

Frequently Asked Questions (FAQ): Advance Care Planning and Management of Advance Directives

Updated March 10, 2014

1. Q: Can we alter or adapt the VA Form 10-0137 to include additional questions (<http://www.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf>)?

A: No. VA Form 10-0137 (the VA Advance Directive) is approved by Office of Management and Budget, and therefore the form itself, may not be altered or customized by the facility. The patient completes the form by marking the check boxes and filling in information into the free-text areas and signing it, but the form itself may not be altered or customized. Individual facilities may not alter the form in iMedConsent™ to always display standardized text in the free text areas.

2. Q: Does the VA Advance Directive need to be notarized?

A: The VA Advance Directive is valid in all VA facilities without being notarized. If the patient wants to use the VA Advance Directive in a VA health care setting, this section may be left blank. A VA Advance Directive may, however, require notarization in order to be legally binding outside of the VA health care setting. If a patient wants to use the VA Advance Directive as their advance directive outside of the VA health care setting, he or she would need to determine the VA Advance Directive, is valid in their local community and whether or not a notarization is required. They can do so by talking to their legal advisor or their health care provider. The VA Advance Directive provides space for a Notary's signature and seal if it is required outside of the VA. If the patient chooses to have the document notarized, then the notary can serve as one of the two required witnesses.

3. Q: In terms of notarization of the VA Advance Directive, is it necessary to scan this page along with the previous pages when/if the patient has not completed this page?

A: Yes. The entire VA Advance Directive, even blank pages, should be scanned into the patient's electronic health record.

4. Q: Aren't the terms "Health Care Agent" and "Durable Power of Attorney for Healthcare" synonymous and used interchangeably in legal language? And no matter the term, neither goes into effect until the practitioner has determined that the patient is unable to make medical decisions for him or herself?

A: Durable Power of Attorney for Health Care (DPAHC) is a type of advance directive in which a person designates another person (i.e., a "Health Care Agent") to make health care decisions on the individual's behalf. In other words, a DPAHC is a document; a Health Care Agent is a person. The DPAHC goes into effect as soon as it is executed (signed and witnessed per policy). The Health Care Agent only makes decisions for the patient when the patient has lost decision-making capacity. Decision-making capacity is a clinical determination made by a practitioner that the patient does not have the requisite capacities to make a medical decision.

5. Q: The training mentioned that if a patient has information about alcohol abuse, Human Immunodeficiency Virus (HIV) infection, and/or sickle cell anemia in his or her health record, then the patient should sign a release of information form allowing the surrogate to have access to that information. What if the patient has one of these conditions, does not have decision-making capacity, and has not signed the release of information form and that information is vital for the surrogate to know to make an informed choice, can it still not be released without a signed release of information (<http://vaww.ethics.va.gov/Policy/ADTraining.asp>)?

A: Health information concerning alcohol abuse, Human Immunodeficiency Virus (HIV) infection, and/or sickle cell anemia is governed by special protections under 38 US Code, Section 7332. As part of the advance directive discussion, staff should help patients determine if they need to complete a release of information form (VA Form 10-5345; <http://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf>) to allow VA to share the information in their health record with the patient's surrogate (or others). Unless the patient fills out VA Form 10-5345 specifically authorizing VA to release this information to their surrogate, then only the specific information that the surrogate needs to make an informed health care decision for the patient can be shared with the surrogate.

6. Q: Regarding the priority of surrogates, does a legal or special guardian have priority over the health care agent?

A: No. In VA, the health care agent is higher on the priority of surrogates than the legal or special guardian.

7. Q: The previous version of the VA Advance Directive specified that it would take effect when two or more physicians agreed that the patient met the following conditions – terminally ill or in a permanently unconscious state with no reasonable hope for recovery. The current VA Advance Directive only specifies - "when you can't make healthcare decisions for yourself anymore." Does this mean that if a patient had a stroke or a heart attack and was unable to respond immediately, that they may NOT be treated aggressively?

