

STATE-AUTHORIZED PORTABLE ORDERS (SAPO)

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive defines policy for the use and execution of state-authorized portable do-not-attempt-resuscitation (DNAR/DNR) orders and SAPO for life-sustaining treatment by authorized Department of Veterans Affairs (VA) practitioners.

2. SUMMARY OF MAJOR CHANGES: This is a revised directive that:

a. Updates requirements to align with VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017. This includes specifying steps to ensure consistency between a patient's SAPO and VA Life-Sustaining Treatment (LST) Orders.

b. Expands the definition of "state-authorized portable orders" that are recognized in VA to include specialized forms or identifiers authorized by state law or the state medical board or association.

c. Changes the name of the required electronic health record progress note title for associating SAPO from "Out-of-Hospital Orders" to "State-Authorized Portable Orders" and allows facilities flexibility in adding a suffix to this title to reflect local needs.

d. Removes the requirement for practitioners to write a separate progress note specifying the date, jurisdiction, and description of the substance of the SAPO.

e. Clarifies that SAPO are not required to be offered prior to discharge to Veterans who are admitted only under observation status.

f. Explains that facilities must develop document management processes for rescinding/removing SAPO from Crisis, Warnings, Allergies/Adverse Reactions, and Directives (CWAD) postings, when SAPO are no longer current.

g. Establishes requirements for policy implementation no later than [6 months after publication].

h. To ensure fairness, now requires that each facility accept any valid SAPO from any state. Facilities continue to have discretion in determining the SAPO that will be offered at the facility.

3. RELATED ISSUES: VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009; and VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 17, 2017.

4. RESPONSIBLE OFFICE: The National Center for Ethics in Health Care (10E1E) is responsible for the contents of this directive. Questions may be directed to (202) 632-8457 or to vhaethics@va.gov.

5. RESCISSIONS: VHA Handbook 1004.04, State Authorized Portable Orders (SAPO), dated October 25, 2012, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

CERTIFIED BY:

**BY DIRECTION OF THE UNDER
SECRETARY FOR HEALTH**

/s/ Gerard R. Cox, M.D., MHA
Deputy Under Secretary for Health

/s/ Gerard R. Cox, M.D., MHA
Deputy Under Secretary for Health

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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WHEN A VETERAN PRESENTS TO A VHA FACILITY WITH SAPO AND DOES NOT
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STATE-AUTHORIZED PORTABLE ORDERS (SAPO)

1. PURPOSE

This Veterans Health Administration (VHA) directive defines policy for the use and execution of state-authorized portable do-not-attempt-resuscitation (DNAR/DNR) orders and state-authorized portable orders for life-sustaining treatment by authorized Department of Veterans Affairs (VA) practitioners. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b); Title 38 Code of Federal Regulation (CFR) 17.38.

2. BACKGROUND

a. Patients have expressed concern that their life-sustaining treatment preferences may be ignored in emergency situations. In response, the majority of the 50 states have developed protocols that translate a patient's preferences regarding interventions such as resuscitation, mechanical ventilation, or the provision of artificial nutrition and hydration into portable orders. As a generally accepted standard of medical practice, SAPO are communicated to first responders, for example, ambulance personnel, and clinicians through specialized forms. Examples of such forms are Oregon's Physician Orders for Life-Sustaining Treatment (POLST), or state-authorized identifiers, such as a state-authorized DNAR/DNR bracelet.

b. By legitimizing and standardizing these protocols, states are promoting community-wide use as well as provider adherence to ensure that a patient's life-sustaining treatment decisions are respected by emergency medical service providers and receiving health care facilities.

c. Title 38 CFR 17.38 establishes that care must be provided by the VA to individuals in accordance with generally accepted standards of medical practice.

d. In keeping with this authority and VA's commitment to promoting Veteran-centered care and ensuring that Veterans' values, goals, and treatment preferences are respected and reflected in the care they receive, VHA supports the use of SAPO.

