ACP Clinical Updates/Implications

Presenter:
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Advance Care Planning Manager at Parkview Health

What is an Advance Directive?

An advance directive (AD) is a legal document a patient can use to:

- Appoint a health care representative (HCR) to speak on his/her behalf in the event of a loss of decisional capacity; and
- Express healthcare decisions and/or treatment preferences for future care.

Indiana Legislative Session 2021 – Senate Enrolled Act 204

Cause for celebration

- SB 204 passed unanimously in the Senate (46 – 0) and House (92 – 0)
- Senate Bill 204 was signed by Governor Holcomb on April 15, 2021.
- The Bill became an Enrolled Act which became Public Law 50 on July 1, 2021.
- This is our "advance directive overhaul law."

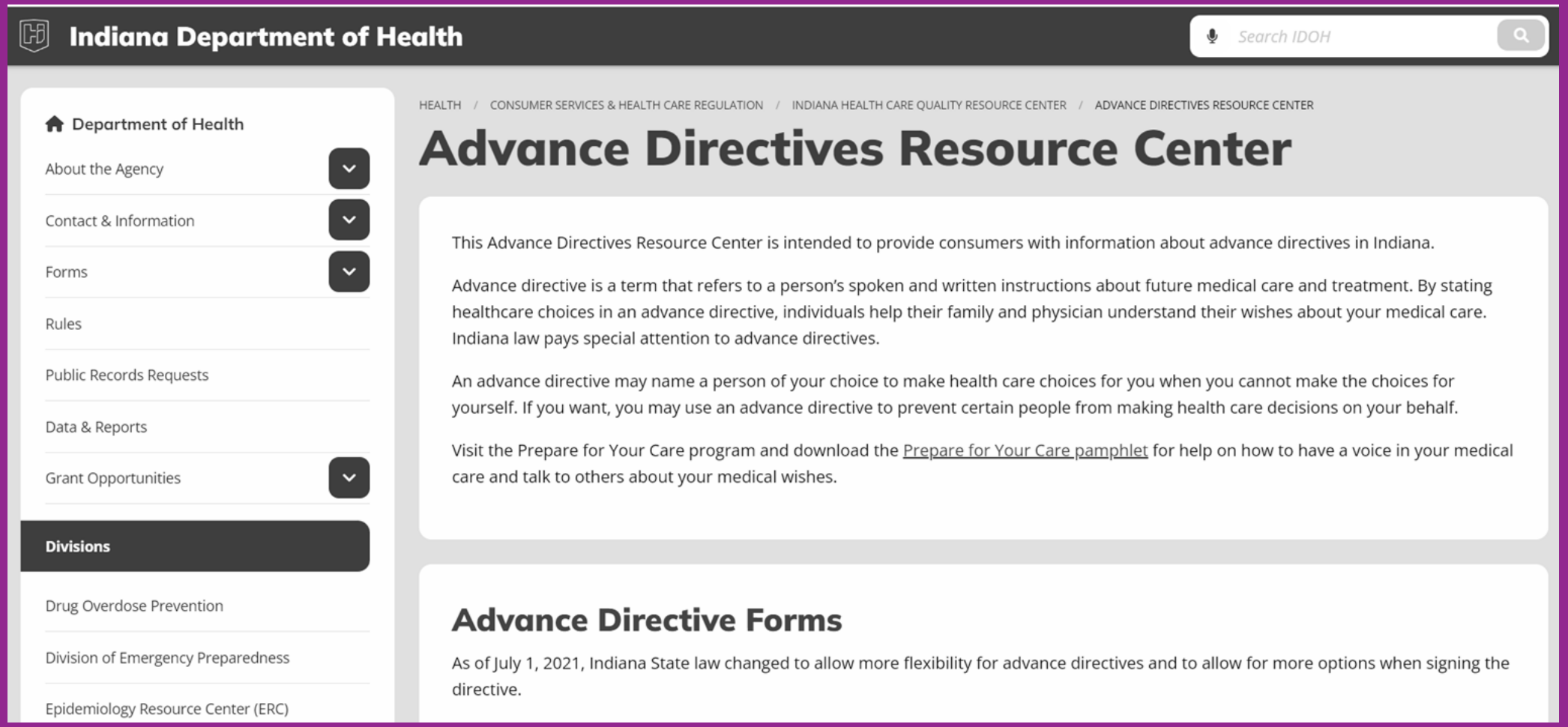
When Do These Changes Take Effect?

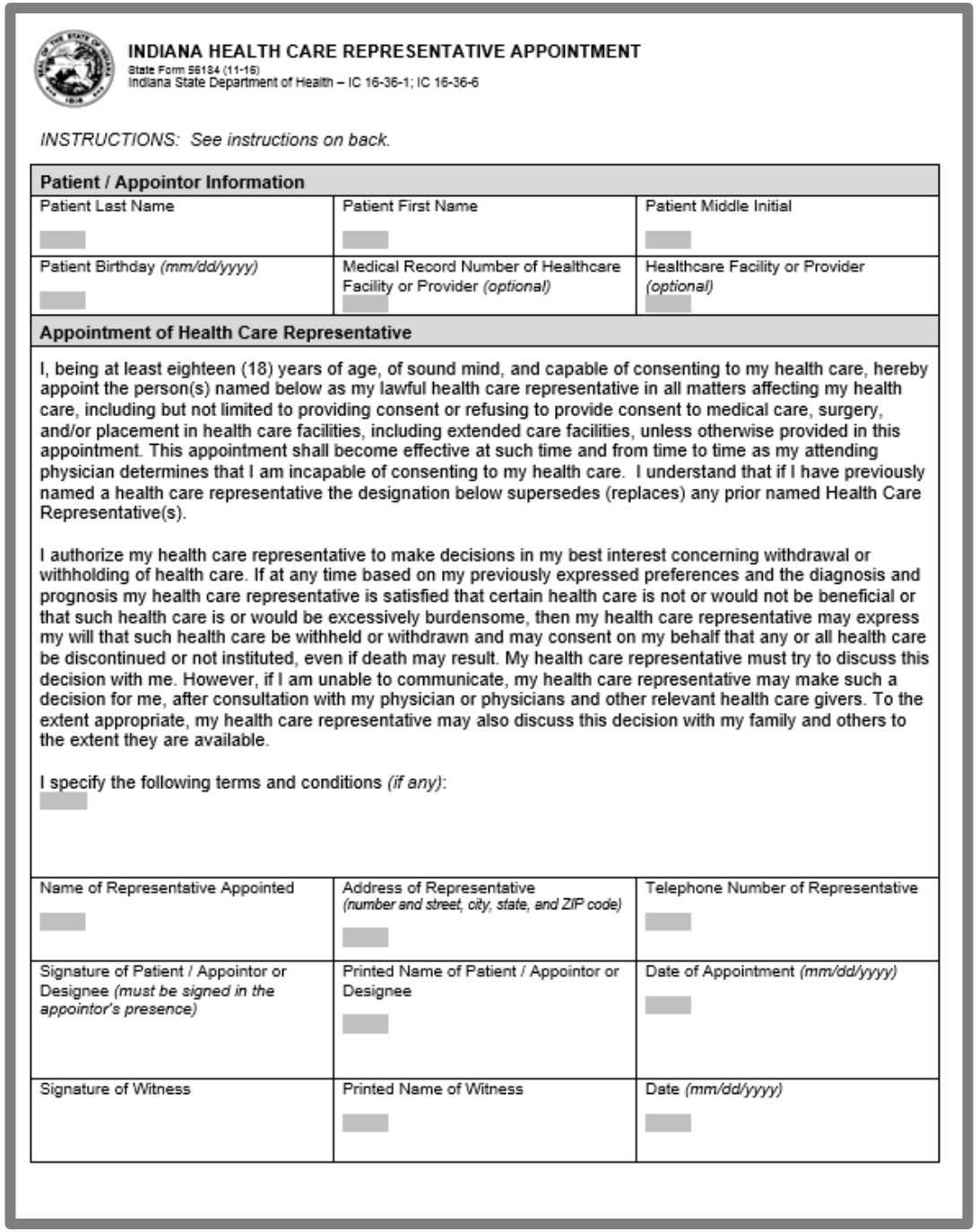
- This legislation took effect on July 1, 2021, meaning a person with decisional capacity can sign a new AD. Starting January 1, 2023, everyone must follow the all components of the law.
- Advance directives completed before January 1, 2023, under the old laws, will remain legally valid and do not need to be updated unless by the patient's choice.
- A later-signed advance directive is presumed to be revoked and replaces all earlier ones signed by the same patient, unless the later AD specifically says otherwise.

