advance directives and learn how to express their wishes regarding health care through conversations and the completion of advance directives.

Organizations and individuals interested in participating in National Health Care Decisions Day should visit the NHDD Web site at: [www.nationalhealthcaredecisionsday.org](http://www.nationalhealthcaredecisionsday.org).

The NHDD initiative also is working with providers and facilities to ensure that individual wishes are respected, whatever they may be.

The **ABA Commission on Law and Aging** offers the following free resources to help make, discuss, and document future health care wishes and decisions:

### **Making Medical Decisions for Someone Else: A How-to Guide**

<http://www.abanet.org/aging/pdfs/genlproxyguide2009.pdf>

### **Tool Kit for Health Care Advance Planning**

[www.abanet.org/aging/pdfs/consumer\\_tool\\_kit\\_bk.pdf](http://www.abanet.org/aging/pdfs/consumer_tool_kit_bk.pdf)

### **Myths and Facts About Advance Medical Directives**

[www.abanet.org/aging/pdfs/myths\\_and\\_fact\\_about\\_HC\\_AD.pdf](http://www.abanet.org/aging/pdfs/myths_and_fact_about_HC_AD.pdf)

Additional resources on advance planning and end-of-life legal issues can be found at ABA Law Info: Your Gateway to Information on Legal Topics that Affect Your Life ([www.abalawinfo.org/fam1.html](http://www.abalawinfo.org/fam1.html)).

## Law Day 2010

## Law in the 21st Century: Enduring Traditions, Emerging Challenges

Law Day - May 1, 2010

Economic markets are becoming global, transactions require cultural adaptation and understanding, populations are more mobile, and communication technologies, such as the Internet, bridge distances and time zones to form new communities around the world.

In such a world, all of us must renew our commitment to the enduring principles of law, become knowledgeable about other legal systems, recognize the need to adapt our practices, and acquire new cultural understandings.

In a global era, matters such as human rights, criminal justice, intellectual property, business transactions, dispute resolution, human migration, and environmental regulation become not just international issues—between nations—but shared concerns.

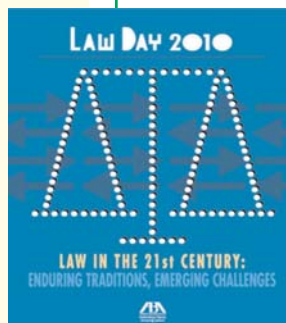
Law Day 2010 provides us with an opportunity to understand and appreciate the emerging challenges and enduring traditions of law in the 21st century.

## Are You Ready for Law Day?

The **2010 Law Day Planning Guide** will be available in January. Be sure you receive your copies and sign up for your planning guide on [www.lawday.org](http://www.lawday.org).

You can download artwork and logos from the site for use on your promotional materials.

If you are a law day event planner, you can also sign up for the law day listserve.



# Legal Guide for the Seriously Ill Helps People Understand Financial and Legal Options at the End of Life

The onset of a serious illness or injury can affect much more than a person's health. Knowing what steps to take to get one's financial and legal affairs in order is often vitally important not only to the affected individual, but to his or her loved ones, as well.

The *Legal Guide for the Seriously Ill*—a project by the American Bar Association Commission on Law and Aging commissioned by the National Hospice and Palliative Care Organization—was designed for both the seriously ill individual and those caring for someone who is seriously ill. The guide explains “seven key steps” in a brief, clear way while offering additional tips and resources for readers looking for more detailed information and guidance.

The recently released guide addresses societal issues that have gained prominent media attention in recent years, such as paying for health care, managing health and personal decisions, and patient rights. In addition, the *Legal Guide for the*

*Seriously Ill* sheds light on new legislative and regulatory changes, such as the recently enacted American Recovery and Reinvestment Act of 2009, which provides a 35 percent subsidy of the COBRA premium for up to nine months.

“The *Legal Guide for the Seriously Ill* is a great resource for anyone facing a serious illness. The book provides critical tools that help readers understand their options, make informed decisions, and minimize some of the anxiety they may be feeling about their financial and legal affairs at this stage of life,” said **ABA President Carolyn Lamm**.

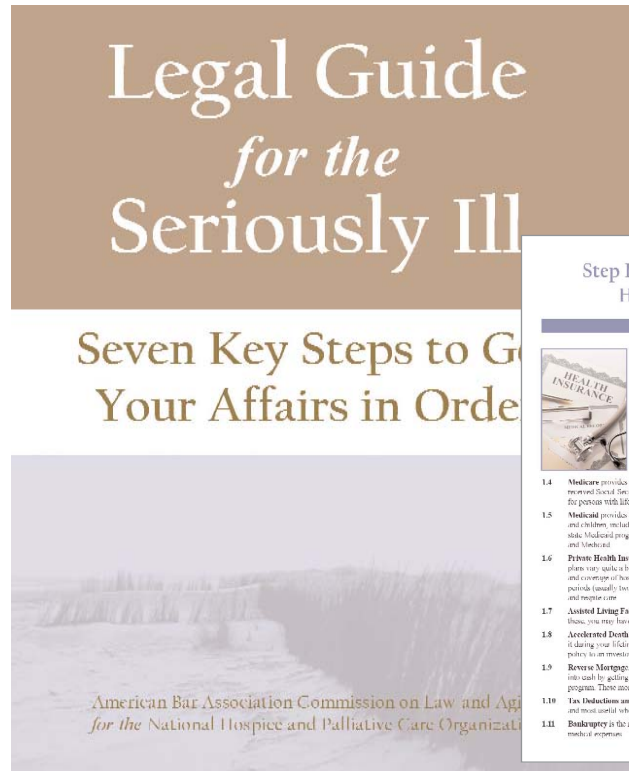
**J. Donald Schumacher**, president and CEO of NHPCO added, “Hospice and palliative care organizations are frequently asked for information regarding end-of-life planning and decision-making. This guide will be a tremendous resource to them, as well as to faith communities, caregiver organizations, aging service providers, hospitals, and others who work to support people living with a serious illness.

**Ellen M. Klem**, staff attorney of the ABA Commission on Law and the Aging, reminds readers that the book does not give legal advice, but will “arm readers with knowledge about the options they have during this difficult time.”

The views expressed in the book have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and, accordingly, should not be construed as representing the policy of the ABA.

The book is available online at [http://www.caringinfo.org/UserFiles/File/PDFs/AdvanceCarePlanningLegalIssues/Legal\\_Guide\\_for\\_Seriously\\_Ill.pdf](http://www.caringinfo.org/UserFiles/File/PDFs/AdvanceCarePlanningLegalIssues/Legal_Guide_for_Seriously_Ill.pdf).

Editor's Note: Review copies are available by sending an e-mail to Ellen M. Klem at [kleme@staff.abanet.org](mailto:kleme@staff.abanet.org). If you publish a review of this book, please send tearsheets or a copy for our files to Ellen M. Klem, American Bar Association, Commission on Law and Aging, 740 15th Street, N.W., Washington, DC 20005.



### Step 1: Plan How to Pay for the Health Care You Need

**The Basics**

Several benefits and financial strategies may be needed to pay for health care. This section discusses the basics of health care financing, including coverage of fees, and coverage of hospice and comfort care. It also discusses long-term care insurance and possible financial tools for paying for long-term care, assisted living, home care, and respite care.

- Workers' Compensation Benefits** or employer-based health insurance may be available to you if you are employed at the time of illness.
- Social Security Disability Benefits** are available to you if you are disabled, or if you have a medical condition that is expected to last a year or more.
- Volunteer Benefits**, volunteer and certain family member benefits, health care benefits, or both from the U.S. Department of Veterans Affairs.
- Medicare** provides basic health care benefits to persons over age 65 and also to certain Social Security disability benefits for at least two years. It covers a wide range of services, including hospital care, medical services, and durable medical equipment.
- Medicaid** provides comprehensive medical and long-term care benefits to men and women with limited income and assets. It covers a wide range of services, including hospital care, medical services, and durable medical equipment.
- Private Health Insurance** is the primary source of accident coverage for those who are not covered by Medicare, Medicaid, or other government programs. It may also provide coverage for long-term care, assisted living, home care, and respite care.
- Assisted Living Facility or Continuing Care Retirement Communities**. If you are able to live in a facility, you may be able to get a refund of your investment.
- Accelerated Death Benefits**. If you have life insurance, you may be able to get it during your lifetime by receiving accelerated death benefits or a viatical settlement.
- Reverse Mortgage**. Home owners with substantial equity in their homes may be able to get a reverse mortgage through the HUD/HECM Home Equity Conversion Mortgage program. These mortgages do not need to be repaid until the home is sold or the owner dies.
- Tax Deductions and Credits**. Do not overlook possible deductions and credits, and consult with your tax advisor regarding the value of your health care expenses.
- Bankruptcy** is the most extreme option for dealing with ongoing debt caused by health care expenses.

### Step 2: Make a Plan to Manage Your Health and Personal Decisions

**The Basics**

If you are seriously ill, it is likely that others will have to make health care decisions for you at some point. It is important to plan for this in advance. Advance health care planning allows you to articulate every medical decision, habit, you need to discuss with your doctor.

- Who you want to be your **decision maker** (your health care agent, proxy, or surrogate) if you are unable to make decisions on your own.
- What **guidance** you would want to give your health-care decision maker for making health care decisions for you.
- How you will **communicate** the plan? This is where health care advance directive documents, such as the power of attorney for health care, and the living will, come in.
- How **more decision makers** described before spring directly from advance health-care planning.
- Consider organ or tissue donation**.
- Consider making burial and interment plans**.

**Decision & Action Steps**

- Pick a health care agent.** The first step is to choose the person whom you want to legally authorize to make your health care decisions if you are unable to speak for yourself. This person is called your health care agent, proxy, surrogate, health-care representative, or vice versa. The label used depends on your state.

In choosing an agent, ask yourself who knows you well and would be able to act on your wishes, regardless of time or distance. The person should also be someone who can be strong advocacy for you and who would handle conflicting views of family members, friends, and medical personnel.

### Step 3: Make a Plan to Manage Your Money and Property

**The Basics**

The management of your financial affairs remains an active issue. You will be able to continue control of your assets to the greatest extent possible, if you plan in advance. Planning involves you to think about who you would want to manage your money if you were unable to do so and how you want to do so.

Your money and property (your estate) will be passed to your heirs in the event of your death. It is important to plan for this in advance. Advance health care planning allows you to articulate every medical decision, habit, you need to discuss with your doctor.

If you are seriously ill, it is likely that others will have to make health care decisions for you at some point. It is important to plan for this in advance. Advance health care planning allows you to articulate every medical decision, habit, you need to discuss with your doctor.

Who you want to be your **decision maker** (your health care agent, proxy, or surrogate) if you are unable to make decisions on your own.

What **guidance** you would want to give your health-care decision maker for making health care decisions for you.

How you will **communicate** the plan? This is where health care advance directive documents, such as the power of attorney for health care, and the living will, come in.

How **more decision makers** described before spring directly from advance health-care planning.

**Consider organ or tissue donation**.

**Consider making burial and interment plans**.

**Resources & Tips**

For help in identifying a health care agent:

- Customer Care Line for Social Care Advance Planning, ABA Commission on Law and Aging, available free at [www.abanet.org](http://www.abanet.org). This web book contains guidance for picking an agent, as well as helping you fill out your advance directives.
- Multi-state Igniter (Choosing Who and How to Act) by Caring Commission Online, at [www.caringinfo.org](http://www.caringinfo.org). Planning Model Advance Directive (Choosing Health Care Agents) from [www.caringinfo.org](http://www.caringinfo.org).

## In Practice

# Short Attention-span Theater: Training Tips for Webinar Presenters

By David Godfrey

The convergence of technology and economy are making Webinars a more popular option for training. Today's Web interfaces have more capabilities and require less technical ability to present or participate in than just a few years ago. In addition, the economy has put the squeeze on many travel and training budgets, making Webinars an increasingly appealing option for presenting, training, and sharing ideas. Here are a few tips for making the most out of your Webinar training.



