

Solo Aging - Not for Sissies!

Week 4 Healthcare &
Legal Docs



**I WANT YOU
TO TURN OFF
YOUR CELL PHONE**



I WANT YOU
TO TURN OFF
YOUR CELL PHONE



I WANT YOU
TO USE THE
MICROPHONE



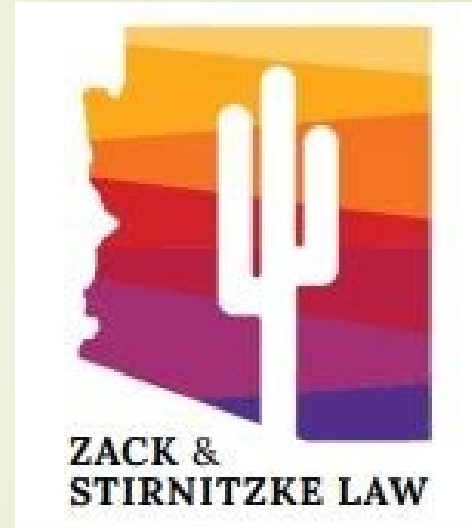
Hold Those Questions

Except for **Definitions** and **Clarifications**

A New Resource for You: **Veronica Stirnitzke**



- JD from Washburn University School of Law
- BS in Aerospace Studies from Embry Riddle Aeronautical University
- BA in History from the University of Arizona.
- Eight years of practice in both Oregon and Arizona.





Primary Estate Planning Documents

- ➡ Will
 - ➡ Trust
 - ➡ Financial Power of Attorney
 - ➡ Health Care Power of Attorney
 - ➡ Living Will (Advance Directive)
- 

Wills & Trusts

What a Will, a Revocable Trust, and an Irrevocable Trust Each Do

Each does a different job, and the right mix depends on what you own and what you are guarding against.

YOUR SITUATION	Will	Revocable Trust	Irrevocable Trust
Probate	Goes through it	Avoided if funded	Avoided if funded
Estate Tax	No reduction	No reduction	Can remove assets
Step-Up in Basis	Preserved	Preserved	Depends on drafting
Medicaid	No protection	No protection	Can help after lookback
Control of Assets	Full, until death	Full	Given up
Setup Cost	\$300 to \$1,000	\$1,500 to \$5,000	\$3,000 to \$10,000+

EASY TO MISS

Beneficiary forms, TOD and POD accounts, retirement accounts, and life insurance pass straight to the named person and override all three. A trust controls only what you retitle into it.

The Two Powers of Attorney Do Very Different Jobs

One names who manages your money if you cannot. The other names who makes your medical decisions. Most estate plans need both.

Financial POA

FINANCES

Your Money

Names an agent to handle financial and legal affairs.

WHAT IT COVERS

Property

Bank accounts, bills, taxes, real estate, legal filings.

WHEN IT STARTS

You choose

Immediately, or only at incapacity if written that way.

WHEN IT ENDS

At death

Authority stops. Your executor takes over under the will.

Medical POA

HEALTHCARE

Your Care

Names an agent to make medical decisions for you.

WHAT IT COVERS

Treatment

Care choices, providers, facilities, end-of-life wishes.

WHEN IT STARTS

Incapacity

Only when you cannot make or voice decisions yourself.

WHEN IT ENDS

At death

It has no role in settling or passing on your estate.

vs.

WORTH KNOWING

A financial POA must be written as durable to keep working after incapacity, the one moment it exists for. State names vary; many call the medical one a healthcare proxy.

Power of Attorney vs. Durable POA

A durable POA is still a power of attorney. The difference is whether state law and the document allow it to remain effective if you become incapacitated.

Power of Attorney

Durability Depends on the Document and State Law

A POA that is not durable generally ends if you become incapacitated.

SURVIVES INCAPACITY **Not Necessarily**
Some states require durability language. Others presume durability unless the document says otherwise.

WHEN IT STARTS **Depends on the Document**
The authority may begin immediately or upon a specified future event.

ENDS AT **Death**
The agent's authority generally stops when the principal dies.

Durable POA

Designed to Survive Incapacity

A durable POA remains effective even if you can no longer manage your own financial or legal affairs.

SURVIVES INCAPACITY **Yes**
That continued authority is what makes the POA durable.

WHEN IT STARTS **Now or Later**
It may begin immediately or become effective after a defined triggering event, depending on the document and state law.

ENDS AT **Death**
The executor, trustee, and other estate arrangements take over after death.

vs.

ALSO TRUE

Durability and effective date are separate decisions. A durable POA can begin immediately or later, and state law determines the default. Read the actual document rather than relying on its title.

Anna:

My financial questions are:

1) Does having **Transfer On Death** on my financial accounts avoid probate?

2) If yes, why would a person have a Trust (and its associated costs to set it up and then to administer upon death) instead of TOD?

What Passes Directly to Heirs, and What the Court Controls

What keeps assets out of court is how they are titled and who you name as beneficiary, not whether you have a will.

Avoids Probate

Passes directly to heirs

- ✓ **Revocable trust**, once it is funded
- ✓ **TOD or POD** beneficiary on accounts
- ✓ **Joint tenancy** with right of survivorship
- ✓ **Life insurance** with a named beneficiary
- ✓ **401(k) or IRA** with a named beneficiary
- ✓ **TOD or Lady Bird deed** on real estate

Goes Through Probate

The court controls it

- ✗ **A will**, which instructs the court, not skips it
- ✗ **Accounts** with no beneficiary listed
- ✗ **Real estate** held in your name only
- ✗ **A trust** created but never funded
- ✗ **Life insurance** payable to your estate
- ✗ **Assets to a minor** with no custodian

PLANNED VS. UNPLANNED PROBATE

Planned probate has named assets, listed heirs, and clear instructions. Unplanned probate leaves the court to figure it out, which stretches estates to 18 months or longer.

Laura:

My niece has a **special needs trust**. For my **IRAs**, I have listed her special needs trust as a **beneficiary**. My IRAs are with Schwab and Hughes Federal Credit Union.

1. Will the investment company and credit union honor that or will they try to give her inheritance to her directly?
2. If I can't list the special needs trust as a beneficiary on my IRAs, how else can my niece get an inheritance from the IRAs without risking her government assistance status?

The Medical Side



**TOLD MY WIFE I
WANTED TO BE
CREMATED. SHE
MADE ME AN
APPOINTMENT FOR
TUESDAY.**



Group Discussion – Take 5

Values Review – C&C Workbook pg. 21-23

- Very Important items from the list?
- What's important to you when you are dying?
- Life sustaining measures?
- Feelings about medical procedures?
- Physical or Mental Limitations that affect your decisions?
- Nursing home or Care Facility wants?
- Hospice Care?
- Participation level?
- Truth?
- Rituals, traditions, observations?

