AFFILIATE MARKET MEETING

Q3 2025– October 8, 2025

Agenda

- **Advanced Care Planning for Chronically Ill Patients with Multiple Chronic Conditions- Presented by** Dr. Thomas Cornwell
- **End of Life Care Data Analysis-** Presented by Adam Matsil
- **Advanced Illness and Frailty Coding-** Presented by Kiersten Kinchen
- Q & A

Advance Care Planning for Chronically Ill Patients

Thomas Cornwell, MD

Village Medical™

Objectives

- Review Palliative Care

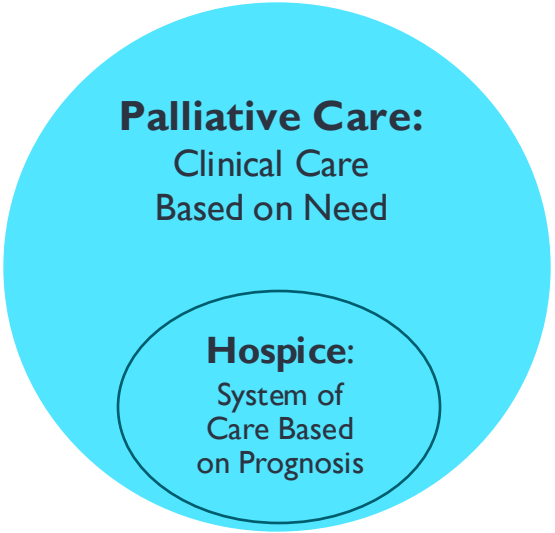
- Describe the Why, When, What and How of Advance Care Planning

Why? “Numerous studies have raised concerns about the quality of end-of-life (EOL) care provided to older adults in the US, with little change across 30 years of research.” Medicare spending on patients in their last year of life accounts for 25% of program expenditures, with median spending in the last 6 months alone exceeding $25,000 in many parts of the country. Medicare-Covered Services Near the End of Life in Medicare Advantage vs Traditional Medicare | Health Policy | JAMA Health Forum | JAMA Network 07/24

Demystifying Palliative Care

- **PALLIATIVE CARE[1,2] (AKA Serious Illness Care, Advanced Illness Management, Supportive Care)**
  - **Team-Based** care for people with **Serious Illness** based on needs not prognosis—often not terminal
  - Focuses on **Goals of Care** conversations and **Symptom Relief** to improve the physical, social, emotional, and spiritual **Quality of Life** for both patient and family
  - **Offered simultaneously** with all appropriate medical treatments
  - CHF and COPD are not cured, they are palliated.

- **HOSPICE CARE**
  - An **insurance benefit**
  - Palliative care for people with **≤ 6-month life expectancy**
  - **Interdisciplinary team** covered by Medicare/insurance
  - **Hospice patients should often continue to be seen for continuity, to manage chronic problems, prevent acute care utilization, & capture HCCs.**



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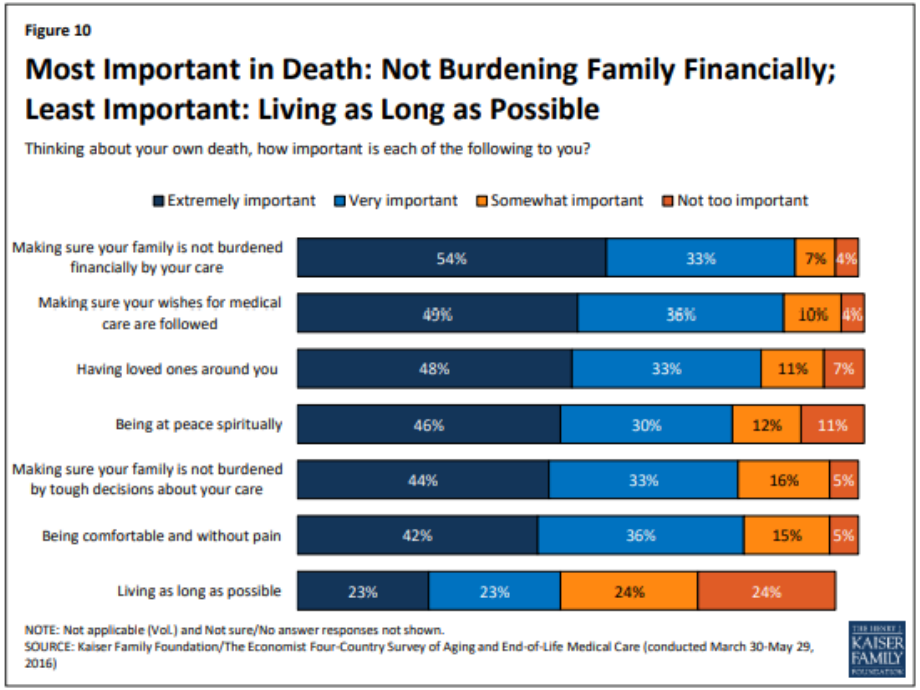
[1] Center to Advance Palliative Care (CAPC): https://getpalliativecare.org/whatis/
[2] National Hospice and Palliative Care Organization (NHPCO): https://www.nhpco.org/palliativecare/explanation-of-palliative-care/

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal (e.g., Health Care Power of Attorney/ Agent/Proxy) and Medical (e.g., DNR, POLST, MOST) documents to ensure wishes are carried out
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild, etc.)
    - Consensus: “interested persons” determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment

Why Advance Care Planning? **Our patients want it!**

Views and Experiences with End-of-Life Medical Care in the U.S.[1]

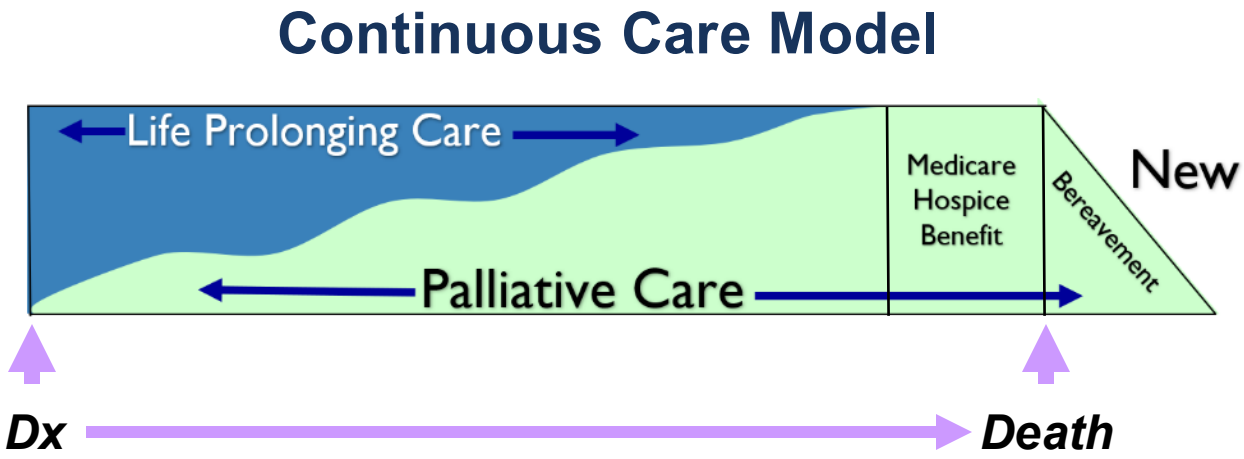


- 87% patients/families wanted the **biggest say**
- **70% prefer to die at home**, only 31% do
- 27% with documented end-of-life (EOL) wishes, #1 reason = **49% "not gotten around to it." Need to help patients "get around to it."**
- Consistent conversations **normalize ACP**
- "**Hope for the best, plan for the rest**." Planning prevents or lessens crises.
- 100% of patients will benefit
- ↓ family burden and ↑ family satisfaction
- ↑ patient satisfaction

[1] https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings/

When Advance Care Planning, Goals of Care Conversations, Palliative Care?

EARLY, LONGITUDINAL, EVOLVE



When Advance Care Planning?

- Advance Care Planning is longitudinal, evolving process
  - 5 D's
    - Decade Birthday
    - Diagnosis
    - Deterioration (Discharge)
    - Divorce
    - Death of loved one
- Annual Wellness Visits, Annual Physicals

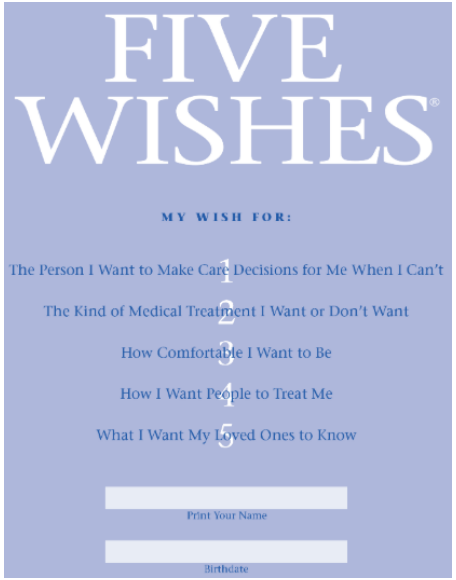
- AD Prevalence[1]
  - 33% Healthy adults
  - 38% with serious disease

"There's no easy way I can tell you this, so I'm sending you to someone who can."

[1] Yadav N, et al. *Approximately One in Three US Adults Completes Any Type of Advance Directive for End-of-Life Care*. Health Affairs July 2017; 36(7)

Advance Care Planning WHAT?

- Advance Directives (AD) Options
  - State forms—often legalese, can be difficult to understand; free
  - 5 Wishes: Legal in 46 states—not in KS, NH, OH, TX; includes POAHC / Agent / Proxy and Living Will; $5 each or $1 if purchase ≥ 25.
    1. The Person I Want to Make Care Decisions for Me When I Can't
    2. The Kind of Medical Treatment I Want or Don't Want
    3. How Comfortable I Want to Be
    4. How I want People to Treat Me
    5. What I Want My Loved Ones to Know
  - PREPARE for your care: Legal in 50 states—slight variance in forms to meet state requirements; includes POAHC/Proxy, Living Will, Organ Donation; free
  - DNR (DNR, POLST, POST, MOLST, MOST)
    - Required by paramedics to avert out-of-hospital CPR
    - Provider signature required in most states
    - Some states only physicians can sign (e.g., GA)



VillageMD's more Efficient, Effective, & Impactful ACP Program

PREPARE™ for your care

Village Medical has Partnered with PREPARE™ for Your Care

Increasing patient impact AND simplifying Advance Care Planning for Physicians + APPS

- PREPARE for Your Care: web-based advance directives legal in all **50** states
- Patient-facing website with informational & instructional videos on the 5-Step process + Advance Directives 5th grade level, English & Spanish
- Evidence-based (UCSF) (no provider involvement required) and the only National Council on Aging endorsed
  - ↑ practice AD completion 8.5% → 43%[1,2]
  - 50% ↑ clinician responsiveness and documentation[1,2]
  - MyChart patient portal message ⇒↑ AD completion 2019 18% → 2021 54% (86% in serious illness patients)[2]

[1] Sudore et al. JAMA IM 2017; Sudore et al. JAMA IM 2018;
[2] Walling, Sudore, et al. *J Palliat Med*. 2019.

PREPARE™

A Program To Help You Make Medical Decisions for Yourself and Others

- Step 1 Choose a Medical Decision Maker
- Step 2 Decide What Matters Most in Life
- Step 3 Choose Flexibility for Your Decision Maker
- Step 4 Tell Others About Your Medical Wishes
- Step 5 Ask the Medical Care Team Questions

www.PREPAREforYourCare.org

Step 1 Choose a Medical Decision Maker

Choose someone you trust to help make decisions for you in case you become too sick to make your own decisions.