A Webinar is “short attention-span theater.” Limiting your topic is critically important. To

be effective, a Webinar needs to communicate a message in less than an hour. One way to approach it is to think of a Webinar as a prime-time television sitcom—a short, single story presented in 6 to 10 minute segments. Plan to communicate your message in short segments and include “commercial breaks” in the form of polls and quizzes to break the program up.

When people sign on to view a Webinar, the presenter and the audience will see a “log on report” that indicates how many people are participating. Statistically, as the Webinar program progresses audience members will start to log off. Thus, time is of the essence in presenting Webinars—you must reach the audience early while you still have their attention. This requires ruthless editing of your message to what can be communicated clearly, yet quickly.

Just like a television program, it helps to make your Webinar presentation visually interesting. In the early days of television, news programs were little more than a single camera pointed at a news reader. Today television news is a mul-

timedia presentation, with graphics and video designed to grab and hold the audiences' attention. There are a wide range of presentation options for Webinars. Generally, if you can view or hear it on your computer then you also can share it with your audience in a Webinar. The most common presentation tool for creating a Webinar is PowerPoint software.

PowerPoint presentations form the core of most Webinars. Following are a few tips for creating effective and memorable PowerPoint presentations.

Limit the text to two or three phrases per slide. Limit each point phrase to not more than four or five words. The purpose of the text on your Powerpoint slides is to reinforce your message, not to serve as an outline. Edit the text to the point that the slides alone, without your commentary, are all but meaningless. If you have a paragraph of text that really needs to be used, it should appear as the only thing on the slide (other than clip art).

PowerPoint has a wide range of standard slide templates. Select a template (or background) that is visually appealing and uses color to attract the audiences' attention to effectively communicate your message.

The layout of the text and graphics on the slide is also an important part of communicating the message. PowerPoint offers a variety of slide layouts. Alternate the slide layouts to organize the material in interesting and logical ways.

Use clip art and illustrations on every slide to reinforce your message. Illustrations serve a number of purposes: they help the viewer understand the message and they prompt the viewer's mind to draw connections between the illustration and the message. PowerPoint offers an extensive searchable online library of free clip art. You can also insert pictures and illustrations from your own scanned images or files into PowerPoint slides. PowerPoint will also create and insert diagrams and charts and import audio and video clips.

A “Welcome” slide featuring a picture of the presenter often helps to add a human face to the disembodied voice on a Webinar.

Use different type faces, sizes, and colors for emphasis.

Animation adds visual interest, as the motion attracts attention and maintains interest.

The use of humor and emotion can be an effective way to communicate a message. For example, one of my most popular ethics presentations was illustrated with cartoons.

One of the most powerful presentations that I have ever seen contained a couple of carefully selected crime scene photographs to underscore the message on elder abuse. A slide show that makes an audience sit on the edge of their seats wondering if the next point will make them laugh (or cry) is a powerful communications tool.

You can also use quizzes and polls to actively involve the audience. The biggest challenge for a presenter is that they

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can't see or hear the audience to gauge their reactions. A presenter can test the audiences' level of understanding and involvement by inserting quizzes and polls into the presentation. Most Webinar platforms have a special option for interactive live polls. Use this option if you can; if you can't use this option, insert a quiz or have people answer using an audio or dial-in function. These tools add a level of interactivity to a Webinar that dramatically increases audience participation. Most Webinar platforms also have an online live chat function. The chat function allows participants to type comments or questions that can be viewed by other participants. The presenter (or organizer) generally has control over who can send messages to whom. The chat function is a great tool for receiving questions from the audience. Optimally, the presenter should have an assistant present to review the messages and forward them to the presenter. I normally build a question break (commercial break) into my Webinar every 10 minutes.

Overall, Webinars are a great low-cost tool for communicating with a dispersed audience. Understanding the medium and carefully crafting the presentation will greatly improve the effectiveness of your Webinar.

### *Inside the Commission*

In October, the ABA Commission on Law and Aging welcomed for the second time an international law student intern. **Danielle Valdenaire** is a student from the prestigious *Sciences Po* (Institute of Political Sciences) and *Paris X Nanterre* in Paris, France.



Ms. Valdenaire is assisting staff attorneys on a wide range of substantive legal issues, including international aspects of elder rights, guardianship, elder-friendly offices, elder law courses offered in law school across the U.S., and health care advance directives.

Ms. Valdenaire also is providing useful tips to staff on French cuisine, fashion, and way of life.

Ms Valdenaire will return to Paris in September, where she still has two more years of studying before she graduates.



**Danielle Valdenaire** with staff attorneys **Ellen Klem** and **Leslie Fried** at a visit to the U.S. Supreme Court.

## Get Connected, Stay Connected On Elderbar

Join **Elderbar**, the listserv that brings together public and private sector legal advocates and the aging network. **Elderbar** is for you if you are an:

- Elder law attorney
- Title IIIB legal services provider
- Legal services developer
- Senior hotline attorney or staff
- Long-term care ombudsman
- Senior Health Insurance Benefits Program staff
- Area agency on aging staff
- State unit on aging staff
- OAA-funded elder rights advocate
- LSC, IOLTA-funded, or other non-profit or public sector legal services organization
- Law school elder law or clinical staff
- State or local bar association elder law section or committee leader
- Service provider in the aging network
- National law and aging advocate

**Elderbar** gives you the opportunity to communicate across the boundaries of the law and aging networks and the public and private legal sectors. Share ideas and information about programs, bar section and committee activities, and learn how others are responding to the increasing demand and finite funding for legal services for seniors.

**Elderbar** is a project of the ABA Commission's National Legal Assistance Support Center as part of its role in the National Legal Resource Center, funded by the Administration on Aging. It is a closed list; messages can only be posted and read by members.

To get connected to **Elderbar** send your name, e-mail address, and professional affiliation to David Godfrey at [Godfrey@staff.abanet.org](mailto:Godfrey@staff.abanet.org).

## Inside Practice

### Communicating with Lawyers

By David Godfrey, Senior Attorney  
ABA Commission on Law and Aging

Communicating with lawyers can be a challenge for non-lawyers. Lawyers are trained to evaluate the world in very specific ways. From the first day of law school most are trained to examine every situation by looking for the legal issue, relevant facts, rule of law, application of the rule to the facts, and conclusion or the expected outcome. This methodology is commonly known as “IRAC,” standing for issue, rule, application, and conclusion.<sup>1</sup> This structured methodology dominates the thought process of lawyers and creates a major challenge when non-lawyers try to communicate with them.

The first key to communicating with a lawyer is to lead with the problem or legal issue. The legal issue is the problem or concern that the client needs help with that may have a legal solution. If you lead the conversation with background information on the client many lawyers will wonder when you are going to get to the point. They will continually sift through the facts and background information trying to determine the legal issue or issues. Leading with the issue or problem will help to focus the lawyer’s thinking. Typical law school cases and exams feature multiple issues buried in complex facts, training attorneys to look for multiple and hidden or underlying issues in every fact pattern; so don’t be surprised when the lawyer finds different or multiple legal issues.<sup>2</sup>

The outcome of most legal questions is driven by the facts. So the next key to effective communication with an attorney is to know as many relevant facts as possible that may have an impact on the legal issues. Unless the health and social status of the client are relevant to the outcome of the legal issue, most lawyers will disregard those facts. Disregarding the psycho-social facts runs against the training in many fields, such as social work, leading to a communications hurdle.

Capacity, the clients’ ability to make and communicate informed decisions understanding the risks, benefits, and consequences of the decision being made, is very important to a lawyer when offering advice. If you suspect that the client lacks capacity, it is essential to explain your concerns.

Lawyers are bound by a strict set of ethical rules that regulate their behavior to protect clients and the integrity of the legal system.<sup>3</sup> Lawyers want to talk to the client and give advice to the client. They may consider whoever they give

advice to first their client with regard to that issue. A lawyer can only offer advice to one side of any disagreement and there are strict limits on what a lawyer can reveal about a client and a client’s legal matter.

Lawyers have a duty to be a “zealous advocate” for their client.<sup>4</sup> If there are two sides to the story, a lawyer can only be an advocate for one side.<sup>5</sup> It is impossible to be a zealous advocate for both sides of a case, so lawyers are limited to offering advice to only one side of any disagreement.<sup>6, 7</sup> If a lawyer is offering advice to two people who have irreconcilable differences, the lawyer may be forced by the ethical rules to withdraw from representing both of them.<sup>8</sup> Even in joint representation, the ethical obligations apply to each client individually.<sup>9</sup> It is unethical for an attorney to continue to represent one client if doing so results in the breach of an ethical duty to another client.<sup>10</sup>

Confidentiality rules strictly limit what a lawyer can say about the representation of a client.<sup>11</sup> The lawyer can only disclose this information if it is legally necessary to do so to represent the client or if the client grants permission.<sup>12</sup> This means that a lawyer may ask others for information about a client, but they are unlikely to be able to share information. The rule allows clients to share intimate secrets with a lawyer without fear of disclosure.<sup>13</sup> But this can make communicating with a lawyer a one-way street. Rest assured, the lawyer is not ignoring you; they just can’t start down the slippery slope of disclosure.

Making it clear what outcome you want and how far you want to take an issue will improve communications with a lawyer. Lawyers are trained to be arguers and fighters and defend their clients to the end of the law. Knowing up front what outcome a client is looking for and how much of a fight the client wants will temper the response of a lawyer. Lawyers will tell you if they think a prolonged battle would have a better outcome, but the decision on how far to press a case belongs to the client.<sup>14</sup>

Lawyers are not born, they are trained. Most are trained in a methodology of thought that starts with the legal issue, the facts, the rule of law, application of the rule to the facts, and drawing a conclusion. The rules of ethics limit who a lawyer can offer advice to and what they can say about representation of a client. Understanding how lawyers think and communicate makes it easier for others to communicate with them.

### Notes

1. <http://en.wikipedia.org/wiki/IRAC>
2. Law school is as much about learning to think and communicate in a structured way as it is about learning the basics of the law.
3. [http://www.abanet.org/cpr/mrpc/mrpc\\_toc.html](http://www.abanet.org/cpr/mrpc/mrpc_toc.html)

*Continued on next page*

## Consumer Resource/Health Decisions

### Harvard School of Medicine Publishes Health Care Power of Attorney and Living Will

Harvard Health Publications, in consultation with Anne Fabiny, MD, chief of geriatrics at the Cambridge Health Alliance and assistant professor of medicine, Harvard Medical School, and **Charles Sabatino, JD, director, American Bar Association Commission on Law and Aging**, has released a new publication to help people understand and prepare a health care power of attorney and living will

Living wills and health care proxies are legal documents that people can use to let others know about their health care wishes in the event that they become unable to speak for themselves.

This publication guides people through the process of thinking about what their health care options might be, explains medical terms and procedures, and helps people think about the kind of end-of-life care they might want.

The publication also provides three forms: a health care power of attorney; a health decisions worksheet, and an advance directives tracking sheet.

The guide is available for \$15 in both print and electronic PDF. Order online at:

[http://www.health.harvard.edu/special\\_health\\_reports/the-health-care-power-of-attorney-and-living-will](http://www.health.harvard.edu/special_health_reports/the-health-care-power-of-attorney-and-living-will)

### Contents

#### What are advance directives?

What is a health care power of attorney?

What is a living will?

What is a do-not-resuscitate order (DNR)?

Which documents do you need to have?

#### Step One: Deciding on your wishes for care

How specific should you be in your directives?

Talking to your doctor

Understanding key medical procedures

Understanding medical and legal terms

#### Step Two: Choosing a health care agent

The basics

Talking to your health care agent

Privacy rules and health care agents

#### Step Three: Creating your advance directives

What are your goals for care?

Who needs to have your advance directives?