ISDH Documents: Some Are No Longer Available

ISDH Resource Center

https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/





INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 55184 (11-16)
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday *(mm/dd/yyyy)*	Medical Record Number of Healthcare Facility or Provider *(optional)*	Healthcare Facility or Provider *(optional)*

Appointment of Health Care Representative

I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

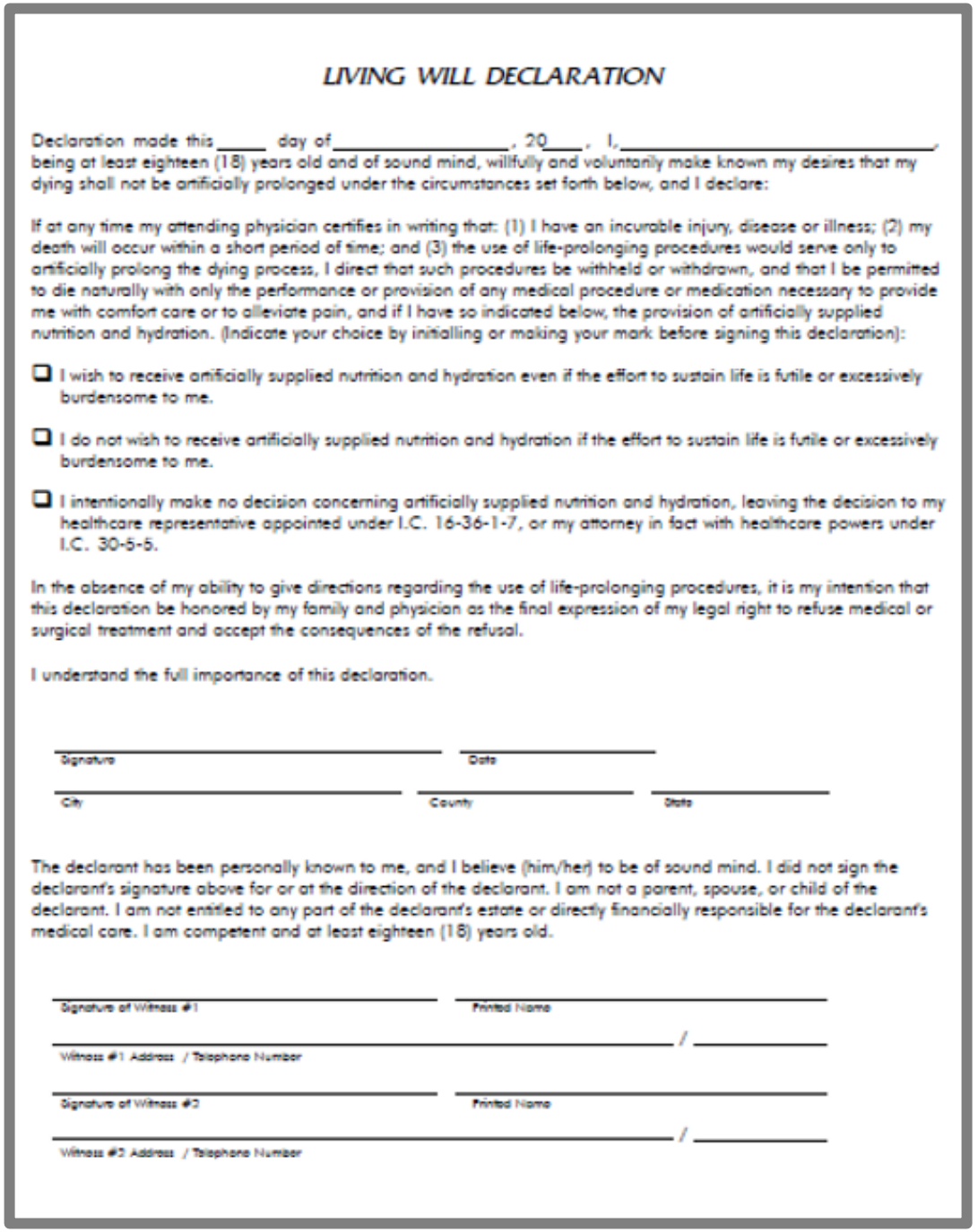
I specify the following terms and conditions *(if any)*:

Name of Representative Appointed	Address of Representative *(number and street, city, state, and ZIP code)*	Telephone Number of Representative
Signature of Patient / Appointor or Designee *(must be signed in the appointor's presence)*	Printed Name of Patient / Appointor or Designee	Date of Appointment *(mm/dd/yyyy)*
Signature of Witness	Printed Name of Witness	Date *(mm/dd/yyyy)*

No Longer Available on the ISDH Website

Health Care Representative Appointment

This form can be completed until December 31, 2022. New ones created are not valid after this date but previously completed versions will remain valid.



LIVING WILL DECLARATION

Declaration made this _____ day of _____, 20___, I, _____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease or illness; (2) my death will occur within a short period of time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialling or making your mark before signing this declaration):

☐ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

☐ I do not wish to receive artificially supplied nutrition and hydration if the effort to sustain life is futile or excessively burdensome to me.

