

## ADVANCE CARE PLANNING AND MANAGEMENT OF ADVANCE DIRECTIVES

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook defines procedures for enabling health care staff to fulfill their obligation to support advance care planning for Veterans.

**2. SUMMARY OF CHANGES:** The major changes in this Handbook:

a. Brings this Handbook into alignment with Public Law 111-163, Section 504. Section 504 allows practitioners to disclose, without the patient's authorization, information from the patient's record relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia to the patient's surrogate if the patient lacks decision-making capacity and the practitioner deems the information necessary for the surrogate to give informed consent on behalf of a patient.

b. Remove outdated references and inactive hyperlinks.

c. Include language to make this Handbook consistent with The Joint Commission standard for mental health advance directives (CTS.01.04.01, 2011). This new standard requires organizations that serve adults with serious mental illness to document whether the adult has a mental health advance directive.

d. Eliminates the requirement that all advance directives and related discussions with patients be linked specifically to the "D" in the Crisis, Warnings, Allergies and/or Adverse Reactions and Directives (CWAD) postings of the electronic medical record. To make the Handbook consistent with the documentation requirements required by VHA Health Information Management, the associated note titles must still be linked to the CWAD postings, but no specific letter is required.

e. Update language to permit Patient-Aligned Care Teams to deliver services that meet the requirements of this Handbook.

f. Include language to make this Handbook consistent with the meaningful use certification criteria for advance directive screening.

**3. RELATED ISSUES:** None.

**4. RESPONSIBLE OFFICE:** The National Center for Ethics in Health Care (10P6) is responsible for the contents of this Handbook. Questions are to be addressed to the Ethics Center at 202-632-8457.

**5. RESCISSION:** VHA Handbook 1004.02, dated July 2, 2009 is rescinded.

**6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before, December 31, 2018.

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**DISTRIBUTION:** E-mailed to the VHA Publications Distribution List 1/24/2013

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## ADVANCE CARE PLANNING AND MANAGEMENT OF ADVANCE DIRECTIVES

**1. PURPOSE:** This Veterans Health Administration (VHA) Handbook establishes procedures for enabling health care staff to fulfill their obligation to support advance care planning for Veterans. **AUTHORITY:** 38 U.S.C. § 7301(b); 38 CFR § 17.32.

### 2. BACKGROUND:

a. Department of Veterans Affairs (VA) policy on advance care planning is based on ethical and legal standards regarding the rights of all patients. These standards reflect a broad public consensus that:

(1) All adult patients who have decision-making capacity have the right to accept or refuse proposed medical or mental health treatments or procedures, regardless of the expected consequences; and

(2) For patients who have lost decision-making capacity, the health care preferences they stated in advance need to be honored to the extent permitted by clinical and professional standards, and the law.

b. Passage of the Patient Self-Determination Act (PSDA) in 1990, codified into Federal law at 42 U.S.C. § 1395cc(f), established the right of all patients with decision-making capacity to state their treatment preferences in advance, and the related responsibilities of health care organizations.

(1) The PSDA applies only to those health care organizations that participate in Medicare and Medicaid, but it provides the model and context for VHA policy on advance care planning. Specifically, the PSDA requires:

(a) Health maintenance organizations, hospitals, home care agencies, and nursing homes to ensure that each patient receives, upon admission or enrollment:

1. Written information regarding their right to accept or refuse medical treatment; and

2. An opportunity to express, in an advance directive, their preferences concerning future medical care.

(b) Health care providers to ask each patient if they have an existing advance directive and, if not, to offer assistance in completing one.

(2) PSDA concepts, which were incorporated into policy in 1991, are carried forward and elaborated in this Handbook and in 38 CFR § 17.32.

c. VA policy regarding advance care planning is consistent with VA's commitment to ensure that patients' values, goals, and treatment preferences are respected and reflected in the care they

receive. VA is committed to creating a health care environment that promotes patient-centered care and shared decision making; an ongoing collaborative process between practitioners and patients or their surrogates, to which the practitioner contributes knowledge of medicine and the patient contributes values, preferences, and health care goals. Practitioners who speak with their patients about their preferences are better equipped to faithfully interpret those preferences if, or when, the patient loses decision-making capacity.

d. Patients and health care providers need encouragement, assistance, and resources for thinking and talking about patients' preferences regarding future health care choices. Patients need information and guidance to understand the implications of their preferences and to express them unambiguously. For those who wish to complete an advance directive and for those who have already done so, policies and mechanisms are needed to ensure appropriate identification, documentation, and handling. Thus, VHA staff has an important role in advance care planning.

e. At the same time, staff needs to recognize that advance care planning may occur without any action on their part, outside of health care settings. Numerous educational materials, forms, and registry services are widely available in print and online to assist Veterans in their private deliberations, or in conversations with trusted advisers or loved ones.