A good decision maker will:

- ask doctors questions
- respect your wishes

If there is no one to choose right now, do Steps 2, 4, and 5.

How To Say It:

"If I get sick in the future and cannot make my own decisions, would you work with my doctors and help make medical decisions for me?"

OR

"I do not want to make my own medical decisions. Would you talk to the doctors and help make medical decisions for me now and in the future?"

Step 2 Decide What Matters Most in Life

This can help you decide on medical care that is right for you.

Five questions can help you decide what matters for your medical care:

1. **What is most important in life?** Friends? Family? Religion?
2. **What experiences have you had** with serious illness or death?
3. **What brings you quality of life?** Quality of life is different for each person. Some people are willing to live through a lot for a chance of living longer. Others know certain things would be hard on their quality of life.
4. **If you were very sick, what would be most important to you:**

   To live as long as possible even if you think you have poor quality of life?

   Or, to try treatments for a period of time, but stop if you are suffering?

   Or, to focus on quality of life and comfort, even if your life is shorter?
5. **Have you changed your mind about** what matters most in your life over time?

Step 3 Choose Flexibility for Your Decision Maker

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

How To Say It:

Total Flexibility:

"I trust you to work with my doctors. It is OK if you have to change my prior decisions if something is better for me at that time."

Some Flexibility:

"It is OK if you have to change my prior decisions. But, there are some decisions that I never want you to change. These decisions are…"

No Flexibility:

"Follow my wishes exactly, no matter what."

Step 4 Tell Others About Your Medical Wishes

This will help you get the medical care you want.

How To Say It:

To Your Decision Maker and Medical Care Team:

"This is what is most important in my life and for my medical care…"

To Your Medical Care Team and Family and Friends:

"I chose this person to be my decision maker and I want to give them (TOTAL, SOME, or NO) flexibility to make decisions for me."

Your medical care team can help you put your medical wishes on an advance directive form.

Step 5 Ask the Medical Care Team Questions

- **Write down** questions ahead of time.
- **Bring someone** with you.
- Tell medical providers at the **start of the visit** if you have questions.

How To Say It:

Ask the Medical Care Team About:

- **Benefits** – the good things that could happen
- **Risks** – the bad things that could happen
- **Options** for different kinds of treatment
- **Most important:** "What will my life be like after the treatment? Will it help my quality of life?"

Make Sure You Understand:

"What I'm hearing you say is…"
"Is this right?"

Go to **PREPAREforYourCare.org** to get easy to read advance directives. These forms allow you to put your wishes in writing.

Michigan Advance Health Care Directive

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

This form has 3 parts:

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

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

This person will be your advocate.

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

Part 2 **Make your own health care choices, Page 7**

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

Part 3 **Sign the form, Page 13**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on Page 14.
If you choose a medical decision maker, they must also sign on Page 15.

Your Name

Developed by PREPARE for your care
www.prepareforyourcare.org

Instrucción anticipada de atención de salud de Michigan

Michigan Advance Health Care Directive

Este formulario le permite indicar cómo desea ser atendido si usted no puede hablar por sí mismo.

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

Este formulario consta de 3 partes: This form has 3 parts:

Parte 1 **Escoger una persona decisora, página 3**
Part 1: Choose a medical decision maker, page 3

Una persona decisora es una persona que puede tomar decisiones médicas por usted si usted no puede tomarlas por sí mismo.
A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

Esta persona será su representante. This person will be your advocate.

También se les llama un agente de salud, defensor del paciente, o un sustituto.
They are also called a health care agent, patient advocate, or surrogate.

Parte 2 **Tomar sus propias decisiones de atención de salud, página 7**
Part 2: Make your own health care choices, page 7

Este formulario le permite escoger el tipo de atención de salud que desea. De esta manera, las personas encargadas de su cuidado no tendrán que adivinar lo que desea si no puede decirlo por usted mismo.
This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Parte 3 **Firmar el formulario, página 13** Part 3: Sign the form, page 13
El formulario se debe firmar antes de que se pueda usar.
The form must be signed before it can be used.

Usted puede llenar la Parte 1, la Parte 2, o ambas. You can fill out Part 1, Part 2, or both.

Llene solamente las partes que desee. Siempre firme el formulario en la Parte 3.
Fill out only the parts you want. Always sign the form in Part 3.

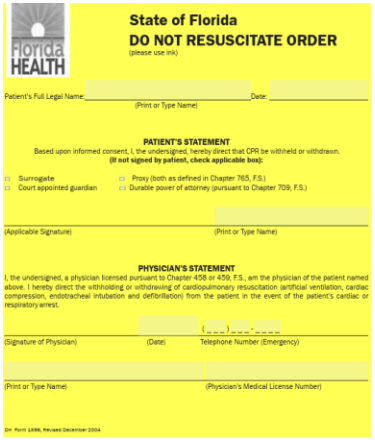
Es necesario que 2 testigos firmen en la página 14. Si elige una persona decisora, esa persona debe también firmar en la página 15. 2 witnesses need to sign on page 14. If you choose a medical decision maker, they must also sign on page 15.

Su Nombre Your Name

Developed by PREPARE for your care
www.prepareforyourcare.org

DNR Advance Directives

- Out of hospital DNR forms are medical orders for paramedics or other health care personnel to not provide resuscitative care (e.g., CPR) at the end of life. Some DNR documents (e.g., POLST, MOST, etc.) instruct acute care settings on desired care and unwanted care (e.g., ventilators, tube feeding).
- DNR forms are legislated by states with different names and requirements:
  - Florida: DNR. Signed by MD/DO, PA, or NP "registered for autonomous practice. No witness. Yellow paper.
  - Georgia: POLST: Signed by MD/DO. 2 physician signatures if signed by surrogate decision maker and not HCPOA. No witness. POLST executed in another state is valid if "substantially similar."
  - Michigan: Signed by MD/DO, NP, PA. Requires reaffirmed or redone yearly. Pink 65-stock or white card stock with pink border.
  - Nevada: Signed by MD/DO, NP, or PA.
  - New Hampshire: DNR & POLST. Signed by MD/DO, NP, or PA. DNR pink paper. POLST yellow paper. Need to order.


State of Florida
DO NOT RESUSCITATE ORDER
(please use ink)

Patient's Full Legal Name: _____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT
Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):
☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

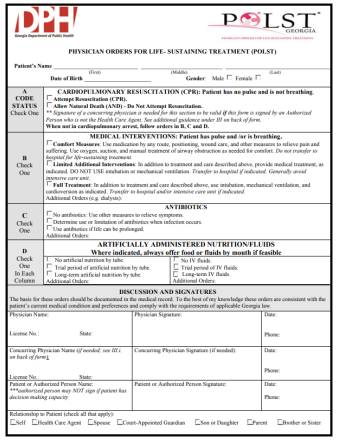
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT
I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(Signature of Physician) (Date) (___)___-____
Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2004


DPH Georgia Department of Public Health
POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ (First) (Middle) (Last)
Date of Birth _____ Gender: ☐ Male ☐ Female

A CODE STATUS Check One
☐ CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.
☐ Attempt Resuscitation (CPR).
☐ Allow Natural Death (AND) - Do Not Attempt Resuscitation.
** Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.
When not in cardiopulmonary arrest, follow orders in B, C and D.

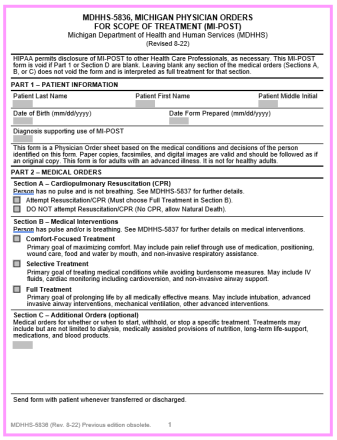
B Check One
MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.
☐ Comfort Measures: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment.
☐ Limited Additional Interventions: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. Transfer to hospital if indicated. Generally avoid intensive care unit.
☐ Full Treatment: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated.
Additional Orders (e.g. dialysis):

C Check One
ANTIBIOTICS
☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.
Additional Orders:

D Check One or In Each Column
ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS
Where indicated, always offer food or fluids by mouth if feasible
☐ No artificial nutrition by tube.
☐ Trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.
Additional Orders:
☐ No IV fluids.
☐ Trial period of IV fluids.
☐ Long-term IV fluids.
Additional Orders:

DISCUSSION AND SIGNATURES
The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: _____ Physician Signature: _____ Date: _____
License No.: _____ State: _____ Phone: _____
Concurring Physician Name (if needed; see III 1. on back of form): _____ Concurring Physician Signature (if needed): _____ Date: _____
License No.: _____ State: _____ Phone: _____
Patient or Authorized Person Name: _____ Patient or Authorized Person Signature: _____ Date: _____
**Unauthorized person may NOT sign if patient has decision making capacity. Phone: _____
Relationship to Patient (check all that apply):
☐Self ☐Health Care Agent ☐Spouse ☐Court-Appointed Guardian ☐Son or Daughter ☐Parent ☐Brother or Sister


MDHHS-5836, MICHIGAN PHYSICIAN ORDERS
FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION
Patient Last Name | Patient First Name | Patient Middle Initial
Date of Birth (mm/dd/yyyy) | Date Form Prepared (mm/dd/yyyy)
Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

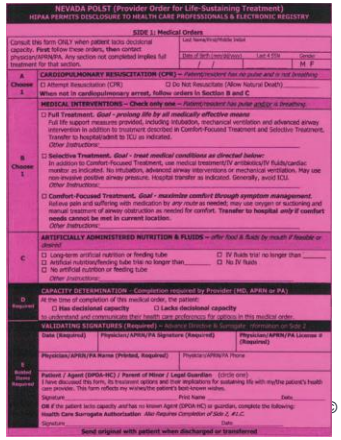
PART 2 – MEDICAL ORDERS
Section A – Cardiopulmonary Resuscitation (CPR)
Person has no pulse and is not breathing. See MDHHS-5837 for further details.
☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions
Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.
☐ Comfort-Focused Treatment
Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
☐ Selective Treatment
Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
☐ Full Treatment
Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Send form with patient whenever transferred or discharged.

MDHHS-5836 (Rev. 8-22) Previous edition obsolete. 1


NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

SIDE 1: Medical Orders
Consult this form ONLY when patient lacks decisional capacity. Post follow these orders, then current physician/APRNPA. Any section not completed implies full treatment for that section.
Last Name/Suffix Initial | Date of Birth (mm/dd/yyyy) | Last 4 SSN | Gender M F
When not in cardiopulmonary arrest, follow orders in Section B and C

A Choose 1
CARDIOPULMONARY RESUSCITATION (CPR) – Patient/resident has no pulse and is not breathing.
☐ Attempt Resuscitation (CPR) ☐ Do Not Resuscitate (Allow Natural Death)

B Choose 1
MEDICAL INTERVENTIONS – Check only one – Patient/resident has pulse and/or is breathing.
☐ Full Treatment. Goal - prolong life by all medically effective means
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention in addition to treatment described in Comfort-Focused Treatment and Selective Treatment. Transfer to hospital/admit to ICU as indicated.
Other Instructions:
☐ Selective Treatment. Goal - treat medical conditions as directed below:
In addition to Comfort-Focused Treatment, use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally, avoid ICU.
Other Instructions:
☐ Comfort-Focused Treatment. Goal - maximize comfort through symptom management.
Relieve pain and suffering with medication by any route as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
Other Instructions:

C
ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – offer food & fluids by mouth if feasible or
☐ Long-term artificial nutrition or feeding tube ☐ IV fluids trial no longer than _____
☐ Artificial nutrition/feeding tube trial no longer than _____ ☐ No IV fluids
☐ No artificial nutrition or feeding tube
Other Instructions:

CAPACITY DETERMINATION – Completion required by Provider (MD, APRN or PA)
At the time of completion of this medical order, the patient:
☐ Has decisional capacity ☐ Lacks decisional capacity
To understand and communicate their health care preferences for options in this medical order.