☐ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my healthcare representative appointed under I.C. 16-36-1-7, or my attorney in fact with healthcare powers under I.C. 30-5-5.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full importance of this declaration.

_____ _____
Signature Date

_____ _____ _____
City County State

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

_____ _____
Signature of Witness #1 Printed Name

_____ / _____
Witness #1 Address / Telephone Number

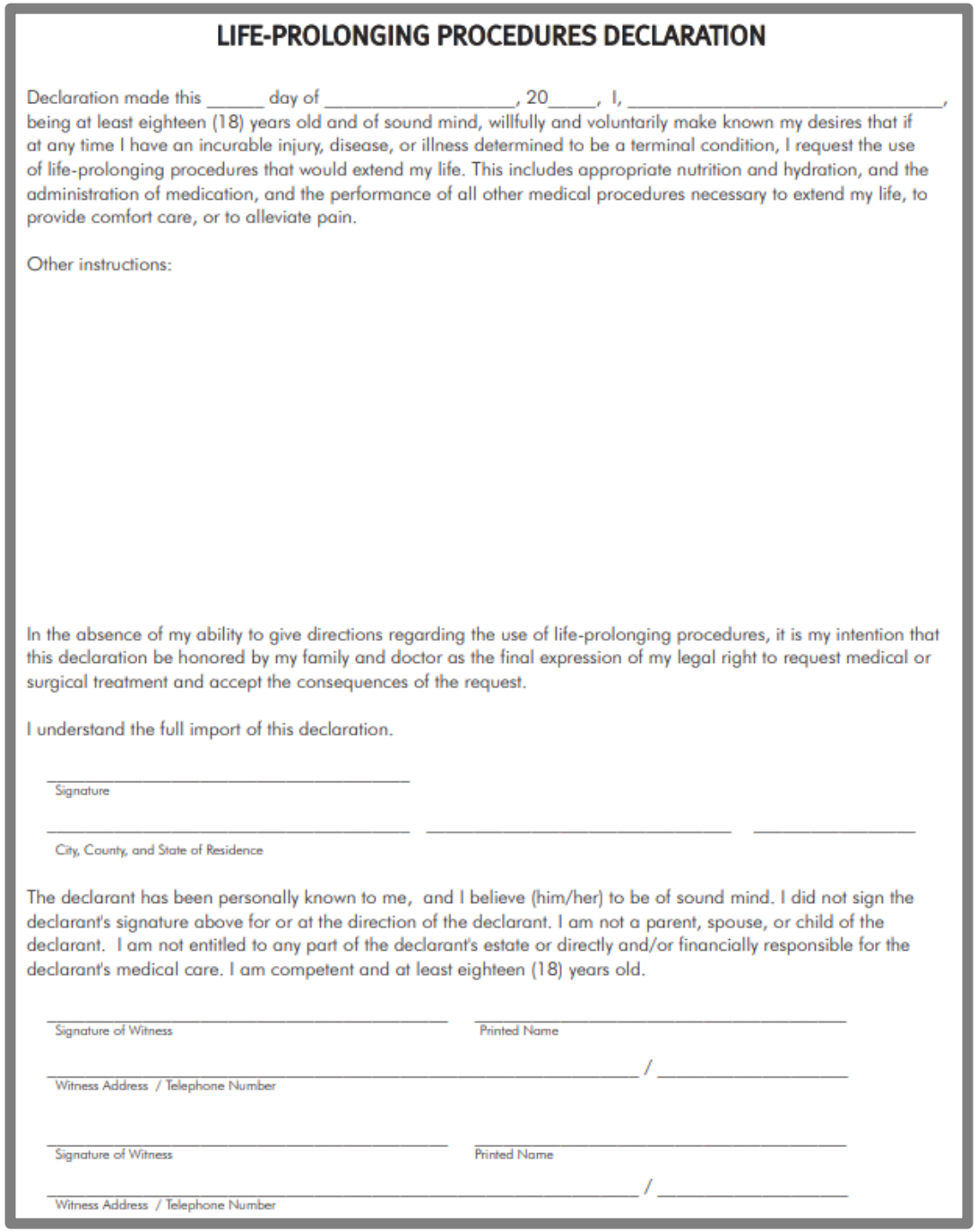
_____ _____
Signature of Witness #2 Printed Name

_____ / _____
Witness #2 Address / Telephone Number

No Longer Available on the ISDH Website

Living Will Declaration

This form can be completed until December 31, 2022. New ones created are not valid after this date but previously completed versions will remain valid.



LIFE-PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, and the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

Other instructions:

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and doctor as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

_____
Signature

_____ _____ _____
City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly and/or financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

_____ _____
Signature of Witness Printed Name

_____ / _____
Witness Address / Telephone Number

_____ _____
Signature of Witness Printed Name

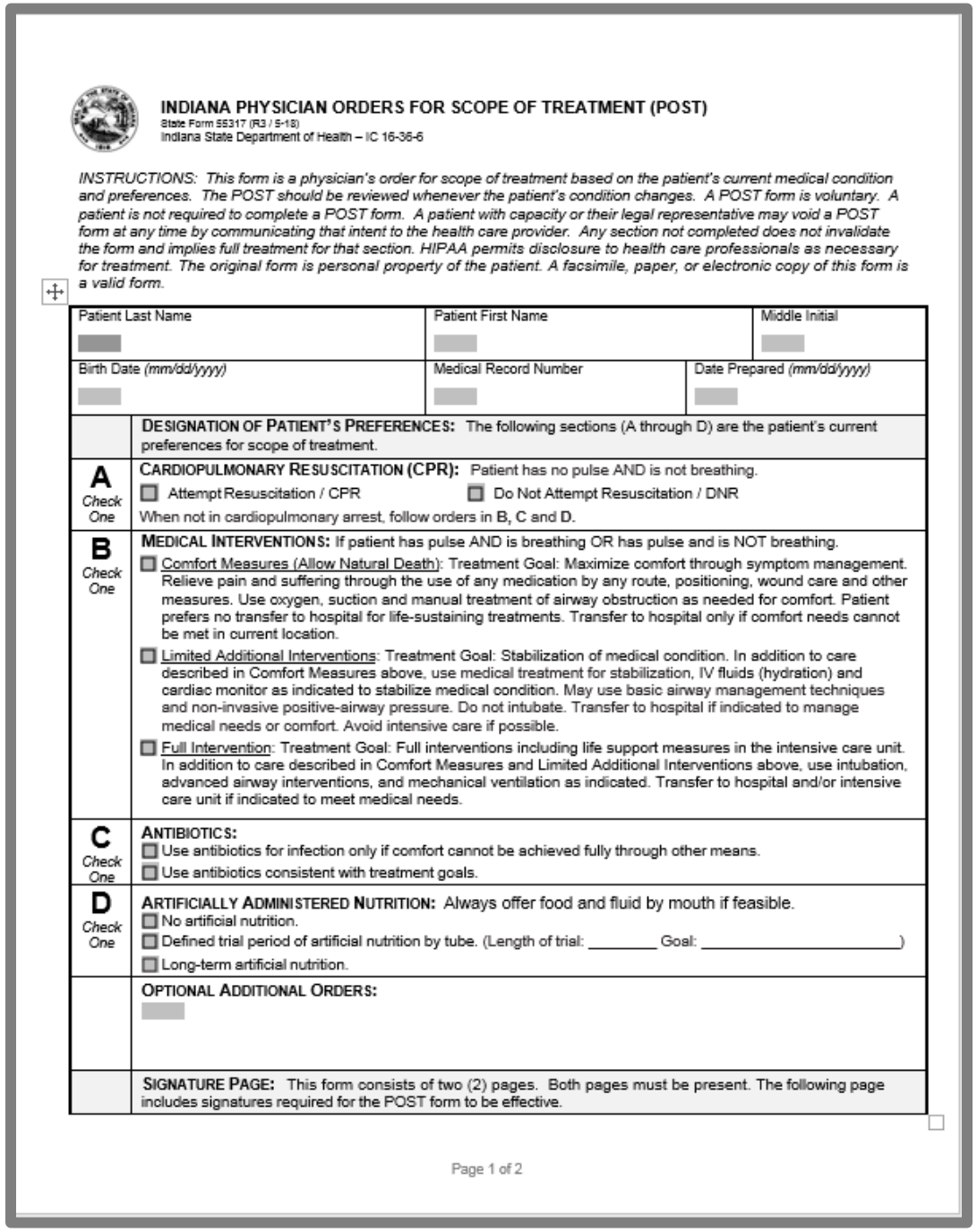
_____ / _____
Witness Address / Telephone Number