### 3. DEFINITIONS:

a. **Advance Care Planning.** Advance care planning is a process for identifying and communicating an individual's values and preferences regarding future health care for use at a time when that person is no longer capable of making health care decisions. It may occur in or outside of health care settings, can be done by anyone with decision-making capacity, and may or may not involve health care professionals directly. Advance care planning may, but does not necessarily, result in a written advance directive document. *NOTE: The process of eliciting, documenting, and respecting patients' preferences regarding their current care, such as preferences to receive or forgo cardiac pulmonary resuscitation (CPR) or other life-sustaining treatments, is distinct from advance care planning.*

b. **Advance Directive.** An advance directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions. Although verbal statements may also be extremely useful in determining the prior preferences of a patient who subsequently loses decision-making capacity, statements that have been committed to writing in a formal advance directive document are accorded special authority, as described in this Handbook. Do Not Attempt Resuscitation Order (DNAR/DNR) orders, State-authorized portable orders, or other life-sustaining treatment orders are not considered advance directives. *NOTE: An advance directive is not to be used as the basis for decision making while the patient has decision-making capacity. The existence of an advance directive never precludes the requirement to discuss treatment options with a patient who has decision-making capacity.*

c. **Types of Advance Directives.** The various types of advance directives are:

(1) **Durable Power of Attorney for Health Care.** A Durable Power of Attorney for Health Care (DPAHC) is a type of advance directive in which an individual designates another person (i.e., a “Health Care Agent”) to make health care decisions on the individual’s behalf. *NOTE: In some states, a DPAHC is called a Health Care Proxy.*

(2) **Living Will.** A living will is a type of advance directive in which an individual indicates personal preferences regarding future treatment options. A living will typically includes preferences about life-sustaining treatment, but it may also include preferences about other types of health care (e.g., mental health treatment, blood transfusions, pain management). *NOTE: Living wills must not be confused with care plans (e.g., palliative care plans, life-sustaining treatment plans) or orders (e.g., DNAR/DNR orders, state-authorized orders for life-sustaining treatment), which are written by health care professionals.*

(3) **Mental Health (or Psychiatric) Advance Directive.** A mental health or psychiatric advance directive is for patients whose future decision-making capacity is at risk due to mental illness. In this type of directive, the individual indicates preferences about future mental health care (e.g., hospitalization, medications, restraints, and/or electroconvulsive therapy). *NOTE: VA encourages patients to record their preferences regarding mental health care on VA Form 10-0137, VA Advance Directive: Living Will and Durable Power of Attorney for Health Care. When mental health preferences are recorded on VA Form 10-0137, the advance directive is considered a mental health advance directive. VA also recognizes State-authorized mental health advance directives (see paragraph 3c(4)).*

(4) **State Authorized Advance Directive.** A state-authorized advance directive is a non-VA DPAHC, living will, mental health directive, or other advance directive document that is legally recognized by a particular State. The validity of State-authorized advance directives is determined pursuant to applicable State law. For the purposes of this definition, “applicable State law” can mean the law of the State where the advance directive was signed, the State where the patient resided when the advance directive was signed, the State where the patient now resides, or the State where the patient is receiving treatment. VA works to resolve any conflict between those State laws regarding the validity of the advance directive by following the law of the State that gives effect to the wishes expressed by the patient in the advance directive. Although some States place restrictions on the content or applicability of advance directives, such restrictions do not apply in VA. *NOTE: Questions about the validity of a State-authorized advance directives in VA should be referred to VA Regional Counsel or to the Office of General Counsel (OGC).*

(5) **Department of Defense Advance Medical Directive.** A Durable Power of Attorney for Health Care (DOD)-authorized advance directive is drafted for members of the armed services or military dependents by a military attorney. This may include a DPAHC or a living will. Federal law exempts such advance directives from any requirement of form, substance, formality, or recording that is provided for under the laws of an individual State. Federal law requires that this type of advance directive be given the same legal effect as an advance directive prepared and executed in accordance with the laws of the State concerned (see Title 10 United States Code (U.S.C.) § 1044c, and DOD Directive 1350.4).

(6) **VA Advance Directive.** A VA advance directive is a completed VA Form 10-0137. In VA, this form is used by patients to document treatment preferences for both medical and mental health care. *NOTE: VA Form 10-0137 may, or may not, be recognized by non-Federal health care facilities.*

d. **Decision-Making Capacity.** Decision-making capacity is a clinical judgment about a patient's ability to make a particular type of health care decision at a particular time. In clinical practice (and law), a patient's decision-making capacity is generally presumed; however, when the patient's medical condition or observed behavior raises questions about the patient's decision-making capacity, the responsible practitioner must make an explicit determination based on assessment of the patient's ability to do all of the following:

- (1) Understand the relevant information;
- (2) Appreciate the situation and its consequences;
- (3) Reason about the options; and
- (4) Communicate a choice.