State-specific information

Changing your advance directives

#### Pitfalls, fixes, and tips for tough conversations

#### The forms

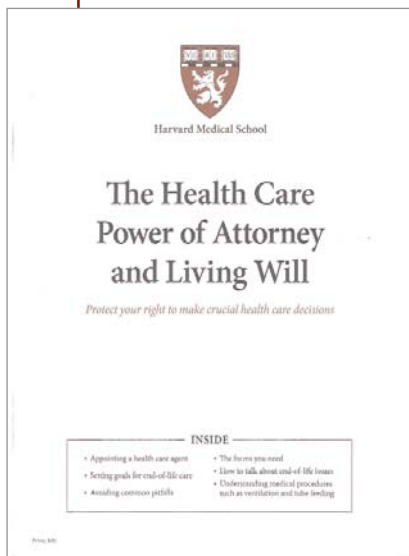
Tips for filling out your directives

Form 1: Health Care Power of Attorney

Form 2: Health Decisions Worksheet

Form 3: Advance Directives Tracking Sheet

#### Resources



## Communicating with Lawyers

*Continued from previous page*

4. Model Rules of Professional Conduct, Preamble and Scope (2).
5. Model Rules of Professional Conduct 1.7.
6. *Id.*
7. Some legal work does not have a truly opposing side and attorneys routinely enter into joint representation of more than one client in those matters.
8. Model Rules of Professional Conduct 1.16.
9. Model Rules of Professional Conduct 1.6, 1.7, and 1.16.

10. Model Rules of Professional Conduct 1.16 for example of a breach of the duty of confidentiality under rule 1.6.
11. Model Rules of Professional Conduct 1.6.
12. *Id.*
13. See Comments 1-4 of Rule 1.6. the ability of a client to reveal secrets is essential to the client attorney relationship and lawyers hear it all—who clients love and hate, who they trust and don't, who they have loved and lost, births, marriages, divorces and crimes that they have never told anyone about.
14. Model Rules of Professional Conduct 1.2.

## National Legal Resource Center

### AOA, National Legal Resource Center Partners Launch Web site

Visit: [www.NLRC.AoA.gov](http://www.NLRC.AoA.gov)

By Omar R. Valverde, Esq.

The Administration on Aging and the partners of the National Legal Resource Center (NLRC) have launched a Web site designed to provide resource support to aging and legal networks across the country.

The NLRC Web site creates a much-needed portal to important support tools designed to help providers better serve older consumers facing difficult legal issues impacting their independence, health, and financial security. Legal problems can include the potential loss of a home through foreclosure; consumer scams that destroy nest eggs; physical abuse, neglect, and exploitation; problems in long-term care facilities; and difficulties accessing public benefits essential to remaining financially secure, independent, and healthy. These and other legal problems facing older adults are on the increase as a result of the economic downturn.

The NLRC is a collaborative effort of five national non-profit organizations known for their work and expertise in legal and aging services support. These organizations include the **ABA Commission on Law and Aging**, Center for Elder Rights Advocacy, National Consumer Law Center, National Senior Citizens Law Center, and the Center for Social Gerontology.

Legal resources accessible through NLRC partners and the NLRC Web site are targeted towards a broad range of legal and elder rights advocates and organizations, including: state unit on aging directors, state legal assistance developers, state LTC ombudsman, area agency on aging staff, aging and disability resource center staff, Title IIIB legal providers, Legal Services Corporation providers, senior legal hotlines, states involved in integrated legal service delivery initiatives, and other professionals involved in protecting the rights of older persons. In previous years, members of these target audiences did not have the advantage of having of a stream-

lined entry point into a comprehensive legal support system that the new NLRC Web site now provides.

The NLRC partner organizations leverage their resources to assist aging and legal service providers in effectively responding to an increasing number of older persons facing legal issues related to income security, health and long-term care, housing, consumer fraud, and elder abuse. The Web site provides a wealth of information on every major category of law impacting older persons. Important news on legal developments can be accessed through the Web site. Aging and legal service entities throughout the country can be located with the click of a map. In addition, a highly significant innovation includes the ability for legal and aging service providers to directly request intensive case consultation and training on the most difficult and pervasive legal issues facing older persons, through an easy online request process.

Other NLRC Web site features focus on assisting states and provider networks in developing effective and high-quality legal and aging service delivery systems. Current adverse economic conditions have created a proliferation of legal problems impacting older adults, while state budgets and legal service providers are facing a pernicious situation of static or dwindling resources to meet the increasing demand.

Legal and aging services administrators can now use the NLRC Web site to access technical assistance on the efficient, cost-effective, and targeted provision of legal services to older persons in the most social or economic need. Technical assistance is available on a wide variety of legal service delivery issues, including the development of legal service delivery standards or guidelines; effective outreach and targeting strategies, assessing legal needs and service delivery capacity; and developing statewide reporting systems that capture program outcomes and measure service delivery impact. Intensive technical assistance is also available through the Web site to professionals involved in providing legal counsel through senior legal helplines, including support in the development of reporting and data collection systems, innovative case management systems, targeting and outreach strategies, funding strategies and integration strategies that permanently incorporate helplines into the broader tapestry of legal service delivery.

These difficult economic times require new and accessible tools to aid providers who are on the front lines of keeping older Americans independent, healthy, and financially secure in their homes and communities. Aging and legal services providers throughout the country are highly encouraged to explore and take full advantage of the resources available through the NLRC partners and the new NLRC Web site.

Visit [www.NLRC.AoA.gov](http://www.NLRC.AoA.gov) today!

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*Omar R. Valverde, Esq., is the aging services program specialist at the Office of Elder Rights, Administration on Aging, U.S. Department of Health and Human Services in Washington.*

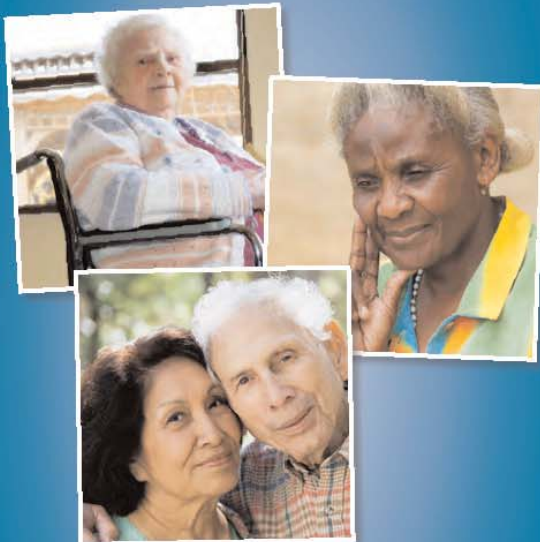
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## State Advance Directive Registries

*Continued from page 23*

an AD registry. The word “registry” is intended to mean a central repository for storing ADs primarily for proxy or health care provider access. It does not include methods of storing an AD in a personal health record. In each state, the designated department in charge of the registry was contacted, and state informants were interviewed via telephone and email. The author was able to interview a knowledgeable person about each state registry except for Arizona and New Jersey. Seven private national registries also were contacted, although only three responded: America Living Will Registry, DocuBank, and U.S. Living Will Registry.

This paper provides a summary and analysis of the current status of state AD registries based on this survey. First, it provides a brief introduction regarding the AD and its development. Second, it addresses the advent of AD registries and the various methods states have used in implementing them. Third, it reviews current status of operating registries and their use by individuals and health care providers. Finally, it discusses challenges, alternatives, and recommendations to the continued existence of state AD registries.

### The Advance Directive

The stories of Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo underscore the importance of contemplating and making known one’s desires for end-of-life care. Major legal battles ensued over the decision to withdraw life support from each of these young adults, who were left in a persistent vegetative state due to tragic circumstances. In each of these cases, having an AD may have made a difference in the health care decisions that were made subsequent to their incapacity. Advance directives are legal documents that allow people to retain control over their medical care when they are unable to speak for themselves.<sup>4</sup> These documents come in a variety of forms: the living will, durable power of attorney for health care, or some combination thereof. A living will sets out treatment preferences and a durable power of attorney for health care designates someone to make health care decisions on another’s behalf. Every state has one or more advance health care directive statutes.

While studies show that there is widespread public support for advance care planning, it is estimated that only 18 percent to 30 percent of Americans have executed one form of these documents.<sup>5</sup> The majority are white, older females who are highly educated and from the middle or upper classes.<sup>6</sup> This number is slightly higher for acutely or chronically ill patients.<sup>7</sup>

A sustained criticism of the AD is its accessibility when needed,<sup>8</sup> since having an AD is only as good as the known existence and accessibility of the document.<sup>9</sup> The statistics regarding locating ADs are discouraging. Despite the requirement in the Patient Self-Determination Act (PSDA) to ask patients whether or not they have an AD, the executed documents rarely make it into the patients’ medical records.<sup>10</sup> It is estimated that 35 percent of ADs cannot be found when needed<sup>11</sup> and that 65 percent to 76 percent of patients’ physicians are not aware that their patients have an AD.<sup>12</sup> People store their ADs anywhere from safety deposit boxes to shoe boxes, or they forget where they put the documents altogether, thus defeating the purpose of having an AD at all.<sup>13</sup> Having a secure repository where ADs can quickly and easily be retrieved by health care providers or named proxies seems like an obvious solution to the problem.

### Advent of the Advance Directive Registry

In recent years, some states have addressed the issue of accessibility by establishing statewide registries for residents to store their ADs. Since the first legislation authorizing a registry was enacted in Louisiana in 1990,<sup>14</sup> as of mid-2009, eleven states have enacted legislation mandating the creation of a registry for health care ADs<sup>15</sup> (Arizona, California, Idaho, Louisiana, Maryland, Montana, Nevada, North Carolina, Oklahoma, Vermont, Virginia, and Washington).<sup>16</sup> In addition, two states have similar legislation currently pending (Alaska and Michigan).<sup>17</sup> Of the twelve states that have enacted legislation, Oklahoma,<sup>18</sup> Virginia,<sup>19</sup> and Maryland<sup>20</sup> are still in the process of establishing their registries.

In legislation regarding the development of state health networks, Kentucky and Oregon have instructed their health boards to consider AD registries as a future option.<sup>21</sup> Oregon recently passed legislation mandating the creation of a registry for Physicians’ Orders for Life-Sustaining Treatment (POLST) forms.<sup>22</sup> West Virginia also is working on a state AD registry that will be run by the Center for End-of-Life Care, but there is no legislative mandate creating it.<sup>23</sup>

There also are seven private registries available nationwide.<sup>24</sup> U.S. Living Will Registry currently hosts three state registries,<sup>25</sup> and both America Living Will Registry and DocuBank are developing methods to contract with states to provide the service.<sup>26</sup>

In summary, nine of the states that have passed legislation establishing AD registries have fully operational registries as of mid-2009.<sup>27</sup> Louisiana was the first state to establish a registry in 1991, and the registry is housed in the publications office under the secretary of state.<sup>28</sup> Most state

registries operate through the secretary of state's office,<sup>29</sup> a few are managed through the department of health,<sup>30</sup> and one (Montana) is headed by the office of consumer protection in the department of justice.<sup>31</sup> Most state registries store electronic copies of ADs and are based online, but California and Louisiana maintain physical registries with electronic databases holding information about their registrants.<sup>32</sup> Every operational state registry has an informational Web site with links regarding ADs and information about how to register an AD.<sup>33</sup>

Most states have developed their own registries, but three states (Nevada, Vermont, and Washington) have contracted with a private company, U.S. Living Will Registry.<sup>34</sup> For these states, all ADs are stored in the same registry, and each state has its own personalized Web page through which individuals can access the registry.<sup>35</sup>

### Documents That Can Be Registered

All states allow patients to register a living will in the registry, and all but Louisiana permit filing a durable health care power of attorney (HCPOA). Louisiana will not process any other form than a living will declaration, but if any other form is filed with a living will, the publications office will attach it to the living will and keep it on file.<sup>36</sup> Arizona, North Carolina, and Washington allow psychiatric advance directives (PADs)<sup>37</sup> to be filed in the registry,<sup>38</sup> and Idaho,

Maryland, and Washington permit POLST forms to be included.<sup>39</sup> Declarations of anatomical gifts may be registered in Maryland, North Carolina, Oklahoma, and Virginia.<sup>40</sup> These declarations are included in the statutory advance directive forms in Maryland and Oklahoma.<sup>41</sup> Nevada also permits registering a do-not-resuscitate order (DNR order).<sup>42</sup> Table 1, below, illustrates the documents that may be included in a registry in each state.