No Longer Available on the ISDH Website

Life-Prolonging Procedures Declaration

This form can be completed until December 31, 2022. New ones created are not valid after this date but previously completed versions will remain valid.

ISDH Documents: Still Available



INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)
State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	**Medical Record Number**	**Date Prepared** *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in B, C and D.

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Page 1 of 2

Still Available on the ISDH Website

POST Form (Physician Orders for Scope of Treatment – Page 1)

Has not changed under the new law.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature *(required by statute)*	Print Name *(required by statute)*	Date *(required by statute)* (mm/dd/yyyy)

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity *(required by statute)*	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
  (A) the individual is a qualified person; and
  (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.
(2) An advanced chronic progressive frailty.
(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
  (A) there can be no recovery; and
  (B) death will occur from the condition within a short period without the provision of life prolonging procures.
(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G	**DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:** ☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Power of Attorney
H	**SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT** My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA *(required by statute)*	Print Treating Physician / APRN / PA Name *(required by statute)*	Date *(required by statute)* (mm/dd/yyyy)

Physician / APRN / PA office telephone number *(required by statute)*	Physician / APRN / PA License Number *(required by statute)*	Health Care Professional preparing form if other than the physician / APRN / PA

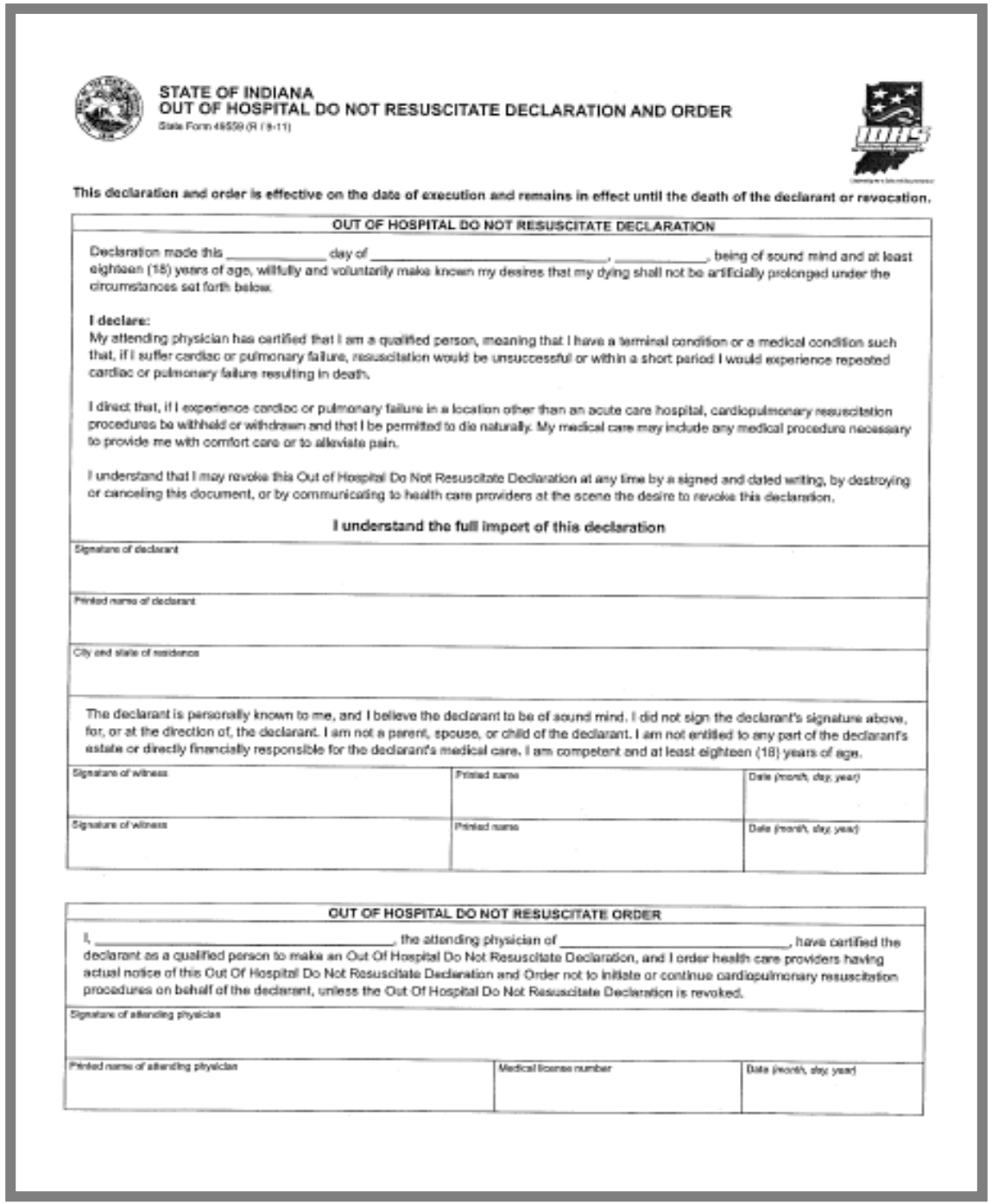
I	**APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.