*NOTE: In contrast, "competence" is a legal determination made by a court of law. See VHA Handbook 1004.01 for information related to determination of decision-making capacity.*

e. **iMedConsent™.** iMedConsent™ is a commercial software product that facilitates proper completion and documentation of the informed consent process for treatments and procedures that require signature consent. The program also facilitates electronic completion of VA Form 10-0137 (see VHA Handbook 1004.06).

f. **Surrogate Decision Maker.** The surrogate decision maker (surrogate) refers to an individual or decision-making process authorized under VHA policy for making decisions on behalf of a patient who lacks decision-making capacity (see VHA Handbook 1004.01 for information about surrogate selection, hierarchy, and the surrogate's role in health care decision making). *NOTE: Outside VHA, the surrogate decision maker is sometimes referred to as the proxy decision maker.*

(1) **Health Care Agent.** A health care agent (HCA) is a person selected by the patient and named in a DPAHC to make health care decisions on the patient's behalf if, or when, that individual can no longer do so. In VHA, a HCA is first in the hierarchy of surrogate decision makers and is authorized to make decisions about all types of health care on the patient's behalf.

(2) **Legal Guardian or Special Guardian.** A legal guardian or a special guardian (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. The terms "guardian" and "conservator" are used synonymously. *NOTE: Some State laws may limit the authority of a guardian to specific types of health care decisions. While State-imposed limitations do not apply in VA, specific court-imposed limitations to the authority of a guardian do apply in VA.*



(3) **Close Friend.** A close friend is any person 18 years or older who has shown care and concern for the patient's welfare and is familiar with the patient's activities, health, religious beliefs, and values (see paragraph 14a(5) for documentation requirements of a close friend as a surrogate).

**4. SCOPE:** This Handbook provides procedures for protecting the right of all VHA patients to express, in advance, their health care preferences in case they lose decision-making capacity. It defines the obligations of health care staff to help Veterans consider the types of health care decisions that might need to be made in the future, and presents VHA's requirements for the management of advance directives. It encompasses advance care planning for the full-range of health care decisions that may be relevant for patients who have lost decision-making capacity. *NOTE: Related issues such as the assessment of decision-making capacity, surrogate decision making, and informed consent are covered in VHA Handbook 1004.01.*

#### **5. PROGRESS NOTE TITLES:**

a. To ensure that advance directives and related discussions with patients can be easily identified in the health record, three distinct progress note titles have been established. The note titles 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), and must be used as follows:

(1) **“Advance Directive.”** The “Advance Directive” note title is used to document the entry of an advance directive document into the patient's record (either scanned or completed electronically). This title must be used only to document the filing of an advance directive.

(2) **“Rescinded Advance Directive.”** The “Rescinded Advance Directive” note title is used to document the patient's revocation of an advance directive and the invalidity of the associated directive. (See paragraph 13 for information about managing the rescission process and appropriate documentation).

(3) **“Advance Directive Discussion.”** The “Advance Directive Discussion” note title is used to document an advance care planning discussion between the practitioner and patient. Discussion about an advance directive that is already in the health record may be documented either with a note titled “Advance Directive Discussion,” or in an addendum to the “Advance Directive” note associated with the subject directive.

b. To support the national roll-up of data about Advance Directives, only these three note titles are approved for local use in the Computerized Patient Record System (CPRS) to document Advance Directives and advance care planning discussions between the practitioner and patient. Any other locally developed note titles used for documenting Advance Directives or advance care planning discussions between the practitioner and patient must be discontinued, and past encounters using those note titles must be appropriately renamed to one of the three note titles listed in paragraph 5a.

c. The note titles “Advance Directive,” “Rescinded Advance Directive,” and “Advance Directive Discussion” must not be used to document DNAR/DNR discussions. The facility CPRS progress note title for documenting DNAR/DNR discussions and orders must not use the terminology “Advance Directive.”

d. The note titles “Advance Directive,” “Rescinded Advance Directive,” and “Advance Directive Discussion” must not be used to document state-authorized portable orders (SAPO) discussions (see VHA Handbook 1004.04).

e. For facilities that are still using locally developed note titles that are different note titles from those specified in preceding paragraph 5a, and for facilities that are using “Advance Directive” note titles for purposes other than those described in this Handbook, see paragraph 8a.

## 6. ADVANCE DIRECTIVE NOTIFICATION AND SCREENING:

a. Consistent with the PSDA, VA requires notification and screening regarding advance directives. *NOTE: There may be circumstances when it is not possible to perform advance directive notification and screening, such as the patient is not conscious and no surrogate is available.* Notification and screening, which may be performed by the admitting clerk or other designated staff, must include:

(1) **Notification.** All patients must be given written notification stating their right to accept or decline medical treatment, to designate an HCA, and to document their treatment preferences in an advance directive. Patients must be informed that VA does not discriminate against patients based on whether or not they have an advance directive. *NOTE: VA Form 10-0137A (Your Rights Regarding Advance Directives) satisfies these notification requirements (see Appendix B).*

(2) **Screening.**

(a) All Patients and Community Living Center (CLC) residents must be asked whether they have an advance directive or a mental health advance directive. *NOTE: As noted in paragraph 4, advance directives are sometimes known by other names such as Living Will, DPAHC, or Psychiatric Advance Directive. Screeners can use all of these terms to inquire whether a Veteran has an advance directive.*

(b) If patients and CLC residents indicate they have an advance directive, the screener must ask for a copy of these documents for filing in the patient’s health record (see paragraph 12a).

