The ABCs of ACPs

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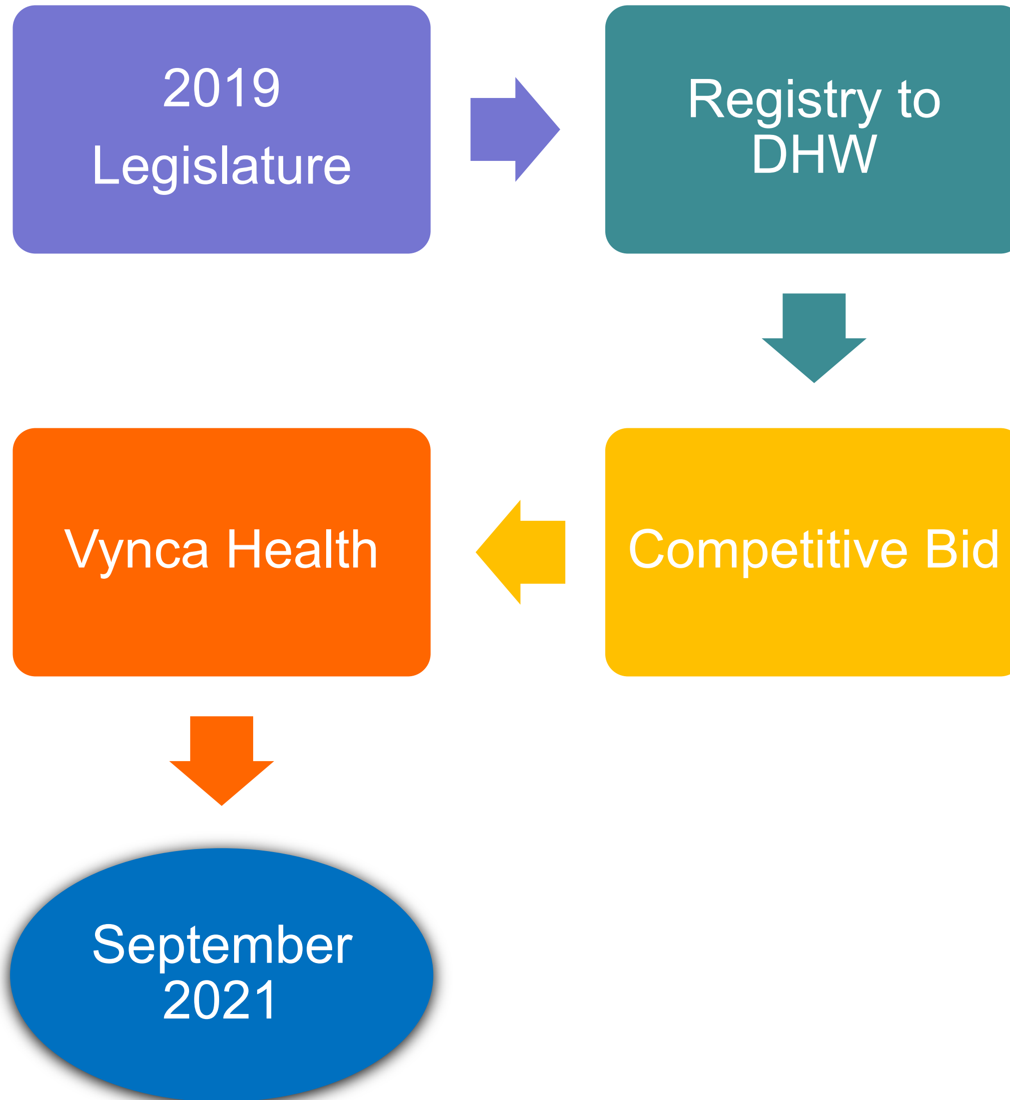
Advance Directives

The Idaho POST

Idaho Healthcare Directive Registry

August 5, 2021

How did we get here?