TUBES
WIRES
CHAOS

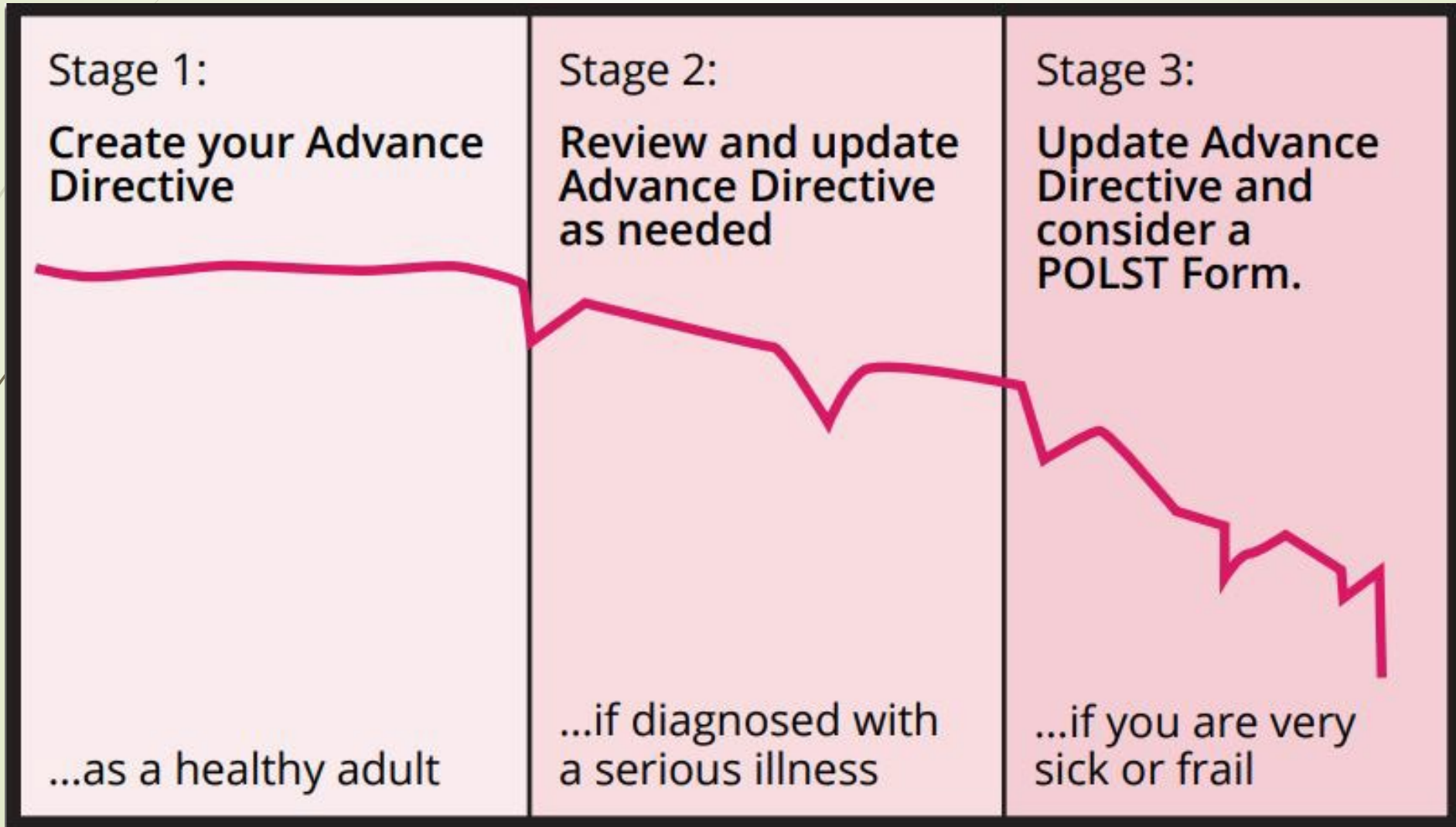
ZDOCGMD



Advance Directives

Document that states what kind of care you want or don't want for when you can't communicate

Advance Directives





Advance Directives Examples

1. Five Wishes
2. Compassion & Choices
3. AZ Life Care Planning
Packet/Attorney General

Five Wishes – Aging With Dignity

<https://agingwithdignity.org/programs/five-wishes/>

FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care¹ Decisions for Me When I Can't

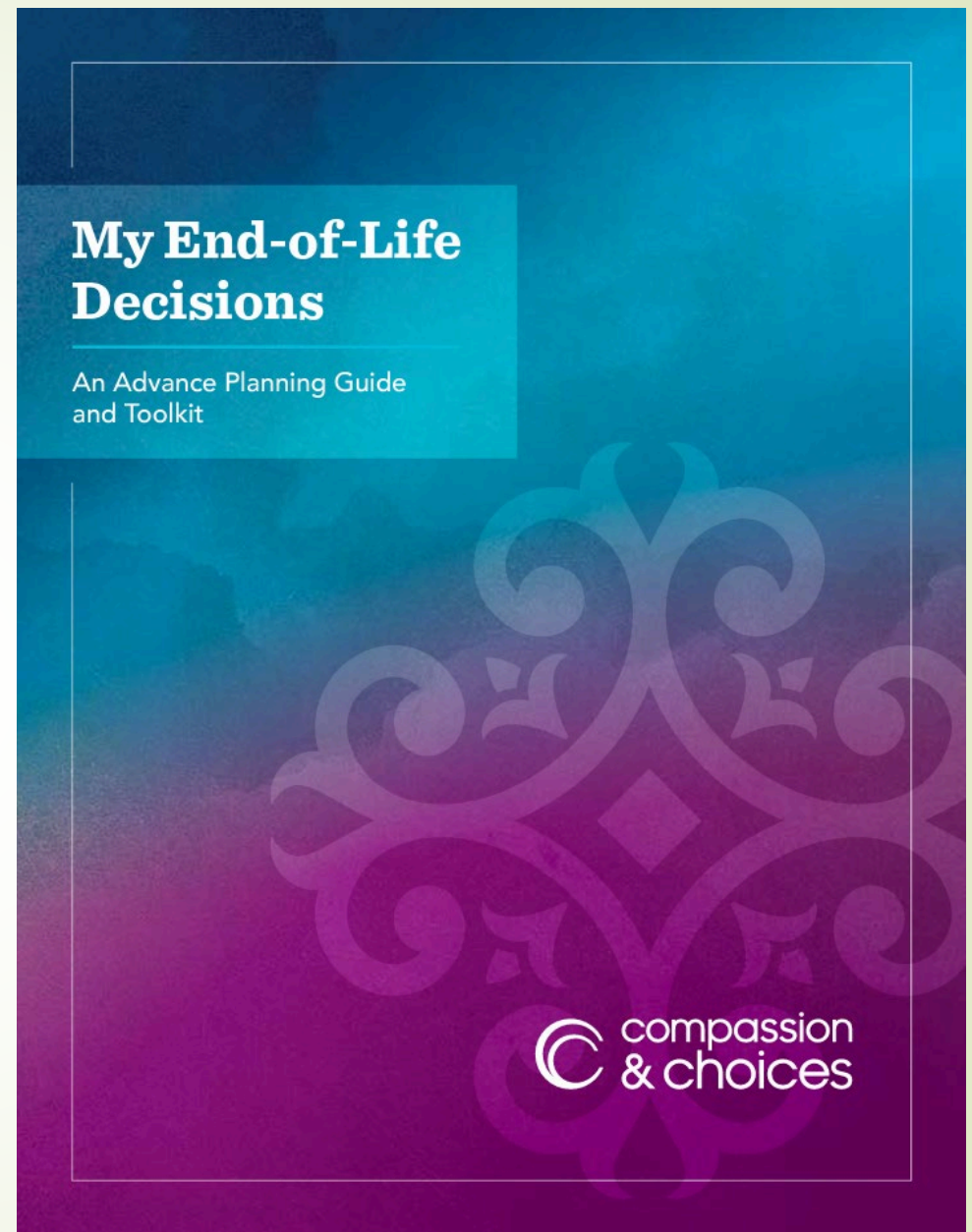
What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want to be comfortable. Wish 3 says what can be done to make me comfortable.
- I want to be offered food and fluids by mouth if it is safe for me to eat and drink. I want to be kept clean and warm.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