### Registration Process

The process of registering an AD is very similar among all the states with operating registries, particularly for those online. The registries in California and Louisiana only store physical copies of ADs. California requires its registrants to complete a registration form and either indicate the location of their AD or attach a copy of it.<sup>43</sup> The information on the registration form is entered into an electronic database, and the AD, if supplied, is filed.<sup>44</sup> Upon receipt of an AD in Louisiana, the publications office date-stamps the document and keeps it in its archives.<sup>45</sup> If an individual submits more than one copy to the Louisiana registry, the office will date-stamp each copy and return additional copies to the registrant.<sup>46</sup>

The remaining seven state registries create an electronic copy of the registrant's AD that is accessible online.

*Continued on page 38*

**Table 1**

State	Living Will	HCPOA	PAD	POLST*	Anatomical Gift	DNR Order
Arizona	X	X	X			
California	X	X				
Idaho	X	X		X		
Louisiana	X					
Maryland	X	X		X	X	
Montana	X	X				
Nevada	X	X				X
North Carolina	X	X	X		X	
Oklahoma	X	X			X	
Vermont	X	X				
Virginia	X	X			X	
Washington	X	X	X	X		

\* States use a variety of titles and resulting acronyms to describe the same document. Variations include Instructions on Current Life-Sustaining Treatment Options, Medical Orders for Life-Sustaining Treatment (MOLST), Medical Orders for Scope of Treatment (MOST), and Physician Orders for Scope of Treatment (POST).

## Let the ABA Commission On Law and Aging Help You in Your Work

The ABA Commission on Law and Aging provides valuable professional and consumer resources, technical assistance and legal education, and research on a wide-range of critical issues affecting older persons, including:

- Legal Services Access and Delivery
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- Guardianship and Conservatorship
- Dispute Resolution and Mediation
- Professional Ethical Issues
- Housing Options and Needs
- Health and Long-term Care Quality, Planning, and Decision-making
- Social Security, Medicare, Medicaid, and Other Public Benefit Programs

The ABA Commission on Law and Aging provides a forum for legal professionals to communicate and share ideas on two active listserves—**Elderbar** and **Collaborate**—and distributes a bimonthly e-journal *Bifocal*.

Find up-to-date and practical information on the Commission's publications Web page, which offers an extensive catalog of professional and consumer resources on a wide range of issues of concern to elder law practitioners, advocates, and older persons.

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## State Advance Directive Registries

*Continued from page 37*

Registrants in these states submit a copy of their AD to the department overseeing the registry, along with a registration agreement and a fee, if the state requires one. Personal contact and identifying information are usually entered into a database maintained by the department, and the department creates an electronic copy of the AD. After uploading the AD into the registry, most of the states who maintain an online registry return the submitted documents to the registrant.<sup>47</sup> Vermont, like California, allows individuals the choice of registering the location of their ADs rather than the document itself.<sup>48</sup> All states send registrants at least one wallet card indicating that they have registered an AD with the state. For the states that maintain an online registry, the wallet card also contains the access codes for the documents in the registry. Montana, Nevada, Vermont, and Washington also provide the registrant with sticky labels to affix to a driver's license, insurance card, or anything else that the registrant desires.<sup>49</sup> Upon request, Louisiana also will supply its registrants with a do-not-resuscitate bracelet.<sup>50</sup>

Registrants in Arizona go through an additional verification process to confirm the content of the documents registered.<sup>51</sup> Before the AD is officially entered into the registry, the state returns a printed record of the registration to the registrant to verify that all information contained therein is accurate.<sup>52</sup> After the state receives confirmation that the information is correct, it issues a wallet card with file number and password to the registrant.<sup>53</sup>

Maryland and Montana are required by law to review ADs submitted to their registries for legal sufficiency,<sup>54</sup> and Idaho also reviews the documents for legal sufficiency even though not statutorily required.<sup>55</sup> A few state statutes explicitly relieve the office overseeing the registry of the responsibility to verify whether the AD submitted to the registry complies with legal requirements before registering the document.<sup>56</sup> While an additional step for the state, reviewing documents for legal sufficiency before filing them in the registry helps ensure that the document filed will be legally effective.

North Carolina and Virginia's statutes require any document submitted to the registry to be notarized.<sup>57</sup> Of all of the documents that North Carolina permits to be filed in the registry,<sup>58</sup> the only document that North Carolina does not statutorily require to be notarized is a declaration of anatomical gift.<sup>59</sup> However, Virginia's AD statute does not require notarization for an AD to be legally valid; it simply requires an AD to be witnessed by two parties.<sup>60</sup> These inconsistent requirements may be problematic for people who have already executed ADs and would then like to register them. The additional notarization requirement in effect requires registrants to re-execute their ADs. It does not advance the goal of increasing access to documents because it creates another barrier for people to use the service.

### Access

California and Louisiana are the only state registries in which the registrant's AD cannot be accessed online. California will supply a copy of an AD upon request to a registrant, a health care provider, public guardian, agent appointed in an AD, or legal representative of the registrant.<sup>61</sup> Parties requesting informa-

tion regarding the AD must verify their identity, and their request for a copy of the AD must be accompanied by a written statement of the need for the information.<sup>62</sup> If an emergency department of a general acute care hospital requests information, California law requires the secretary of state to respond to this request by the close of business on the next business day.<sup>63</sup> This requirement may be impractical given that people usually do not spend more than 24 hours in an emergency room, and the delay would be even longer if the patient requested the information on a Friday.

Louisiana maintains a database of registrants available to the general public on its Web site. The database contains an alphabetical listing of the names of registrants, the dates their documents were registered, and the dates the documents were executed;<sup>64</sup> however, the registered AD is not accessible online, and no other personal identifying information is available.<sup>65</sup> The publications office will provide a copy of the registered document to registrants, family members of registrants, or attending physicians or health care facilities upon request.<sup>66</sup>

All other states with operating registries provide their registrants with identification codes to access electronic copies of the registered documents online. Arizona, Idaho, and North Carolina limit access only to those who possess an individual's access codes.<sup>67</sup> The remaining states<sup>68</sup> allow broader access to approved health care providers who have registered with the service so that health care providers can

access patients' ADs with patient identifying information, such as name, date of birth, and social security number, as opposed to needing an access code.

Montana is unique in that it allows its registrants to choose between two privacy levels allowing individuals to access their ADs.<sup>69</sup> The standard privacy level allows the registrant, appropriate health care providers, anyone with the registrant's name and access code, and anyone with the social security number, date of birth, and mother's maiden name to access the declaration.<sup>70</sup> The higher privacy level only allows the registrant, appropriate health care providers, and anyone with the registrant's name and access code to access the registry.<sup>71</sup> This allows registrants to determine how accessible they want their AD to be. Choosing the standard privacy level allows people to search for a registrant's AD even if they do not have the access codes, but have enough identifying information about the registrant. Electing the higher privacy level ensures that only people who the registrant has given the access code to, outside of health care providers, are able to access the registered AD.

The primary advantage of the electronic registry is its accessibility. Health care providers or proxies can access the document whenever and wherever there is a computer with connection to the Internet. With sufficient security in place, this method of access better serves the purpose of the registry by ensuring that documents may be easily and quickly retrieved.

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## ***New Resources/Health Decisions***

### **Comprehensive Chart Features Links to State-specific Advance Directive Forms**

**N**ow posted on the ABA Commission on Law and Aging's health decisions resources page is a handy chart that will link you directly to free downloadable advance directive forms and information from state bar associations and other reputable state groups. The chart was created by Danielle Valdenaire.

Access the chart at: <http://new.abanet.org/aging/Pages/HealthDecisions.aspx>

### **Advance Care Planning in Health Reform (formerly Misrepresented As "Death Panels")**

**H**ouse Bill 3962, America's Affordable Health Choices Act of 2009, is the health care reform bill adopted by the House. Since the advance care planning provisions in it have received a lot of distorted attention, it is important to look closely at what's in the bill. To see a summary of the advance care planning and palliative care provisions contained in the House bill go the ABA Commission's health decisions Resources page at: <http://new.abanet.org/aging/Pages/HealthDecisions.aspx>

No similar provisions exist in Senate versions of health reform legislation.

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States that allow health care providers to access the registry independent of a registrant's personal access codes are most likely to achieve the desired effect of the registry. If access is limited to only those people who are in possession of a patient's access code, the responsibility still lies with the registrant to ensure that those who would need a copy of the document to have the access codes. While this strategy seems appropriate in concept given privacy concerns, it does not provide pertinent parties with greater access to the document than they would have had if the patient simply gave those parties a copy of the document. Storing the AD online merely seems to protect against misplacement of the document by the recipient. Allowing health care providers greater access to the registry helps bridge the gap between an individual creating an AD independent of receiving health care and the health care provider who eventually treats the individual.

### Fees Charged and Funding for the Registry

Only three states impose a fee for registering an AD. California charges \$10,<sup>72</sup> North Carolina charges \$10 per document registered,<sup>73</sup> and Louisiana charges \$20 to register and \$5 to revoke.<sup>74</sup> Louisiana is the only state that imposes a fee for revoking an AD independently of filing a new document. The other six states that have operational registries provide this service free of charge to their residents.<sup>75</sup> A few state statutes permit imposing fees for registering documents but have chosen not to do so.<sup>76</sup> No state statutorily prohibits collecting fees for registering documents, but some state statutes<sup>77</sup> specifically prohibit fees for revocation. California is the only state that statutorily prohibits charging fees for accessing the registry, even though none of the states charge fees for health care providers to access the registry.<sup>78</sup>

In each of the three states that charge a registration fee, that is the primary source of funding for the registry. Louisiana does not appear to have any funding outside of the fee charged for the service.<sup>79</sup> North Carolina received initial funding to establish the registry, but is now supported by registration fees.<sup>80</sup> California's registry is also supported by business fees paid to the secretary of state for other services in addition to AD registration fees.<sup>81</sup> Arizona's registry is privately funded by donors including Hospice of the Valley.<sup>82</sup> Other states either have money appropriated by the legislature or use state general funds to support the program.<sup>83</sup> Idaho's costs are absorbed by the annual appropriation to the secretary of state.<sup>84</sup>

An obvious concern is that charging for this service may deter people from registering their ADs<sup>85</sup> and that it may exclude individuals with low incomes.<sup>86</sup> Yet, states report that without alternative funding, they have to rely on revenue from fees in order to support operation of the registry. States that do not currently charge fees for the service may be faced with imposing fees for registration if the state is not able to continue funding the project. For instance, this year the governor of Washington proposed cutting the budget for the registry by 80 percent because of state budget cuts.<sup>87</sup> With the help of Compassion and Choices of Washington, a nonprofit organization that focuses on improving care and expanding choice at the end of life, the registry was preserved, but funding for promotional efforts has been significantly reduced.<sup>88</sup> Maryland has a statute authorizing a registry, but no registry has ever been created because there is no funding for the project, and the state continues to face budget cuts.<sup>89</sup> Thus, for a state to adequately maintain, or even initially develop, its registry, it is important to secure stable funding through the legislation authorizing its creation.