IDAHO HEALTHCARE DIRECTIVE REGISTRY

Your voice. Your choice.

IHDR@dhw.Idaho.gov

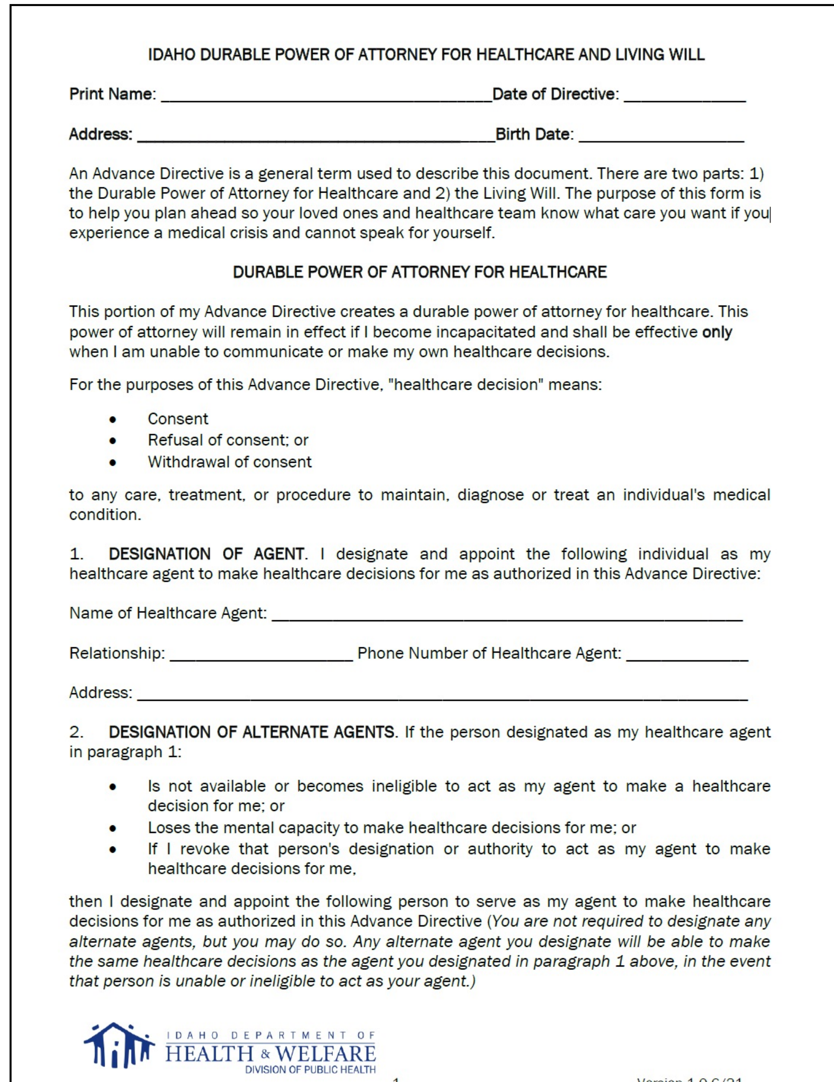
208-334-5501

New Advance Directive Form

- Idaho Advance Directive includes two parts:
  - Durable Power of Attorney for Healthcare
  - Living Will

- Durable Power of Attorney:
  - Healthcare Agent and alternates

- Used to create digital version



IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: ______________________________ Date of Directive: __________

Address: ________________________________ Birth Date: ______________

An Advance Directive is a general term used to describe this document. There are two parts: 1) the Durable Power of Attorney for Healthcare and 2) the Living Will. The purpose of this form is to help you plan ahead so your loved ones and healthcare team know what care you want if you experience a medical crisis and cannot speak for yourself.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT**. I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Advance Directive:

Name of Healthcare Agent: ____

Relationship: ________________ Phone Number of Healthcare Agent: __________

Address: ____

2. **DESIGNATION OF ALTERNATE AGENTS**. If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Advance Directive (*You are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Living Will