3. DEFINITIONS

a. **Cardiopulmonary Resuscitation.** Cardiopulmonary resuscitation (CPR) is the use of Basic Life Support and Advanced Cardiac Life Support (see paragraph 11.a) in an attempt to restore spontaneous circulation following cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). CPR is a life-sustaining treatment.

b. **Computerized Patient Record System.** Computerized Patient Record System (CPRS), for purposes of this directive, refers to the electronic health record software in use by VHA. It also includes associated software, such as the Veterans Health Information Systems and Technology Architecture (VistA) and the image storage software (VistA Imaging). The specific software used may be changed, but these

requirements should remain in place for any software application(s) that are developed to replace CPRS.

c. **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 an 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 treatment options.
- (4) Communicate a choice.

NOTE: *In contrast to decision-making capacity, "competence" is a legal determination made by a court of law. NOTE: See VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009, for information related to determination of decision-making capacity.*

d. **Do Not Attempt Resuscitation Order.** A do not attempt resuscitation order (DNAR/DNR) order is one which establishes that CPR shall not be attempted for a patient in cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). Patients with a DNAR/DNR order should still receive clinically-appropriate emergency interventions short of CPR for example, medications, fluids, oxygen, manual removal of an airway obstruction or abdominal thrusts (the Heimlich maneuver), unless otherwise specified in life-sustaining treatment orders.

e. **Goals of Care Conversation.** A goals of care conversation (GoCC) is a conversation between a health care practitioner and a patient or surrogate for the purpose of determining the patient's values, goals, and preferences for care, and based on those factors, making decisions about whether to initiate, limit, or discontinue life sustaining treatment (LST). Other health care team members may contribute to the GoCC as specified in VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Document & Honoring Patient's Values, Goals and Preferences, dated January 11, 2017.

f. **Life-Sustaining Treatment.** Life-sustaining treatment (LST) is a medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment (e.g., artificial nutrition and hydration, mechanical ventilation).

g. **Life-Sustaining Treatment Plan.** An LST plan is a treatment plan resulting from a GoCC about LSTs.

h. **Life-Sustaining Treatment Progress Note.** An LST progress note is a health record progress note that documents a GoCC and the resulting LST plan using a nationally standardized CPRS progress note template.

i. **Life-Sustaining Treatment Order.** An LST order is a DNAR/DNR order or any other order to limit or not place limits on one or more LST.

j. **Life-Sustaining Treatment Order Set.** The LST Order Set is a nationally standardized CPRS order set for documenting orders to limit or not place limits on one or more LST. Orders documented in the LST Order Set will not expire or automatically discontinue based upon dates, timeframes, or patient movements for example, admission, discharge, and transfer, but will remain in effect unless they are modified based on a revised LST plan.

k. **Medical Emergency.** For the purposes of this directive, a medical emergency is a situation in which immediate medical care is necessary to preserve the patient's life or avert serious impairment to the patient's health and the practitioner determines that delaying medical care in order to discuss the SAPO with the patient or patient's surrogate, if applicable, would increase the hazard to the life or health of the patient.

l. **Practitioner.** For the purposes of this directive, a practitioner is an attending physician or other licensed independent practitioner (LIP) in charge of the patient's care, (including advanced practice registered nurses (APRN) with full practice authority) or who serves as consultant for GoCCs and LST planning. Practitioner also includes the following team members only when an attending physician or other LIP has delegated to them the responsibility for conducting GoCCs and writing LST plans and LST orders, including DNAR/DNR orders:

(1) Resident. A resident is an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, or podiatrists, and whom participates in patient care under the direction of supervising practitioners. ***NOTE: For the purpose of this directive, the term resident includes individuals in their first year of training, who are sometimes referred to as interns, and individuals in approved subspecialty graduate medical education programs, who are also referred to as fellows.***

(2) APRNs without full practice authority whose scope of practice agreement or other formal delineation of job responsibility explicitly authorizes them to write LST progress notes and LST orders, including DNAR/DNR orders.