D Required
VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate Information on Side 2
Date (Required) | Physician/APRN/PA Signature (Required) | Physician/APRN/PA License # (Required)
Physician/APRN/PA Name (Printed, Required) | Practice/APRN/PA Phone

E Guided Review Required
Patient / Agent (SDMA-HC) / Parent of Minor / Legal Guardian (circle one)
I have discussed this form, its treatment options and their implications for sustaining life with my/the patient's health care provider. This form reflects my wishes/the patient's best-known wishes.
Signature _____ Print Name _____ Date _____
OR if the patient lacks capacity and has no known Agent (SPOA-HC) or guardian, complete the following:
Health Care Surrogate Authorization. Also Requires Completion of Side 2, #1.C.
Signature _____ Date _____
Send original with patient when discharged or transferred


HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. ATTACH PINK DNR FORM IF PATIENT HAS ONE.
Medical Record # (Optional)

New Hampshire POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/advance-approved-patients-pdf).

Patient Information. Having a POLST form is always voluntary.
This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form
Patient First Name: _____
Middle Name/Initial: _____ Preferred name: _____
Last Name: _____ Suffix (Jr, Sr, etc): _____
DOB (mm/dd/yyyy): _____ State where form was completed: _____
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-_____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.
Page 1
☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)
☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)
This will override an DNR ordered via separate DNR order will be disregarded. RSA 137-J:24 VIII.

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.
Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.
Page 1
☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
☐ Comfort-Focused Treatments. Goal: Maximize comfort through symptom management, allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

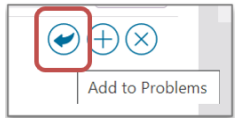
C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
EMS protocols may limit emergency responder ability to act on orders in this section.

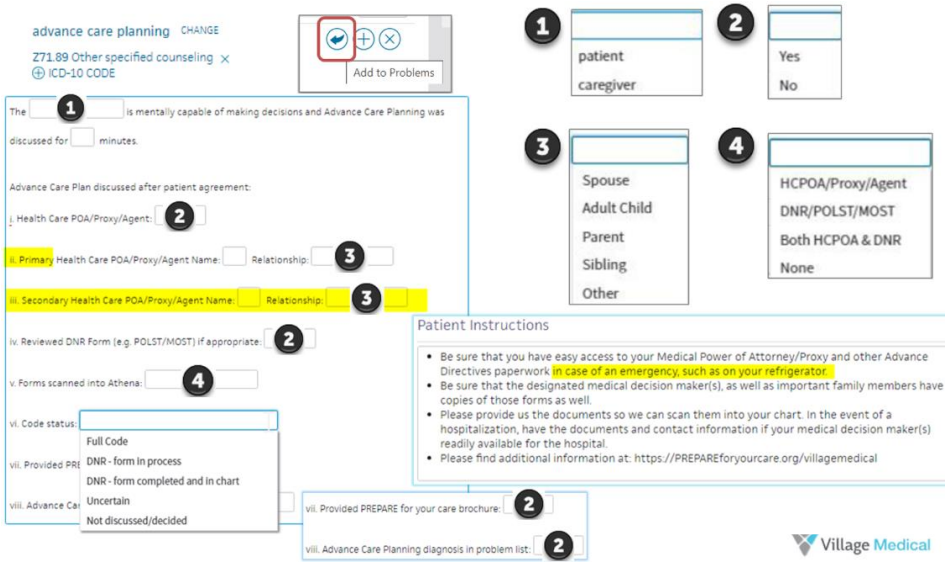
D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)
Page 2
☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition that is surgically placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURES: Patient or Patient Representative (Required documents are valid)
I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.
☒ (Required) The most recently completed valid POLST form supersedes all previously completed POLST forms.
If other than patient, print full name. Authority:
F. SIGNATURES: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.
I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order.
☒ (Required) Date (mm/dd/yyyy) (Required) Phone #: (Required)
Printed Full Name: _____ License/Cert. #:
Supervising physician (if NP/PA) ☐ NA License #:
A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2023

Documenting ACP in Problem List (PL)

- Village Medical uses the problem list to store and communicate ACP information.
  - Placing “Advance Care Planning” in Reason for Visit to generate template in the A/P (see below & in Appendix) & fill in ACP information
  - “Arrow” over ACP information to problem list
  - Update ACP information as it evolves
- Summarize information in the “Note” box include POA names, code status, wishes regarding ventilation, tube feeding, hospital, place of death, funeral wishes, etc.





She was born and raised Catholic. She would like a catholic burial, will be buried next to husband in Perim Maine. He was 82 ys old and passed away in 2022, at home and she remembers nurses were there. She "I'm never going back the the hospital again." Her wishes are to pass away at home, not in a hospital.

From 12-19-2024 visit:
The patient is not mentally capable of making decisions

Advance Care Plan discussed after patient agreement:

i. Health Care POA/Proxy/Agent: Yes

ii. Primary Health Care POA/Proxy/Agent Name: Maurice Granville Relationship: Adult Child

iii. Secondary Health Care POA/Proxy/Agent Name: Greg Granville Relationship: Adult Child

iv. Reviewed DNR Form (e.g. POLST/MOST) if appropriate: N/A

v. Forms scanned into Athena: MOLST

vi. Code status: DNR - form completed and in chart

vii. Provided PREPARE for your care brochure: Yes

viii. Advance Care Planning diagnosis in problem list: Yes

During her stay at Cedar View, pt DPOAH was activated. Her code status was changed from FULL to DNR, No Artificial Hydration, No artificial Nutrition and No Dialysis.

There is a Mass Healthcare Proxy on file and scanned into chart. Facility is requesting NH be completed

Last modified by tcornwell3 | 01-25-2025, 07:29 PM

Billing Advance Care Planning

- ACP services include explanation and discussion of advance directives **with or without completing forms**. Examples of forms include:
  - Power of Attorney for Health Care (POAHC)/PREPARE for Your Care/State Forms/5 Wishes
  - Do Not Attempt Resuscitate (DNR); Physician/Medical Orders for Life-Sustaining Treatment (P/MOLST)
- **99497** – Advance care planning; *first 30 min* (**minimum 16 minutes**): **wRVU = 1.50 ($87)**
- **99498** – Advance care planning; *each add'l 30 minutes* (min 46 minutes): wRVU = 1.40 (use with 99497)
- Must be face-to-face with the patient, family members or surrogate
- May be furnished by an Advance Practice Provider (APP)
- Social worker/RN time can be included with a provider order and the provider present in the office. Best practice is for the provider to sign the social worker/RN ACP note
- May be billed in conjunction with AWV (no copay), E/M, TCM, CCM
- Provider must obtain and document **verbal patient consent** for ACP discussion to include possible copay
- ACP discussion and **time spent must be documented**
- No limit on how often ACP can be done as long as there is medical necessity

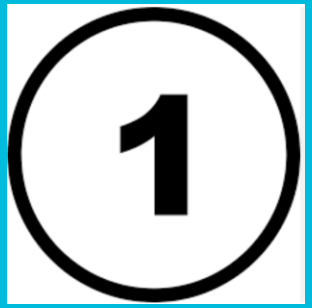
Resources for Advance Care Planning

- Advance Care Planning Modules (4): https://360.articulate.com/review/content/61913866-1804-4601-8131-c839e700df68/review
  1. The Why and When of Advance Care Planning
  2. The How of Advance Care Planning
  3. Palliative Care and Hospice
  4. Goals of Care and Serious Illness Conversations.
- PREPARE for your care: PREPARE
  - PREPARE brochures in waiting rooms and exam rooms for providers/MAs to discuss and encourage completion.
  - PatientPoint and or signage for free HCPOA
- Five Wishes: Home · Five Wishes
- FL, GA, MI, NV, and NH PREPARE advance directives, state DNR forms, and a sample 5 Wishes were sent to Rashida Morgan rmorgan@villagemd.com

End-of-Life Care Opportunity

Presented by Adam Matsil

Literature



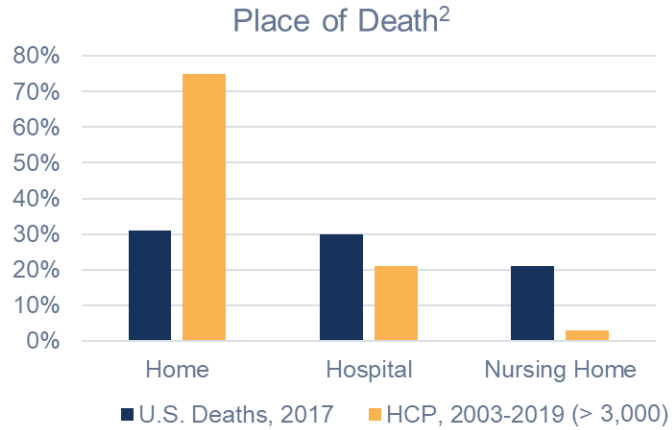
Why Advance Care Planning? Data supports its effectiveness.

1. “Numerous studies have raised concerns about the quality of end-of-life (EOL) care provided to older adults in the US, with little change across 30 years of research.” Medicare spending on patients in their last year of life accounts for 25% of program expenditures, with median spending in the last 6 months alone exceeding $25,000 in many parts of the country. Medicare-Covered Services Near the End of Life in Medicare Advantage vs Traditional Medicare | Health Policy | JAMA Health Forum | JAMA Network Nicolas 07/24

2. Hospice decreases cost at end of life: $2,813 last 3 days; $6,806 last week; $8,785 last 2 weeks; $11,747 last month; $10,908 last 3 months. Family out of pocket expenditures were lower for hospice enrollees: $71 last 3 days; $216 last week; $265 last 2 weeks; $670 last month. Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018 | Health Policy | JAMA Health Forum | JAMA Network Aldridge 02/2022

Strong advance care planning can have huge impact on end-of-life care utilization and cost

Medicare Spend in Final Year of Life **25%** of $747B[1]



U.S. Deaths 2015[3]		HCP Deaths 2017-2019
65%	**Hospitalization** in final 90 days of life	37%
29%	**ICU** in final 30 days	5%
50%	On **Hospice**	76%
	Median **HCP LOS**	1.3 years

[1] Riley, Lubitz; *Long-Term Trends in Medicare Payments in the Last Year of Life*, Health Services Research, 4/2010
[2] Cross, Warraich; *Changes in the Place of Death in the United States;* NEJM, 12/19
[3] Teno; Site of Death, Place of Care, and Health Care Transitions Among US Medicare Beneficiaries, JAMA 2018

Financial Opportunity

VMD performed slightly better than benchmark of 65% for % admitted last 90D and on hospice at time of death

Market	# Deceased	% Acute Admit Last 90D *FFS Avg = 65%*	% ICU Admit Last 30D *FFS Avg = 29%*	% On Hospice (REACH Only) *FFS Avg = 50%*	% ACP Conversation	% ACP Document Uploaded
All Markets	**4,680**	**58%**	**33%**	**54%**	**36%**	**14%**
Houston	1,576	63%	34%	53%	65%	14%
Phoenix	1,130	55%	36%	56%	32%	14%
Atlanta	670	58%	31%	63%	21%	11%
Detroit	303	46%	25%	45%	9%	9%
Kentucky	225	60%	26%	48%	35%	24%
New Hampshire	238	60%	27%	54%	10%	9%
Texas Growth	286	62%	39%	56%	4%	6%

1. As an enterprise, compared to a 2015 study of Medicare FFS beneficiaries:
    1. Performed slightly better at % admitted last 90 days of life (58% actual vs 65% average) and % passing away on hospice (54% actual vs 50% average).
    2. Performed slightly worse than benchmark for % ICU admissions last 30 days of life (33% vs 29% average).
2. Overall, 36% of patients had a documented ACP conversation prior to death (ACP billed or ACP on problem list) and 14% had some sort of ACP document uploaded into Athena.
    1. Houston was most successful in this area, where 65% of patients who passed away had evidence of an ACP conversation occurring.