A: No. In a medical emergency the patient's consent is implied by law. Unless the patient has a Do Not Attempt Resuscitation order (DNAR order) to withhold resuscitation or other orders to withhold life-sustaining treatments, the practitioner may provide necessary medical care in emergency situations without the patient's or surrogate's express consent if immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient, the patient is unable to consent, and the practitioner determines that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient (see VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*). The VA Advance Directive reads, "If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you." This language is referring to circumstances when the patient lacks decision-making capacity. Decision-making capacity is a clinical determination, made by a practitioner, that a patient does not have the requisite capacities to make a medical decision.

8. Q: Will there be a national form for mental health preferences coming in the future or is each station responsible for developing and updating their own mental health preferences form?

A: VA policy does not exceptionalize mental health care by distinguishing mental health advance directives from medical advance directives. Accordingly, a patient's preferences for mental health care may be recorded on the VA Advance Directive form. The VA Advance Directive is a mental health advance directive when it contains mental health preferences in part III b or if additional pages are added to the form.

9. Q: I have had patients make statements on the VA Advance Directive form saying "I want to be on life support for 30 days and then disconnect it." Is this a valid entry for a patient to make?

A: Yes. Patients can use the VA Advance Directive to do all of the following: 1. Name specific people to make health care decisions for them; 2. Describe preferences for how they want to be treated; and 3. Describe preferences for medical care, mental health care, long-term care, or other types of health care. Under the Section C (Additional Preferences) of the Living Will section of the document, patients can write other important preferences for their health care that are not described somewhere else in the document. In the above scenario, the patient can list his/her preference under the "additional preferences" section. For patients who have lost decision-making capacity, the health care preferences they stated in advance will be discussed with their surrogate. Decisions will be made that are consistent with the patient's advance directive to the extent their preferences are permitted by clinical and professional standards, permitted by law, and are agreed to by the surrogate.

10. Q: Who can access iMedConsent™?

A: All staff members who have access to CPRS can access iMedConsent™. The program launches from the CPRS tool drop down menu.

11. Q: How can a patient ensure their same-sex spouse or same-sex partner is their surrogate decision-maker?

A: On June 26, 2013, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. Based on that decision, the Department of Justice will no longer enforce the provisions of U.S. Code, Title 38 whose definition of "spouse" and "surviving spouse" prohibited the Department of Veterans Affairs from providing benefits to same-sex married couples. Based on the decision, VA is now able to treat all married individuals equally as legally recognized spouses, regardless of gender.

With regard to surrogate decision making, VA personnel will accept a same-sex spouse's word that they are the Veteran's spouse, without requiring a marriage license, just as they would for opposite-sex spouses -- unless there is evidence to suggest that the person is not the spouse. For the surrogate priority list, spouses, regardless of gender, are recognized as first in order of priority under legal "next-of kin" (the third tier in the surrogate hierarchy after Health Care Agent and legal guardian or special guardian).

VA is not necessarily able to accord this same legal recognition to unmarried partners. An unmarried partner would fall under the fourth-tier of the priority list – as a "close friend." Patients can ensure that their preferred surrogate is at the top of VA's surrogate priority list by appointing that person as their Health Care Agent in a Durable Power of Attorney for Health Care.

12. Q: If a patient is not legally divorced from an "ex-spouse," is the VA obligated to contact the spouse to inquire about them serving as surrogate decision maker?

A: Yes, unless the patient who lacks decision making capacity has an authorized surrogate who would be higher on the priority list. The authorized surrogate is the person at the highest level of the hierarchy who is willing and able to serve in that role. In VA, the order of surrogate priority is: (1) Health Care Agent; (2) Legal guardian or special guardian; (3) Next-of-kin in the following order of priority: spouse; adult child; parent; sibling; grandparent; and grandchild; and (4) Close friend. In the scenario above, if the patient had not appointed a health care agent in a durable power of attorney for health care and did not have a legal or special guardian appointed by the court, VA would be obligated to contact the spouse to inquire about serving as surrogate decision maker. Patients can make sure their preferred surrogate is at the top of VA's surrogate hierarchy by appointing that person as their health care agent.

13. Q: What is a special guardian?

A: Legal Guardian or Special Guardian is an individual appointed by a court of appropriate jurisdiction to make health care decisions for a person who has been declared legally incompetent.