Birthdate

Compassion & Choices

- Values Worksheet
- Assisted Living Facility Rider
- Hospital Visitation Form
- Sectarian Healthcare Directive
- My Particular Wishes



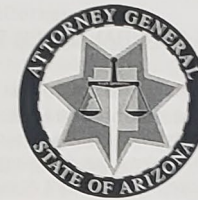
Arizona Life Care Planning

(Handout & Discuss)

LIFE CARE PLANNING

Advance Directives for Making Your Health Care Decisions

Provided by
The Office of Arizona Attorney General,
Kris Mayes



MAIL FORMS TO:

AZ Healthcare Directives Registry
2901 N. Central Ave. Ste. 1100
Phoenix AZ 85012

OR

Email:

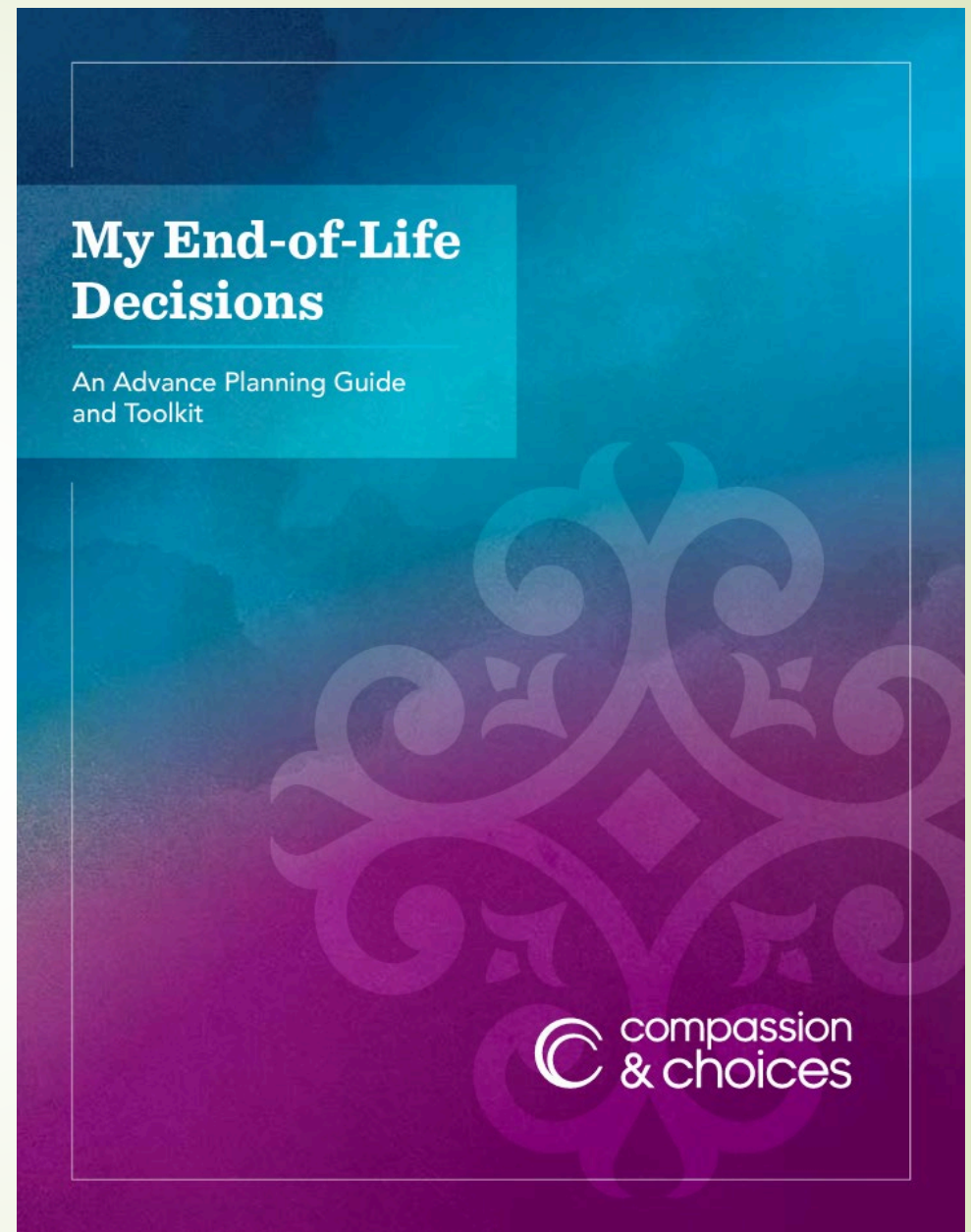
documents@azhdr.org

OR

Fax: 602-264-8823

Compassion & Choices

- Sectarian Healthcare Directive
- Assisted Living Facility Rider
- Hospital Visitation Form



DECISIONS FOR SPECIFIC THERAPIES

(Note: If you are unsure of the purpose of any of the following medical therapies, please speak with a health professional for clarification.)

If my mental or physical state has deteriorated, the prognosis is grave, and there is little chance that I will ever regain mental or physical function, I would like the following:

	YES	TRIAL PERIOD*	NO
1. Antibiotics if I develop a life-threatening infection of any kind			
2. Dialysis if my kidneys cease to function, either temporarily or permanently			
3. Artificial ventilation if I stop breathing			
4. Electroshock if my heart stops beating			
5. Heart-regulating drugs including electrolyte replacement if my heartbeat becomes irregular			
6. Cortisone or other steroid therapy if tissue swelling threatens vital centers in my brain			
7. Stimulants, diuretics or any other treatment for heart failure if the strength and function of my heart is impaired			
8. Blood, plasma or replacement fluids if I bleed or lose fluid circulating in my body			
9. Artificial nutrition			
10. Artificial hydration			

* Doctors may see whether the therapy quickly reverses my condition. If it does not, I want it discontinued.

Sectarian Healthcare Directive

I understand that circumstances beyond my control may cause me to be admitted to a healthcare institution whose religious or moral policy conflicts with instructions in my advance directive.

My consent to admission shall not constitute implied consent to procedures or courses of treatment mandated by ethical, religious or other policies of the institution if those procedures or courses of treatment conflict with this advance directive.

Furthermore, I direct that if the healthcare institution in which I am a patient declines to follow my wishes as set out in my advance directive, I am to be transferred promptly to a hospital, nursing home or other institution that will agree to honor the instructions set forth in this advance directive.

My preferred choices of medical facility to which I'd like to be admitted or transferred are:

1.

2.

3.

I hereby incorporate this provision into my advance directive and into any other previously executed documents to guide healthcare decisions.

Assisted Living Facility Rider

Rider to Residential Agreement With Assisted-Living Facility



Having this rider in place helps ensure that an assisted-living facility will respect a resident's wishes for end-of-life care.