LIVING WILL
Directive to Withhold or to Provide Treatment

This portion of my Advance Directive creates my Living Will which allows me to make choices about any life-sustaining medical treatment I want or do not want. This Advance Directive shall be effective only if I am unable to communicate my instructions and:

A. I have an incurable injury, disease, illness or condition AND a medical doctor who has examined me has certified:

i. That such injury, disease, illness, or condition is terminal; and
ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
iii. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

B. I have been diagnosed as being in a persistent vegetative state.

If you are diagnosed as pregnant, special conditions and limitations may apply.

IF I AM IN ONE OF THE ABOVE SITUATIONS, my choices are as follows: *(Choose Box 1, 2, or 3 below, check the box, and initial the line after the box you checked).*

Regardless of the box chosen, pain and symptom management (comfort care) will be provided.

1 ☐ ______ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started and, if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and hydration.

OR

2 ☐ ______ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and hydration as follows:

*Check **one** box* and initial the line after the box you checked:

A. ☐ _______ Only artificial hydration
B. ☐ _______ Only artificial nutrition
C. ☐ _______ Both artificial hydration and nutrition

OR

3 ☐ ______ If my death is imminent, I want all medical treatment, care, and procedures necessary to sustain my life, including artificial nutrition and hydration.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Version 1.0 6/21

- Decision to withhold or provide treatment
- Optional provisions: free form text for specific desires and wishes
- Idaho POST form verification
- Only signed by individual creating the directive
  - Witness, notary, and clinician signature not required

New Registry Features

- Secretary of State records
- Individuals can create log-in and digital version
- “My Shared Circle”
- Clinicians register and view existing
- Clinicians can create digital POST with electronic signatures
- Preparer can begin developing POST but must be signed by physician, PA, Advance Practice Nurse
- Clinician can invite patient to the portal
- Hard copy versions can be attached
- DHW website: resources and link to registry

Advance Planning Documents

POST	Other ADs
1. Document designed primarily for those who are seriously ill or have some life limiting condition (i.e. chronic end stage disease, cancer) 2. Is a physician order recognized throughout the healthcare continuum 3. Is active and in force as soon as the document is signed 4. Protected and legally enforced by statute – most states have legislation recognizing post in their state and others that meet the same legal stipulations 5. Requires the input and signature of a LIP	1. Designed for use by all persons over the age of 18 2. Usually has two components a. Durable Power of Attorney for Healthcare – defines and authorizes legal surrogate b. Living will i. only in force when the criteria have been met (If person is unable to communicate instructions **AND** has an incurable or irreversible injury, illness or condition **AND** a medical doctor has certified that the condition is terminal **AND** life support would only serve to artificially prolong life **AND** death is imminent ii. provides surrogate and healthcare providers with information regarding wishes c. Additional instructions – provides for details regarding patient wishes (beyond the information in the living will) 3. May be completed with or without a healthcare provider

Living Will – Common Myth

Common Myth:

- A nursing home or Assisted Living Facility can require that you have a living will in place in order to be admitted.

Reality:

- Federal law prohibits a health care facility discriminating against a patient for not having a living will or health care power of attorney. Nonetheless, it is not uncommon for assisted care facilities and nursing homes to suggest that one is needed prior to admission.

Living Will – Common Myth #2

Myth:

- If Emergency Medical Services (EMS) are called to resuscitate you and are shown a copy of your living will, they will respect your wishes.

Reality:

- EMS first-responders will resuscitate a patient even if that patient is known to have signed a living will electing against receiving artificial life sustaining procedures. EMS personnel will attempt to resuscitate because they do not have the benefit and protection of two physicians on site, certifying that patient death is imminent regardless of the use of artificial life sustaining procedures.