(c) All patients and CLC residents must be asked whether they want more information about advance directives and whether they want assistance in completing the advance directive forms. If so, the screener must direct the patient to the requested assistance (see paragraph 11).

b. Advance directive notification and screening is required at:

(1) Check-in for a patient’s first primary care appointment, unless there is documentation of advance directive notification and screening within the last year;

(2) Check-in for a patient's first mental health care appointment, unless there is documentation of advance directive notification and screening within the last year; and

(3) Check-in at a VHA Ambulatory Surgery Center for a patient procedure, unless there is documentation of advance directive notification and screening within the last year.

(4) Each admission to a VHA inpatient facility (including hospital, mental health care facility, CLC, nursing home, or domiciliary facility);

(5) Each admission to VA home care or hospice care; and

(6) As part of hospital discharge planning when the patient is discharged to a long-term care or rehabilitation facility in the community.

c. **Documentation.**

(1) For all patients in all settings, compliance with the requirements for advance directive notification and screening must be documented in the patient's health record.

(2) The documentation process must use the approved health factors "Advance Directive Yes" and "Advance Directive No." These health factors are structured data elements that document the response to the question of whether or not the patient has an advance directive.

(3) VA has developed a national standardized note title, "Advance Directive Notification and Screening" that matches the requirements of this 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.

(4) The note titles "Advance Directive," "Advance Directive Discussion," and "Rescinded Advance Directive" must not be used to document advance directive screening or notification.

(5) The documentation process can be accomplished through the use of the national note title "Advance Directive Notification and Screening" tied to a reminder dialog template or clinical reminder to populate the "Advance Directive Yes" and "Advance Directive No" health factors. A template that supports this requirement is available at: <http://vaww.ethics.va.gov/activities/policy.asp>. **NOTE:** *This is an internal Web site and is not available to the public. Use of this template is recommended but not required.*

**7. RESPONSIBILITIES OF THE NATIONAL CENTER FOR ETHICS IN HEALTH CARE:** The National Center for Ethics in Health Care is responsible for:

a. Providing ethics consultation services to the field for conflict resolution regarding interpretation and implementation of a patient's advance directive.

- b. Referring unresolved conflicts to Regional Counsel or General Counsel, when appropriate.
- c. Collaborating with VHA Program Offices to develop appropriate monitoring for implementation of advance care planning procedures as delineated in this Handbook.
- d. Providing field support for advance care planning to include: educational materials (available at: <http://vaww.ethics.va.gov/>), policy interpretation and clarification, dissemination of best practices, and support for local IntegratedEthics<sup>®</sup> (IE) Programs. *NOTE: This is an internal Web site and is not available to the public.*

**8. RESPONSIBILITIES OF THE MEDICAL FACILITY DIRECTOR:** The medical facility Director or designee is responsible for:

- a. Ensuring that local policy and procedures, consistent with this Handbook, are developed, published, and implemented, no later than 6 months after the publication of this Handbook. These procedures must ensure that note titles and health factors are being appropriately deployed at the facility. The requirement to use standardized note titles has been in place since 2009. If the facility is still not using these procedures then an explicit transition should be planned. The transition should include: input from clinical experts; input from IE staff; identification of all note titles currently in use that document advance directives, advance care planning discussions, and related activities such as DNR orders and out of hospital orders for life-sustaining treatment; review of clinical processes associated with the use of these note titles; a plan for renaming Advance Directive note titles to correspond to the three specific titles listed in subparagraph 5a of this policy; a plan for establishment of new note titles to document DNR discussions and out-of-hospital orders, if necessary; plan to correct the mapping of note titles to CWAD postings, if necessary; and plan for advance notification and education for clinicians prior to any note title changes.
- b. Identifying those VHA staff responsible for conducting notification and screening regarding advance directives, and for ensuring their appropriate training.
- c. Ensuring that the approved health factors (e.g., Advance Directive Yes, Advance Directive No) are used in the documentation process for advance directive screening.
- d. Identifying those VHA staff responsible for providing patients with information regarding advance directives and providing assistance in completing advance directive forms, if needed, and for ensuring VHA staff complete their appropriate training (see paragraph 11a).
- e. Establishing and promoting clear, efficient channels of communication to facilitate the re-titling of revoked advance directive documents (see VHA Handbook 1907.01 for re-titling procedures and guidance) (see paragraph 13d).
- f. Supporting Information Technology (IT) systems that enable the requirements of this Handbook.

g. Ensuring that requirements for note title naming and usage established in paragraph 5 have been implemented and that these nationally-established note titles are the only local note titles used for CPRS documentation of Advance Directives and advance care planning discussions. **NOTE:** *Advance Directive note titles are not to be used for CPRS documentation of DNR discussions or SAPO discussions.*

h. Ensuring that the mandated procedures for health record review committee oversight regarding compliance with nationally-standardized note titles are followed (see VHA Handbook 1907.01).

i. Establishing a patient scheduling and referral system that leads to efficient coordination of the requirements of this Handbook.

j. Ensuring that the facility has a systematic process to ensure that Patient-Aligned Care Teams (PACT) or primary care providers are accountable for meeting the requirements of paragraph 9.

k. Ensuring that clinical staff know and follow the content of this Handbook.