Among all Medicare VBC patients across VMD, 28% have had some sort of ACP conversation and 6% have an ACP-related document uploaded

	All Medicare VBC			Tier 4			VMH Enrolled			CM Enrolled		
Market	**# Patients**	**% ACP Convo**	**% ACP Document**	**# Patients**	**% ACP Convo**	**% ACP Document**	**# Patients**	**% ACP Convo**	**% ACP Document**	**# Patients**	**% ACP Convo**	**% ACP Document**
All Markets	**174,181**	**28%**	**6%**	**11,141**	**44%**	**17%**	**2,728**	**90%**	**49%**	**12,060**	**41%**	**8%**
Houston	58,682	55%	6%	4,243	70%	16%	1,327	92%	39%	5,041	67%	9%
Phoenix	39,555	22%	5%	2,143	42%	18%	600	95%	60%	3,131	29%	7%
Atlanta	21,327	22%	5%	1,400	39%	16%	275	88%	43%	1,162	33%	9%
Detroit	11,036	6%	5%	665	12%	13%	90	64%	43%	1,323	7%	5%
Kentucky	4,996	29%	14%	324	43%	31%	171	91%	61%	345	36%	17%
New Hampshire	11,957	4%	1%	776	12%	7%	105	55%	50%	722	5%	1%
Texas Growth	14,439	4%	3%	900	5%	6%		N/A		105	7%	5%
Denver	12,189	4%	13%	690	24%	42%	160	85%	95%	231	9%	29%

Notes and Commentary

1. All currently live Medicare VBC patients.
2. ACP conversation: ACP CPT code has been billed or ACP is on the problem list (limited to practices using Athena).
3. ACP document: either DNR or POA uploaded into Athena.
4. Across all Medicare VBC patients, 28% have had an ACP conversation and 6% have an ACP-related document uploaded into Athena.
5. VMH is setting the bar high: among all enrolled patients, 90% have had an ACP conversation and 49% have an ACP-related documented uploaded into Athena.

For ~170k VBC lives - last 90D of life for 4.6k deceased patients accounts for ~7% of MedEx and ~8% of admits
4K admits in last 90D of life drive ~$61M in MedEx. Decreasing EOL admits by 20% could lead to $12M of savings

Market	# Deceased	Market Total MedEx ($M)	MedEx Last 30D of Life ($M)	MedEx Last 90D of Life ($M)	Market Total IP Acute Admits	IP Acute Admits Last 30D of Life	IP Acute Admits Last 90D of Life
All Markets	**4680**	**$2,038**	**$74 (4%)**	**$145 (7%)**	**36,094**	**2,849 (8%)** *Readmits = 650 (23%)*	**4,087 (11%)** *Readmits = 1,129 (28%)*
Houston	1576	$784	$29 (4%)	$58 (7%)	14,668	1,045 (7%) *Readmits = 267 (26%)*	1,579 (11%) *Readmits = 500 (32%)*
Phoenix	1130	$427	$16 (4%)	$29 (7%)	6,981	622 (9%) *Readmits = 127 (20%)*	894 (13%) *Readmits = 208 (23%)*
Atlanta	670	$275	$10 (4%)	$21 (8%)	5,035	385 (8%) *Readmits = 94 (24%)*	572 (11%) *Readmits = 161 (28%)*
Detroit	303	$115	$5 (4%)	$10 (8%)	1,886	180 (10%) *Readmits = 40 (22%)*	218 (12%) *Readmits = 67 (31%)*
Kentucky	225	$57	$3 (6%)	$6 (10%)	1,019	159 (16%) *Readmits = 27 (17%)*	194 (19%) *Readmits = 39 (20%)*
New Hampshire	238	$121	$4 (3%)	$7 (6%)	2,173	146 (7%) *Readmits = 28 (19%)*	200 (9%) *Readmits = 45 (23%)*
Texas Growth	286	$157	$5 (3%)	$8 (5%)	3,000	186 (6%) *Readmits = 42 (23%)*	266 (9%) *Readmits = 70 (26%)*
Denver	252	$103	$3 (3%)	$6 (6%)	1,332	126 (10%) *Readmits = 25 (20%)*	164 (12%) *Readmits = 39 (24%)*

Notes and Commentary

1. Looking at cost and utilization for attributed patients who passed away between 4/2024 – 3/2025 for payors with validated claims data.
    1. Includes MA patients who were attributed at time of death (excludes hospice).
2. Across all markets, utilization last 30D of life accounts for 4% of all medical spend ($74M) and 8% of all admits (N=2,849).
3. As an enterprise, utilization last 90D of life accounts for 7% of all medical spend ($145M) and 11% of all admits (N=4,087).
4. Readmits account for ~20-25% of all acute admissions in the last 30D of life.
5. Houston, New Hampshire, and the Texas Growth markets had the lowest cost & utilization at end-of-life compared against the other VMD markets.
6. Kentucky was at the higher end of cost/utilization at EOL across VMD markets.

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VM Provider Survey on ACP

Provider Survey: >15% response rate in 2 days

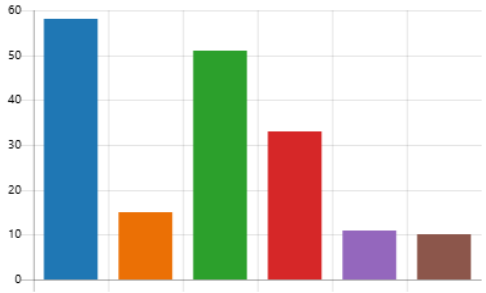
Initial results from survey shows providers find ACP important but are looking for tools and care team support to ensure it's completed for their patients. Misconceptions about barriers

1. Advance Directives are important for the following populations (choose all that apply)

All adults with serious illness	60
All adults ≥ 65	61
All adults ≥ 18	53
Advance directives are not im...	0

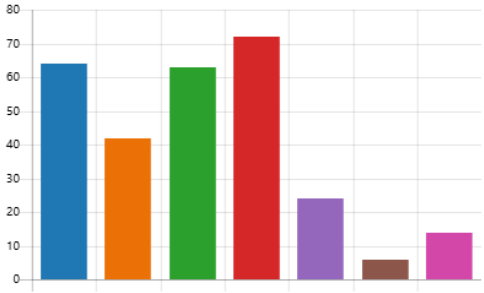
2. What barriers do you have in helping patients complete advance directives (choose all that apply)?

Lack of time	58
Lack of training	15
Patient unwillingness	51
Difficulty getting witnesses or ...	33
No barriers	11
Other	10



3. What resources would help you with patient advance directive completion (choose all that apply)?

Having an advance directive t...	64
Having a website that explains...	42
Having medical assistants/ oth...	63
Having team support (care ma...	72
Sending out a referral to a Vill...	24
No additional resources needed	6
Other	14



4. I believe that advance care planning is an important part of a provider practice, and we should dedicate resources to provide this service.

Strongly agree	72
Agree	27
Neutral	4
Disagree	0
Strongly disagree	0

Free text responses to provider ACP survey

ur experience with advance directive conversations and form completion?

Responses
Not sure what to do for patients who continue to not complete despite monthly efforts made
Introducing the forms and what they mean is straight forward. Taking the time to discuss nuances is vital but hard to come by in 15 minute slots, particularly with folks that need it most. A dedicated visit to discuss advance directives or team member who can discuss/review with them outside of scheduled OV times would be great.
VMH is being held accountable for completion of these documents in the home where there is less support staff available. A Notary would be beneficial to the completion and finalization of documents.
Not really possible to discuss and complete during AWVs. Not enough time allotted.
Difficult to fit in to a packed office visit but repeated short conversations are impactful. Multiple reminders needed to get it done and brought in, SW/CM can assist w these reminders. Witness usually not a problem but SW can help w that also
I have been addressing this at my patient's annual wellness or physical every year for years.
All our clinical leads are certified public notaries. Patients leave with the form but they do not bring it back. We need follow up resources.

ur experience with advance directive conversations and form completion?

I give them the AZ advanced care directive packet and only about 20% of patients actually fill it out and bring it back
Offer incentives for patients to bring the forms back
There should be someone designated to assist patients with this form other than providers.
Many patients either do not have someone to appoint, or do not want to complete the paperwork. I believe it is very much a generational thing. Most are generally unconcerned about completing the paperwork because they would name their spouse, who legally is already the decision maker.
Those team members who are not interacting with the family/patient consistently tend to become disconcerted and harried when asked to reach out more than once, and then it falls back on the provider to make the attempts
I believe ACP is an integral part in the care of our high risk patients, and believe it should be incentivized in order for completion, otherwise, honestly it will not get done to the degree it is being completed. I believe the goal was too high, and i say this because according to June's numbers released in this months clinical excellence meeting, less than 17% of markets and less than 18% of providers made the 55% mark. Hindsight is awesome, for its initial year, I would have set bar lower, based on pre VBI ACP numbers, and would have set a mid year goal similar to the AWV mid year goal. I believe we are the best of the best, but i also believe in realistic goals. Also we should have direct access to the status of all goals that have direct impact

Free text responses to provider ACP survey

ur experience with advance directive conversations and form completion?	
	N/A
There is too much time wasted during patient check in and MA processing that by the time the provider can see the patient we are in a rush to prevent delaying other patients.	PREPARE was a great resources for patients and they enjoyed how easy it was to comprehend.
My previous experience working in primary care only stressed discussion of ACD discussion for medicare pts during AWV's. I'm happy this is being encouraged to be done regularly by Village Medical.	I get two extremes that makes it difficult to complete forms, some patients are not ready or want to complete the forms and others have a challenge in getting the forms either notarized or witnessed
recommend training MAs to give a printed AD form to patients at the time of AWV.	I have the forms printed and ready to hand out to patient but have trouble finding time to add it to the note documentation and getting it done as part of the visit.
Working virtually except occasionally fill in at clinics, just not experienced in completing advanced directives	helping pt filling out the forms and explaining the forms to pts and their family are very important for getting the forms completed.
Do not have time to take 16 minutes to discuss when I only have 15 minutes for AWVs and physicals.	See comments on previous sections
it is important but some time it is not an easy conversation with patient.	20 minute visits are not enough time to go over ALL their health concerns AND discuss advanced directives, so a referral team to help with this would be very helpful!
I'm ELNEC and Corewell trained and certified in Respecting choices, ADV DIR and goals of care discussions	I'd more training/information on the proper procedure for initiating this discussion and getting this done for my patients.
N/A	

Free text responses to provider ACP survey

main issue is the time commitment, Village wants to hit on so many metrics this would be one more. By themselves its possible to do but in aggregate they become incredibly burdensome to get through a visit.
AWV does not allow ample time for this complex and sensitive issue, albeit necessary. If it goes to family in advance to complete with family members is ideal. Second best, is the patient taking home the form to drop off at a later time. Third best is the MAs or other care team members to assist in completing the form. Minimally PCP should be informed. As a PRN provider completing AWVs, I don't feel that the first time meeting a patient is the time to complete it.
No
A simple form with simple language would be the easiest for our patients.
Lack of time is main limitation. My average appointment time is 15 min.
Patients do not know what the forms are for. Some patients are not unwilling. Need form in different languages. Recommend a video for patients.
many patients dont understand all the options available or what each options means or feel overwhelmed by this topic or that it is something for only dying patients , we need better info to give them on all the terms and different options and what each choice means - also in hospital versus out of hospital