### Updating the Registry

Only three states annually contact their registrants to update and verify information on file in the registry. Nevada, Vermont, and Washington, which all contract with U.S. Living Will Registry, send an annual renewal letter asking its registrants to confirm that the AD on file still reflects the registrant's wishes and to update personal information (name, address, phone number, and birth date) and emergency contact information.<sup>90</sup> Washington contacts the registrant or next of kin if the letter is returned.<sup>91</sup>

Three states have procedures in place for purging the registry of ADs of deceased registrants. Arizona, Idaho, and Nevada's statutes allow for cooperation with the state vital statistics department to share death certificates with the department overseeing the AD registry so that deceased registrants' ADs can be removed from the system.<sup>92</sup> Idaho's statute requires that the secretary of state update the registry through this method at least every two years,<sup>93</sup> and Arizona and Nevada's statutes require this to be done at least once every five years.<sup>94</sup>

Advance care planning is an ongoing process, and providing an annual renewal service helps promote the purpose and integrity of the AD by ensuring that the document on file with the registry accurately reflects the registrant's current wishes.<sup>95</sup> There are a variety of reasons that the AD registered may quickly become outdated: people change their minds, relationships evolve, health conditions change, the AD on file may have been revoked, or a new one created altogether. If any of these events transpire, but do not get

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communicated to the registry, an annual verification may serve as a reminder to make the appropriate changes. Even the minimum process of updating personal and emergency contact information at least serves the purpose of reminding the registrant of their registered AD. It is better to specifically address validity of the document on file and request that the registrant confirm that the document reflects their current wishes.

## Use of the State Registry

Examining the number of registrations and the number of times the registry is accessed should be illustrative of the extent to which the AD registry is meeting its primary goal of making ADs more accessible. In theory, the total number of registrations will demonstrate how many people are filing documents with the registry, and the number of times the registry has been accessed will show whether the registry has actually improved access to ADs for patients, family members, and health care providers.

### Number of Advance Directives Registered

Only a small number of people in states with registries have taken advantage of the service. Table 2, on page 42, demonstrates the number of total ADs registered in each state and the percentage of those people as compared to the entire population of the state. Since people 60 years of age and older are twice as likely to complete an AD,<sup>96</sup> the number of ADs registered has also been compared with the state population over the age of 65. The states are listed in order of the years the registries were established.

Overall registration numbers are small, but many of the registries have only been in operation for a short time. Table 2 displays the year each of the registries began operating. Louisiana is home to the oldest operating registry, with the first registrations in 1991.<sup>97</sup> California's registry was initially created for durable powers of attorney for health care, and the legislature amended the statute in 2000 to authorize the registry to hold ADs.<sup>98</sup> All of the subsequent registries have developed within the last seven years. Each state reports that the total number of ADs registered increases each year, as does the annual number of ADs registered. There is no indication of any correlation between the number of years of registry operation and the number of registrants or percentage of the population with ADs registered. For example, table 2 shows that the number of participants and percentage of the population registering in several younger state registries exceeds that of the two oldest registries (Louisiana and California).

State informants have reported a correlation between the number of ADs registered and two particular events: (1) the death of Terri Schiavo in March 2005 and (2) community education and outreach efforts. The number of registrants dramatically increased during *Schiavo's* case in 2005 in states that had registries operating at that time (California, Louisiana, and North Carolina).<sup>99</sup> For example, California experienced a 60 percent increase in registrations, Louisiana experienced a 56 percent increase, and North Carolina experienced a 64 percent increase.<sup>100</sup> While registration continues to be higher than before *Schiavo's* death, the number of new registrations were reportedly lower the year following her death, but have continued on an upward trend since then.

**These correlations support the notion that people are less apt to consider end-of-life decisions on their own and more willing to take action when the issues are directly presented to them.**

In addition to the increase spurred by the *Schiavo* case in 2005, almost all registries notice an increase in registrants following publicity campaigns and outreach efforts.<sup>101</sup> All states, except two,<sup>102</sup> sponsor educational seminars or attend health and senior informational fairs to advertise and promote the program.<sup>103</sup> In Vermont, the governor proclaimed an advance directive week at the end of September 2007, which helped draw public attention to the registry and resulted in a significant increase in registrations the following month.<sup>104</sup> Montana also notices an increase in registrations when the attorney general speaks to the public about the program.<sup>105</sup>

These correlations support the notion that people are less apt to consider end-of-life decisions on their own and more willing to take action when the issues are directly presented to them.<sup>106</sup> Since there is not a constant stream of nationally publicized end-of-life cases like Terri Schiavo's, the degree of use of the registries will depend heavily on education and outreach programs.

Unfortunately, few states statutorily require programs for public outreach and education, and funding for the maintenance of registries is limited. Education and outreach programs are only statutorily mandated in Maryland and Montana.<sup>107</sup> California is required by statute to "develop information about end-of-life care, advance health care directives, and registration of the advance health care directives at the registry."<sup>108</sup> A few state statutes<sup>109</sup> mention that funds, either through fees or legislative appropriations, shall

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be used for promoting and maintaining the registry.<sup>110</sup> Vermont's statute simply requires that information be posted on the secretary of state's public Web site.<sup>111</sup> Louisiana's registry relies solely on its Web site for publicity, since that was all the state statute required.<sup>112</sup>

Clearly, states have limited resources to educate the public and promote the registries. Some states have partnered with non-profit organizations focused on end-of-life care and other related issues to help promote and advertise the registry.<sup>113</sup> While these partnerships can help the state with the work of education and outreach, these partnerships may also depend on funding through the state.<sup>114</sup> Most statutes allow states to accept voluntary contributions, but states may also have to seek outside funding. Idaho, for example, did not successfully obtain funding for the registry from outside sources while developing its registry.<sup>115</sup>

If a state does not have adequate funding to pursue significant promotional efforts, it is difficult to measure the utility of a registry simply by looking at the registration numbers. It is unclear whether low registration numbers are due to a lack of interest or a lack of awareness. Private registries report that people in states that have registries continue to register with alternative private registries.<sup>116</sup> This indicates an interest in the concept of a registry, but perhaps a lack of knowledge about the state registry. Furthermore, the registries that focus education and outreach to their online resources may be isolating older adults, who are generally not as computer savvy as younger generations. Consequently, enrollment may suffer simply because people are not aware of the state registries and states do not have sufficient funding to promote them adequately.

### Number of Times the Registry Is Accessed

Another way of measuring the usefulness of a registry may be by evaluating whether ADs are being accessed through it. Only three states<sup>117</sup> track the number of times that the registry is accessed, and the numbers from those states do not

**Table 2**

Year Registry Established	State	Total ADs Registered†	Percentage of State Population Registered‡	Percentage of State Population Over 65 Registered§
1991	Louisiana	5,414	0.12	1.04
1995	California	2,500	0.007	0.06
2002	North Carolina	13,522	0.15	1.23
2005	Arizona**			
2006	Montana	8,326	0.87	6.23
2007	Idaho	4,883	0.32	2.79
2007	Vermont	4,700	0.76	5.57
2008	Nevada	2,013	0.07	0.70
2008	Washington	724	0.01	0.10

† Numbers as of May 31, 2009. Louisiana Web site, *supra* note 33; California interview, *supra* note 32; North Carolina interview, *supra* note 68; Montana interview, *supra* note 13; Idaho interview, *supra* note 39; Vermont interview, *supra* note 34; Nevada interview, *supra* note 34; Washington interview, *supra* note 34.

‡ Percentage calculated using state population estimates from U.S. Census Bureau, Population Division, Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007, <http://www.census.gov/popest/states/NST-ann-est2007.html> (last visited July 23, 2009).

§ Percentage calculated using elderly population by state from U.S. Department of Health and Human Services, Administration on Aging, A Profile of Older Americans: 2008, 9, <http://www.mowaa.org/Document.Doc?id=69>.

\*\* Data not available

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reveal much insight. In Washington where there are only 724 registrants, 107 ADs have been accessed,<sup>118</sup> but in Nevada where over 2,000 people have registered, the state reports that only a handful have been accessed.<sup>119</sup> Both registries have been fully operational for a little more than a year.<sup>120</sup> California's registry has been operating for more than a decade, but the state reports that the greatest number of requests for a patient's AD has been two per year.<sup>121</sup> These numbers fail to indicate whether or not these registries are being utilized for their intended purpose, especially since they do not identify who is accessing the registry and for what purpose they are accessing it. Consequently, it is unclear how effective the registry is in making it easier to access registered documents.

### Need for Additional Studies

To adequately evaluate whether state AD registries are serving a useful purpose, more qualitative and quantitative research is necessary. Additional considerations include an evaluation of:

- the public's interest or desire in having a registry. Survey research may reveal whether the public has an interest in using it and if people may be more likely to execute advance planning documents if they could store their documents in the registry.
- health care providers' interest or desire in a registry. Survey research may determine whether the registry is an asset or a burden to health care providers.
- the public's awareness of the registry. Survey research may determine whether people are not aware that their state has a registry or if they are aware of the registry and do not make the effort to register their documents.
- the purpose for which the AD was accessed to determine if the AD was used after it was accessed or not.
- the number of deaths that have ADs in relation to the number of deaths where the registry was accessed.<sup>122</sup>

### Challenges to a Registry's Viability

Although many state AD registries have only been in existence for a few years, their lives may be short-lived. The primary challenges that threaten the viability of state AD registries include public awareness and funding, inherent flaws in the registry model, potential development of a

national AD registry, potential development of POLST registries, and electronic health records.

### Public Awareness and Funding

Reportedly, states have received positive responses to the AD registries,<sup>123</sup> but since there is a strong positive correlation between the number of registrants and public outreach and awareness initiatives, the continued use and access of any registry largely depends a state's ability to continue or even enhance public education and outreach efforts. This proves to be a challenge for states that have limited resources to pursue these efforts, particularly when only two states<sup>124</sup> with AD registry statutes mandate education and outreach programs.

Studies consistently find that knowledge of ADs does not in itself increase their use: the majority of people who know what an AD is do not complete one.<sup>125</sup> Studies also show that comprehensive interventions educating and reminding individuals to complete ADs increase the percentage of individuals who execute ADs by anywhere from 30 percent to 40 percent.<sup>126</sup> America Living Will Registry notes that people are more likely to register an AD when they complete the AD and register it at an event that the organization is hosting.<sup>127</sup> Similarly, all states that engage in education and outreach sessions in the community recognize an increase in registration after such events take place.<sup>128</sup> Thus, it appears that continuing proactive educational and promotional efforts appear would produce an overall increase in AD registrants.

However, education and outreach efforts are limited by available funding. Unfortunately, funding for state registries is limited and at risk for cut backs. For example, due to current financial constraints, the registry in Washington is receiving substantially reduced funding.<sup>129</sup> Most funding must be dedicated to maintaining the registry, which severely limits its promotional efforts.<sup>130</sup> While states are still optimistic about increasing enrollment, without funding for promotional and outreach efforts, registry enrollment may stagnate.

Federal support could help the state AD registry financially. On May 21, 2009, Sen. Rockefeller (D.W.V.) introduced the Advance Planning and Compassionate Care Act, comprehensive legislation addressing the need for education and outreach regarding completion of ADs and end-of-life care in general.<sup>131</sup> It includes development of advance care planning resources, a national public education campaign, a national uniform policy on advance care planning, provider education and training in palliative care, and advance care planning coverage under Medicare, Medicaid, and CHIP.<sup>132</sup> It also includes an amendment to the Public Health Service

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Act awarding grants to states on a competitive basis for funding state AD registries.<sup>133</sup>

### Inherent Flaws in the Registry Model

The success of a registry depends on educating and motivating individuals to take action to complete an AD and file it with the registry. However, the effort needed to register an AD and to access the AD in many of the surveyed states may be just as great or greater than the effort needed to give copies of one's AD directly to one's health care providers, proxy, and family without relying on a registry as an intermediary.

Arguably, a registry is most valuable in those circumstances where the health care provider has not been given a copy of one's AD or has no knowledge of whether an AD even exists. Since the continued existence of registries is dependent upon educating and assisting individuals to complete ADs and register them, then it seems more productive to take the education and outreach one step further and ensure that the documents reach designated proxies and patients' medical records rather than a registry. For states that allow access to the registry only by those who have the patient's access codes, the AD is no more accessible than if the appropriate parties had a copy of the AD in the first place. Individuals who have registered their AD still have to be proactive about making sure important parties have the access codes. In states that allow health care providers to access ADs through a direct search feature, the health care providers could simply look to the medical records to locate the AD, if health systems were structured to record ADs in medical records routinely.