(3) Physician assistants whose scope of practice agreement or other formal delineation of job responsibility explicitly authorizes them to write LST progress notes and LST orders, including DNAR/DNR orders.

NOTE: Even if licensed, residents appointed as trainees are never considered LIP. They do not have privileges, but function under the clinical privileges of the supervising practitioner. See VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012. LIP social workers and LIP psychologists are not considered "practitioners" for the purposes of this directive.

m. **State-Authorized Portable Order.** A state-authorized portable order (SAPO) is a specialized form or identifier, for example, DNAR/DNR bracelets or necklaces, authorized by state law or the state medical board or association that translates a patient's preferences regarding specific life-sustaining treatment decisions into standing portable medical orders. Portable medical orders are designed to be easily recognizable and understood by first responders and other health care personnel. Portable medical orders travel with the patient whenever the patient is transported to or from a health care facility. A few examples of SAPO forms include; Oregon's Physician Orders for Life-Sustaining Treatment (POLST); West Virginia's Physician Orders for Scope of Treatment (POST); New York's Medical Orders for Life Sustaining Treatment (MOLST); Minnesota's POLST, and out-of-hospital DNAR/DNR orders for example, New York State's Out-of-Hospital DNR order form.

n. **Surrogate Decision Maker.** A surrogate decision maker (surrogate) is an individual or decision-making process, authorized by VHA Handbook 1004.01, to make health care decisions on behalf of a patient who lacks decision-making capacity.

NOTE: For additional information about surrogate selection, priority, and the surrogate's role in health care decision-making see VHA Handbook 1004.01.

4. POLICY

It is VHA policy that Veterans' valid SAPO are recognized and honored and that authorized VA practitioners write such orders consistent with the requirements of this directive; applicable federal law, regulations, and policy; relevant clinical standards; their VHA scopes of practice; and the requirements of the state or state medical board or association that authorizes the SAPO.

5. HONORING VETERANS' SAPO IN A MEDICAL EMERGENCY

a. If a Veteran presents with SAPO in a medical emergency, the VA practitioner must act in accordance with the Veteran's SAPO, unless:

(1) There are VA LST notes and orders in the Veteran's electronic health record more recent than the SAPO. In such circumstances, the more recent VA LST notes and orders have priority. **NOTE:** It is important to review LST progress notes and addenda as well as orders because LST progress notes and addenda may include documentation of decisions not reflected in LST orders for example, full code.

(2) There is a reason to doubt the validity of the SAPO, such as the form or identifier is inconsistent with known requirements, required signatures are missing, or the form or identifier has clearly been tampered with.

(3) The Veteran indicates by unambiguous verbal or non-verbal instructions that the SAPO are to be rescinded.

b. When the patient has been stabilized to the extent that there is no longer a medical emergency, the practitioner must ensure consistency between SAPO and VA LST orders, per paragraphs 6b.(3) and 6b.(4), and document SAPO, per paragraph 7.

NOTE: See flowchart in Appendix A for more information about honoring veterans' SAPO in a medical emergency.

6. OFFERING AND WRITING SAPO IN VA AND ENSURING CONSISTENCY WITH VA LST ORDERS

a. Based on the facility's determination of the SAPO that will be offered at the facility, (for example, within the facility's catchment area – for more information, see paragraph 8.e.(6)), VA practitioners must offer Veterans the opportunity to have such orders written or revised in the following circumstances:

(1) When SAPO are requested by a Veteran or, if the Veteran lacks decision-making capacity, by the Veteran's surrogate;

(2) Prior to discharge for Veterans who have existing SAPO, practitioners must discuss with the Veteran or surrogate whether the SAPO will remain as-is or whether revisions are needed. If revisions are needed and desired by the Veteran, the authorized practitioner must provide new SAPO to the Veteran at discharge. **NOTE:** SAPO are not required to be offered to Veterans admitted under only observation status; and