Resident and Facility agree that Facility will be the Resident's "home," with the dignity and privacy that concept implies. Resident hopes to remain in this home for the duration of their life.

Facility will respect Resident's end-of-life choices and will not delay, interfere with nor impede any lawful option of treatment or nontreatment freely chosen by Resident or Resident's authorized healthcare proxy or similar representative, including any of the following end-of-life options:

- » Hospice or palliative care services in the home;
- » Forgoing or directing the withdrawal of life-prolonging treatments;
- » Aggressive pain and/or symptom management, including palliative sedation¹;
- » Voluntary refusal of food and fluids², with palliative care if needed;
- » Any other option not specifically prohibited by the law of the state in which Facility is located.

Resident Signature *(Please print this document and sign with a pen.)*

Date

Facility Representative Signature *(Please print this document and sign with a pen.)*

Date

¹ Khader and Mrayyan, *The Use of Palliative Sedation for Terminally Ill Patients: Review of the Literature and an Argumentative Essay*, *J Palliat Care Med* 2015, 5:4

² Compassion & Choices, *Voluntary Stopping Eating and Drinking*, [CompassionAndChoices.org/wp-content/uploads/2016/10/VSED-FINAL-2.17.17.pdf](https://www.compassionandchoices.org/wp-content/uploads/2016/10/VSED-FINAL-2.17.17.pdf)

Hospital Visitation Form

Hospital Visitation Authorization (Advance Directive Addendum)



This form enables people not traditionally recognized as family members to gain priority visitation rights. Once completed and signed, it should be kept with the advance directive.

I, _____,
residing at _____ in _____
County, state of _____, do hereby give notice and authorization
that if I should become ill or incapacitated through any cause that necessitates my hospitalization,
treatment or long-term care in a medical facility, it is my wish that the following person(s),
_____,
be given first preference in visiting me in such medical or treatment facility, whether or not they are
parties related to me by blood or law, unless or until I freely give contrary instructions to medical
personnel on the premises involved.

Executed this _____ day of _____ (month), _____ (year)
at (location of signing) _____
by: _____
Signature (Please print this document and sign with a pen.) Date

WITNESS SIGNATURES:

WITNESS 1

WITNESS 2

Signature (Please print this document and sign with a pen.)

Signature (Please print this document and sign with a pen.)

DNR's vs EMT's



Do Not Resuscitate - DNR

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE or "DNR")

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

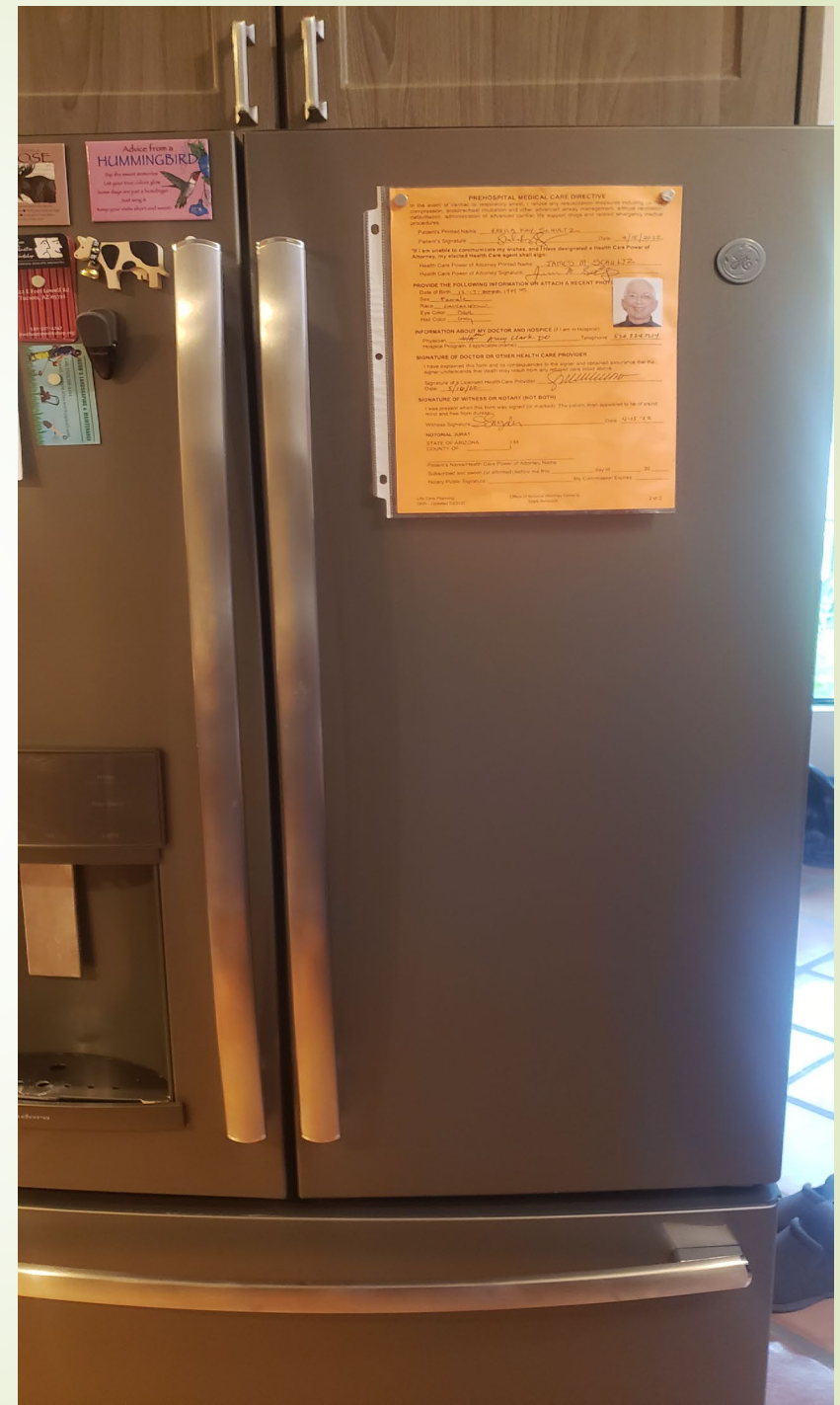
This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

- (a) under the age of 18
- (b) related to you by blood, adoption, or marriage
- (c) entitled to any part of your estate
- (d) appointed as your agent
- (e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.



Medical Alert Bracelets for Arizona



➡ <https://www.stickyj.com/category/dnr-jewelry-bracelets-arizona/>

POLST & MOLST

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information.

Having a POLST form is always voluntary.

This is a medical order,
not an advance directive.
For information about
POLST and to understand
this document, visit:
www.polst.org/form

Patient First Name: _____
Middle Name/Initial: _____ Preferred name: _____
Last Name: _____ Suffix (Jr, Sr, etc): _____
DOB (mm/dd/yyyy): ____/____/____ State where form was completed: Arizona
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1	☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)	☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)
--------	--	--

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1	☐ Full Treatments (required if choose CPR in Section A). <u>Goal: Attempt to sustain life by all medically effective means.</u> Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
	☐ Selective Treatments. <u>Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion).</u> May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
	☐ Comfort-focused Treatments. <u>Goal: Maximize comfort through symptom management; allow natural death.</u> Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).