The Respecting Choices program in La Crosse, Wisconsin, demonstrates the significant impact of AD education and outreach initiatives on individuals completing ADs and health care providers' ability to locate a patient's AD in the medical record when needed. Respecting Choices is a comprehensive and systematic AD education program administered community-wide by the not-for-profit, major health systems in La Crosse, Wisconsin.<sup>134</sup> The program was developed to ensure that written ADs are always available in a medical record by engaging and educating hospital staff, the public, and patients about advance care planning.<sup>135</sup> A study of 540 decedents in the community conducted two years after the program was implemented in 1993 produced dramatic results.<sup>136</sup> Eighty-five percent of all decedents had a written AD, and 95 percent of those documents were in the decedent's medical record.<sup>137</sup> Furthermore, treatment preferences

stated in a written AD were consistently followed.<sup>138</sup> An updated, unpublished study of the area produced even higher percentages.<sup>139</sup> At the time of the initial study, the hospitals were using paper medical records. Now the hospitals' electronic health records systems make it even easier for physicians to access a patient's AD and to review and update that patient's desires as the patient continues to receive care.<sup>140</sup>

Respecting Choices builds advance care planning into the routine of care in the health care system.<sup>141</sup> This way, a physician is more familiar with a patient's end-of-life wishes, and the AD is more likely to end up in the patient's medical record.<sup>142</sup> Individuals in the community who complete ADs and have not yet received care at one of the hospitals in the area identify where they are likely to receive acute care, and the medical records departments create charts for their ADs.<sup>143</sup> Patients who have filed an AD with the hospitals' medical records systems are issued a wallet card, which indicates that the patient has executed an AD, identifies what type of AD the patient has executed, includes the name and phone number of a designated agent for health care decisions, and notes the location of the AD with the phone number for the medical records department that stores it.<sup>144</sup> The hospitals have not had to create a new system and have not incurred significant new costs.<sup>145</sup>

This particular study suggests that ADs have the greatest impact when they are found in a patient's medical record. Studies generally demonstrate that multi-component interventions are most successful in educating people about end-of-life options and getting people to complete ADs.<sup>146</sup> Consequently, while a registry may be helpful in achieving greater access to ADs, with proper education and outreach, an independent registry does not seem to be necessary if ADs consistently make it into patients' medical records. Using medical records in effect as a registry encourages end-of-life conversation among patients and providers and directly bridges the gap registries are intended to overcome.

### National Registry

The concept of establishing a national registry has been of interest to researchers and policymakers for some time.<sup>147</sup> A nationally hosted registry servicing all of the states would render individual state AD registries obsolete. Currently, only private registries operate on a national scale, servicing residents from all fifty states, and some internationally. The Advance Planning and Compassionate Care Act includes a provision requiring the GAO to do an investigation regarding the feasibility of a national AD registry.<sup>148</sup> In theory, a national registry would be advantageous because it would be accessible throughout the entire country. It would be most effective if health care providers were able to search the reg-

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istry for their patients, no matter where they live and without requiring an access code. Health care providers would be able to access a patient's documents when needed, whether or not they could locate the patient's access codes. This would also assuage fears of health care providers not being able to access an AD if a patient is traveling or in a state that does not have its own registry. Nevertheless, whether there is one national registry or fifty state registries, the creation of any system requires significant education and outreach programming so that individuals and health care providers will use it.

### **POLST Paradigm Registries**

States may also find registries for POLST forms more favorable than AD registries. The POLST paradigm was developed in Oregon as a method of translating patient preferences for life-sustaining treatment into a treatment plan in the form of physician orders addressing the patient's here-and-now condition.<sup>149</sup> The medical orders are documented on a brightly colored form that follows the patient across health care settings.<sup>150</sup> This form is most appropriate for "seriously ill persons with life-limiting or terminal illnesses."<sup>151</sup> States across the country are following Oregon's lead and are adopting the use of forms similar to POLST with variations on the name and resulting acronym:<sup>152</sup> nine states have initiated statewide programs akin to POLST, and several other states and communities are developing programs.<sup>153</sup> Although Oregon's statute establishing its health board instructed the health board to consider the use of a registry for health care ADs, Oregon Health and Sciences University petitioned instead for a POLST registry as a more valuable option because POLST forms dictate immediate treatment plans consistent with patient goals in high probability emergency situations.<sup>154</sup>

Oregon's POLST registry is housed in a secure, electronic database and is only accessible by Emergency Medical Services (EMS) via an unpublicized phone number that EMS is already trained to call upon arriving at an emergency medical scene.<sup>155</sup> Three states<sup>156</sup> that have AD registries also permit filing POLST forms in their registries,<sup>157</sup> but there is no variation in protocol for accessing POLST forms over any other form filed with the registry. For an AD registry to effectively serve as a registry for POLST forms, the wallet notification card issued to the registrant would have to specifically indicate that a POLST form is on file, and the information contained in the POLST form would have to be readily available to emergency personnel.

### **Electronic Health Records**

Another issue for state AD registries is the advent of and future transition to electronic health records (EHRs). Prior to

the enactment of the AD registry legislation in Maryland, the State Advisory Council on Quality Care at the End of Life conducted a report as to the viability of a state AD registry. The report's primary concern was that a switch to EHRs would obviate the need for a registry.<sup>158</sup> Thus, all of the time, effort, and money poured into the project would have been for naught. Conversion to completely electronic health records systems has been slow among health care providers, and it, like the AD registry, depends largely on availability of funds.<sup>159</sup>

During President Bush's term in office, he pushed the medical profession to move to EHRs.<sup>160</sup> Likewise, the Obama administration has demonstrated its commitment by calling for the transition to EHRs by 2014 and appropriating \$19 billion of the American Recovery and Reinvestment Act of 2009 to health information technology.<sup>161</sup>

The concepts of EHRs and an electronic AD registry are not necessarily mutually exclusive as long as the registry can be closely connected to patients' medical records. Kentucky has passed legislation establishing an e-Health Network Board, which is responsible for "implement[ing] and oversee[ing] the operation of an electronic health network in [the] Commonwealth."<sup>162</sup> As part of this online medical records initiative, the statute calls for the board to consider various models for the e-Health Network that "shall be capable of ... serv[ing] as a registry of the existence and location of advance directives related to health care or mental health treatment..."<sup>163</sup> While the e-Health initiative is in its very early stages, it may evolve to host registries for various types of records, including immunization records and advance directives.<sup>164</sup> It is possible that the use of an EHR system will complement, rather than eliminate the functionality of, an AD registry.

The overall impact of EHRs on advance care planning is unclear, but initial studies demonstrate that the use of electronic health records for advance care planning has a promising future.<sup>165</sup> "Electronic health records can automatically remind physicians to initiate advance care planning or advance directive completion, and also make it possible to share medical record documentation about preferences and proxies among providers within a system."<sup>166</sup> Physicians who receive an electronic reminder are more likely to initiate advance care planning discussions with patients.<sup>167</sup> In these studies, the patients were also more likely to complete an AD as a result of this conversation.<sup>168</sup> The electronic medical records system used in La Crosse, Wisconsin, also allows the physician to dictate notes about conversations the physician has with the patient about advance care planning, which are retrievable under a category labeled "Advance Directive."<sup>169</sup> Electronic health records working in tandem with a multi-

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component advance planning program like Respecting Choices could prove to be a highly effective method of increasing advance directive use and access.

### Discussion

Since aggressive education and outreach is necessary for the continued use of state AD registries, it seems more productive to focus education and outreach on making sure that individuals distribute copies of their ADs directly to the people who will need them the most, such as health care providers and family members. This is particularly true in the states that limit access to the AD to individuals who have access codes. If patients need to give health care providers their access codes to see their ADs, the patients may as well give their health care providers a copy of their ADs to put in their medical records.

Policymakers should consider supporting comprehensive programs like Respecting Choices that systematically facilitate end-of-life decision making and ensure that ADs are routed directly into patients' medical records. The Respecting Choices program focuses on enhancing communication between health care providers and individuals, and enhancing end-of-life conversations, rather than relying on the less personal intermediary device of an AD registry. This type of program demonstrates a high rate of AD completion, availability, and ease of access. It also removes the additional cost of establishing a registry, thereby allowing a state to use its funds for more education and outreach efforts.

If states continue to develop independent registries, they should consider:

- Linking the registry with hospital medical records. Conversion to electronic medical records will make storing ADs in medical records even easier and will likely obviate the need for an independent AD registry.
- Focusing more efforts on community education and outreach and possibly contracting with non-profit organizations and health care providers to assist in this effort.
- Securing stable funding for the registry and its promotion. Without funding, states cannot engage in the education and outreach that is essential to people utilizing the service.
- Operating through a private national registry. This relieves the state of the cost and burden of setting up a secure system on their own.

- Making the responsibilities of the office overseeing the registry clear in the statute. This ensures that the goals of the registry are carried out when put into practice.

### Conclusion

While the access goals of state AD registries are laudatory, the registries fail to demonstrate whether they are achieving their intended purpose. Consequently, additional studies are necessary to determine the registries' effectiveness. Registries also face many challenges that may undercut their continued existence. First, it is clear that education and public outreach are crucial components to the success of any registry system, as well as any advance care planning system, and that states lack sufficient funding to implement programs that would increase public awareness of their existence. Second, the state registry model inadvertently inhibit advance planning communications between patients and their health care providers by, instead, focusing educational efforts on registering ADs rather than on sharing them directly with providers. Third, the creation of a national registry may obviate the need for individual state registries. Fourth, POLST registries also may evolve into a more favorable option because of the explicit clinical direction contained in POLST forms. Finally, the use of EHRs may streamline the advance care planning process and serve as an effective registry for ADs. The use of medical records to store ADs may alleviate concerns posed by these challenges and may prove to be a more effective method for states to achieve the desired goals of AD registries. Ultimately, a comprehensive and systematic education campaign like Respecting Choices that ensures that patients' ADs are stored in their medical records may be the most effective way for states to achieve increased use of and access to ADs.

### Notes

1. See, e.g. Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 *The Hastings Ctr. Rept.* 30 (Mar./Apr. 2004); Daniel P. Hickey, *The Disutility of Advance Directives: We Know the Problems, but Are There Solutions?* 36 *J. Health L.* 455 (2003); Peter H. Ditto, et. al, *Advance Directives as Acts of Communication*, 161 *Archives of Internal Med.* 421 (2001); E.J. Larson and T.A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 *Wake Forest L. Rev.* 249 (1997); Diane E. Hoffmann, Sheryl I. Zimmerman & Catherine J. Tompkins, *The Dangers of Directives or the False Security of Forms*, 24 *J.L. Med. & Ethics* 5 (1996).
2. Arizona, California, Idaho, Louisiana, Maryland, Montana, Nevada, New Jersey, North Carolina, Vermont, Virginia, and Washington.
3. Kentucky and Oregon.

