Advance Care Planning in Indiana

Susan Hickman, PhD
Indiana University
Regenstrief Institute

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What is Advance Care Planning?

"…a continuum of care planning focused on preparing patients and surrogates for communication and medical decision-making…"

Hickman et al, 2023

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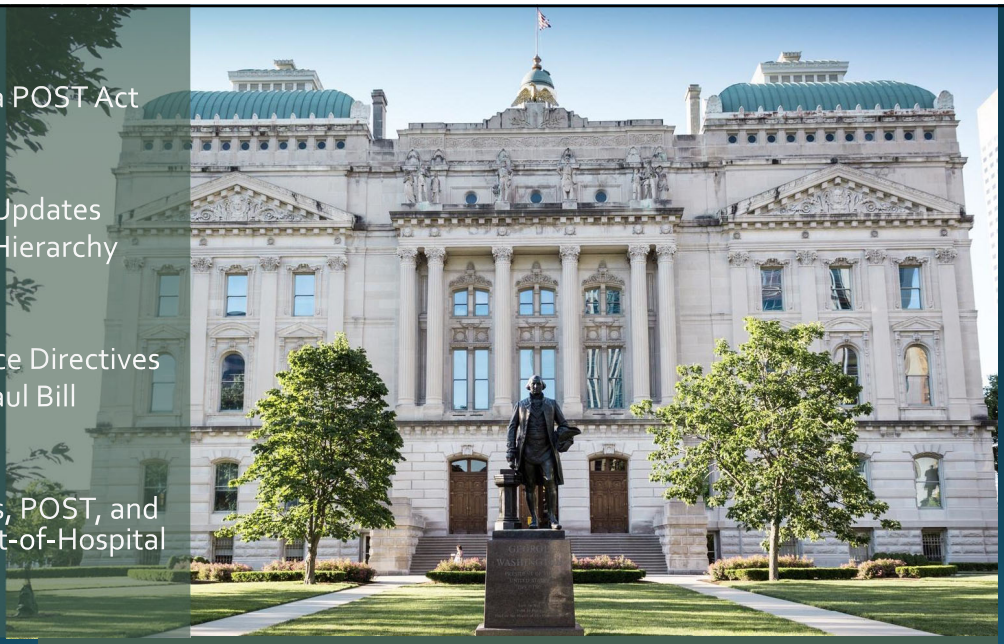
2013
Indiana POST Act

2018
POST Updates
Proxy Hierarchy

2021
Advance Directives
Overhaul Bill

2023
Proxies, POST, and the Out-of-Hospital DNR



A decade of policy work to improve our laws

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Advance Directive

- Advance Directive Components:
  - Name 1 or more health care representatives (HCRs)
  - State specific health care decisions and/or treatment preferences, including preferences for life-prolonging procedures or palliative care
- No official or mandatory form or language for the AD

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Signing a new Advance Directive

- Sign before
  - Notary OR
  - Two witnesses
- One witness can be a spouse or relative

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Indiana Declarations – Mandatory Language

Indiana Living Will

If at any time my [illegible] physician cert[illegible]iting that: (1) I have an incurabl[illegible], or illness; ([illegible]ath will occur within a short t[illegible] of life prolo[illegible]procedures would serve or[illegible]tificia[illegible]n the dyin[illegible]ss, I direct that such proc[illegible]be withh[illegible]hdrawn[illegible]hat I be permitted to d[illegible]ally with o[illegible]for[illegible]r provision of any medical pro[illegible]or medicatio[illegible]ovide me with comfort care or t[illegible]e pain, and, [illegible]icated below, the provision of ar[illegible]plied nut[illegible]ydration.

Indiana Life-Prolonging Proce[illegible]laration

I, _____ h[illegible]eighteen (1[illegible]d and of sound mind, w[illegible]tarily make k[illegible]y desire that if at any t[illegible]ave[illegible]ble injury, d[illegible]or illness determined t[illegible]ermina[illegible]n, I reque[illegible]se of life-prolongin[illegible]dures tha[illegible]tend[illegible]. This includes appro[illegible]utrition and[illegible] administration[illegible]ation, and th[illegible]. of all other medical pro[illegible]ecessary to *life, to provide comfort care,* [illegible]absence of my ability to give directi[illegible]se 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 request medical or surgical treatment and accept the consequences of the request.

I understand the full importance of this declaration.