[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

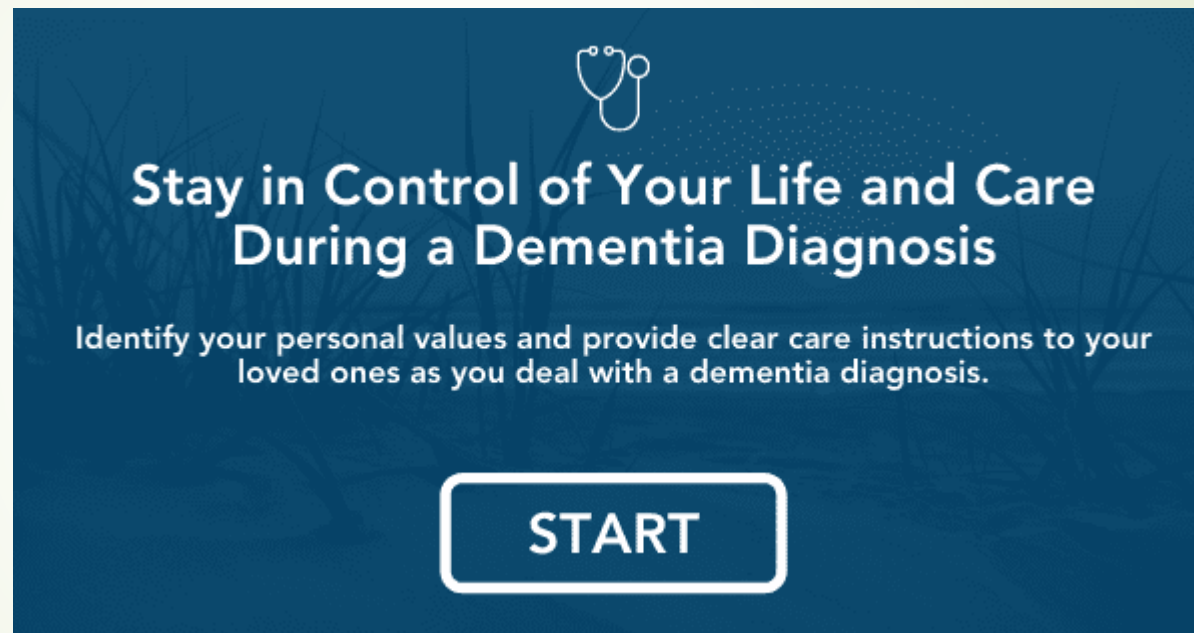
Pick 1	☐ Provide feeding through new or existing surgically-placed tubes	☐ No artificial means of nutrition desired
	☐ Trial period for artificial nutrition but no surgically-placed tubes	☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

Compassion and Choices

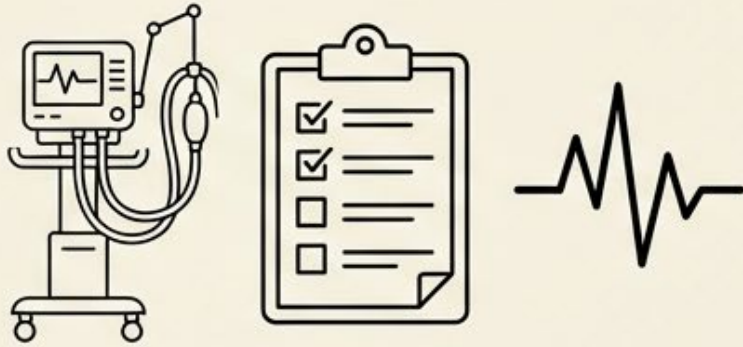
Dementia Values & Priorities Tool



Dementia Values & Priorities Tool

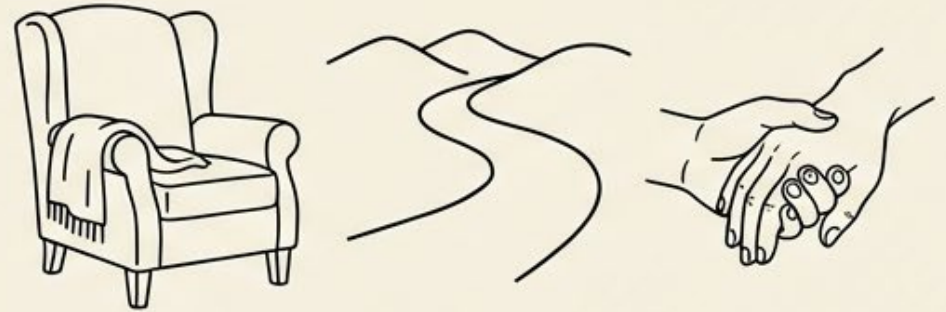
The Wrong Tool for the Job

Standard Advance Directive



- Focus: End-of-life medical crisis
- Timeframe: A single moment (ICU)
- The Question: "Which machines do you want?"