14. Q: Can a patient appoint more than one health care agent? If so, how is this done?

A: The patient may appoint an "alternate health care agent" under the DPAHC section of the VA Advance Directive. The second person can be appointed to make health care decisions for the patient in the event the first person is not available.

15. Q: Can a patient add a third health care agent in the free text section of the VA Advance Directive?

A: Yes. A patient could appoint a third health care agent, who would be contacted if the second health care agent (the alternate health care agent) was not available. The "additional preferences" section (part II C) of the VA Advance Directive provides space for patients to write other important preferences about their health care that are not described somewhere else in the document.

16. Q: What are the situations where an advance directive would not be honored?

A: For patients who have lost decision-making capacity, the health care preferences they stated in an advance directive need to be honored to the extent permitted by clinical and professional standards, and the law. Preferences listed in an advance directive that are not permitted in VA, such as physician assisted suicide, would not be honored. Additionally, preferences would not be honored in circumstances where the wishes of the patient were unclear or ambiguous or the conditions stated in the living will are not met by current conditions of the patient.

17. Q: If a patient needs to update the contact information in the DPAHC, do they need to complete a new document, or can an addendum be made on the original "Advance Directive" progress note?

A: If a patient wants to update or revise a VA Advance Directive, a new one needs to be created and documented in the electronic health record. The old advance directive must be rescinded.

18. Q: If a patient has a State-authorized Advance Directive and a VA Advance Directive, which one takes precedence?

A: Patients may wish to have a State-authorized Advance Directive instead of, or in addition to, a VA Advance Directive. This is especially appropriate for patients who live in a state where a VA Advance Directive may not be recognized. If a patient completes both types of advance directive, they need to make sure the two documents are consistent with each other. If valid advance directives contain conflicting information, the most recent one (as determined by examination of the date applied by the patient at the time the document was signed) prevails.

19. Q: Why would a patient complete a VA Advance Directive and a State-authorized Advanced Directive?

A: Depending on the state, the VA Advance Directive may not be recognized as a legally binding document in non-VA settings. If the patient lives in a state that does not recognize the VA Advance Directive, the patient should consider completing both a VA Advance Directive and their state's advance directive. Both types of advance directive are legally binding within VA. If the patient completes both types of advance directive, advise the patient to make sure the two documents are consistent with each other.

The VA Advance Directive was drafted with input from the Department of Justice (DOJ). If VA needs to go to court to enforce the terms of a VA Advance Directive, the DOJ determines whether the case will be brought to court. The language in the VA Advance Directive is drafted to try to ensure that DOJ will take the patient's case to court. A State-authorized Advance Directive may not meet the standards held by DOJ in order for VA to be able to have the advance directive enforced by the courts.

20. Q: If a state does not recognize the VA Advanced Directive, does the patient need to complete a State-authorized Advance Directive or can the patient just have the VA Advance Directive notarized?

A: If the patient lives in a state that does not recognize the VA Advance Directive and they want to have a valid advance directive for care outside of the VA, the patient should consider completing both a VA Advance Directive and a State-authorized Advance Directive. Both types of advance directive are legally binding within VA. Completing the State-authorized Advance Directive will ensure there is a valid advance directive if the patient ends up in a hospital outside of the VA system. If the patient completes both types of advance directive, they need to make sure the two documents are consistent with each other.

21. Q: If there is only one witness available to sign the VA Advance Directive, is the document valid?

A: VHA Handbook 1004.02 establishes the requirement that the VA Advance Directive must be signed by the patient in the presence of two witnesses. The witnesses must attest that they have witnessed the signing of the advance directive, that they are not appointed as health care agent in the advance directive, that they are not financially responsible for the care

of the patient making the advance directive, and that to the best of their knowledge, are not named in the patient's will.

22. Q: What documentation is necessary to qualify someone as a close friend?

A: The close friend must present a signed, written statement that will be placed in the patient's electronic health record describing (with specific examples) that person's relationship to, and familiarity with, the patient. Social workers, or other staff, must verify, in a signed and dated progress note, that this requirement has been met.