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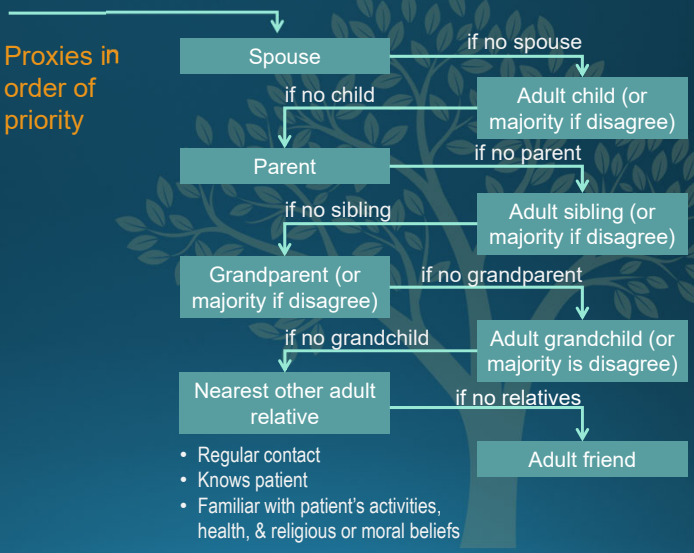
Proxy Decision-Makers

Proxy = person who can consent to health care on behalf of an individual who does NOT have a legally appointed health care representative

Proxies in order of priority



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When the resident is incapcitated or incompetent….

Legally Appointed Health Care Representative

- Consent to health care
- Receive and access patient's medical records
- Authorize an autopsy
- Complete anatomical gifts (i.e. organ donation)
- Authorize burial or cremation after patient's death
- Consent to mental health treatment if patient loses decisional capacity
- Apply for public benefits (e.g., Medicaid/CHOICE); access patient's financial records and assets to prepare applications.

Proxy Decision-Makers

- Consent to health care

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HCR and Pxoxy Responsibilities

- Be "reasonably available"
  - able to be contacted without undue effort; and
  - willing and able to act in a timely manner considering the urgency of that individual's health care needs or health decisions.
- Provides informed consent to healthcare treatment on behalf of the patient if the patient loses decision-making capacity.

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HCR and Proxy Standards of Conduct

- If the patient is unable to independently make healthcare decisions:
  - HCR must always act in good faith
  - Make health care decisions believes the patient would make
  - Decisions must closely align with the patient's express or implied intentions (if known) or in best interest
  - Attempt to comply with with instructions, desires, preferences stated by patient, or POST signed by patient

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Best Interest

- 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.

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Where can we find new AD forms?

- Great question!
  - There is no official form
  - Indiana Department of Health only required to post links to forms that meet state requirements
  - HCR form easily updated, may post
  - Indiana Department of Homeland Security controls OHDNR but it has not been updated
- Indiana Patient Preferences Coalition Model Form Project