(3) Prior to discharge or upon completion of outpatient encounters with Veterans for whom VA LST orders have been written. These SAPO must be written to align with the Veteran's VA LST orders. If modifications to the patient's LST note and orders are needed, follow the requirements in paragraph 10 of VHA Handbook 1004.03. **NOTE:** SAPO are not required to be offered to Veterans admitted only under observation status.

b. In VA, a GoCC is the basis for writing orders related to life-sustaining treatment, including SAPO, and for ensuring consistency between VA LST orders and SAPO. Therefore:

(1) When writing SAPO for a Veteran who has no VA LST orders, the practitioner must initiate a GoCC with a Veteran or surrogate and also write an LST note and orders as required by VHA Handbook 1004.03.

(2) Before writing SAPO for a Veteran who has LST orders, the practitioner must ensure that the LST orders and SAPO are consistent.

(3) When a Veteran presents with SAPO and has no VA LST orders, the practitioner must initiate a GoCC with a Veteran or surrogate and also write an LST note and orders as required by VHA Handbook 1004.03. **NOTE:** See flowchart in Appendix A for more information.

(4) When a Veteran presents with SAPO and has VA LST orders, the practitioner must ensure that the LST orders and SAPO are consistent.

c. If a Veteran who presents with SAPO is determined to lack decision-making capacity and have no surrogate, the practitioner must request District Chief Counsel's assistance to obtain a special guardian for health care, or write LST notes and orders consistent with the SAPO and then, within 24 hours, generate a consult to engage the multidisciplinary committee review process. If, during the multidisciplinary committee review process, the patient experiences a medical emergency, treatment will be based on the documented orders reflecting the SAPO. **NOTE:** See *VHA Handbook 1004.03 for more information on the multidisciplinary committee's role in establishing life-sustaining treatment plans for patients who lack decision-making capacity and have no surrogate.*

d. Within VA, SAPO may only be written by VA practitioners who are authorized under both state law or the state medical board or association to write SAPO, and who are authorized by VHA Handbook 1004.03 to write DNAR/DNR and other life-sustaining treatment orders. If a provider does not have authority to write a SAPO, but determines that SAPO are appropriate, the provider must follow locally-established procedures for identifying an authorized practitioner who will write the orders. Providers who are not authorized within VHA to write LST orders are not permitted to write SAPO while functioning in their VHA capacity. **NOTE:** See *VHA Handbook 1004.03 for more information about authorization to write LST orders. Completion of SAPO using telemedicine must follow the requirements of the issuing state or state medical board or association regarding placement and timing of the patient or surrogate's signature.*

7. SAPO DOCUMENTATION

a. If a Veteran presents with SAPO or a VA practitioner writes SAPO, VA staff must:

(1) Follow locally developed processes for ensuring that paper SAPO are promptly scanned into the Veteran's electronic health record and are associated with the mandated progress note title, per paragraph 8.e(4)(a) below. **NOTE:** See *VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015, paragraph 25.g. for policy regarding scanning protocols.*

(2) Ensure that the original paper document is returned to the Veteran or surrogate decision maker.

b. Non-current SAPO must be rescinded/removed from CWAD postings according to local facility processes.

8. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN).

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all VHA health facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with the requirements of this directive; applicable federal law, regulation, and policy; their VHA scopes of practice; relevant clinical standards; and applicable requirements of the state or state medical board or association that authorizes the SAPO(s).

c. **National Center for Ethics in Health Care.** The National Center for Ethics in Health Care is responsible for providing communications, ethics consultation services, and interpretation to the field regarding the policy and procedures outlined in this directive.

d. **Office of Health Information Governance.** The Office of Health Information Governance is responsible for ensuring that the requirements for processes and electronic health record documentation set forth in this policy are communicated to other VA offices that coordinate and develop contracts or develop software for the VHA electronic health record.

e. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that the requirements of this policy are implemented no later than 6 months after publication date of February 26, 2019.