Advanced Illness & Frailty

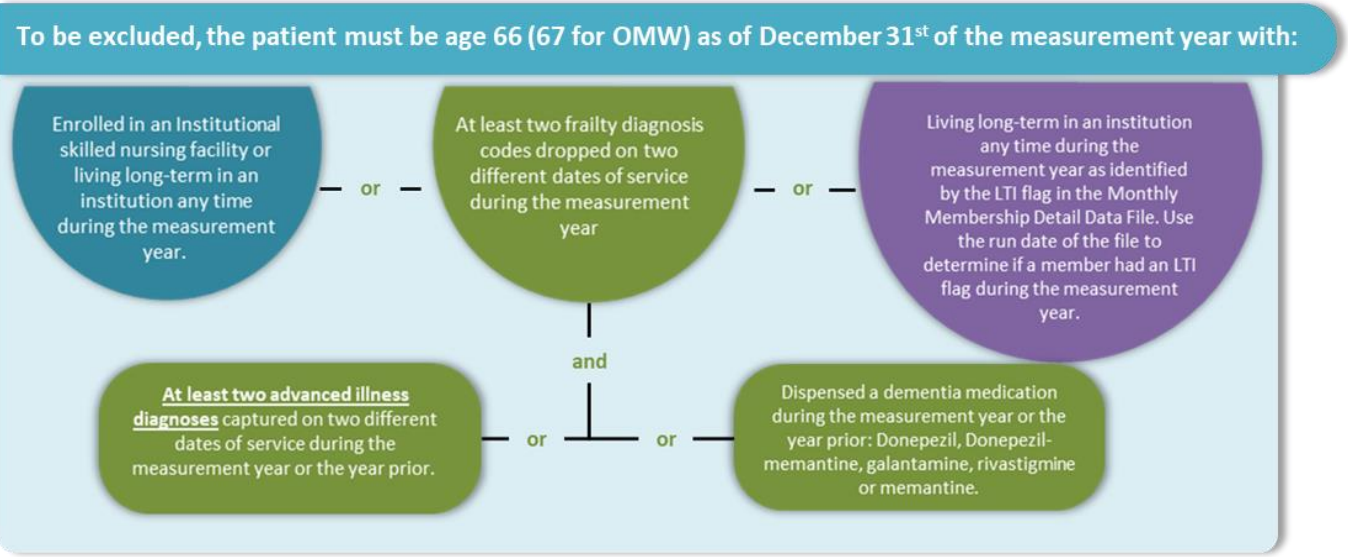
- Advanced Illness & Frailty Exclusions
- HEDIS measures that allow exclusions
- Dementia medications that excludes patients
- Common Advanced Illness & Frailty codes
- Frailty Order Set and Macro

Presented by Kiersten Kinchen

VillageMD

Advanced Illness & Frailty Exclusions

Quality measures may not benefit older adults with limited life expectancy and advanced illness.
Additionally, unnecessary tests or treatments could burden these patients or even be harmful. For that reason, the National Committee for Quality Assurance (NCQA) has ***allowed additional exclusions*** to the Healthcare Effectiveness Data Information Set (HEDIS) measures, for patients with advanced illness & frailty.



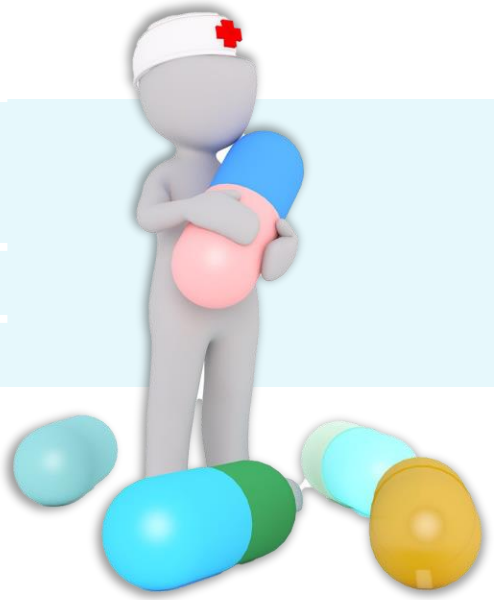
What HEDIS measures allow Advanced Illness & Frailty exclusions?

- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Glycemic Status Assessment for Patients with Diabetes (the measure formerly known as Hemoglobin A1c control with Diabetes)
- Controlling Blood Pressure (CBP)*
- Eye Exam for Patients with Diabetes (EED)
- Osteoporosis Management in Women Who Had a Fracture (OMW)*
- Kidney Health Evaluation for Patients with Diabetes (KED)*

*Patients aged 81 and older can be excluded with frailty alone for these measures.

Which Dementia Medications will exclude patients?

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine



Common ICD-10 Codes

Frailty codes

Pressure Ulcers (Stages 1-4)	L89.000 through I89.90-96
Home Oxygen/ Ventilator Respiratory Devices	99504 - Home visit for mechanical ventilation care [Z99.11] Dependence on respirator [ventilator] status [Z99.81] Dependence on supplemental oxygen [E0465, E0466, E0470-0472] Home ventilator/ PPV/ Respiratory Assist Device [E0424-25, 0430-31, 0433-35, 0439-44] Oxygen
Living in LTC Facility	[Z59.3] Problems related to living in residential institution [Y92.199] Unspecified place in other specified residential institution as the place of occurrence of the external cause
ADLs/ Home Care	[Z74.1] Need for assistance with personal care [Z74.2] Need for assistance at home and no other household member able to render care [Z74.3] Need for continuous supervision [Z74.8] Other problems related to care provider dependency [Z74.9] Problem related to care provider dependency, unspecified [E0163, 0165, 0167-68, 0170-71] Commode Chair [E0250-51, 0255-56, 0260-61, 0265-66, E0270, 0290-97, 0301-04, 0462] Hospital Bed [G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001-1005, T1019, T1020- 1022, T1030, T1031] Home Health Skilled Nursing Services
Falls	[W01.0XXA - W01.198S] Fall on same level from slipping, tripping, and stumbling [W06.XXXA-XXXS] Fall from bed [W07.XXXA-XXXS] Fall from chair [W08.XXXA-XXXS] Fall from other furniture [W10.0XXA-XXS] Fall from escalator [W10.1-10.9XXA-XXS] Fall from sidewalk curb, incline, stairs and steps [W18.00-18.09XA-XS] Striking against unspecified/other object or glass with subsequent fall [W18.11-18.12XA-XS] Fall from or off toilet [W18.2XXA-XXS] Fall in shower or bathtub [W18.30-18.39XA-XS] Fall on same level, unspecified or due to stepping on object [W19.XXXA-XXXS] Unspecified Fall [Z91.81] History of falling
Mobility Issues	[R26.2] Difficulty in walking, not elsewhere classified [R26.89] Other abnormalities of gait and mobility [R26.9] Unspecified abnormalities of gait and mobility [Z74.09] Other reduced mobility [R54] Age-related physical debility [Z99.3] Dependence on wheelchair [Z73.6] Limitation of activities due to disability [Z74.01] Bed confinement status [Z74.09] Other reduced mobility [E0100, 0105, 0130, 0135, 0140-141, 0143-144, 0147-149] Cane/ Walker [E1130, 1140, 1150, 1160-61, 1170-1172, 1180, 1190, 1195, 1200, 1220, 1240, 1250, 1260, 1270, 1280, 1285, 1290, 1295-98] Wheelchair
Failure to Thrive	[R53.1] Weakness [R53.81] Other malaise [R62.7] Adult failure to thrive [R63.4] Abnormal weight loss [R63.6] Underweight [R64] Cachexia [M62.50] Muscle wasting and atrophy, not elsewhere classified, unspecified site [M62.81] Muscle weakness (generalized) [M62.84] Sarcopenia

Advanced Illness codes

Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J98.2, J98.3
Pulmonary Fibrosis	J84.10, J84.112, J84.17
Other Respiratory	J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92
Dementia **Creutzfeldt-Jakob Disease**	F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.96, F10.97, G31.01, G31.09, G31.83 A81.00, A81.01, A81.09
Alzheimer's	G30.0, G30.1, G30.8, G30.9
Parkinson's **Huntington's**	G10, G12.21, G20
CKD Stage 5/ ESRD	I12.0, I13.11, I13.2, N18.5, N18.6
Alcohol and Hepatic Disease	K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69
Heart Failure (Acute & Chronic)	I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9
Cancer	Leukemia (not having achieved remission or in relapse); Malignant neoplasm of brain, pancreas; Secondary and unspecified malignant neoplasm of lymph nodes, lung, mediastinum, pleura, other respiratory organs, small intestine, large intestine and rectum, peritoneum and retroperitoneum, liver and hepatic bile ducts; Secondary malignant neoplasm of other digestive organs, kidney and renal pelvis, bladder, other urinary organs, skin, brain, cerebral meninges, other parts of nervous system, bone, bone marrow, ovary, adrenal gland, breast, genital organs, other specific sites, other unspecified sites;

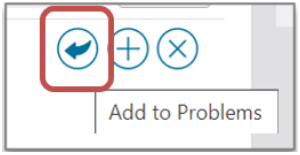
APPENDIX

Documenting in A/P: Reason for visit "Advance Care Planning"

advance care planning CHANGE

Z71.89 Other specified counseling ×

⊕ ICD-10 CODE



The [1] is mentally capable of making decisions and Advance Care Planning was discussed for [ ] minutes.

Advance Care Plan discussed after patient agreement:

i. Health Care POA/Proxy/Agent: [2]

ii. Primary Health Care POA/Proxy/Agent Name: [ ] Relationship: [3]

iii. Secondary Health Care POA/Proxy/Agent Name: [ ] Relationship: [3]

iv. Reviewed DNR Form (e.g. POLST/MOST) if appropriate: [2]

v. Forms scanned into Athena: [4]

vi. Code status:

- Full Code
- DNR - form in process
- DNR - form completed and in chart
- Uncertain
- Not discussed/decided

vii. Provided PRE

viii. Advance Ca

1
- patient
- caregiver

2
- Yes
- No

3
- Spouse
- Adult Child
- Parent
- Sibling
- Other

4
- HCPOA/Proxy/Agent
- DNR/POLST/MOST
- Both HCPOA & DNR
- None

Patient Instructions

- Be sure that you have easy access to your Medical Power of Attorney/Proxy and other Advance Directives paperwork in case of an emergency, such as on your refrigerator.
- Be sure that the designated medical decision maker(s), as well as important family members have copies of those forms as well.
- Please provide us the documents so we can scan them into your chart. In the event of a hospitalization, have the documents and contact information if your medical decision maker(s) readily available for the hospital.
- Please find additional information at: https://PREPAREforyourcare.org/villagemedical

vii. Provided PREPARE for your care brochure: [2]

viii. Advance Care Planning diagnosis in problem list: [2]

Village Medical

Measuring Success: Village Medical Process Measures

Village Medical Georgia

Report Month	# Patients	% ACP Problem List	% ACP Billed Last 12 Months	% Scanned DNR Document	% Scanned POA Document
September 2025	21,342	6.3%	3.4%	1.6%	3.8%
August 2025	21,327	6.3%	3.5%	1.6%	3.7%
July 2025	21,113	6.2%	3.5%	1.5%	3.6%

Village Medical at Home Georgia

Report Month	# Patients	% ACP Problem List	% ACP Billed Last 12 Months	% Scanned DNR Document	% Scanned POA Document
September 2025	272	83.8%	43.8%	26.8%	29.8%
August 2025	275	83.6%	46.2%	25.1%	30.2%
July 2025	278	83.8%	43.9%	20.9%	27.0%

Village Medical Michigan

Report Month	# Patients	% ACP Problem List	% ACP Billed Last 12 Months	% Scanned DNR Document	% Scanned POA Document
September 2025	10,924	2.6%	1.5%	0.8%	4.0%
August 2025	11,036	2.4%	1.4%	0.8%	3.9%
July 2025	10,785	2.3%	1.4%	0.7%	3.9%

Village Medical at Home Michigan

Report Month	# Patients	% ACP Problem List	% ACP Billed Last 12 Months	% Scanned DNR Document	% Scanned POA Document
September 2025	92	60.9%	12.0%	39.1%	16.3%
August 2025	90	57.8%	10.0%	40.0%	13.3%
July 2025	85	52.9%	7.1%	35.3%	12.9%

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal/Medical documents (e.g., HCPOA / Agent / Proxy and DNR) to ensure wishes are carried out if unable to communicate
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild)
    - Consensus: “interested persons” determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment
- **Florida**http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0765/Sections/0765.401.html
  - Appointed guardian; spouse; adult child (majority available); parent; sibling (majority); adult relative who has exhibited special care and concern; a close friend; LCSW proxy designated by Ethics Committee pursuant to chapter 491
  - Restrictions: If sign POLST 2 doctors to sign. HCPOA only need 1.