Page 2 of 2

Still Available on the ISDH Website

POST Form (Physician Orders for Scope of Treatment – Page 2)

Has not changed under the new law.



STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER
State Form 46559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date (month, day, year)
Signature of witness	Printed name	Date (month, day, year)

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Printed name of attending physician	Medical license number	Date (month, day, year)

Still Available on the ISDH Website

Out of Hospital Do Not Resuscitate Declaration and Order

Under the new law, this form did not change in appearance or content but has signatory changes.

Out Of Hospital DNR Declaration and Order

Signatory Changes

NP and PAs can now sign

An attending physician, advanced practice registered nurse, or physician assistant may certify that a patient is a qualified person if the attending physician, advanced practice registered nurse, or physician assistant determines, in accordance with reasonable medical standards, that one (1) of the following conditions is met:

- (1) The person has a terminal condition
- (2) The person has a medical condition such that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

Out Of Hospital DNR Declaration and Order

Signatory Changes

Representative

- A person's representative may execute an out of hospital DNR declaration for the person under only if the person (patient) is:
  - (1) at least eighteen (18) years of age; and
  - (2) incompetent.
- A person's representative is either
  - A legal guardian or other court appointed representative responsible for making health care decisions for the person
  - A health care representative or an attorney in fact for health care appointed under IC 30-5-5-16.

A Few Key Details

There will no longer be an Indiana state Life-Prolonging Procedures Declaration.

There is no longer a separate psychiatric advance directive.

The state of Indiana is no longer required to maintain advance directive forms. The ISDH Website only has the Out of Hospital DNR and POST Forms available.

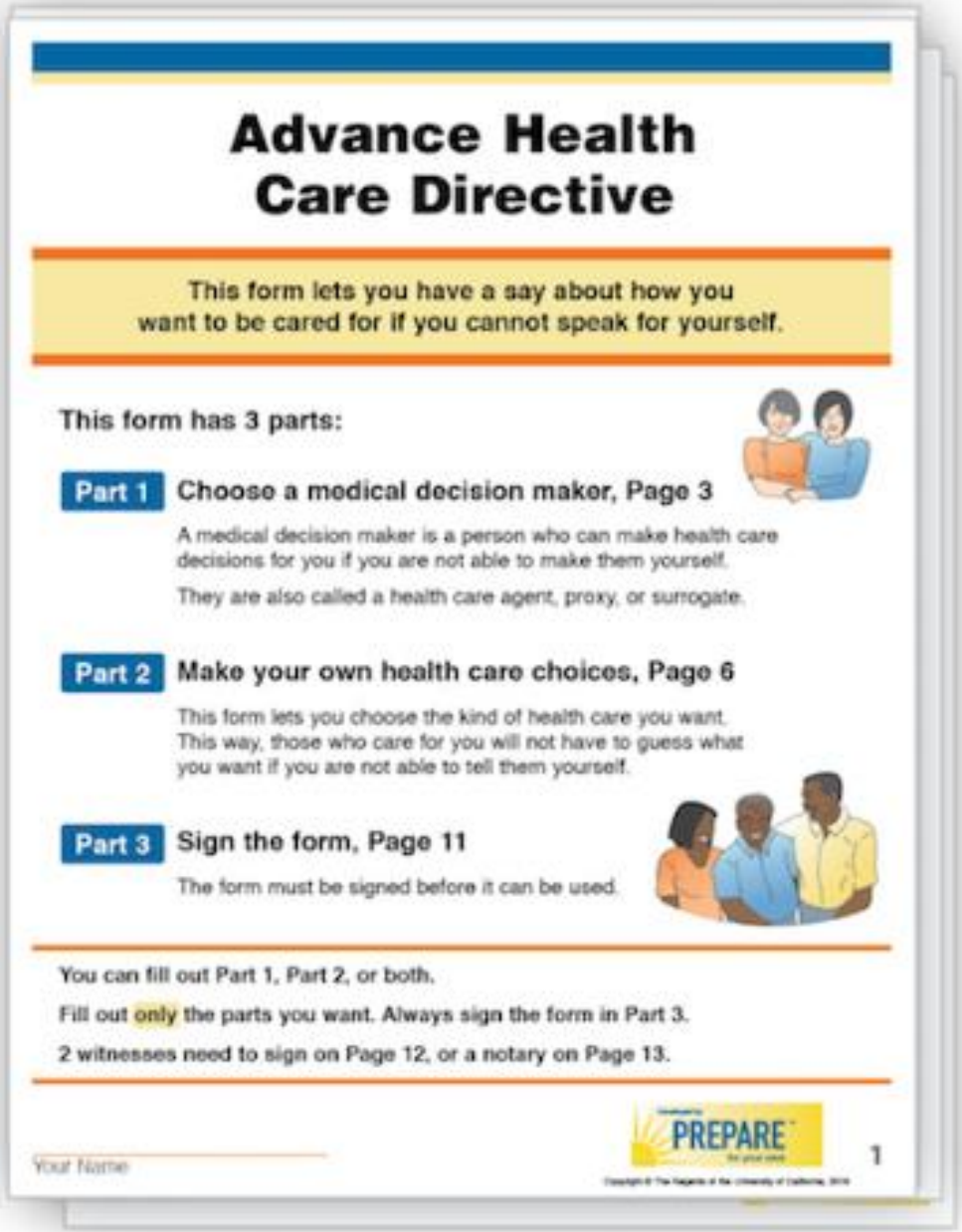
Updated Signing Requirements of Advance Directive Forms

The patient must sign the form. The patient can also direct someone to sign in his/her direct presence if unable to sign.

The form must be signed by two adult witnesses or one notarial officer.

An Advance Directive can either be signed on paper or electronically.

Forms You Could Be Seeing: Prepare for Your Care



Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 **Choose a medical decision maker, Page 3**

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

They are also called a health care agent, proxy, or surrogate.

Part 2 **Make your own health care choices, Page 6**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 **Sign the form, Page 11**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