#### **9. RESPONSIBILITIES OF THE PRIMARY CARE PROVIDER OR THE PATIENT ALIGNED CARE TEAM:**

a. The primary care provider is responsible for reviewing an advance directive with the patient at the next clinic appointment or as soon as reasonably possible after a new or revised advance directive is entered into the patient's record. The primary care provider may delegate this responsibility to a member of the Patient Aligned Care Team (PACT). Responsibilities may only be delegated to those staff who have been identified as responsible for providing patients with information regarding advance directives and assistance in completing advance directive forms (see subparagraph 8d). If delegated, the PACT member must discuss their review with the primary care provider, and other PACT members, as appropriate. **NOTE:** *Review of a new or revised advance directive with the patient by the primary care provider is strongly encouraged.*

b. The primary care provider or PACT is responsible for:

(1) Initiating conversations about advance care planning periodically (at intervals no longer than 3 years) and whenever the primary care practitioner or PACT observes a significant change in the patient's health status (e.g., a diagnosis or change in the patient's condition that affects their life expectancy). In addition, primary care providers or PACT must initiate these conversations more frequently with patients who are at high risk of losing decision-making capacity (e.g., patients with cerebrovascular disease, early dementia, or serious mental or life-limiting illnesses).

(2) Raising the issue of advance care planning with all patients who have decision-making capacity, explaining that they do this with all their patients. These conversations may be brief, or more extensive, depending on the patient's circumstances

. For patients who request more information or assistance completing advance directive forms, the primary care provider, or PACT may provide the information or assistance, or make a referral to another qualified individual (see paragraph 11).

(3) Giving patients pertinent educational materials (e.g., provide written material such as those listed in Appendix C).

(4) Encouraging patients to discuss their preferences for future health care with their loved ones.

(5) Explaining the potential benefits of advance care planning in general, and of advance directives in particular, especially for patients who are at high risk of losing decision-making capacity (e.g., patients with cerebrovascular disease, early dementia, or other serious mental or life-limiting illnesses).

(6) Highlighting the particular benefits of appointing a HCA, especially if a problem related to surrogacy is anticipated (e.g., patients who have no family, patients who would want a surrogate other than the person authorized in VHA Handbook 1004.01, patients with multiple surrogates at the same priority level who may disagree with each other).

(7) Describing the limitations of advance directives. *NOTE: Pertinent information is contained in the references cited in Appendix C.*

(8) For patients who already have an advance directive in the health record, reviewing the advance directive with the patient to help ensure it is up to date, and that it states the patient's intentions clearly (see paragraph 14a(3)).

(9) If the patient has more than one advance directive in the record, asking the patient to indicate which one(s) remains active and which, if any, needs to be rescinded because of changes in the patient's preferences (see paragraph 13).

(10) Documenting that the required advance care planning discussion occurred and summarizing the significant content.

(a) When the discussion results in the patient completing an advance directive, the advance directive must be filed with a progress note titled "Advance Directive" (see paragraph 12a for an explanation of "filed").

(b) Documentation of the discussion that led to the filing of an advance directive can be in the form of an addendum to the "Advance Directive" note associated with that advance directive or in a separate note titled "Advance Directive Discussion."

(c) When there is discussion, but no advance directive, the note needs to have the title "Advance Directive Discussion."

(d) When the discussion concerns an existing advance directive, documentation can be in the form of an addendum to the “Advance Directive” note associated with that directive or may be made in a separate note titled “Advance Directive Discussion” (see paragraph 5).

**10. RESPONSIBILITIES OF THE MENTAL HEALTH CARE PRACTITIONER OR THE MENTAL HEALTH CARE TEAM:** For patients who are receiving mental health treatment, the mental health care practitioner or mental health care team is responsible for:

a. All of the items in paragraph 9 if the patient does not have a primary care provider or PACT.

b. Providing or referring patients for assistance in advance care planning or completion of mental health advance directive forms, upon request (see paragraph 11).

c. When treating a patient who has lost decision-making capacity, determining if the patient has an advance directive by looking in the CWAD postings, checking the advance directive for any mental health preferences, and following all procedures outlined in paragraph 14 for the implementation of an advance directive, as appropriate.

**11. PATIENT-REQUESTED ADDITIONAL INFORMATION ABOUT ADVANCE DIRECTIVES OR ASSISTANCE IN COMPLETING ADVANCE DIRECTIVE FORMS:**

VA must provide additional information about advance directives and assistance in completing forms for all patients who request this service. This includes information and assistance with mental health advance directives. This assistance may be provided by social workers or others who are appropriately trained, and must be available to patients in all clinical settings.

a. Designated practitioners need to ensure that the patient understands the meaning of advance care planning and advance directives, including the information listed in paragraph 9b(3) to 9b(9). For patients who already have an advance directive, practitioners also need to cover points in paragraph 9b(10). Possible clinical scenarios and treatment options need to be discussed with attention and sensitivity to the patient’s individual circumstances, needs, and culture.

b. **Forms.** If requested, appropriately trained staff must assist the patient in completing:

(1) **VA Form 10-0137, VA Advance Directive: Living Will & Durable Power of Attorney for Health Care.** VA Form 10-0137 is a combined DPAHC (Part II) and living will (Part III). A Veteran who does not want to specify treatment preferences may still designate an HCA to make treatment decisions on their behalf. Additionally, a Veteran may specify treatment preferences without designating an HCA. **NOTE:** VA Form 10-0137 is available electronically on the VA internet Forms website at <http://www.va.gov/vaforms>, the VA intranet Forms website at <http://vaww.va.gov/vaforms> (This is an internal web site not available to the public), in iMedConsent™ (“Shared” category), and with a link on the National Center for Ethics in Health Care web site at <http://vaww.ethics.va.gov>, (This is an internal web site not available to the public.) and My HealthVet at <http://www.myhealth.va.gov>. VA recognizes State-authorized and DOD advance directives to the extent they are consistent with VA policy.

(a) To provide further information about their treatment goals, specific treatment preferences, etc., patients may choose to attach one or more additional page(s) to VA Form 10-0137. Attached pages must be initialed and dated. To ensure that the patient's record is complete, VA Form 10-0137 and any supplemental pages must be filed together, to create a single document.

(b) VA Form 10-0137 must be signed by the patient in the presence of two witnesses. Witness attestation means only that the individual saw the patient sign the form. Neither witness may knowingly be named as a beneficiary in the patient's will, be appointed as a HCA in the advance directive, or be financially responsible for the patient's care. No employee of the VA facility in which the patient is being treated may serve as a witness, unless they are:

1. Family members;

2. Non-clinical employees (e.g., Medical Administration, Voluntary Service, Environmental Management Service); or

3. Employees from the Chaplain Service, Psychology Service, or Social Work Service.

*NOTE: Because more responsibilities have been placed on mental health practitioners, including psychologists (see paragraph 10), it is strongly recommended that patients be encouraged not to select psychologists as witnesses, thereby ensuring staff who are recommending treatments are not also witnesses. However, under existing regulation, a psychologist may still act as a witness and witness signatures of psychologists are still considered valid.*

(2) **State-Authorized Advance Directive.** 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 (see paragraph 3c(4)).

(3) **VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information.** Patients may have information in their health record that is protected by 38 U.S.C. § 7332 (specifically, information on individuals who have been diagnosed with substance use disorder (SUD), Human Immunodeficiency Virus (HIV) infection, or sickle cell anemia or who have participated in or were referred to a treatment or activity related to SUD, HIV infection, or sickle cell anemia.) VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, when completed by the patient, permits the release of information protected by 38 U.S.C. § 7332 to the individual authorized on the form. VA Form 10-5345 is not required for the practitioner to disclose information protected by 38 U.S.C. § 7332 to surrogates of patients who lack decision-making capacity when that information is deemed by the practitioner to be necessary for the surrogate to give informed consent on behalf of a patient. Patients who have information protected by 38 U.S.C. § 7332 in their health record need to complete VA Form 10-5345 for the purpose of authorizing release of information protected by 38 U.S.C. § 7332 to individuals other than their authorized surrogate such as other family members or to the surrogate when the information is not necessary to make



a decision about the patient's care. Patients with information protected by 38 U.S.C. § 7332 in their health record are to be advised of these procedures and offered the opportunity to complete VA Form 10-5345.

c. **Timing.** Appointments for information pertinent to advance care planning and/or completion of forms needs to occur promptly after the request is made.

d. **Documentation.** Document that the patient-requested advance care planning discussion occurred and summarize the significant content.

(1) When the discussion results in the patient completing an advance directive, the advance directive must be filed or scanned with a progress note titled "Advance Directive."

(2) Documentation of the discussion that led to the filing of an advance directive can be in the form of an addendum to the "Advance Directive" note associated with that advance directive or in a separate note titled "Advance Directive Discussion."

(3) When there is discussion, but no advance directive, the note needs to have the title "Advance Directive Discussion."

(4) When the discussion concerns an existing advance directive, documentation can be in the form of an addendum to the "Advance Directive" note associated with that directive or may be made in a separate note titled "Advance Directive Discussion" (see paragraph 5).

**12. MANAGEMENT OF ADVANCE DIRECTIVE DOCUMENTS:** Required procedures for filing and managing advance directive documents include:

a. **Filing the Advance Directive in the Patient's Electronic Health Record.** Advance directive forms that are submitted by the patient in hard copy (on paper) need to be promptly scanned into the patient's health record through VistA Imaging with an accompanying progress note titled "Advance Directive." Alternatively, staff may use the iMedConsent program to help patients electronically complete VA Form 10-0137, and directly save the signed advance directive in VistA Imaging. The facility's iMedConsent administrator must ensure that the progress note automatically generated by iMedConsent is titled "Advance Directive."

b. **Advance Directive CWAD Posting.**

(1) The "Advance Directive" note title must be configured to generate a CWAD posting to alert staff that the patient has an advance directive on file (see VHA Handbook 1907.01). This note title must only be used for:

(a) Notes documenting the scanning of a hard copy advance directive document; and

(b) Notes automatically generated when iMedConsent saves an advance directive document to VistA.