23. Q: Does the patient also need to sign the "close friend" written statement?

A: No. VHA Handbook 1004.02 does not require the patient to sign the written statement by the close friend.

24. Q: Can a patient have more than one valid advance directive on file?

A: A patient may have more than one valid advance directive. For example, a patient who lives in New York may wish to have a New York state-authorized advance directive in addition to a VA Advance Directive. However, a patient may not have more than one valid VA Advance Directive at the same time.

25. Q: Is there a VA form a patient needs to complete to rescind an advance directive? If not, what is recommended?

A: The patient does not need to complete a specific VA form in order to rescind an advance directive. To ensure that documents in the patient's electronic health record are consistent with their health preferences, whenever a patient revokes an advance directive, the responsible practitioner must do all of the following:

1. Write an addendum to the "*Advance Directive*" progress note associated with the directive that the patient is revoking stating that the directive signed on (indicate the date) was revoked and describe the discussion with the patient that resulted in revocation;
2. Request that the responsible party (typically, the Chief of Health Information Management Service) changes the progress note titled associated with the revoked advance directive to "*Rescinded Advance Directive.*" You and your staff may find it helpful to implement a quality assurance activity at the local level to ensure that revoked advance directives are being appropriately retitled.
3. File a new advance directive, if applicable, with the progress note title "*Advance Directive.*"

26. Q: Can health care providers other than social workers complete the "Advance Directive Discussion" progress note?

A: Yes. VHA Handbook 1004.02 establishes certain requirements for the primary care practitioner or Patient Aligned Care Team (PACT) and the mental health care practitioner or mental health care team related to advance care planning. VHA Handbook 1004.02 also establishes the requirement that the facility Director identify staff responsible for providing patients with information about advance directives and assistance in completing advance directive forms and ensuring their appropriate training. All staff members who conduct advance care planning discussions should use the "Advance Directive Discussion" progress note title to document the discussion; however the content of the note may be different

depending on the responsibility fulfilled by the particular staff member (http://vaww.va.gov/VHAPublications/ViewPublication.asp?pub_ID=2967).

27. Q: Which advance directive progress note titles should be linked to CPRS?

A: The three approved progress note titles used for documenting advance directives and advance care planning discussions (“Advance Directive,” “Advance Directive Discussion,” and “Rescinded Advance Directive”) must be linked to the Crises, Warnings, Allergies and/or Adverse Reactions and Directives (CWAD) postings of the Text Integration Utility (TIU) in Veterans Health Information Systems and Technology Architecture (VistA). VA has developed a national standardized note title, “Advance Directive Notification and Screening” that matches the requirements of Handbook 1004.02 policy. It is recommended that facilities use this note title to document the notification and screening requirements of this Handbook. However use of this note title is not required. The note titles “Advance Directive,” “Advance Directive Discussion,” and “Rescinded Advance Directive” must not be used to document advance directive screening or notification.

28. Q: How do I find out if a state recognizes the VA Advance Directive as a legal document?

A: Questions about the validity of advance directives should be referred to the Regional Counsel staff assigned to your facility.

29. Q: What is the difference between a State-authorized Advance Directive and State-authorized Portable Orders?

A: A state-authorized advance directive is a non-VA durable power of attorney for health care, living will, mental health directive, or other advance directive document that is legally recognized by a particular State. An advance directive is a statement of the patient’s preferences about future health care decisions. State-authorized portable orders (SAPO’s) are specialized forms or identifiers (e.g., DNAR bracelets or necklaces) authorized by state law, that translate a patient’s preferences with regard to specific life-sustaining treatment decisions into portable medical orders. An advance directive is not an order.

30. Q: Who should I contact if I have a question about Handbook 1004.02 or a question about an active patient case related to advance care planning or a patient’s advance directive?

A: For policy clarification or questions related to an active patient case, please contact your local IntegratedEthics (IE) program officer or your local Ethics Consultation Service. A list of key IE personnel by facility and VISN is available under the “Important IE Program Links” heading at: <http://vaww.ethics.va.gov/integratedethics/index.asp>.