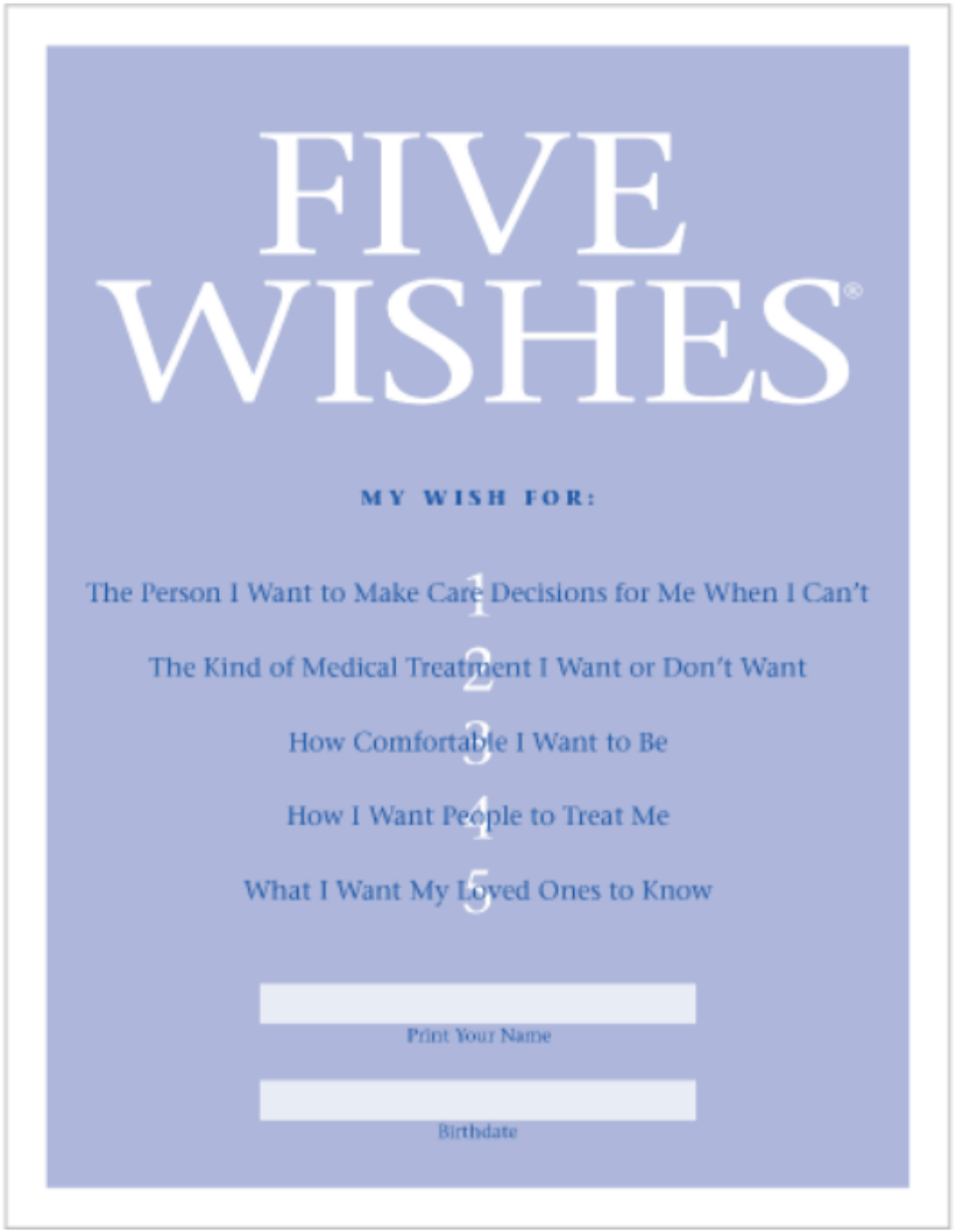
2 witnesses need to sign on Page 12, or a notary on Page 13.

PREPARE

Your Name

1

Forms You Could Be Seeing:
Five Wishes


FIVE WISHES®

MY WISH FOR:

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

2 The Kind of Medical Treatment I Want or Don't Want

3 How Comfortable I Want to Be

4 How I Want People to Treat Me

5 What I Want My Loved Ones to Know

Print Your Name

Birthdate

Prepared by: Jeffrey S. Dible
FROST BROWN TODD LLC
201 N. Illinois Street, Suite 1900
P. O. Box 44961 Indianapolis, IN 46244-0961
T: 317.237.3811 M: 765.412.4772 F: 317.237-3900
jdible@fbtlaw.com

Forms You Could Be Seeing: Indianapost.org Forms

_____ I specifically disqualify the following individual(s): _____ _____ from later being appointed as a Health Care Representative for me, and from receiving delegated authority from any of my Health Care Representative(s), and from acting as my proxy under IC 16-36-7-42 and -43.

_____ My Health Care Representative(s) named above are **NOT** authorized to delegate authority to other persons. *If this space is NOT initialed, any Health Care Representative may delegate his or her authority to a competent adult or other person in a written document that the Representative signs in the same manner as this Advance Directive.*

_____ My Health Care Representative(s) are **NOT** authorized to consent to mental health treatment for me. *If this space is NOT initialed, each Health Care Representative will have authority to consent to mental health treatment for me if I am not capable of consenting.*

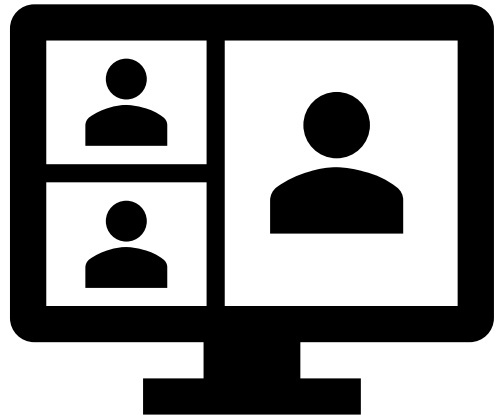
_____ My Health Care Representative(s) are **NOT** entitled to receive compensation from my money or property for the acts and services that they perform on my behalf. *If this space is NOT initialed, each Health Care Representative will be entitled to receive reasonable compensation from my money or property.*

Forms You Could Be Seeing: Indianapost.org Forms Language from Longer Sample Form