(2) A CWAD posting must also be generated by an “Advance Directive Discussion.”

c. **Updating or Modifying an Advance Directive.** If a patient wants to update or revise a VA advance directive, a new one needs to be created and documented, and the old directive must be rescinded (see paragraph 13).

d. **Providing a Copy of the Advance Directive to the Patient.** Upon completion of an advance directive, a paper copy must be offered to the patient. If the document is completed or provided in hard copy (paper) form, the original needs to be given to the patient. If the advance directive is completed using iMedConsent, a printed copy of the completed, signed document must be offered to the patient. Once the advance directive is entered in the patient’s health record, requests for copies must follow the procedures specified in Handbook 1605.1.

e. **Advising Patients to Share Copies of Advance Directives.** In addition to their VA health care provider, patients need to be advised to give copies of their advance directive to their designated HCA, family members and loved ones, and any non-VA health care providers who may be involved in their care.

### **13. RESCISSION OF AN ADVANCE DIRECTIVE:**

a. A patient who has decision-making capacity may revoke their advance directive at any time by using any means expressing the intent to revoke.

b. 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 VA advance directive at the same time. If a new VA Form 10-0137 is entered in the record, all previous versions of VA Form 10-0137 are invalidated. Furthermore, the responsible practitioner must take action to rescind the previous VA Form 10-0137.

c. To ensure that the patient’s electronic health record is clear, 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 DATE was revoked and describing the discussion with the patient that resulted in revocation;

(2) Request that the responsible party (typically, the Chief, Health Information Management Service) change the progress note title associated with the advance directive which the patient revoked, to “Rescinded Advance Directive;” and

(3) File a new advance directive, if applicable, with the note title “Advance Directive.”

d. The medical facility Director or designee is responsible for establishing and promoting clear, efficient channels of communication to facilitate the re-titling of revoked advance directive

documents (see VHA Handbook 1907.01 for re-titling procedures and guidance) (see paragraph 8e). Notes titled “Rescinded Advance Directive” must be linked to the CWAD postings.

#### 14. IMPLEMENTATION OF ADVANCE DIRECTIVES:

a. **Prerequisites.** Prior to acting upon any advance directive, VA practitioners must carry out the following five steps: *NOTE: Decisions regarding the limitation or withdrawal of life-sustaining treatments are the responsibility of the attending physician and may not be delegated to another practitioner.*

(1) Determine that the patient lacks the capacity to make the particular decision in question. Patients are presumed to have decision-making capacity, unless an appropriate clinical evaluation determines that the patient lacks decision-making capacity, the patient is a minor, or the patient has been ruled incompetent by a court of law (see VHA Handbook 1004.01).

(2) Ensure that the advance directive appears to be valid for use in VA. Note the following points regarding validity in VA (each of which applies to the extent that the advance directive does not conflict with clinical or professional standards or VA policy):

(a) VA recognizes and honors throughout its health care system any valid VA advance directive, any State-authorized medical or mental health advance directive that is valid in one or more States under applicable State law (see paragraph 3c(4)), and any valid DOD advance directive.

(b) If more than one “Advance Directive” note is in the CWAD postings, practitioners must take extra care to check the validity of each advance directive. If the patient has more than one VA Form 10-0137, only the most recent form remains valid (see paragraph 13).

(c) If a patient has more than one valid advance directive (e.g., a VA advance directive and a State-authorized advance directive), all apply. For any inconsistent or overlapping elements, the information in the document with the most recent date supersedes the information in the prior document. *NOTE: Practitioners may wish to consult Regional Counsel or the facility Ethics Consultation Service to make a determination about specific cases in which the patient lacks decision-making capacity and the advance directives are inconsistent. See VHA Handbook 1004.01 for procedures regarding informed consent for patients who lack decision making capacity.*

(3) Personally read the advance directive in its entirety.

(4) Ensure that the relevant clinical criteria that may be described in the directive are met (e.g., “If I am unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery,” or “if I have pain or other severe symptoms that cannot be relieved,” or “if I experience an active psychosis”).

(5) Identify the authorized surrogate decision maker, if any, as specified in VHA Handbook 1004.01, and follow the decision-making process in following paragraph 14b. If the authorized

surrogate is a close friend, the close friend must present a signed, written statement (to be filed in the medical record) describing (with specific examples) that person's relationship to, and familiarity with, the patient. Social work service, or other staff, must verify, in a signed and dated progress note that this requirement has been met.

b. **Decision-Making Process.** The process of decision making for patients who lack decision-making capacity is the same whether or not the patient has an advance directive. This needs to be a collaborative process between the surrogate, if any, and the clinical team. The surrogate's decision must be based on substituted judgment, or, if the patient's values and wishes are unknown, on the patient's best interests (see VHA Handbook 1004.01).

(1) **Patients Who Have an Authorized Surrogate.**

(a) If the patient has designated an HCA, the responsible practitioner, or designee, must contact that person to act as the patient's surrogate. If the patient has not designated an HCA, the authorized surrogate must be identified as specified in VHA Handbook 1004.01.