4. Susan E. Hickman, Bernard J. Hammes, Alvin H. Moss, & Susan W. Tolle, *Hope for the Future: Achieving the Original Intent of Advance Directives*, The Hastings Ctr. Rep., S26 (Nov./Dec. 2005); Charles P. Sabatino, *et al.*, ABA Legal Guide for Americans Over 50, 106 (Random House 2006).
5. Anne Wilkinson, Neil Wenger, & Lisa R. Shugarman, Rand Corporation, *Literature Review on Advance Directives*, 14 (2007), available at <http://aspe.hhs.gov/daltcp/reports/2007/advdirlr.pdf>.
6. Hickey, *supra* n. 1, at 460.
7. Wilkinson, *supra* note 5, at 14.
8. See generally Hickey, *supra* n. 1; Fagerlin, *supra* n. 1; RAND Health, *Advance Directives and Advance Care Planning: Report to Congress* (2008), available at <http://aspe.hhs.gov/daltcp/reports/2008/ADCongRpt.pdf>.
9. Hickman, *supra* n. 4, at S30 (“Finally, perhaps the most crucial elements of more successful advance directive programs are policies and procedures... to assure that any written plan is available when needed.”).
10. Hickey, *supra* n. 1, at 461.
11. U.S. Living Will Registry Fact Sheet, <http://www.uslivingwill-registry.com/factsheet.shtm> (last visited July 7, 2009).
12. Wilkinson, *supra* n. 5, at 15.
13. Telephone interview with Joan Eliel, program specialist, Office of Consumer Protection and Victim Services, Montana Department of Justice (May 28, 2009) [hereinafter Montana interview].
14. La. Rev. Stat. Ann. § 40:1299.58.3 (Westlaw through 2008 Reg. Sess.).
15. The New Jersey legislature authorized the creation of a registry for “advance directives for mental health care” or psychiatric ADs (PADs). N.J. Stat. Ann. § 30:4-177.59 (West, Westlaw through 2009). These are special ADs for mental health care decisions and are beyond the scope of this review. See National Resource Center on Psychiatric Advance Directives, [www.nrc-pad.org/index.php](http://www.nrc-pad.org/index.php) (last visited July 15, 2009).
16. Ariz. Rev. Stat. Ann. §§ 36-3291 to -3297 (Westlaw through 2009 legislation); Cal. Prob. Code §§ 4800–4806 (West, Westlaw through 2009 Reg. Sess.); Idaho Code Ann. § 39-4515 (Westlaw through 2009 legislation); Md. Code Ann., Health—Gen. §§ 5-619 to -626 (West, Westlaw through 2009 Reg. Sess.); Mont. Code Ann. §§ 50-9-501 to -505 (Westlaw through 2007 Reg. Sess.); Nev. Rev. Stat. §§ 449.900–965 (Westlaw through 2007 Reg. Sess.); N.C. Gen. Stat. Ann. §§ 130A-465 to -471 (West, Westlaw through 2009 Reg. Sess.); 2009 Okla. Sess. Laws 236; Vt. Stat. Ann. tit. 18, §§ 9701–9719 (Westlaw through 2008 legislation); Va. Code Ann. § 54.1-2994 (West, Westlaw through 2009 Reg. Sess.); Wash. Rev. Code Ann. § 70.122.130 (West, Westlaw through 2009 legislation). North Dakota enacted registry legislation in 2009, but was not included in this review. See 2009 North Dakota Laws Ch. 216 (S.B. 2237).
17. H.B. 71, 26th Leg., 2009 Sess. (Ak. 2009); H.B. 4942, 95th Leg., Reg. Sess. (Mi. 2009).
18. The governor of Oklahoma signed the legislation on May 21, 2009, and the statute will become effective on November 1, 2009. 2009 Okla. Sess. Laws 236.
19. Virginia is currently accepting proposals for a state registry. Telephone interview with Kimberly Barnes, policy analyst, Virginia Department of Health (May 26, 2009) [hereinafter Virginia interview].
20. The Maryland legislature authorized creation of a registry, but it has withdrawn funding for the project. Telephone interview with Jack Schwartz, former assistant attorney general and director of health policy in the state of Maryland (June 2, 2009).
21. Ky. Rev. Stat. Ann. § 216.267 (West, Westlaw through 2008 legislation); Or. Rev. Stat. § 414 references & annots. (West, Westlaw through 2009 Reg. Sess.).
22. 2009 Or. Laws 529. POLST is distinct from an AD in that it secures end-of-life wishes by transforming them into medical orders authorized by a physician. Telephone interview with Terri Schmidt, MD, professor of emergency services, Oregon Health Sciences University (June 24, 2009).
23. E-mail from Alvin H. Moss, professor of medicine and director, Center for Health Ethics and Law, Robert C. Byrd Health Sciences Center, West Virginia University, to Charles P. Sabatino, director, ABA Commission on Law and Aging (July 3, 2009) (on file with author).
24. America Living Will Registry, DocuBank, FullCircle Registry, Gifts Advance Directive Registry, MedicAlert Foundation, MyHealthWishes.org, and U.S. Living Will Registry.
25. Telephone interview with Joseph Barmakian, MD, Founder, U.S. Living Will Registry (June 1, 2009).
26. Telephone interview with Barbara Hetrick, community education director, America Living Will Registry (June 1, 2009); Telephone interview with Randi Siegel, president, DocuBank (June 26, 2009).
27. Arizona, California, Idaho, Louisiana, Montana, North Carolina, Nevada, Vermont, and Washington.
28. Telephone interview with Kittye Delaune, publications office, Louisiana secretary of state (May 19, 2009) [hereinafter Louisiana interview].
29. Arizona, California, Idaho, Louisiana, North Carolina, Nevada.
30. Maryland, Vermont, Virginia, Washington.
31. Montana Department of Justice, Office of Consumer Protection, End-of-Life Registry, <https://app.mt.gov/registry/> (last visited July 7, 2009) [hereinafter Montana Web site]; Montana interview, *supra* n. 13.
32. Telephone interview with Alicia Stewart, notary public and special filing section manager, California secretary of state, and Betsy Bogart, chief of business program division, California secretary of state (June 25, 2009) [hereinafter California interview]; Telephone interview with Kittye Delaune, publications office, Louisiana secretary of state (May 26, 2009) [hereinafter Follow up Louisiana interview].
33. Arizona secretary of state, Arizona Advance Directive Registry, [https://www.azsos.gov/Adv\\_Dir/](https://www.azsos.gov/Adv_Dir/) (last visited July 7, 2009) [hereinafter Arizona Web site]; California secretary of state, Advance Health Care Directive Registry, <http://www.sos.ca.gov/ahcdr/> (last visited July 7, 2009) [hereinafter California Web site]; Idaho secretary of state, Health Care Directive Registry, <http://www.sos.idaho.gov/general/hcdr.htm> (last visited July 7, 2009) [hereinafter Idaho Web site]; Louisiana secretary of state, Living Will Declaration, <http://www.sos.louisiana.gov/tabid/208/Default.aspx> (last visited July 7, 2009) [hereinafter Louisiana Web site]; Montana Web site, *supra* n. 31; North Carolina Department of the secretary of state, Advance Health Care Directive Registry, <http://www.secretary.state.nc.us/ahcdr/> (last visited July 7, 2009) [hereinafter North Carolina Web site]; Nevada secretary of state, Living Will Lockbox, <http://sos.state.nv.us/online/nadr/> (last visited July 7, 2009) [hereinafter Nevada Web site]; Vermont Department of

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- Health, Vermont Advance Directives Registry, <http://healthvermont.gov/vadr/index.aspx> (last visited July 7, 2009) [hereinafter Vermont Web site]; Washington State Department of Health, The Washington State Living Will Registry, <http://www.doh.wa.gov/livingwill/> (last visited July 7, 2009) [hereinafter Washington Web site].
34. E-mail from Kate Thomas, deputy secretary of state for operations, state of Nevada, to Allison Hughes, author (May 26, 2009) [hereinafter Nevada interview] (on file with author); telephone interview with Charon Goldwyn, Vermont Department of Health (June 12, 2009) [hereinafter Vermont interview]; e-mail from Lynn Neumann, Living Will Registry, Washington State Department of Health (May 21, 2009) [hereinafter Washington interview].
  35. Telephone interview with Joseph Barmakian, *supra* n. 25.
  36. Louisiana interview, *supra* n. 28.
  37. *See* n. 15.
  38. Ariz. Rev. Stat. Ann. § 36-3292 (Westlaw through 2009 legislation); N.C. Gen. Stat. Ann. § 130A-466 (West, Westlaw through 2009 Reg. Sess.); Wash. Rev. Code Ann. § 70.122.130 (West, Westlaw through 2009 legislation).
  39. E-mail from Miren Artiach, deputy, Idaho secretary of state, to Allison Hughes, author (May 26, 2009) [hereinafter Idaho interview]; Md. Code Ann., Health—Gen. §§ 5-608.1, 5-619 (West, Westlaw through 2009 Reg. Sess.); Montana Web site, *supra* n. 31 (follow “How to Register” hyperlink).
  40. Md. Code Ann., Health—Gen. §§ 5-603, 5-619 (West, Westlaw through 2009 Reg. Sess.); N.C. Gen. Stat. Ann. § 130A-466 (West, Westlaw through 2009 Reg. Sess.); 2009 Okla. Sess. Laws 236.; Va. Code Ann. § 54.1-2995 (West, Westlaw through 2009 Reg. Sess.).
  41. Md. Code Ann., Health—Gen. § 5-619 (West, Westlaw through 2009 Reg. Sess.); Okla. Stat. Ann. tit. 63, §3101.4 (West, Westlaw through 2009 legislature).
  42. Nev. Rev. Stat. § 449.905 (Westlaw through 2007 Reg. Sess.), amended by 2009 Nev. Stat. 64.
  43. California interview, *supra* n. 32.
  44. *Id.*
  45. Follow up Louisiana interview, *supra* n. 32.
  46. *Id.*
  47. Nevada retains the submitted documents in a physical registry, and Washington destroys the documents. E-mail from Kate Thomas, deputy secretary of state for Operations, state of Nevada, to Allison Hughes, author (May 28, 2009) [hereinafter Follow up Nevada interview] (on file with author); Washington interview, *supra* n. 34.
  48. Vermont Web site, *supra* n. 33.
  49. Montana interview, *supra* n. 13; Nevada interview, *supra* n. 34; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  50. Louisiana interview, *supra* n. 28.
  51. Arizona Web site, *supra* n. 33.
  52. *Id.*
  53. *Id.*
  54. Md. Code Ann., Health—Gen. § 5-625 (West, Westlaw through 2009 Reg. Sess.); Mont. Code Ann. § 50-9-503 (Westlaw through 2007 Reg. Sess.).
  55. Idaho Code Ann. § 39-4515 (Westlaw through 2009 legislation); Idaho interview, *supra* n. 39.
  56. Arizona, Idaho, and Nevada. Ariz. Rev. Stat. Ann. § 36-3294 (Westlaw through 2009 legislation); Idaho Code Ann. § 39-4515 (Westlaw through 2009 legislation); Nev. Rev. Stat. § 449.940 (Westlaw through 2007 Reg. Sess.).
  57. N.C. Gen. Stat. Ann. § 130A-466(b) (West, Westlaw through 2009 Reg. Sess.); Va. Code Ann. § 54.1-2995(B) (West, Westlaw through 2009 Reg. Sess.).
  58. Health care power of attorney, declaration of a desire for a natural death, advance instruction for mental health treatment, and declaration of an anatomical gift.
  59. N.C. Gen. Stat. Ann. §§ 32A-16(3) (health care power of attorney), 90-321(c)(4) (declaration of a desire for a natural death), 122C-72(1) (advance instruction for mental health treatment), 130A-412.7 (declaration of anatomical gift) (West, Westlaw through 2009 Reg. Sess.).
  60. Va. Code Ann. § 54.1-2983 (West, Westlaw through 2009 Reg. Sess.), amended by 2009 Va. Legis. Serv. 211.
  61. California interview, *supra* n. 32.
  62. *Id.*; Cal. Prob. Code § 4800(a) (West, Westlaw through 2009 Reg. Sess.).
  63. Cal. Prob. Code § 4800(b) (West, Westlaw through 2009 Reg. Sess.).
  64. Follow up Louisiana interview, *supra* n. 32.
  65. *Id.*
  66. *Id.* There is no particular protocol for receiving a copy of a registered document; it may be picked up in the office, mailed, or faxed.
  67. Denise E. McClain, *Arizona’s New Health Care Directives Registry: What Everyone Needs to Know*, Ariz. St. U. Retirees Newsl. (Northern Arizona University Retirees Association), available at <http://www4.nau.edu/naura/healthcaredirective.asp> (last visited July 8, 2009); Idaho interview, *supra* n. 39; e-mail from Cheri Myers, director of corporations, North Carolina office of the secretary of state, to Allison Hughes, author (May 29, 2009) (on file with author) [hereinafter North Carolina interview].
  68. Montana, Nevada, Vermont, and Washington.
  69. Mont. Code Ann. § 50-9-503(2)(c)(ii)(B) (Westlaw through 2007 Reg. Sess.).
  70. *Id.*
  71. *Id.*
  72. California interview, *supra* n. 32.
  73. North Carolina interview, *supra* n. 67.
  74. Louisiana interview, *supra* n. 28.
  75. Arizona Web site, *supra* n. 33; Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; Nevada interview, *supra* n. 34; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  76. Idaho’s statute permits a fee not to exceed \$10, but the state would like to continue the service without a fee for as long as possible. Idaho interview, *supra* n. 39. Nevada also permits the secretary of state to impose a registration fee and requires the secretary of state to evaluate the funding for the registry every other year. Nev. Rev. Stat. § 449.955 (Westlaw through 2007 Reg. Sess.). Oklahoma and Virginia’s statutes permit their state board of health to establish fees for the registry not to exceed costs of the service. 2009 Okla. Sess. Laws 236; Va. Code Ann. § 54.1-2995(D) (West, Westlaw through 2009 Reg. Sess.). Fees and funding for Virginia’s registry will be determined as part of