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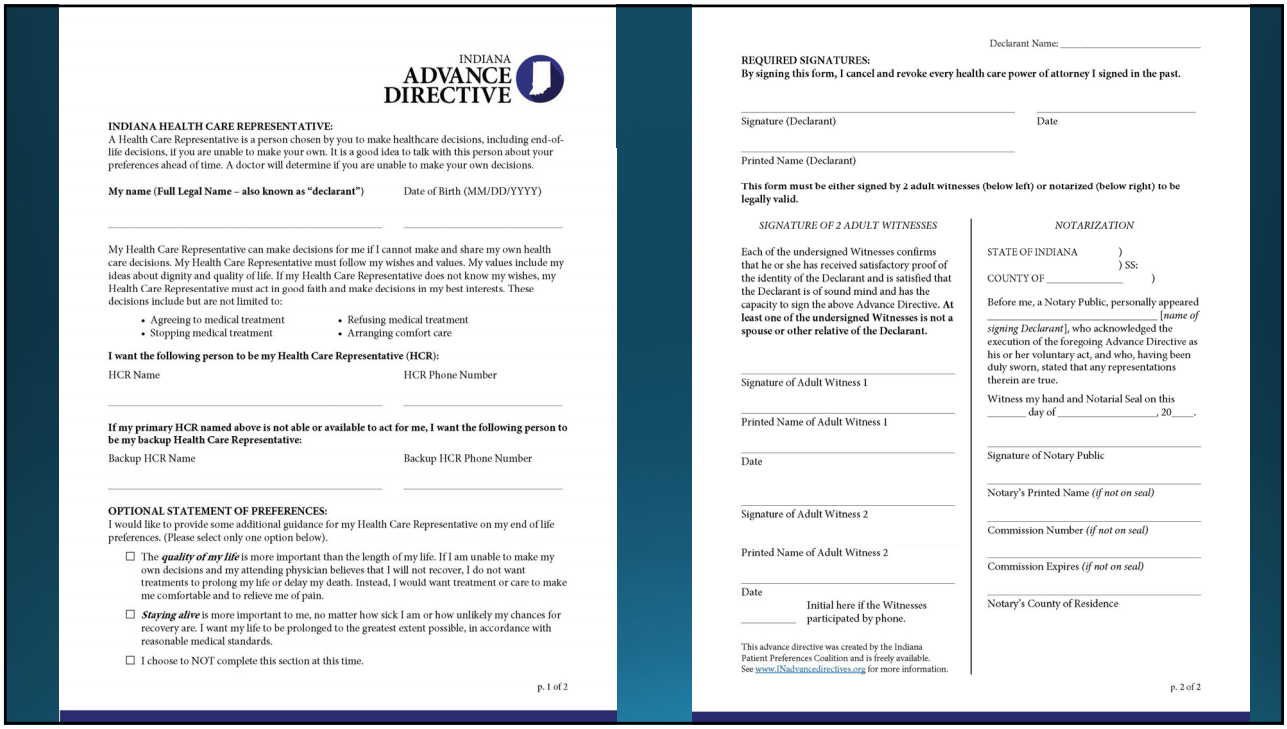

INDIANA ADVANCE DIRECTIVE

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.

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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

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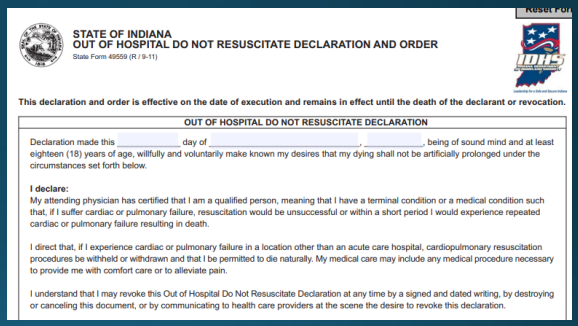
OOHDNR order form

- Advanced practice registered nurses (APRNs) and Physician Assistant's may sign OHDNR
- Remote signing option if unable to physically be in same room
- Proxy may sign if no Legally Appointed Representative (NEW!)



STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER
State Form 49559 (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.

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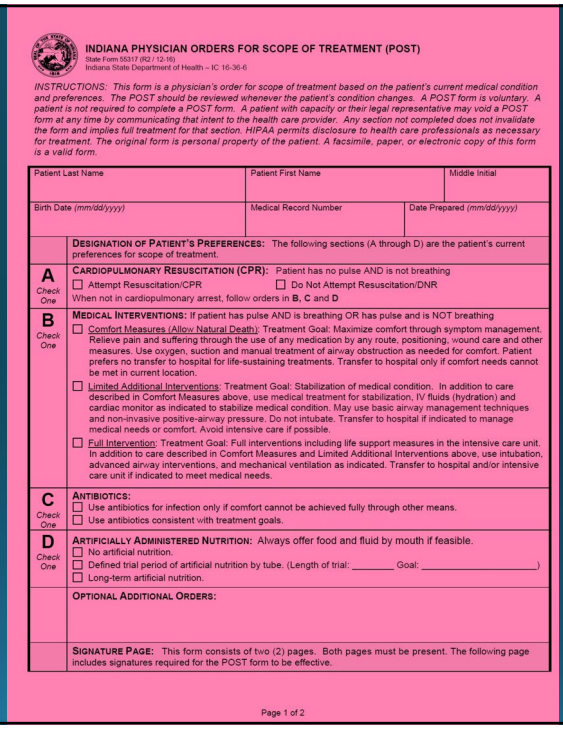
Physician
Orders for
Scope of
Treatment



INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)
State Form 55317 (R2 / 12-18)
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