Which takes us to POST

Physician Order for Scope of Treatment

Physician Orders for Scope of Treatment (POST)

- Legally recognized
    - Inpatient
    - Outpatient
    - Clinics
    - MD offices, etc.
    - EMS
- Intended to direct care consistent with patient wishes
- Not just a DNR form

Physician (Provider) Orders for Scope of Treatment—POST form

- History
  - POST enacted July 2007
    - Legally recognized in all healthcare settings throughout the State of Idaho
    - Must be followed except when:
      - (a) If they believe in good faith that the order has been revoked; or
      - (b) To avoid oral or physical confrontation; or
      - (c) If ordered to do so by the attending physician.
- Today
  - Medical Consent Act rev. of 2012 authorizes, eff. July 1, 2012, Physician, APRN and PA providers to sign the POST

Physician (Provider) Orders for Scope of Treatment—POST form

- Consumer Responsibilities
  - Talk to your spouse/family
  - Determine if a POST document is right for you
    - If not, complete a standard Advance Directive stating your wishes
  - Meet with provider (physician, NP, PA)
  - Have the conversation and complete the form
  - If you complete a POST (or any ACP document) make sure to record it in the Idaho Healthcare Directive Registry
    - If you complete the on-line version of the POST, it is automatically part of the registry

Physician (Provider) Orders for Scope of Treatment—POST form

- HCP Responsibilities
  - Encourage patients to create the AD through the secure, on-line registry portal. If hard copy is used, encourage patients to upload a scanned version to the registry.
    - Provides for a secure place to keep
    - Accessible by HCPs, family, and healthcare agents when needed
    - Stress importance of carrying their registry account log-in information
    - Helps to expedite treatment consistent with patient wishes
  - Always ask if client/patient has a registered AD
    - If so, the AD is accessible to view by the HCP.
    - If not, try to obtain the most updated AD from the patient or the family member

Physician (Provider) Orders for Scope of Treatment—POST form

- Statute update in 2017 specific to (I.C. § 66-405(7)-(8))
  - Updated standard
    - In those situations in which a guardian has been appointed pursuant to § 66-404, a guardian may now authorize the withholding or withdrawal of treatment other than appropriate nutrition or hydration, and a practitioner may act on such authorization, if any of the following circumstances apply:
      - (a) The attending [licensed independent practitioner (“LIP”)] and at least one (1) other LIP certifies that the [patient] is chronically and irreversibly comatose;
      - (b) The treatment would merely prolong dying, would not be effective in ameliorating or correcting all of the respondent’s life-threatening conditions, or would otherwise be futile in terms of the survival of the respondent; or
      - (c) The treatment would be virtually futile in terms of the survival of the respondent and would be inhumane under such circumstances.

SAMPLE POST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTHCARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND ORIGINAL WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

IDAHO POST Form: Portable Medical Orders

Health care professionals should only complete this form after a conversation with their patient or the patient's representative. The POST 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. **Note to Patients: Having a POST form is always voluntary.**

This is a medical order, not an advance directive. For information about POST 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: IDAHO

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 or is not breathing.

Pick 1

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** Requires choosing Full Treatments in Section B)

B. 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

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. 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.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). 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.

☐ **Full Treatment (required if you choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

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
☐ Not discussed or 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.

(required) Date:

If other than patient, print full name:

The most recently completed valid POST form supersedes all previously completed POST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) **Verbal orders are acceptable with follow up signature.**

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care professional authorized by law to sign POST form in state where completed may sign this order]

(required) Date (mm/dd/yyyy): Required / / Phone #: ( )

Printed Full Name: License/Cert. #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

SAMPLE POST

IDAHO POST Form – Page 2 *****PLEASE ATTACH TO PAGE 1*******

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POST orders: (A POST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed: ________ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists
Check everyone who participated in discussion:	☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: ________

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form:**
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
- **Using POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying POST form:** This form cannot be modified. If changes are needed, void form and complete a new POST form.
- **Voiding a POST form:**
  - **If a patient or patient representative (for patient's lacking capacity) wants to void the form:** destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers:** destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to ________
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker