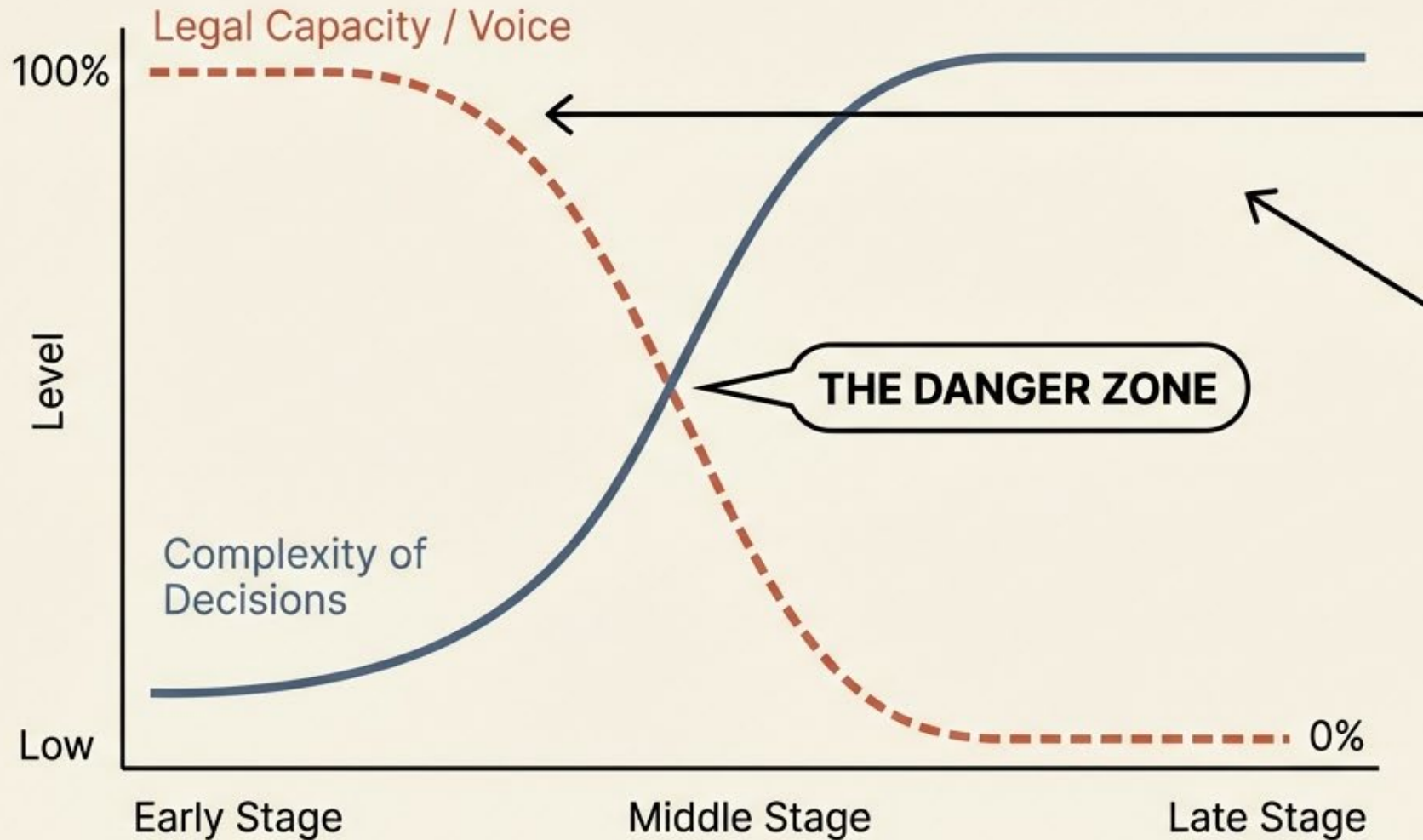
Dementia Reality



- Focus: Daily living and care
- Timeframe: Years of progressive decline
- The Question: "How do you want to live?"

Standard directives are designed for the ICU. Dementia happens in the living room.

The Planning Paradox



1. You can only sign documents HERE (Early).

2. The hardest decisions happen HERE (Middle/Late).

Consequence: Plan early, or your voice disappears before the decisions arrive.

Anne

1. Does Arizona require a doctor's order to determine whether a patient is **terminal**, **incompetent**, etc. so that an agent can start enforcing an advance directive e.g. stop feeding today?

2. Is there a specific **time** that has to pass before the agent can make those decisions on the language of the document?

Compassion and Choices

Dementia Values & Priorities Tool

Understanding Your Care Preferences

On the following pages, select one of these three options to indicate the desired care if you are living with dementia:

Live as Long as Possible

My goal is to live as long as possible and receive [aggressive medical care](#) and [life saving treatments](#). This could include calling 911, going to the hospital or receiving [CPR](#), [nutritional support](#), [artificial hydration](#) or [intubation](#) if needed.

Treat me, but not aggressively

I want to continue medication for chronic health conditions (e.g. diabetes, heart disease) and [treatment](#) for illness (e.g. pneumonia and infections). I want to avoid surgery, long-term [feeding tubes](#), [aggressive treatment](#) and other [life-prolonging care](#).

Allow a Natural Death

Focus on [comfort care](#), avoiding medications and treatments that prolong life. This could include stopping dialysis or blood transfusions, avoiding surgery, turning off pacemaker, or withdrawing treatment for heart disease, diabetes and other health conditions.

Compassion and Choices

Dementia Values & Priorities Tool

Let's get started .

1. If my physician or health care provider has determined my dementia has progressed to advanced or late stage, then I want to:

Live as Long
as Possible



Treat me,
but not
aggressively



Allow a
Natural
Death



Compassion and Choices

Dementia Values & Priorities Tool

8. If I am no longer aware of my surroundings (where I am, the date/year, who is with me), then I want to:

Live as Long
as Possible



Treat me,
but not
aggressively



Allow a
Natural
Death



What to do with the Documents -1

- Store in all relevant places and maintain a record of where the original documents and the copies are filed and when given to each individual.
- Multiple Personal sites: on **refrigerator (Not in freezer)**, in car glove box, or Hospital Go Bag
- Your **Advocate** gets an original
- Key Family Members
- Close friends
- Personal Doctor



What to do with the Documents -2

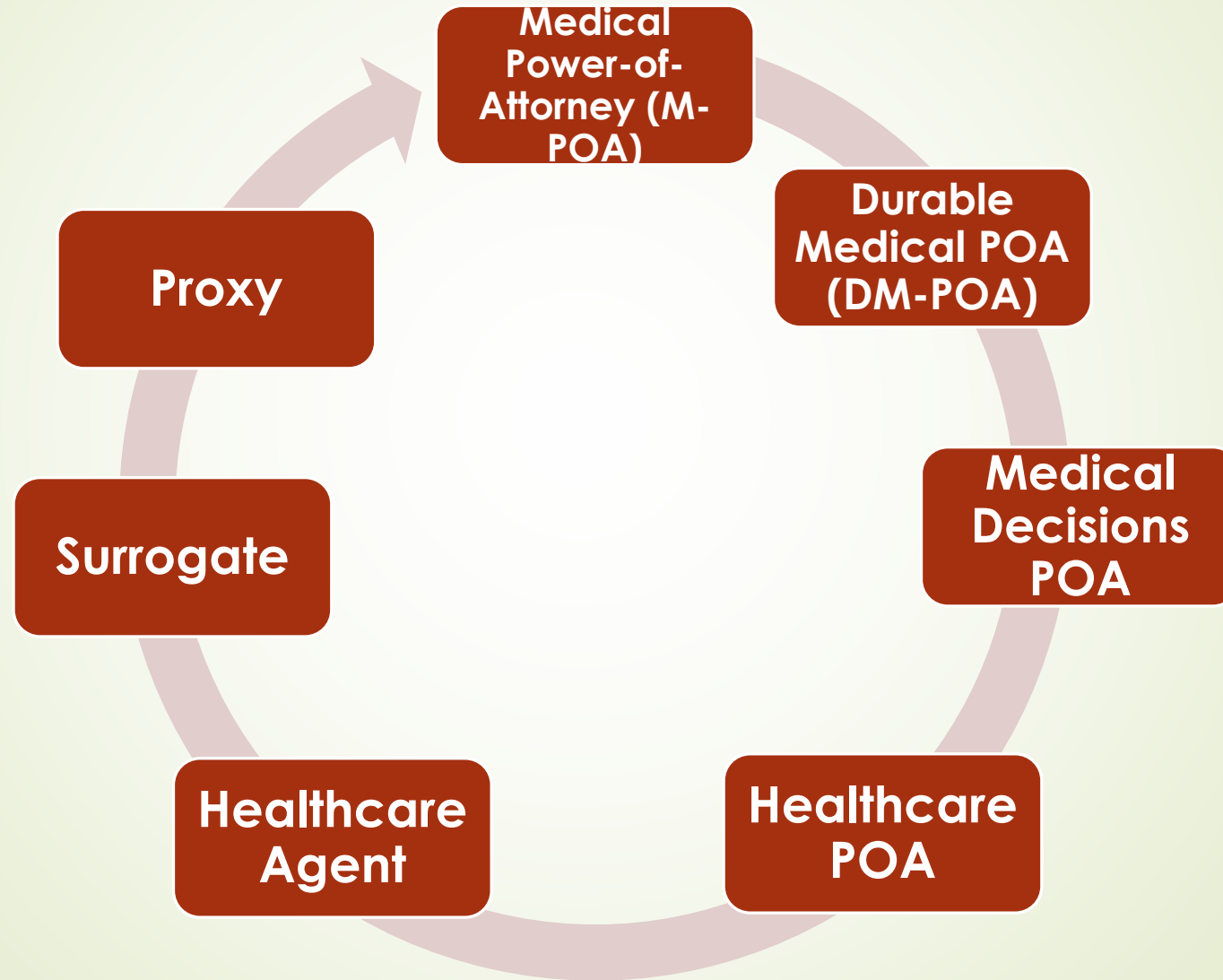
- Hospital Patient Advocate or Records Department
- Personal Attorney, preferably one familiar with Elder Law
- Do not put in safe deposit box or with your will.
- AZ Registry at: <https://azhdr.org/>
- National Registries