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal (e.g., Health Care Power of Attorney/Proxy) and Medical (e.g., DNR, POLST, MOST) documents to ensure wishes are carried out
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild, etc.)
    - Consensus: “interested persons” determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment
- **Georgia Surrogate Decision Maker (Authorized Person)**
  - Order: Spouse; Guardian; Adult Child; Parent; Adult; Sibling; Grandparent; Grandchild; Adult Niece, Nephew, Aunt, Uncle of first degree; Adult Friend
  - Restrictions: If surrogate signs vs. HCPOA then need 2 doctors to sign POLST. HCPOA only need 1.

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal (e.g., Health Care Power of Attorney/Proxy) and Medical (e.g., DNR, POLST, MOST) documents to ensure wishes are carried out
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild, etc.)
    - Consensus: “interested persons” determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment
- **Michigan Surrogate Decision Maker**
  - Legally appoint guardian, spouse, adult child, parent, adult sibling. If no family “an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and is willing and able to make healthcare decisions.”

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal/Medical documents (e.g., HCPOA/Agent/Proxy and DNR) to ensure wishes are carried out if unable to communicate
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild)
    - Consensus: "interested persons" determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment
- **Nevada** NRS: CHAPTER 449A - CARE AND RIGHTS OF PATIENTS (search "surrogate" or "POLST")
  - Order: Spouse or domestic partner, adult children, parents, adult siblings, other relatives by blood or adoption (excluding in-laws); an adult who has exhibited special care or concern for the patient.
  - Restrictions: ECT or involuntary commitment for mental illness.

Advance Care Planning

- **Advance Care Planning (ACP)**: a process that supports adults at **any age** or stage of health in understanding and sharing their **personal values, life goals, and preferences regarding future medical care**.
- **Advance Directives (AD)**: Legal (e.g., Health Care Power of Attorney/Proxy) and Medical (e.g., DNR, POLST, MOST) documents to ensure wishes are carried out
- **State Surrogate Decision Maker (SDM)**: State designated decision maker for an incapacitated patient
  - Who
    - Hierarchy (e.g., spouse, adult child, parents, sibling, grandchild, etc.)
    - Consensus: "interested persons" determine decision maker
  - Restrictions: often behavioral health (psych admission, ECT); sometimes life-sustaining treatment
- **New Hampshire** https://www.gencourt.state.nh.us/rsa/html/X/137-J/137-J-mrg.htm
  - Order: patient's spouse, or civil union partner or common law spouse; adult child; parent; adult sibling; adult grandchild; grandparent; adult aunt/niece/nephew; friend
  - Restrictions: voluntary admission to state institution; psychosurgery or ECT; sterilization; withholding life-sustaining treatment if pregnant;
  - Can consent to clinical trials in certain circumstances.

Florida Do Not Resuscitate Order

- Must be printed on some shade of yellow paper
- No witness required
- Should be easily accessible such as on the refrigerator or at the head or foot of bed
- Below is “Patient Identification Device.” It can be laminated and worn around one’s neck or attached to a key chain (per floridahealth.gov). Equally valid. Not required.

State of Florida
DO NOT RESUSCITATE ORDER
(please use ink)

Patient’s Full Legal Name:_____ Date: _____
(Print or Type Name)

PATIENT’S STATEMENT
Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

- ☐ Surrogate
- ☐ Court appointed guardian
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)

PHYSICIAN’S STATEMENT
I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient’s cardiac or respiratory arrest.

(Signature of Physician) (Date) (___)___-____ Telephone Number (Emergency)

(Print or Type Name) (Physician’s Medical License Number)

DH Form 1896, Revised December 2004

PHYSICIAN’S STATEMENT
I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient’s cardiac or respiratory arrest.

(Signature of Physician) (Date) (___)___-____ Telephone Number (Emergency)

(Print or Type Name) (Physician’s Medical License Number)

DH Form 1896, Revised December 2004

State of Florida
DO NOT RESUSCITATE ORDER

Patient’s Full Legal Name (Print or Type) (Date)

PATIENT’S STATEMENT
Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

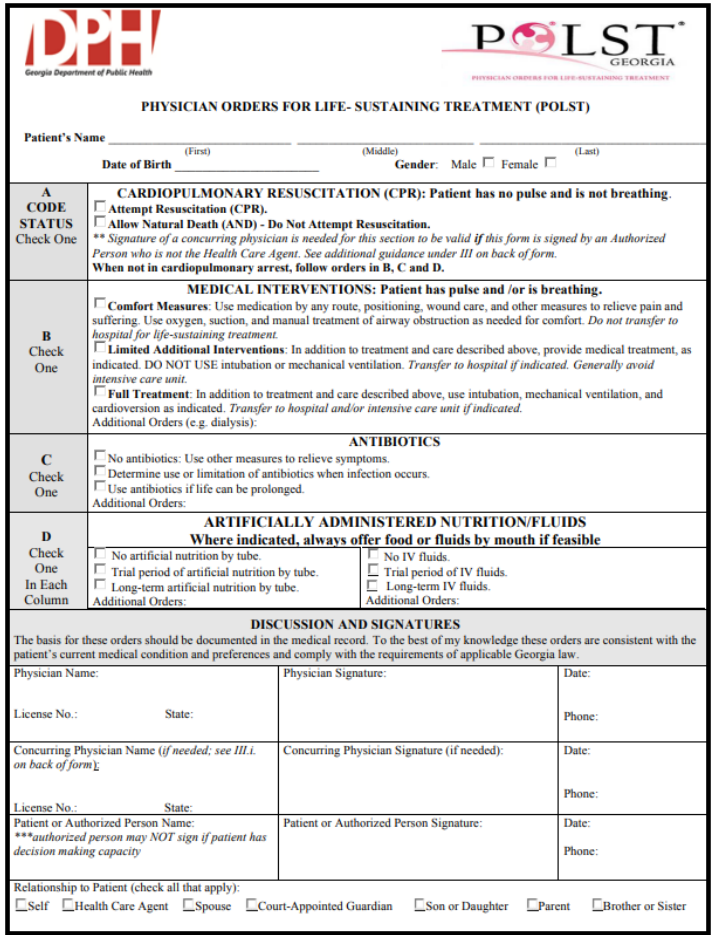
- ☐ Surrogate
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Court appointed guardian
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)

Georgia Physician Orders for Life Sustaining Treatment (POLST)

2015 Senate Bill 109

- POLST is the DNR Order
- Physician Signature
- A copy is valid; 2nd page has instructions
- POLST executed in another state is valid if “substantially similar” to Georgia POLST
- Concurrent Physician signature required if not signed by patient or HCPOA / Agent (i.e., if Surrogate decision maker signs, then two physicians need to sign).



DPH Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ **Gender**: Male ☐ Female ☐

A CODE STATUS Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.
☐ **Attempt Resuscitation (CPR).**
☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.**
** *Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.*
When not in cardiopulmonary arrest, follow orders in B, C and D.

B Check One

MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.
☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.*
☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.*
☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
Additional Orders (e.g. dialysis):

C Check One

ANTIBIOTICS
☐ No antibiotics: Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.
Additional Orders:

D Check One In Each Column

ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS
Where indicated, always offer food or fluids by mouth if feasible

☐ No artificial nutrition by tube.	☐ No IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
Additional Orders:	Additional Orders:

DISCUSSION AND SIGNATURES
The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ***authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):
☐Self ☐Health Care Agent ☐Spouse ☐Court-Appointed Guardian ☐Son or Daughter ☐Parent ☐Brother or Sister

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Michigan Physician Orders for Scope of Treatment (MI-POST)

- MD/DO, APN, PA can sign
- No Witness
- Printed on pink 65-card stock or white card stock with pink border, or similar paper/style to make it easily identifiable.
- Copies, facsimile, and digital versions are permissible.
- Valid for 1 year. After 1 year reaffirmation on back side needs to occur. Reaffirmation good for 1 year after which a new MI-POST needs to be completed.
- MI-POST forms completed after 6/30/23 must be MDHHS-5836.
- Form MDHHS-5837 MI-POST Patient and Family Information Sheet also needs to be signed with copy in chart (next slide).
- POLST forms from other states generally valid.

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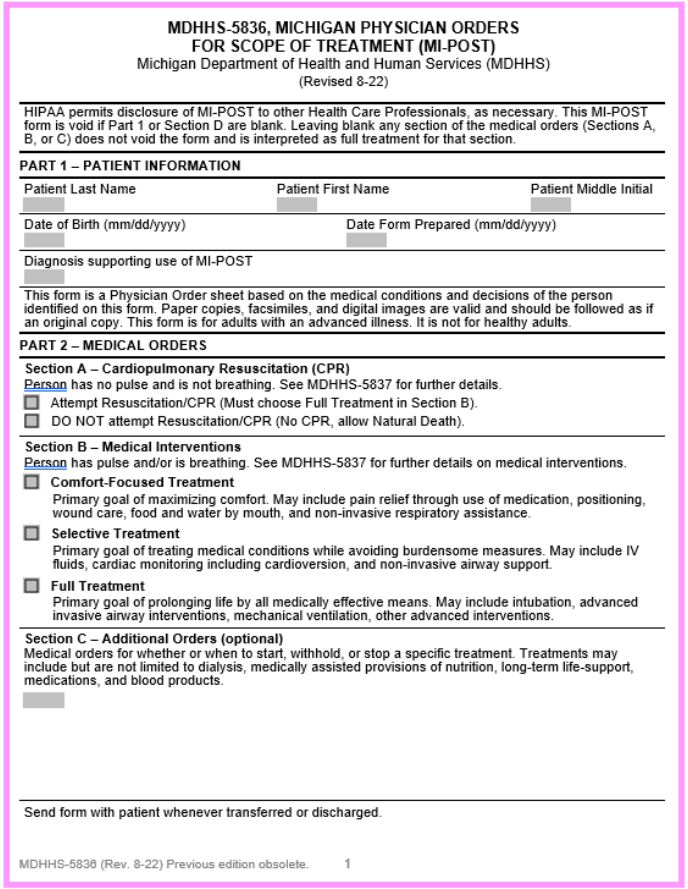


MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name | Patient First Name | Patient Middle Initial

Date of Birth (mm/dd/yyyy) | Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