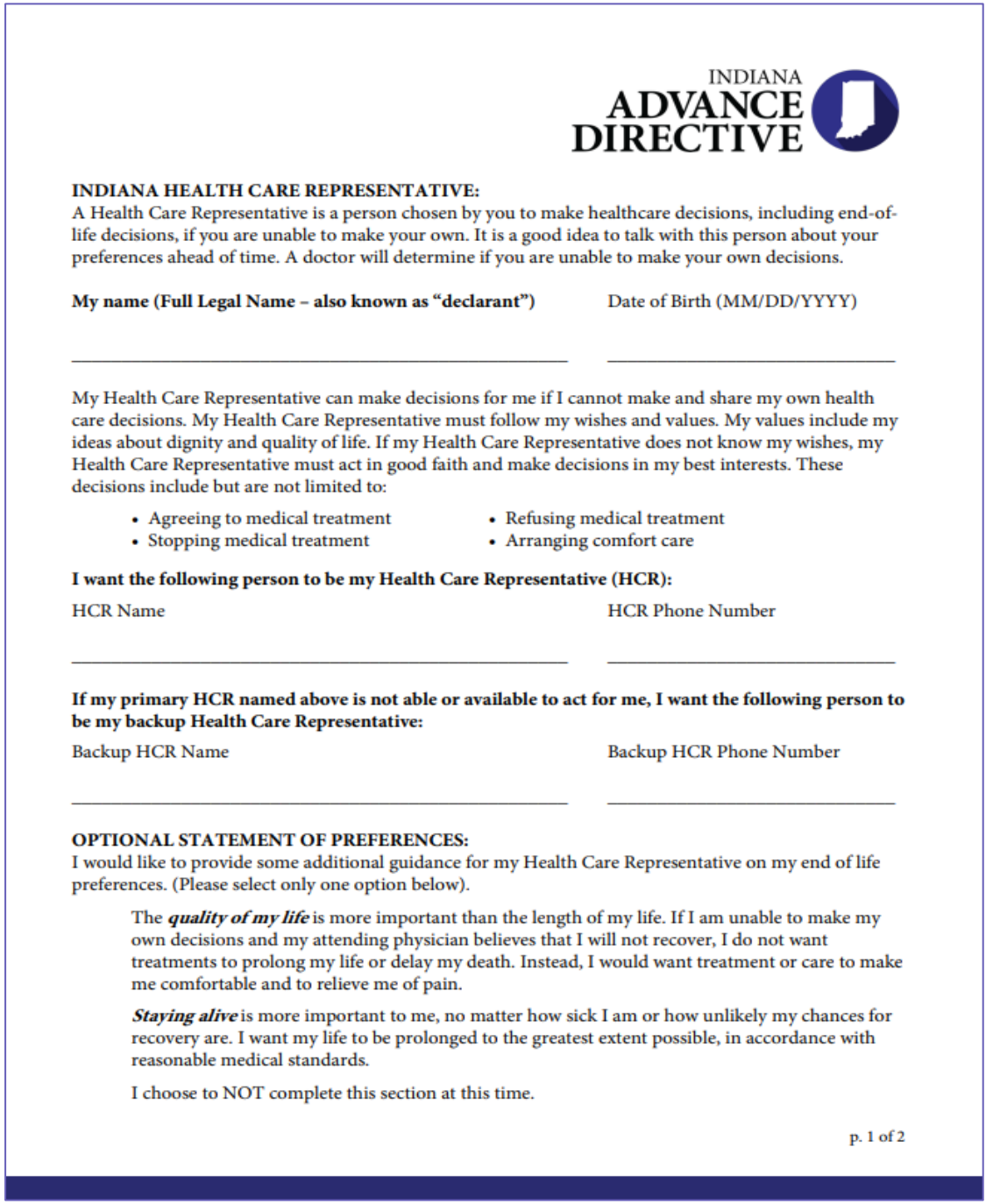
Forms You Could Be Seeing: IPPC Standardized Advance Directive

The Indiana Patient Preferences Coalition: a multi-agency, multi-discipline coalition

- Promoting education, resources, and advocacy in support of high-quality advance care planning that upholds the personal dignity and values of Indiana residents nearing the end of life.
- Collaborated on developing a state form; this form will be available but is not prescriptive nor mandatory.



Forms You Should Start Seeing: IPPC Standardized Advance Directive



INDIANA ADVANCE DIRECTIVE

INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person chosen by you to make healthcare decisions, including end-of-life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (Full Legal Name – also known as "declarant") Date of Birth (MM/DD/YYYY)

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include but are not limited to:

- Agreeing to medical treatment
- Stopping medical treatment
- Refusing medical treatment
- Arranging comfort care

I want the following person to be my Health Care Representative (HCR):

HCR Name HCR Phone Number

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Health Care Representative:

Backup HCR Name Backup HCR Phone Number

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end of life preferences. (Please select only one option below).

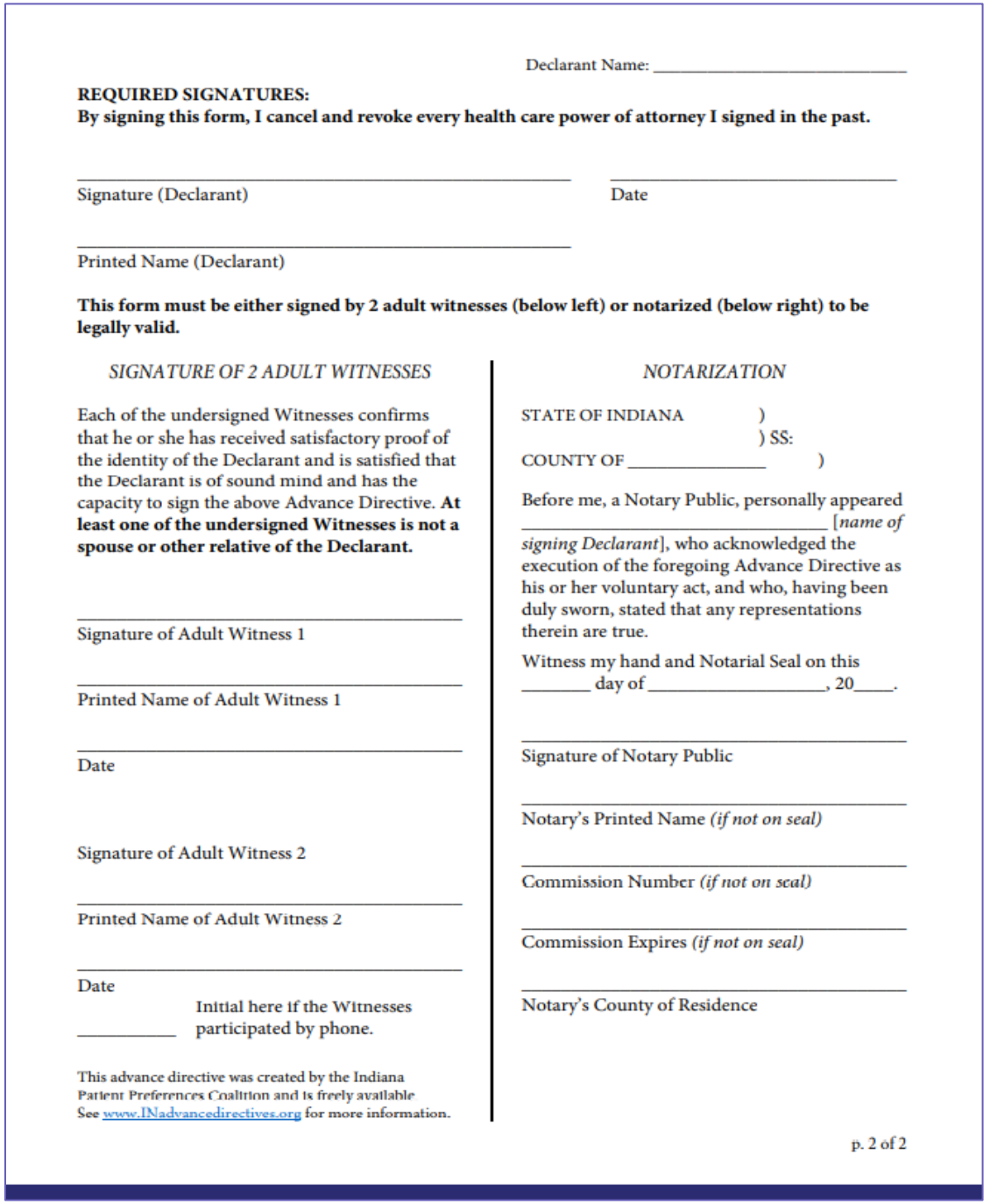
The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