Medical Advocates or Proxies

1. Person who sees that your wishes are carried out
2. Makes sure things are not done to you that you do not want
3. Has your Medical Power of Attorney

Healthcare Advocate's Other Names



When Wishes Aren't Respected at EOL

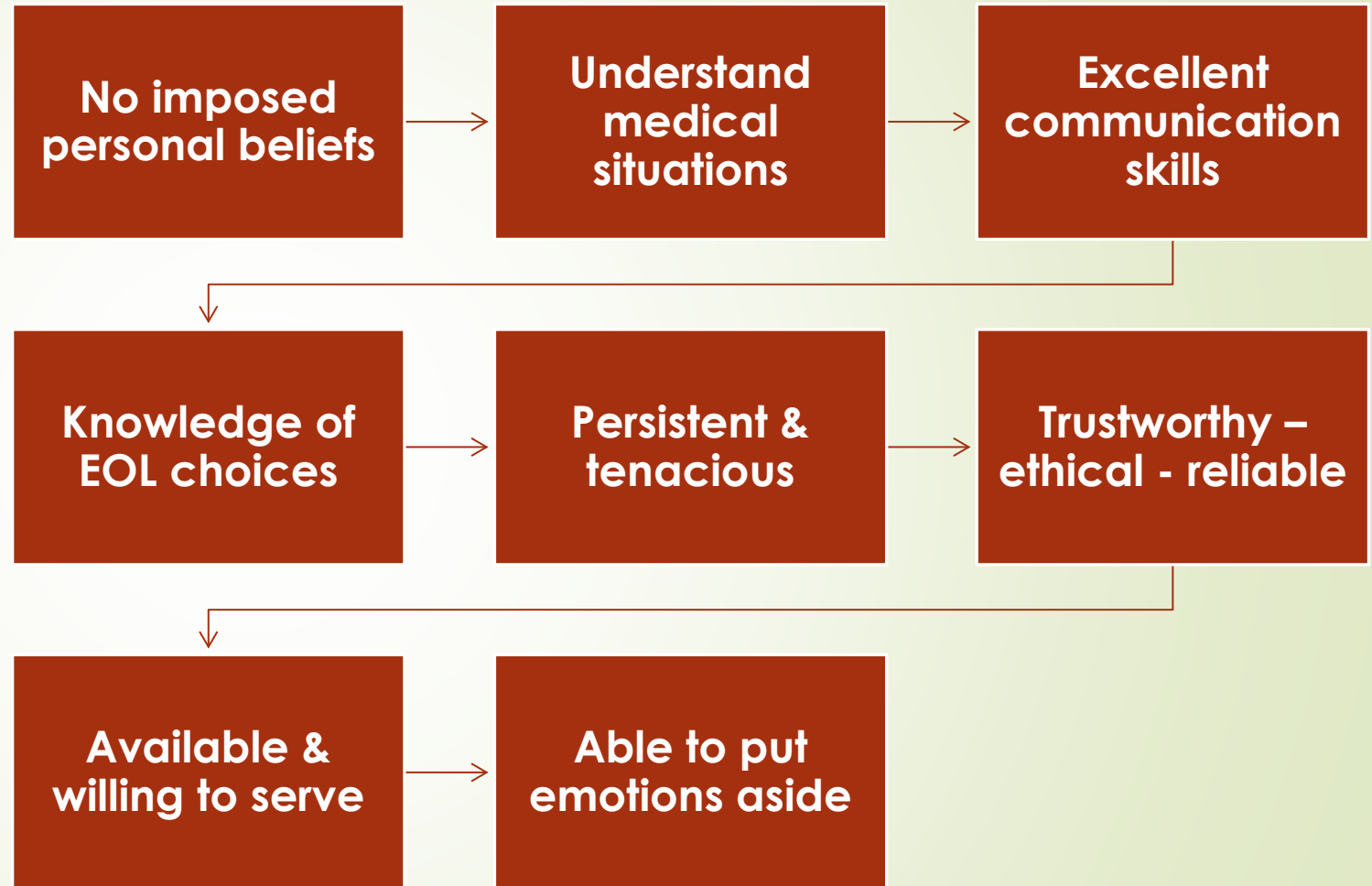
David P. Wood, MD, CMO



Who Will Speak for You?

Selecting an Effective Healthcare Advocate





Avoid Conflicting Authority

- ➡ You should have ONE Primary Advocate.
Choose a secondary and a tertiary as back-ups.
- ➡ Appointing co-advocates is a bad idea.
- ➡ Family members swooping in create chaos & conflict
- ➡ Medical staff ignoring the advocate for the loudest voice
- ➡ When financial POA is the same person as your medical POA?



Duties & Responsibilities of Your Advocate

1. **Clarify your values & preferences:** This involves numerous conversations with your advocate to help understand your values and preferences.
2. **Ensure that your wishes are met:** This is crucial when you cannot make decisions due to incapacity or in an emergency.
3. **Monitor:** the actions and procedures of healthcare professionals. Seek second opinions, consultations, and even transfers when needed. Stay informed!
4. **Consent to or Refusal of Medical Care:** Based on the patient's wishes and goals of care.
5. **Engage with others:** particularly family members & friends, to help them acknowledge, respect, honor, and understand your wishes.

Being an Effective Advocate

- Have the living will, advance directive, POLST, medical POA, financial POA, on hand, and update when needed
- Observe nurses & doctors to identify the medications & treatments they plan to use and ask questions
- Ask for a plan of care
- Speak up if they are not in sync with the patient's wishes
- Remind staff to keep directives/POLST on top of the file/record

If Your Wishes Are Still Not Honored

Suggested recourses:

- Hospitalist or Attending Doctor
- Independent or Hospital Patient Advocate
- Chief Medical Officer or Head Nurse
- Ethics Committee
- Hospital Administrator
- Hospital Legal Department
- Elder Law Attorney
- Last resort: Lawsuit





Solo Ager's Dilemma

What if I don't have an Advocate?

Arizona Hierarchy of Decision-Makers When You Fail to Appoint Someone





Chosen Family

- ➡ "Community is built by doing inconvenient things with inconvenient people at inconvenient times" defining the core of a true **chosen family**.