PART 2 – MEDICAL ORDERS

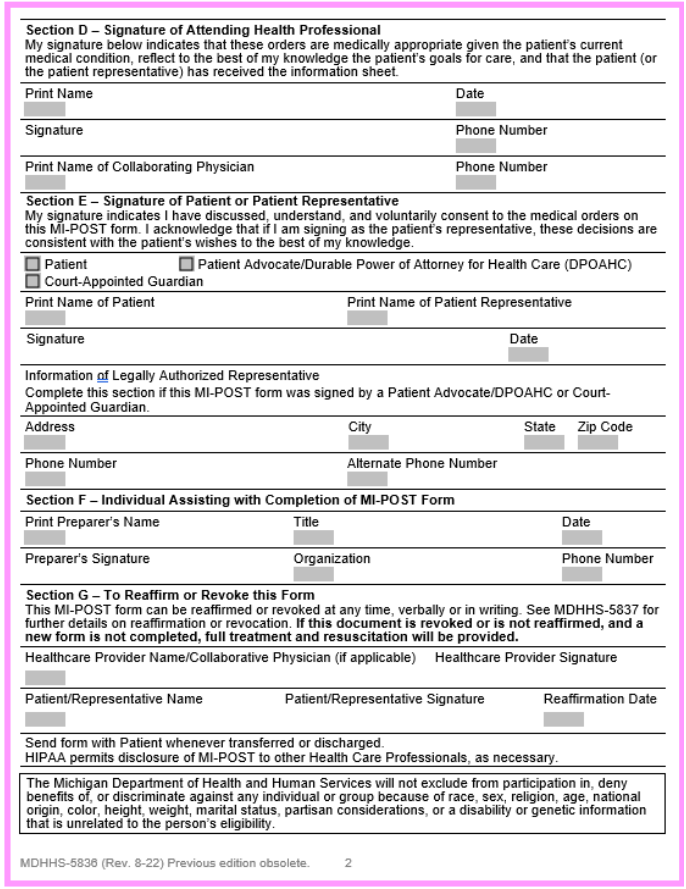
Section A – Cardiopulmonary Resuscitation (CPR)
Person has no pulse and is not breathing. See MDHHS-5837 for further details.
☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions
Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.
☐ **Comfort-Focused Treatment**
Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
☐ **Selective Treatment**
Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
☐ **Full Treatment**
Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Send form with patient whenever transferred or discharged.

MDHHS-5836 (Rev. 8-22) Previous edition obsolete. 1



Section D – Signature of Attending Health Professional
My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name | Date

Signature | Phone Number

Print Name of Collaborating Physician | Phone Number

Section E – Signature of Patient or Patient Representative
My signature indicates I have discussed, understand, and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

☐ Patient ☐ Patient Advocate/Durable Power of Attorney for Health Care (DPOAHC)
☐ Court-Appointed Guardian

Print Name of Patient | Print Name of Patient Representative

Signature | Date

Information of Legally Authorized Representative
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address | City | State | Zip Code

Phone Number | Alternate Phone Number

Section F – Individual Assisting with Completion of MI-POST Form

Print Preparer's Name | Title | Date

Preparer's Signature | Organization | Phone Number

Section G – To Reaffirm or Revoke this Form
This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. See MDHHS-5837 for further details on reaffirmation or revocation. **If this document is revoked or is not reaffirmed, and a new form is not completed, full treatment and resuscitation will be provided.**

Healthcare Provider Name/Collaborative Physician (if applicable) | Healthcare Provider Signature

Patient/Representative Name | Patient/Representative Signature | Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHHS-5836 (Rev. 8-22) Previous edition obsolete. 2

Michigan MI-POST: Requires Patient & Family Information Sheet Signed

- MI-POST forms and the Patient & Family Information Sheet in English, Spanish, and Arabic can be found at: https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/ems/news/mi-post

MDHHS-5837, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST) PATIENT AND FAMILY INFORMATION SHEET
Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

What is a MI-POST?

- An optional, one-page, two-sided medical order with a person's wishes for care in a crisis.
- A part of the advance care planning process that includes choices about Cardiopulmonary Resuscitation (CPR), critical care, and other wanted care.
- A form that guides care only if the person cannot tell others what to do at that time.
- A completed form is signed by the patient/patient representative and the physician, nurse practitioner, or physician's assistant that gives medical advice and suggestions.
- A patient representative may fill out a MI-POST for the person if they are not able to make healthcare choices due to illness or injury.

Who has a MI-POST?

- An adult with advanced illness or frailty, such as advanced, life-threatening heart failure, who talks to a healthcare provider to help determine their choices in care.

Where can a MI-POST be found?

- A blank MI-POST can be found in care settings, including a provider's office, a health care facility or agency, or online.
- Completed forms belong to the person and are kept with the person wherever they live.
- Copies of the form can be given to family, friends, hospitals, and any other places the person wants, but the original stays with the person.

When can a MI-POST be changed?

- The form can be changed at any time by the person or the patient representative, verbally or in writing.
- The form must be revoked or reaffirmed by the patient or patient representative and the attending health professional under the circumstances below. The form must be revoked or reaffirmed within the timeframes outline below or it will be considered VOID.
  - One year from the date since the form was last signed or reaffirmed.
  - 30 days from a change in the patient's attending health professional or change in the patient's level of care, or care setting; or any unexpected change in the patient's medical condition.

How do I reaffirm or revoke a MI-POST?

- Reaffirming this MI-POST form indicates the person has no changes to their treatment choices. Reaffirming requires signatures with dating of reaffirmation on the second page of the form. The form provides space for one reaffirmation. If another reaffirmation is needed, a new MI-POST form should be completed.
- Revocation of this MI-POST form is required if treatment changes are desired. A new MI-POST form should be completed to reflect treatment changes. Write "REVOKED" over the signatures of the patient or patient representative; and the signature(s) of the Attending Health Professional, in Sections D and G, if used, on this MI-POST form. Initial and date the revocations.
  - Write "VOID" diagonally on both sides in large letters and dark ink.
  - Take reasonable action to notify Attending Health Professional, patient, patient representative, and care setting.

What do the types of Medical Interventions mean?

- **Comfort-Focused Treatment** – primary goal of maximizing comfort. Relieve pain and suffering through use of medication by any route, positioning, wound care, and other measures. Use oxygen, manual suction treatment of airway obstruction, and non-invasive respiratory assistance as needed for comfort. Food and water provided by mouth as tolerated. May involve transportation to the hospital if comfort needs cannot be met in current location.
- **Selective Treatment** – primary goal of treating medical conditions while avoiding burdensome measures. In addition to care described in comfort-focused treatment, use IV fluid therapies, cardiac monitoring including cardioversion, and non-invasive airway support (such as a CPAP or BiPAP) as indicated. DO NOT use advanced invasive airway interventions or mechanical ventilation. May involve transportation to the hospital. Generally, avoid intensive care.
- **Full Treatment** – primary goal of prolonging life by all medically effective means. In addition to care described in selective treatment, use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion, and other advanced interventions as medically indicated. Likely to involve transportation to the hospital. May include intensive care.

What if a section on MI-POST was previously left blank or incomplete?

- If a section was previously blank (Section A, B, or C) and is later completed, follow the procedures for reaffirming.

How is a MI-POST different from an advance directive?

- MI-POST tells what care to give and an advance directive tells who can speak (patient advocate) for the person if they are not able.
- An advance directive must be witnessed, the patient advocate must accept the role, and may or may not give information about wishes for care.

How is a MI-POST different from a Michigan Out of Hospital Do-Not-Resuscitate (DNR) order?

- A MI-POST is intended only for adults who may have advanced illness or frailty with a life expectancy of 1 year or less. A DNR order is intended for adults or minors with advanced illness with a life expectancy greater than 1 year.
- A DNR requires two (2) witness signatures. A MI-POST does not require witness signatures.

It is best for anyone with a MI-POST to also legally designate a patient advocate and talk to that person so that they will be prepared to speak on the person's behalf.

I have reviewed this information **BEFORE** signing a completed MI-POST.

Patient Name	Date of Birth
Patient Representative Name (if needed)	
Signature	Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Village Medical™

NEVADA POLST

NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY
Complete this form only after a conversation with the patient or their representative/surrogate. POLST is for patients at risk of a life-threatening clinical event due to a life-limiting medical condition, which may include advanced frailty.

SIDE 1: Medical Orders

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA.

For any section not completed use standard of care.

Last Name/First/Middle Initial

Date of Birth (mm/dd/yyyy) | Last 4 SSN | Gender (X is inclusive of nonbinary): M F X

A Choose 1

CARDIOPULMONARY RESUSCITATION (CPR) – *Patient/resident has no pulse and is not breathing*

☐ Attempt Resuscitation (CPR) – Requires choice of Full Treatment in Section B
☐ Do Not Attempt Resuscitation (No CPR) - Allow Natural Death
When not in cardiopulmonary arrest follow orders in Section B and C

B Choose 1

MEDICAL INTERVENTIONS – Check only one – *Patient/resident has a pulse and/or is breathing.*

☐ **Full Treatment.** ***Goal - sustain life by all medically effective means.***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention. Transfer to hospital/admit to ICU as indicated.

☐ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
Use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally avoid ICU.
*Other Instructions:*_____

☐ **Comfort-Focused Treatment** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medications by *any route* as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location.**
*Other Instructions:*_____

C

ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – *offer food & fluids by mouth if feasible or desired*

☐ Long term artificial nutrition or feeding tube ☐ No artificial nutrition or feeding tube
☐ Artificial nutrition/feeding tube trial
☐ Other instructions_____

D Required

CAPACITY DETERMINATION – Completion required by Provider (Physician, APRN or PA)

At the time of completion of this medical order, the patient:
☐ **Has decisional capacity** ☐ **Lacks decisional capacity**
to understand and communicate their health care preferences for options in this medical order.

E Bolded Items Required

VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate information on Side 2
Electronically signed documents are valid.

Date	Physician/APRN/PA Signature	Physician/APRN/PA License #
Physician/APRN/PA Name (Printed)		Physician/APRN/PA Phone

As the Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian (circle one) I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my wishes / the patient's best-known wishes.
Signature_____**Print Name** _____**Date**_____

OR if the patient lacks capacity *and* has no known agent (DPOA-HC) or guardian, complete the following:
Health Care Surrogate Authorization Also *Requires Completion of Side 2, #1.C.*
Signature_____**Date**_____

Send original with patient when discharged or transferred

NEVADA FORM 021523 (Previous form #090817 is also valid

Additional information available from Nevada POLST: www.nevadapolst.org or Nevada Division of Public and Behavioral Health

NEVADA POLST (Provider Order for Life-Sustaining Treatment)

Patient Name: _____ **DOB:** _____

SIDE 2: Supplementary Information

1. Representative/Surrogate Information – The following may have further information regarding patient's preferences:

A. Advance Directive: AD - Living Will/Declaration ☐ NO ☐ YES
Durable Power of Attorney for Health Care (DPOA-HC) ☐ NO ☐ YES
AD filed with Living Will Lockbox: ☐ NO ☐ YES - Registration #, if known: _____
Other AD location: _____
DPOA-HC – This information must be taken directly from the patient's valid DPOA-HC, not verbally
Appointed agent #1: _____ Telephone No: _____
Appointed agent #2: _____ Telephone No: _____

B. Court-Appointed Guardian ☐ NO ☐ YES Name: _____ Phone: _____

C. Health Care Surrogate: Name (printed): _____
Relationship: _____ Phone: _____

2. PREPARER: Preparer's Name (print): _____ Title/Position (MSW, RN, etc.) _____

3. REGISTRY: Provider should initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Nevada Lockbox at NevadaLockbox.nv.gov

4. ORGAN DONATION – The POLST is *not* an authorization for organ donation, please refer to the patient's state-issued ID

Terms of Use
- The POLST is ALWAYS VOLUNTARY and may not be mandated for a patient.
- The POLST is intended for the seriously ill or frail and for whom a health care professional would not be surprised if they died within a year; others should be offered an AD with a DPOA-HC designation.
- This medical order is to be honored in all care settings. Inpatient order sets should reflect these POLST orders. The POLST is to be followed until voided or replaced by new orders.
- Photocopied, faxed or electronic versions are valid as long as required signatures (Section E) are included.
- When comfort cannot be achieved in the current setting, the patient should be transferred to a setting able to provide comfort.