Staying alive is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

I choose to NOT complete this section at this time.

p. 1 of 2

Forms You Should Start Seeing: IPPC Standardized Advance Directive



Declarant Name: _____

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____
Signature (Declarant) Date

_____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Date

Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

This advance directive was created by the Indiana Patient Preferences Coalition and is freely available See www.INadvancedirectives.org for more information.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name *(if not on seal)*

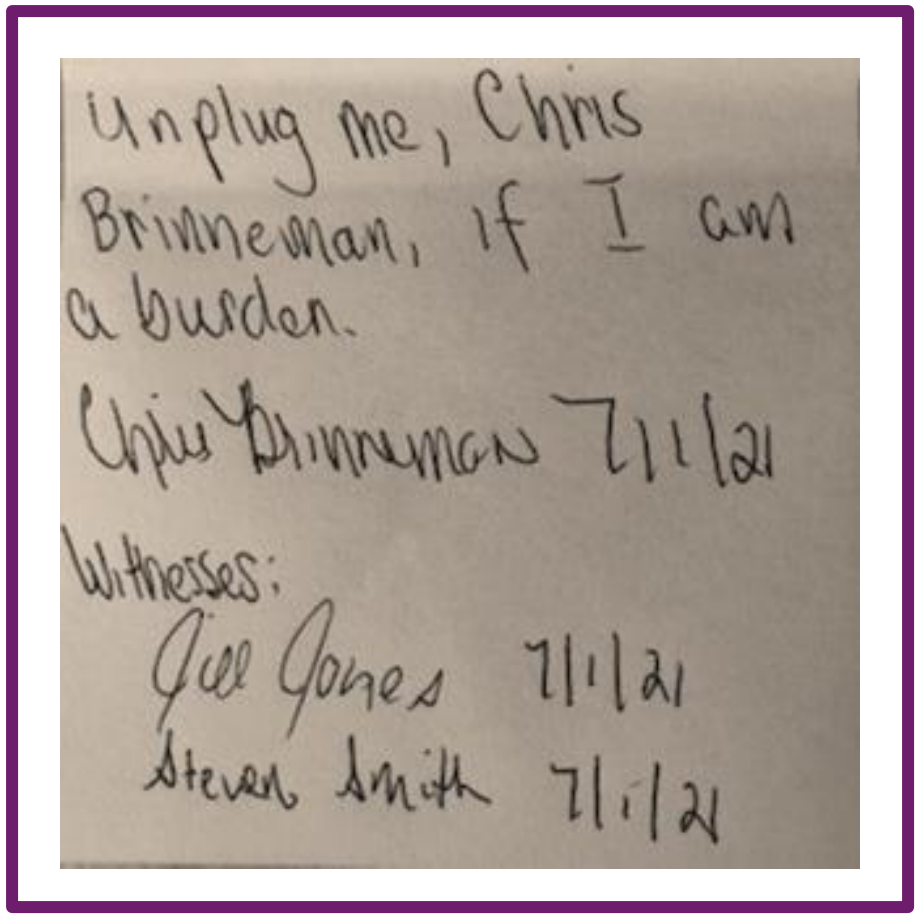
_____
Commission Number *(if not on seal)*

_____
Commission Expires *(if not on seal)*

_____
Notary's County of Residence

p. 2 of 2

Forms You Could Be Seeing: Anything Goes



Healthcare Professionals: Needed Information

Health Care Representative: Only One Role

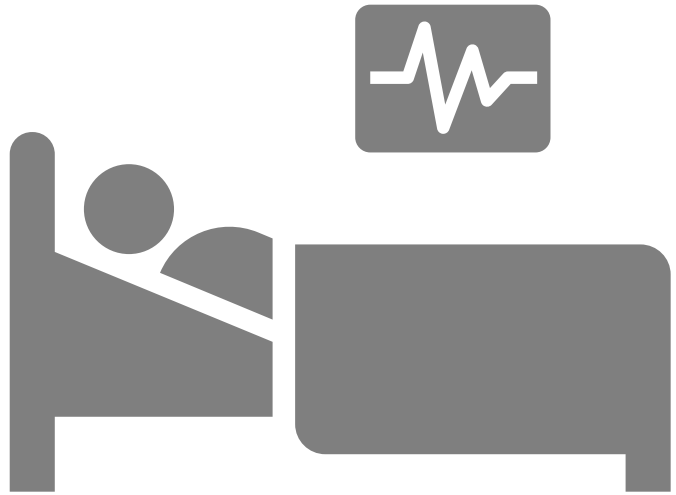
The new Health Care Representative (HCR) combines the roles of the HCR and power of attorney for health care under prior Indiana law.

Health Care Representative: Authority

- The HCR must defer to the patient when the patient has capacity. If the patient loses capacity, the HCR must take the patient's known or implied preferences into account when making decisions and if unknown, the HCR must act in the patient's best interests.
- Best interests means the promotion of the individual's welfare, based on consideration of material factors, including relief of suffering, preservation or restoration of function, and quality of life.

Health Care Representative: Authority (continued)

The HCR can also act on behalf of a patient without capacity including accessing patient medical records, signing POST, applying for public benefits, authorizing an autopsy, and planning for body disposition among other responsibilities.



No Advance Directive?

A proxy is a competent adult who:

- has not been expressly designated in a declaration to make health care decisions for a particular incapacitated individual; and
- is authorized and willing to make health care decisions for the individual who:
  - is not capable of consenting to health care,
  - has not executed an advance directive or who does not have an advance directive currently in effect, and/or
  - has a health care representative designated in the advance directive who is not willing, able, or reasonably available to make health care decisions

Indiana Proxy Decision Making Hierarchy

- Spouse
- Adult Child (or majority if disagree)
- Parent
- Adult sibling (or majority if disagree)
- Grandparent (or majority if disagree)
- Adult Grandchild (or majority if disagree)
- Nearest Other Relative
- Friend

So…

If a person is a decision maker for an individual without capacity, that decision maker must act in the patient's best interests – whether that person is a legally-designated health care representative or a proxy decision maker.

Health Care Provider Acting in Good Faith

A health care provider who acts in good faith reliance on an advance directive or a decision made by a healthcare representative with apparent authority is immune from liability to the patient and to the patient's heirs to the same extent as if the provider had dealt directly with the patient had the patient been competent and not incapacitated.

Where to Get More Info

- The Indiana State Department of Health Advance Directives Resource Center contains links to the Out of Hospital DNR and POST forms.
- Indianapost.org has sample advance directives that can be used in addition to links to national forms that meet state requirements.