Board Certified Patient Advocates

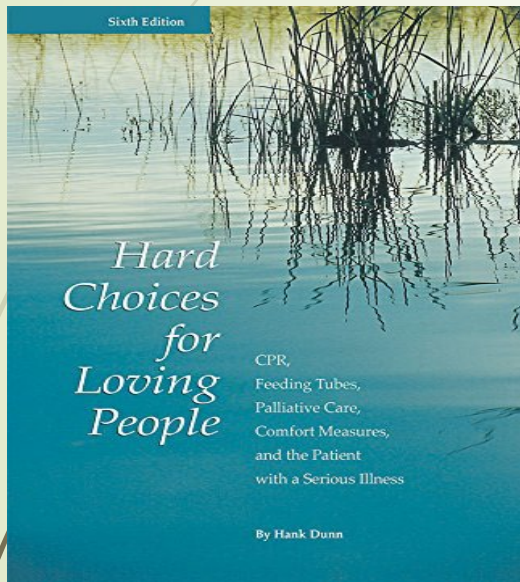
- Professionals, often with healthcare backgrounds, who help patients, or their families navigate the healthcare system to resolve medical issues.
- Independent, not affiliated with any hospital, care facility, insurance company, or pharmaceutical company.
- Certified by a national organization after a rigorous test. A high degree of professionalism and adherence to ethical standards.
- There are more than 1,000 nationwide & they advocate for you!

<https://www.pacboard.org/bcpa-certificant-list/>



Hard Choices for Loving People

K†· ÿ 2Ð ·



1: CPR: Cardiopulmonary Resuscitation



2: Feeding Tubes: Artificial Nutrition and Hydration



3: Cure Sometimes, Comfort Always: Palliative Care and Hospice



4: Treatments to Consider: Help for Decision-making



5: The Journey to Letting Be: Can I “Let Go and Let Be?”

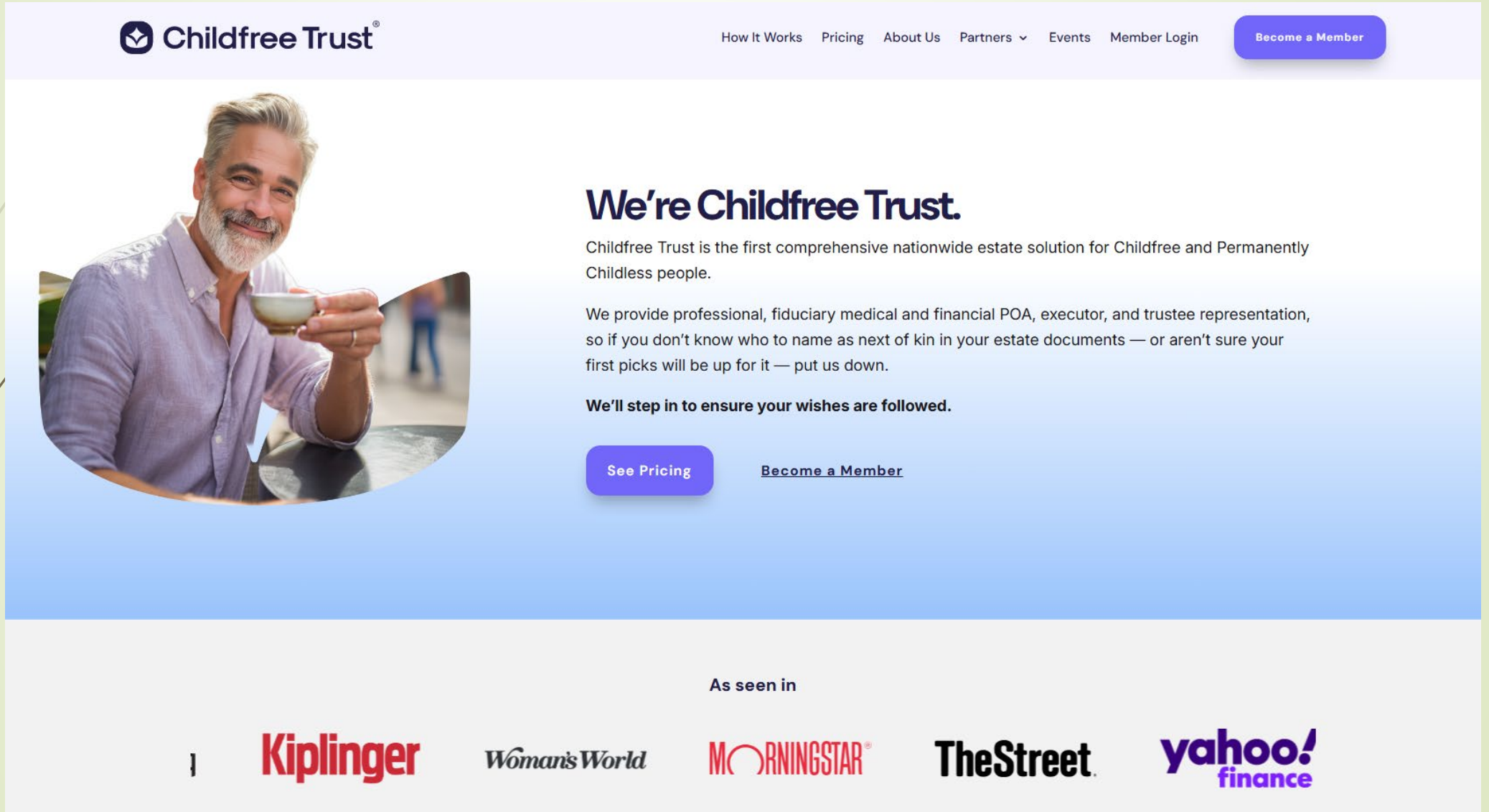
Guide to Being an Effective Advocate

Making Medical Decisions for Someone Else: A How-To Guide



**The American Bar Association
Commission on Law and Aging**

Child-Free Trusts - www.childfreetrust.com



The image shows a screenshot of the Childfree Trust website. The header features the Childfree Trust logo on the left and navigation links (How It Works, Pricing, About Us, Partners, Events, Member Login) and a 'Become a Member' button on the right. The main content area has a large image of a smiling man with a beard holding a cup of coffee. To the right of the image is the heading 'We're Childfree Trust.' followed by a paragraph explaining the service. Below this is another paragraph detailing the services provided. At the bottom of the main content area are two buttons: 'See Pricing' and 'Become a Member'. The footer section is titled 'As seen in' and displays logos for Kiplinger, Woman's World, Morningstar, TheStreet, and Yahoo! Finance.

Childfree Trust®

[How It Works](#) [Pricing](#) [About Us](#) [Partners](#) [Events](#) [Member Login](#) [Become a Member](#)



We're Childfree Trust.

Childfree Trust is the first comprehensive nationwide estate solution for Childfree and Permanently Childless people.

We provide professional, fiduciary medical and financial POA, executor, and trustee representation, so if you don't know who to name as next of kin in your estate documents — or aren't sure your first picks will be up for it — put us down.

We'll step in to ensure your wishes are followed.

[See Pricing](#) [Become a Member](#)

As seen in

Kiplinger *Woman's World* **MORNINGSTAR** **TheStreet** **yahoo! finance**



Elder Law Attorneys

The National Elder Law Foundation (NELF) is the only national organization accredited by the American Bar Association (ABA) to certify practitioners of elder and special needs law. It is a non-profit organization dedicated to developing and improving the professional competence of lawyers practicing elder law.

<https://nelf.org/>

Your Questions...



Next Week

- **Preparing for Physical & Cognitive Change**
- **Meenakshi Dagar M.D.**
 - **Assistant Professor of Medicine
Division of Geriatrics, General
Internal Medicine & Palliative
Care, Banner Health**
- She has an interactive session planned so please bring your **phone** or **lpad**.
- Pre-work will be out shortly



Thank You!
Please Stay to Mingle, Reflect & Discuss