- the current proposal process. Virginia interview, *supra* n. 19.
77. Idaho Code Ann. § 39-4515(3) (Westlaw through 2009 legislation); N.C. Gen. Stat. Ann. § 130A-470(a) (West, Westlaw through 2009 Reg. Sess.); 2009 Okla. Sess. Laws 236; Va. Code Ann. § 54.1-2995(D) (West, Westlaw through 2009 Reg. Sess.).
  78. Cal. Prob. Code § 4801 (West, Westlaw through 2009 Reg. Sess.).
  79. La. Rev. Stat. Ann. § 1299.58.3 (Westlaw through 2008 Regular Session).
  80. North Carolina interview, *supra* n. 67.
  81. California interview, *supra* n. 32.
  82. McClain, *supra* n. 67.
  83. Montana interview, *supra* n. 13; Nevada interview, *supra* n. 34; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  84. Idaho interview, *supra* n. 39.
  85. Maryland State Advisory Council on Quality of Care at the End of Life: Study on a Statewide Advance Directive Registry 2 (Dec. 2005) [hereinafter Maryland State Advisory Council Study].
  86. Telephone interview with Joseph Barmakian, *supra* n. 25.
  87. Kyung M. Song, *State Budget Cuts Endanger Registry for Living Wills*, Seattle Times, Mar. 28, 2009, available at [http://seattletimes.nwsourc.com/html/politics/2008938575\\_livingwill28m.html](http://seattletimes.nwsourc.com/html/politics/2008938575_livingwill28m.html).
  88. *C&C Saves the Living Will Registry*, C&C Connection (Compassion and Choices of Washington, Seattle, Wash.), Spring 2009, available at <http://www.candcofwa.org/news/spr09%20newsletter.pdf>.
  89. Telephone interview with Jack Schwartz, *supra* n. 20.
  90. Nevada interview, *supra* n. 34; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34; Telephone interview with Katie Urban, Support & Client Services, U.S. Living Will Registry (July 1, 2009); e-mail from Anne Della Rosa, Nevada office of secretary of state, to Allison Hughes, author (June 5, 2009) (on file with author); e-mail from Lynn Neumann, Living Will Registry, Washington State Department of Health to Allison Hughes, author (June 5, 2009) (on file with author).
  91. Washington interview, *supra* n. 34.
  92. Ariz. Rev. Stat. Ann. § 36-3294(I) (Westlaw through 2009 legislation); Idaho Code Ann. § 39-4515(8)(b) (Westlaw through 2009 legislation); Nev. Rev. Stat. § 449.935 (Westlaw through 2007 Reg. Sess.).
  93. Idaho Code Ann. § 39-4515(8)(b) (Westlaw through 2009 legislation).
  94. Ariz. Rev. Stat. Ann. § 36-3294(I) (Westlaw through 2009 legislation); Nev. Rev. Stat. § 449.935 (Westlaw through 2007 Reg. Sess.).
  95. Hickman, *supra* n. 4, at S28 (“[S]uccessful advance directive programs also require proactive but appropriately staged timing: some discussion should anticipate health care decisions, but much of it must be revisited as the patient’s prognosis becomes known.”).
  96. AARP, Knowledge Management, AARP Bulletin Poll, “Getting Ready to Go” Executive Summary, 1 (January 2008).
  97. Louisiana Web site, *supra* n. 33.
  98. California interview, *supra* n. 32.
  99. Arizona’s registry was introduced on March 1, 2005, but no information is available as to the number of registrants during its first year in operation.
  100. Percent based on information provided by California, Louisiana, and North Carolina.
  101. California interview, *supra* n. 32; Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; Nevada interview, *supra* n. 34; North Carolina interview, *supra* n. 68; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  102. California and Louisiana do not, and the extent of Arizona’s efforts are not known.
  103. Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; Nevada interview, *supra* n. 34; North Carolina interview, *supra* n. 67; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  104. Vermont interview, *supra* n. 34.
  105. Montana interview, *supra* n. 13.
  106. Werner Gruber, *Life and Death on Your Terms: the Advance Directives Dilemma and What Should be Done in the Wake of the Schiavo Case*, 15 Elder L.J. 503, 506 (2007).
  107. Md. Code Ann., Health—Gen. § 5-622(c) (West, Westlaw through 2009 Reg. Sess.); Mont. Code Ann. § 50-9-505 (Westlaw through 2007 Reg. Sess.).
  108. Cal. Prob. Code § 4806 (West, Westlaw through 2009 Reg. Sess.).
  109. Arizona, Idaho, North Carolina, and Washington.
  110. Ariz. Rev. Stat. Ann. § 36-3291 (Westlaw through 2009 legislation); Idaho Code Ann. § 39-4515(10) (Westlaw through 2009 legislation); N.C. Gen. Stat. Ann. § 130A-470(a) (West, Westlaw through 2009 Reg. Sess.); Wash. Rev. Code Ann. § 70.12.130(7) (West, Westlaw through 2009 legislation).
  111. Vt. Stat. Ann. tit. 18, § 9719(c)(2) (Westlaw through 2008 legislation).
  112. Louisiana interview, *supra* n. 28.
  113. Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; North Carolina, *supra* n. 67; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
  114. Vermont interview, *supra* n. 34.
  115. Idaho interview, *supra* n. 39.
  116. Telephone interview with Joseph Barmakian, *supra* n. 25.
  117. California, Nevada, and Washington.
  118. Washington interview, *supra* n. 34.
  119. Nevada interview, *supra* n. 34.
  120. *Id.*; Washington interview, *supra* n. 34.
  121. California interview, *supra* n. 32.
  122. This approach is much more specific and targets the idea of whether or not the registry is being utilized for its intended purposes. A similar analysis was used in the La Crosse Advance Directives Study of the Respecting Choices Program in La Crosse, Wisconsin. The study, conducted by Bernard J. Hammes, PhD and Brenda L. Rooney, PhD, MPH, evaluated the percentage of decedents with an AD, the percentage of ADs found at the place of death of a decedent, and the percentage of deaths in which ADs were executed whether the wishes were carried out. This detailed analysis gets more to the heart of how often the ADs are used when needed, as opposed to strictly counting how often they are used overall. See *infra* pp. 31–33 and n. 134.
  123. Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; Vermont interview, *supra* n. 34.
  124. Maryland and Montana
  125. Wilkinson, *supra* n. 5, at 22.
  126. *Id.* at 23.
  127. Telephone interview with Barbara Hetrick, *supra* n. 26.

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128. Idaho interview, *supra* n. 39; Montana interview, *supra* n. 13; Follow up Nevada interview, *supra* n. 48; Vermont interview, *supra* n. 34; Washington interview, *supra* n. 34.
129. *C&C Saves the Living Will Registry*, *supra* n. 88.
130. *Id.*; Washington interview, *supra* n. 34.
131. S. 1150, 111th Cong. (2009).
132. *Id.*
133. *Id.*
134. Bernard J. Hammes, PhD & Brenda L. Rooney, PhD, MPH, *Death and End-of-Life Planning in One Midwestern Community*, *Archives of Internal Med.*, 383 (Feb. 23, 1998).
135. Hickman, *supra* n. 4, at S27.
136. Hammes, *supra* n. 134, at 383, 386, 388.
137. *Id.*
138. *Id.* at 383.
139. Telephone interview with Bernard J. Hammes, PhD, director of medical humanities, Gundersen Lutheran Medical Foundation (July 2, 2009).
140. *Id.*
141. *Id.*
142. *Id.*
143. E-mail from Bernard J. Hammes, PhD, Director of Medical Humanities, Gundersen Lutheran Medical Foundation, to Charles P. Sabatino, Director, ABA Commission on Law and Aging (June 16, 2009) (on file with author).
144. Telephone interview with Bernard J. Hammes, *supra* n. 139.
145. E-mail from Bernard J. Hammes, *supra* n. 143.
146. RAND Health, *supra* n. 8, at 29.
147. See Gruber, *supra* n. 106, at 506 (noting the study of the feasibility of a national registry); S. 1150, 111th Cong. (2009) (requiring GAO to conduct a study of the feasibility of a national registry of advance directives); S. 1263, 111th Cong. (2009) (requiring secretary of health and human services to conduct a study of the best methods of storing advance directives, including the feasibility of a national registry); Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 *J. Legal Med.* 1, 34 n.176 (1999); Jill Schachner Chanen, *The Graying of the Law*, 82-Jan. A.B.A.J. 91 (1996) (noting exploration of a central registry for advance medical directives).
148. S. 1150, 11th Cong. (2009).
149. POLST, *Frequently Asked Questions*, <http://www.ohsu.edu/polst/developing/faqs.htm> (last visited July 17, 2009).
150. *Id.*
151. *Id.*
152. Kathy L. Cerminara & Seth M. Bogin, *A Paper About a Piece of Paper: Regulatory Action As the Most Effective Way to Promote Use of Physician Orders for Life-Sustaining Treatment*, 29 *J. Legal Med.* 479, 481–482 n.12 (2008).
153. POLST, POLST State Programs, <http://www.ohsu.edu/polst/programs/state+programs.htm> (last visited July 21, 2009).
154. Telephone interview with Terri Schmidt, *supra* n. 22.
155. *Id.*
156. Idaho, Maryland, and Washington.
157. Idaho interview, *supra* n. 39; Md. Code Ann. Health—Gen. §§ 5-608.1, 5-619 (West, Westlaw through 2009 Reg. Sess.); Washington interview, *supra* n. 34.
158. Maryland State Advisory Council Study, *supra* n. 85, at 3–5.
159. Jeffery Kluger, *Electronic Health Records: What's Taking So Long?* *Time Mag.*, Mar. 25, 2009, available at <http://www.time.com/time/health/article/0,8599,1887658,00.htm>; Steven Reinberg, *Few Hospitals Embracing Electronic Health Records Systems*, *U.S. News and World Rep.*, Mar. 25, 2009, available at <http://health.usnews.com/articles/health/health-day/2009/03/25/few-hospitals-embracing-electronic-health-record.html>.
160. Michael Fletcher, *President Promotes Switching to Electronic Medical Records*, *Wash. Post*, Jan. 28, 2005, at A07, available at <http://www.washingtonpost.com/wp-dyn/articles/A41595-2005Jan27.html>.
161. Robert Steinbrook, MD, *Health Care and the American Recovery and Reinvestment Act*, *New England J. of Med.*, March 12, 2009, available at <http://content.nejm.org/cgi/content/full/360/11/1057>.
162. Ky. Rev. Stat. Ann. § 216.267(1) (West, Westlaw through 2008 legislation).
163. *Id.* at § 216.267(d)(1).
164. Telephone interview with Barbara Baker, Health Policy Advisory, Kentucky Office of the Lieutenant Governor (May 29, 2009).
165. RAND Health, *supra* n. 8, at 38.
166. *Id.* at xvi.
167. *Id.* at 37.
168. *Id.*
169. Telephone interview with Bernard J. Hammes, *supra* n. 144.