Completing a POLST
- If a patient lacks decisional capacity, their DPOA-HC, legal guardian or parent of a minor may complete a POLST. If the patient has no such representative *and* lacks decisional capacity, then a surrogate may complete a POLST for the patient. Surrogates are, in order of authority, a spouse, the majority of adult child(ren), parent(s), a majority of adult sibling(s), the nearest other adult relative of the patient by blood or adoption who is reasonably available or "an adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient".
- A POLST does not replace an Advance Directive (AD). An AD is important to designate a decision-maker (DPOA-HC) in the event the patient becomes incapacitated or documents additional treatment preferences. Always check for inconsistencies between End-of-Life documents and correct as appropriate.
- Completion of a POLST should follow a discussion of the patient's goals, values and how their treatment preferences will impact both their longevity and quality of life.
- Patients discharged home should place the POLST next to their bed or on their refrigerator where EMS is trained to look.

POLST Review - This POLST should be reviewed periodically, and if:
- The patient is transferred from one care setting or level to another, or
- There is a substantial change in patient health status, or
- The patient's treatment preferences change.

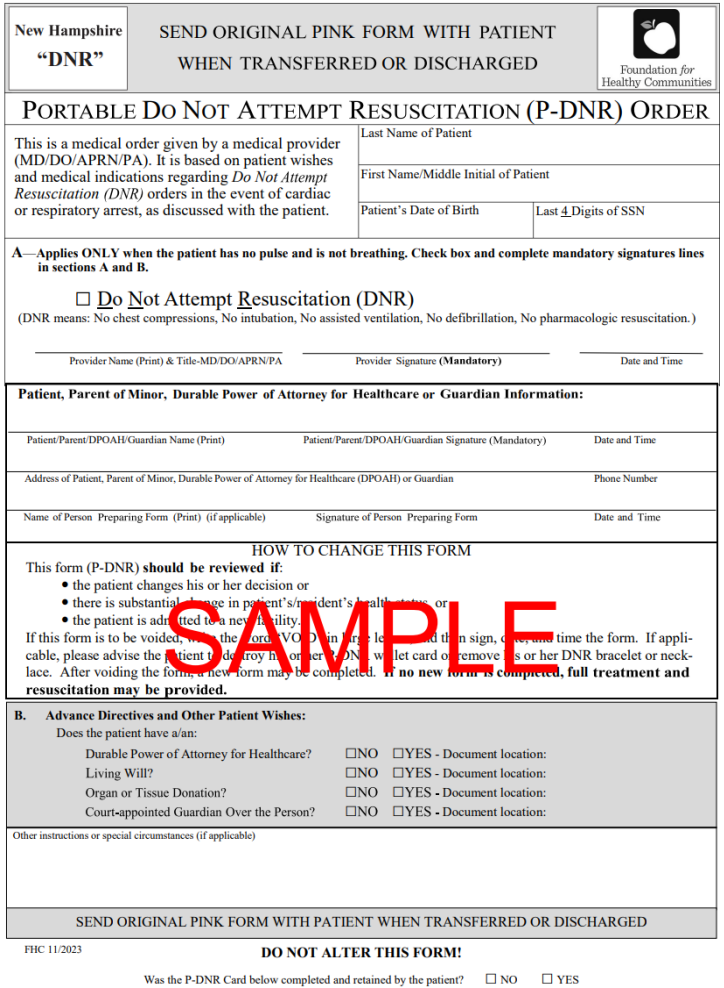
Voiding POLST
- If the patient has decisional capacity, only the patient may void a POLST.
- If the patient lacks decisional capacity, the patient's DPOA-HC, parent of minor or legal guardian may revoke a POLST. However, a surrogate may *only* revoke a POLST completed by the surrogate. (see Completing a POLST, first bullet, above).

For additional information refer to NRS 449A.500 – 581, 2017

NEVADA FORM 021523 (Previous form #090817 is also valid)

- Physician/APP can sign
- Patient, HCPOA, or surrogate decision maker can sign
- Bright pink paper
- Need to order forms from the State of Nevada Division of Public and Behavioral Health
- Information on ordering POLST forms can be found at Order POLST Forms | Nevada POLST. The actual order form can be found at POLST request and survey

NEW HAMPSHIRE PORTABLE DO NOT RESUSCITATE (P-DNR)



New Hampshire "DNR"

SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

Foundation for Healthy Communities

PORTABLE DO NOT ATTEMPT RESUSCITATION (P-DNR) ORDER

This is a medical order given by a medical provider (MD/DO/APRN/PA). It is based on patient wishes and medical indications regarding *Do Not Attempt Resuscitation (DNR)* orders in the event of cardiac or respiratory arrest, as discussed with the patient.

Last Name of Patient

First Name/Middle Initial of Patient

Patient's Date of Birth | Last 4 Digits of SSN

A—Applies ONLY when the patient has no pulse and is not breathing. Check box and complete mandatory signatures lines in sections A and B.

☐ Do Not Attempt Resuscitation (DNR)

(DNR means: No chest compressions, No intubation, No assisted ventilation, No defibrillation, No pharmacologic resuscitation.)

Provider Name (Print) & Title-MD/DO/APRN/PA | Provider Signature **(Mandatory)** | Date and Time

Patient, Parent of Minor, Durable Power of Attorney for Healthcare or Guardian Information:

Patient/Parent/DPOAH/Guardian Name (Print) | Patient/Parent/DPOAH/Guardian Signature (Mandatory) | Date and Time

Address of Patient, Parent of Minor, Durable Power of Attorney for Healthcare (DPOAH) or Guardian | Phone Number

Name of Person Preparing Form (Print) (if applicable) | Signature of Person Preparing Form | Date and Time

HOW TO CHANGE THIS FORM

This form (P-DNR) **should be reviewed if**:

- the patient changes his or her decision or
- there is substantial change in patient's/resident's health status, or
- the patient is admitted to a new facility

If this form is to be voided, write the word VOID in large letters and then sign, date, and time the form. If applicable, please advise the patient to destroy his or her P-DNR wallet card or remove his or her DNR bracelet or necklace. After voiding the form, a new form may be completed. **If no new form is completed, full treatment and resuscitation may be provided.**

B. Advance Directives and Other Patient Wishes:

Does the patient have a/an:

Durable Power of Attorney for Healthcare?	☐NO	☐YES - Document location:
Living Will?	☐NO	☐YES - Document location:
Organ or Tissue Donation?	☐NO	☐YES - Document location:
Court-appointed Guardian Over the Person?	☐NO	☐YES - Document location:

Other instructions or special circumstances (if applicable)

SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

FHC 11/2023

DO NOT ALTER THIS FORM!

Was the P-DNR Card below completed and retained by the patient? ☐ NO ☐ YES

SAMPLE

- Physician or APP can sign. Both form and card need to be signed by all parties. Card to be kept on patient.
- Pink Paper
- Need to order forms from the Foundation for Health Communities https://healthynh.org/initiatives/advance-care-planning/order-form/advance-directives-order-form/

Was the P-DNR Card below completed and retained by the patient? ☐ NO ☐ YES

THIS IS YOUR PORTABLE DNR CARD. REMOVE THE CARD BELOW AND KEEP IT ON YOUR PERSON AT ALL TIMES EVEN IF YOU DECIDE TO WEAR A NH-DNR BRACELET.

Portable-DNR

NEW HAMPSHIRE **DO NOT ATTEMPT RESUSCITATION** ORDER

As this person's licensed medical provider (MD/DO.APRN/PA) I order that this person SHALL NOT BE RESUSCITATED in the event of cardiac or respiratory arrest.

Patient Name (Print) | Patient Signature/Date

Provider Name (Print) | Provider Signature/Date

If applicable: Health Care Agent Name (Print) | Health Care Agent Signature/Date

Portable-DNR

Patient Phone Number

Medical Provider Phone Number

Health Care Agent Phone Number

NEW HAMPSHIRE POLST

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. ATTACH PINK P-DNR FORM IF PATIENT HAS ONE.

Medical Record # (Optional)

New Hampshire POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)
This will constitute a DNR order and no separate DNR order will be required. RSA 137-J:26 V(b).

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/___ | **Phone # :** (___)

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2023

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name: | ☐ Legal Representative ☐ Other emergency contact | Phone #: Day: (___) Night: (___)

Primary Care Provider Name: | Phone: (___)

☐ Patient is enrolled in hospice | Name of Agency: Agency Phone: (___)

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)

☐ Yes; date of the document reviewed: _____
☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)
☐ Advance directive not available
☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name: | Date (mm/dd/yyyy): ___/___/___ | Phone #: (___)

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or to void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in New Hampshire can sign this form.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided.
- **Additional Forms.** Can be obtained by visiting https://healthynh.org/initiatives/advance-care-planning/order-form/.
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

For more information, please call:
Foundation for Healthy Communities
Healthcare Decisions / Advance Directives
(603) 225-0900 / www.healthynh.org

For Barcodes / ID Sticker

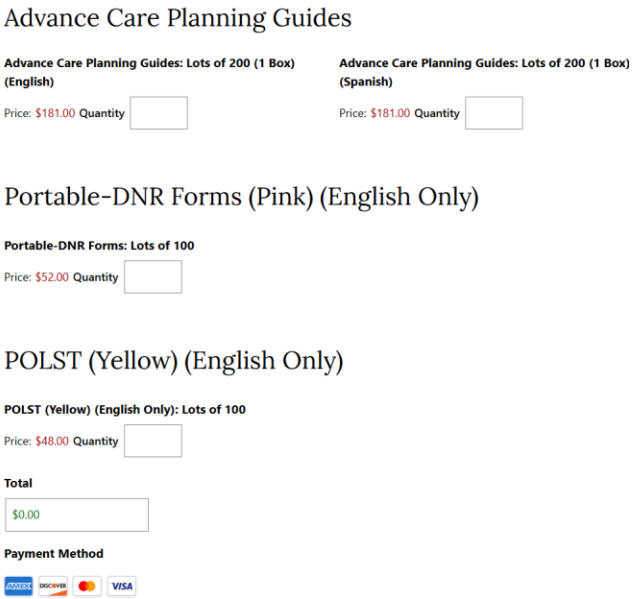
Copied, faxed or electronic versions of this form are legal and valid. 2023

- Physician or APP can sign
- Instructions on back
- "Full Treatments" should not be selected if DNR
- Yellow Paper
- Need to order forms from the Foundation for Health Communities https://healthynh.org/initiatives/advance-care-planning/order-form/advance-directives-order-form/

NEW HAMPSHIRE ADVANCE CARE PLANNING: Order forms/resources through New Hampshire Foundation for Healthy Communities

https://healthynh.org/initiatives/advance-care-planning/

Landing Page to order forms: https://healthynh.org/initiatives/advance-care-planning/order-form/advance-directives-order-form/



Advance Care Planning Guide Advance Care Planning Guide (14 pages)

- Explains DPOA, P-DNR, POLST
- Includes a DPOA with a discussion guide
- DPOA documents the agent & alternate + has a Living Will
- Requires 2 witnesses or a notary public / justice of the peace