(2) Consulting with District Chief Counsel to develop local guidance for clarity as it relates to SAPO, including determination and identification of the categories of practitioners, authorized under state law or the state medical board or association and VHA scope of practice or clinical privileges, to write SAPO for use outside of VHA facilities. ***NOTE: Because states vary regarding the forms or identifiers that may be recognized and the categories of professional who may write SAPO, it is essential that facility staff consult with District Chief Counsel before developing facility-based guidance and procedures.***

(3) Developing protocols identifying authorized practitioners who can write SAPO when a provider is not authorized to write the order under state law or their VHA scope of practice or clinical privileges.

(4) Ensuring document management processes are developed for entering and managing SAPO in a Veteran's electronic health record, to include:

(a) Establishing the mandated local progress note title that will be associated with the SAPO. The title must begin with "State-Authorized Portable Orders" but may include a suffix to reflect local needs for example, "State-Authorized Portable Orders – CA POLST," "State-Authorized Portable Orders – MOLST." ***NOTE: This updated***

directive removes the previous national requirement to use the progress note title: "Out-of-Hospital Orders."

(b) Ensuring that the mandated local progress note title is mapped to the standard title, "State-Authorized Portable Orders."

(c) Ensuring that the mandated progress note title is linked to the CWAD postings.

(d) Ensuring a local facility process for rescinding/removing non-current SAPO from Crisis, Warnings, Allergies and/or Adverse Reactions and Directives (CWAD) postings.

(5) Ensuring that valid SAPO from any state will be accepted at the facility.

(6) Specifying the different types of SAPO that will be routinely offered at the facility. This list must include, at a minimum, the SAPO authorized by the state in which the facility is located, as well as SAPO that are authorized by other states in the facility's catchment area, or where a large number of Veterans served by the facility reside. For example, a facility near the border of Connecticut, New York, and New Jersey might specify that the following types of SAPO must be routinely offered: Connecticut DNR Transfer form; Connecticut DNR Bracelet; New York Nonhospital Order Not to Resuscitate; (DNR Order); New York MOLST; and New Jersey Goals of Care POLST Pilot form.

(7) Ensuring that staff implementing SAPO and who are authorized to write SAPO have been informed about the requirements established in this directive. This includes ensuring that appropriate staff members are familiar with all state forms and identifiers offered by the facility.

(8) Ensuring that relevant SAPO forms and identifiers are available for ready access in units, in clinics, and in community-based settings. **NOTE:** *To facilitate access to state forms, the VA medical facility Director may instruct the iMedConsent Administrator to enter relevant forms into the software library for electronic signature informed consent for easy download.*

f. Facility Chief of Staff and Associate Director for Patient Care Services/Nurse Executive. The Facility Chief of Staff and Associate Director for Patient Care Services/Nurse Executive are responsible for:

a. Ensuring practitioners act in accordance with a Veteran's SAPO as outlined in this directive.

b. Ensuring SAPO are written by VA authorized practitioners in a manner consistent with the requirements of this directive; applicable federal law, regulation, and policy; their VHA scopes of practice; relevant clinical standards; and the requirements of applicable state law or the state medical board or association that authorizes SAPO.

c. Ensuring staff familiarize themselves with the array of SAPO that are offered at their facility.

9. TRAINING

None.

10. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA records control schedule 10-1. If you have any question to the regarding any aspect of records management you should contact your facility records manager or your records liaison.

11. REFERENCES

a. American Heart Association. Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. Circulation. 2010; 122 (18) supplement: 639-946.

b. [VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures](#), dated August 14, 2009.

c. [VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences](#), dated January 11, 2017.

d. [VHA Handbook 1100.19, Credentialing and Privileging](#), dated October 15, 2012.

e. [VHA Handbook 1400.01, Resident Supervision](#), dated December 19, 2012.

f. [VHA Handbook 1907.01, Health Information Management and Health Records](#), dated March 19, 2015.

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