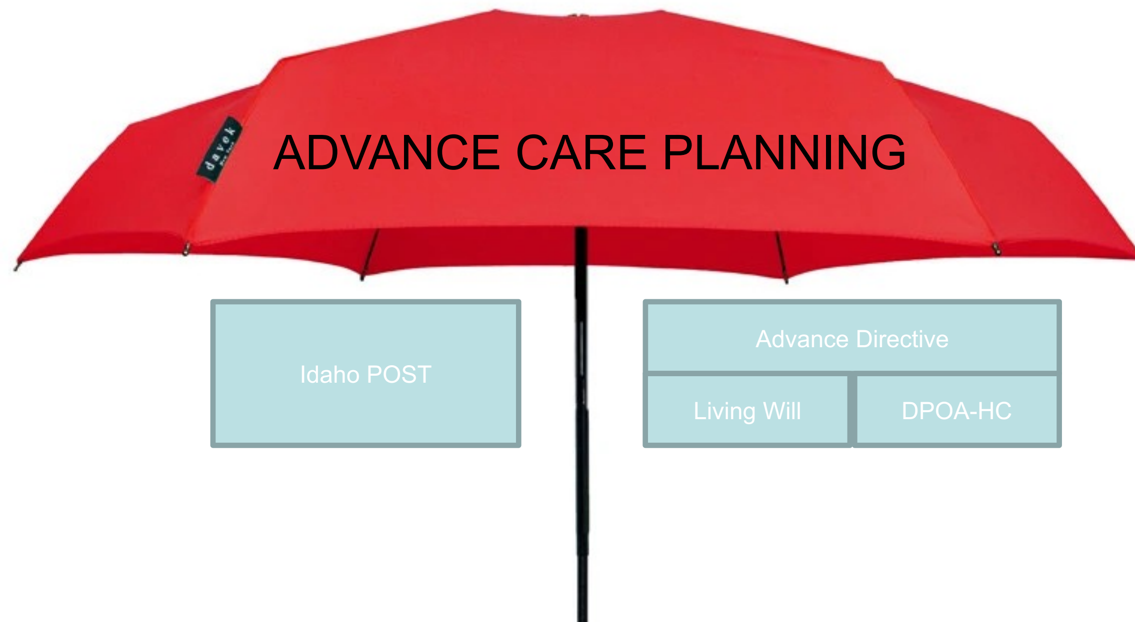
For more information, visit www.polst.org or email info@polst.org Copied, faxed or electronic versions of this form are legal and valid. 2019

Question #1

- The Idaho POST is an Advance Directive
  - Yes
  - No
  - I don't know what the Idaho POST and/or an Advance Directive is

Reality:

- The Idaho POST is a physician order. Both the Idaho POST and Advance Directive fall under the umbrella of Advance Care Planning Documents



Question #2

- A nursing home or Assisted Living Facility can require that the resident have a living will or POST in place in order to be admitted.
  - Yes
  - No
  - Not sure

Reality:

- Federal law prohibits a health care facility discriminating against a patient for not having a living will or health care power of attorney. Nonetheless, it is not uncommon for assisted care facilities and nursing homes to suggest that one is needed prior to admission. What Federal law does require is that each resident has a documented resuscitation status.

Question #3

- If Emergency Medical Services (EMS) are called to resuscitate you and are shown a copy of your living will, they will respect your wishes.
  - Yes
  - No
  - Not sure

Reality:

- EMS first-responders will resuscitate a patient even if that patient is known to have signed a living will electing against receiving artificial life sustaining procedures. EMS personnel will attempt to resuscitate because they do not have the benefit and protection of two physicians on site, certifying that patient death is imminent regardless of the use of artificial life sustaining procedures.

Conclusion

- Advance Care Planning is not a form it is a process
- Most effective and compassionate way to honor patient wished is proactively through the use of advance care planning discussions and recording those discussions on ACP documents

QUESTIONS