(b) Irrespective of any advance directive, the practitioner must obtain informed consent for treatments and procedures, as specified in VHA Handbook 1004.01.

(c) If the advance directive includes a living will, the responsible practitioner must review that document with the authorized surrogate. The purpose of this review is to establish whether or not the criteria the patient specified in the living will have been met, and to determine whether or not the surrogate and the treatment team agree in their interpretation of the patient's expressed preferences and how these apply to the present circumstance.

(d) In cases where the treatment team and the surrogate agree regarding interpretation of the patient's preferences as stated in the living will, the responsible practitioner needs to ensure that the patient is treated in accordance with that interpretation.

(e) In cases where the treatment team and surrogate disagree in their interpretation of the patient's preferences as stated in the living will, and cannot resolve the conflict, the IE Ethics Consultation service must review the case and attempt to bring the parties to consensus.

1. If the IE Ethics Consultation service is unable to resolve the conflict, the service must consult the National Center for Ethics in Health Care. If no resolution is reached, the National Center for Ethics in Health Care must engage Regional or General Counsel for legal action or referral of the matter to a court of appropriate jurisdiction. This is the proper procedure in disputed cases where the facility IE Ethics Consultation service determines that the following conditions exist:

a. The living will and its contents are consistent with clinical and professional standards and VA policy;

b. The relevant statements contained in the living will are clear and unambiguous, and a valid expression of the patient's preferences; and

c. The surrogate is unwilling to authorize treatment consistent with those statements.

2. If the IE Ethics Consultation service determines that this advance directive is unclear or ambiguous or is not a valid expression of the patient's preferences, the treatment team must not use the advance directive as a basis for overriding the surrogate's decision.

(2) **Patients Who Have No Authorized Surrogate.** In cases where there is no authorized surrogate who is available and willing to serve, the practitioner may either follow the procedures outlined in VHA Handbook 1004.01 regarding an alternative decision-making process, or contact Regional Counsel for assistance in obtaining a legal guardian for health care decisions.

c. **Documentation.** The responsible practitioner must document in the patient's health record findings regarding each of the five prerequisites listed in paragraph 14a, the decision-making process that was used, and the decision that was reached.

## **15. IMPLEMENTATION OF PATIENT INSTRUCTIONS IN CRITICAL SITUATIONS:**

A special provision applies to patients who are critically ill and at risk of imminent loss of decision-making capacity. In these circumstances, for patients who have decision-making capacity, but are not physically able to sign an advance directive form or whose existing directive is not readily available, VA is to follow their unambiguous verbal or non-verbal instructions regarding future health care decisions.

a. The patient's instructions must have been expressed to at least two members of the health care team.

b. The substance of these instructions must be recorded in an "Advance Directive Discussion" progress note and must be signed by at least two members of the health care team who were present and can attest to the instructions expressed by the patient.

c. These instructions take effect only if the patient loses decision-making capacity during the critical situation in which the instructions were given.

## **16. REFERENCES:**

a. Title 10 U.S.C. § 1044c.

b. Title 38 U.S.C. § 7332, as amended by Pub. L. 111-163 § 504.

c. Title 42 U.S.C. § 1395cc.

d. Title 38 CFR § 17.32.

e. Title 38 CFR § 1.484.

f. VHA Handbook 1004.01, Informed Consent for Clinical Treatment Procedures.

- g. VHA Handbook 1004.06, IntegratedEthics.
- h. VHA Handbook 1605.01, Privacy and Release of Information.
- i. VHA Handbook 1907.01, Health Information Management.
- j. DOD Directive 1350.4, Legal Assistance Matters at:  
<http://www.dtic.mil/whs/directives/corres/pdf/135004p.pdf>

**APPENDIX A**

**VA FORM 10-0137, VA ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE AND LIVING WILL**

VA Form 10-0137, VA Advance Directive: Durable Power of Attorney for Health Care and Living Will, can be found on the VA Forms website at <http://vaww.va.gov/vaforms> (Intranet) or at <http://www.va.gov/vaforms> (Internet). The form can be printed and distributed to patients. This form will also be stocked by the Hines Service and Distribution Center (formerly known as the Forms and Publications Depot).

**APPENDIX B**

**VA FORM 10-0137A, YOUR RIGHTS REGARDING ADVANCE DIRECTIVES**

VA Form 10-0137A, Your Rights Regarding Advance Directives, can be found on the VA Forms website at <http://vaww.va.gov/vaforms> (Intranet) or at <http://www.va.gov/vaforms> (Internet). The form can be printed and distributed to patients. This form will also be stocked by the Hines Service and Distribution Center (formerly known as the Forms and Publications Depot).



**APPENDIX C**

**VA FORM 10-0137B, WHAT YOU SHOULD KNOW ABOUT ADVANCE DIRECTIVES**

VA Form 10-0137B, What You Should Know About Advance Directives, can be found on the VA Forms website at <http://vaww.va.gov/vaforms> (Intranet) or at <http://www.va.gov/vaforms> (Internet). The form can be printed and distributed to patients. This form will also be stocked by the Hines Service and Distribution Center (formerly known as the Forms and Publications Depot).