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Preparing POST

- Form can be prepared by a physician or his/her designee (e.g., nurse, social worker, chaplain)
  - Should not be filled out by attorneys, patients, or family members!
- Requires signature of patient, legal representative, or proxy (NEW!)
- Requires treating physician/APRN/PA signature to execute
  - Responsible for the orders and confirming decisions are reasonable, medically appropriate

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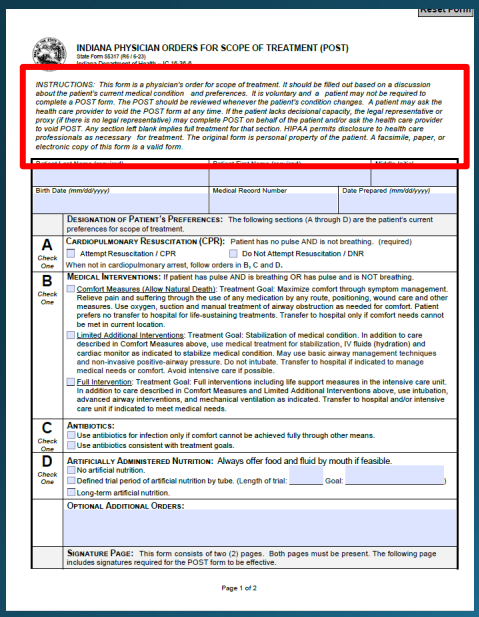


INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R6 / 6-23)

INSTRUCTIONS: This form is a physician's order for scope of treatment. It should be filled out based on a discussion about the patient's current medical condition and preferences. It is voluntary and a patient may not be required to complete a POST form. The POST should be reviewed whenever the patient's condition changes. A patient may ask the health care provider to void the POST form at any time. If the patient lacks decisional capacity, the legal representative or proxy (if there is no legal representative) may complete POST on behalf of the patient and/or ask the health care provider to void POST. Any section left blank 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.

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. (required)
☐ 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.

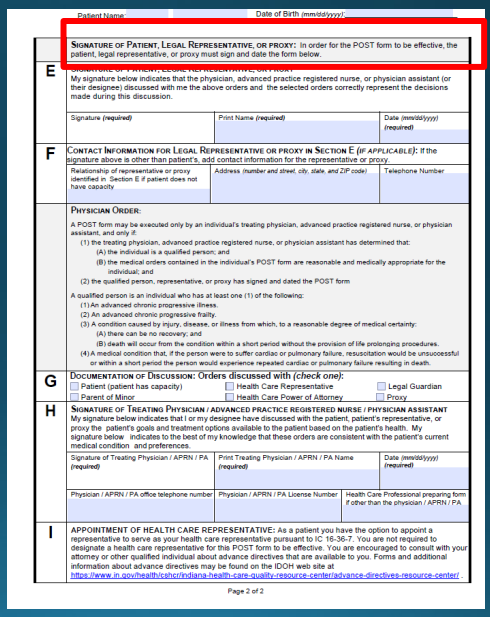
C Check One — **Antibiotics:**
☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.
☐ Use antibiotics consistent with treatment goals.

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



Patient Name | Date of Birth (mm/dd/yyyy)

Signature of Patient, Legal Representative, or Proxy: In order for the POST form to be effective, the patient, legal representative, or proxy must sign and date the form below.

E My signature below indicates that the physician, advanced practice registered nurse, or physician assistant (or their designee) discussed with me the above orders and the selected orders correctly represent the decisions made during this discussion.

Signature (required) | Print Name (required) | Date (mm/dd/yyyy) (required)

F **Contact Information for Legal Representative or Proxy in Section E** (if applicable): If the signature above is other than patient's, add contact information for the representative or proxy.

Relationship of representative or proxy identified in Section E if patient does not have capacity | 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, representative, or proxy 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 procedures.
(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 ☐ Proxy

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, patient's representative, or proxy 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) | Print Treating Physician / APRN / PA Name (required) | Date (mm/dd/yyyy) (required)

Physician / APRN / PA office telephone number | Physician / APRN / PA License Number | Health Care Professional preparing form if other than the physician / APRN / PA

I **Appointment of Health Care Representative:** As a patient you have the option to appoint a representative to serve as your health care representative pursuant to IC 16-36-7. 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 IDOH web site at https://www.in.gov/health/ichcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/.

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Discussion

Thank you!

www.indianapost.org
www.INadvancedirectives.org

Questions? Contact me at
Hickman@iu.edu

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