

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	Policy and Procedure		
Department Compliance	# of Pages: 11		
Policy Name REGIONAL ADVANCED DIRECTIVES & END OF LIFE CARE POLICY	Type of Policy: <input type="checkbox"/> WCHO <input checked="" type="checkbox"/> Regional <input type="checkbox"/> Network		
Policy Number 12.015	Effective Date	Revision Date 01/06/06	Approval Date 02/08/06
Administrative/Board of Directors Sign Off			
Administrative Signature:			Date:
Board of Directors Signature:			Date:

I. PURPOSE

This policy establishes standards by which the Community Mental Health Partnership of Southeastern Michigan (CMHPSM) responds to recipients' rights and choices with advance directives and end of life care. This policy establishes procedures for notifying recipients of relevant state laws and agency policies to assist them with their decision making in these areas; and establishes procedures in which the CMHPSM addresses the special needs of recipients and their families during end of life care. This policy also states the CMHPSM position on hospice/end of life care and identifies the requirements for responding to requests by recipients or their legal representatives to honor Do-Not-Resuscitate Orders.

II. APPLICATION

All recipients while under the care of any Community Mental Health Service Program (CMHSP). All staff, students, volunteers within the CMHPSM, and/or contractual agencies within the regional provider network.

III. DEFINITIONS

Advance Directive: A legally bound notarized document signed by a legally competent adult giving direction to healthcare providers about recipients' treatment choices in specific circumstances including but not limited to medical or psychiatric situations.

Crisis: An emergent situation that is likely to cause reduced levels of functioning in primary aspects of the recipient's life if not addressed as soon as possible.

CMHPSM: Community Mental Health Partnership of Southeastern Michigan. This is the affiliation of four CMHSP's that provide services to recipients either directly or through contract agencies.

CMHSP: Community Mental Health Services Program. This is the agency where services are provided to recipients either directly or through contract agencies.

Devisee: A person who is devised to receive the gift of real property (usually real estate) from a person's last will and testament after the testator's death.

Do-Not-Resuscitate (DNR) Order: A document executed pursuant to Section 3 of the Michigan Do Not Resuscitate Procedure which states that in the event a patient suffers cessation of both spontaneous respiration and circulation, no resuscitation will be initiated.

Durable Power of Attorney (DPOA)- Health Care: A legal advance directive that names a person (Patient Advocate) to act on the signer's behalf in enacting decisions about the signer's medical care if the signer becomes unable to make medical decisions for him or herself.

Individual Crisis Plan: A recipient driven document in which the recipient decides what issues to address in a crisis, which people will be enlisted for support during the crisis, and who will get a copy of the plan. This is a non-legal binding document.

Licensed Hospice Program: A health care program that provides coordinated services for an individual diagnosed with disease/condition with a terminal prognosis. These services are rendered at home or in an outpatient or institutional setting that is licensed under article 17 of the Public Health Code. (PA 368 of 1978).

Patient Advocate: An individual designated to exercise powers concerning another individual's care and medical or mental health treatment, or authorized to make an anatomical gift on behalf of another individual, or both. This person is identified in an advance directive/durable power of attorney as the individual with the ability to act on behalf of the signer in enacting decisions about the signer's medical or psychiatric care if the signer becomes unable to make medical or psychiatric care decisions for him or herself.

Sound Mind: Having an understanding of one's actions and reasonable knowledge of one's family, possessions and surroundings.

IV. POLICY

The CMHPSM supports recipients' rights to develop advance directives as tools by which recipients can exercise self-determination where possible and enhance communication between recipients, their families/friends, and healthcare professionals. The CMHSPM supports recipients' rights to make decisions regarding their end of life care where possible and in accordance with applicable laws. CMHPSM staff shall inform recipients of their right to develop advance directives, including assisting recipients with information or resources in understanding the implementation of and revocability with advanced directives.

A. General Standards

1. The Person Centered Planning process is the mechanism with which the CMHPSM shall use to facilitate communication around the differences between a Crisis Plan, a health care advanced directive, and a psychiatric advanced directive, including how recipients may access additional materials and supports to enact one. (moved from purpose) For those recipients who have identified that they have a Crisis Plan, health care advanced directive, or a psychiatric advanced directive, the Person Centered Planning process will also be an opportunity for recipients to update or review their plan if they desire.
2. In accordance with the Balanced Budget Act (BBA), the CMHSP shall provide all adult recipients with written information at least annually on advance directives policy and applicable state laws, and their rights under those laws.
3. In the event of changes in Michigan law regarding advance directives, the CMHPSM will reflect those changes in written policy and in information provided to recipients. Changes will be made within 90 days after the law becomes effective.
4. All adult recipients will be informed that complaints concerning non-compliance with advance directive policy may be filed through the grievance process of the CMHSP. This may be done through the Member Services department, the Office of Recipient Rights, or by contacting any staff member within a CMHSP.
5. The Person Centered Planning process is used to facilitate the discussion around the policy statements around the use of a Crisis Plan, advance directive, or a durable power of attorney. A recipient may request a referral for assistance in establishing a Crisis Plan or a durable power of attorney.

B. Advance Directives - Psychiatric and Medical/Durable Power of Attorney-Health Care

1. An adult recipient who is of sound mind has the right to enact a Durable Power of Attorney-Health Care, in accordance with the Michigan Patient Self Determination Act.
2. An adult recipient who is of sound mind has the right to enact a psychiatric advanced directive, in accordance with the Michigan Estates and Protected Individuals Code (Public Act 386 of 1998) and the Michigan Mental Health Code.
3. The CMHPSM, in accordance with Michigan law, does not allow the following people/titles to enact advance directives on behalf of their ward:
 - Guardians
 - Spouses
 - Parents
 - Children
 - Grandchildren
 - Siblings
 - Presumptive heirs

- Known devisees at the time of the witnessing
 - Physicians
 - Patient advocates
 - Employees of a life or health insurance provider for the patient
 - Employees of a health facility that is treating the patient
 - Employees of a home for the aged where the patient resides as defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106.
4. The CMHSP will ensure that the recipient's paper and electronic record accurately and clearly reflects the most current Durable Power of Attorney and/or medical or psychiatric advance directive. It is the recipients' responsibility to provide CMHSPM staff with any revisions, revocations (where allowed by law), or updates to their advance directive(s).

C. End of Life Care including Do Not Resuscitate Orders

1. An adult recipient who is of sound mind has the right to Enact a Do-Not-Resuscitate (DNR) order as allowed by the Michigan Do-Not-Resuscitate Procedure Act. A DNR for a recipient may be enacted in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the department of community health. By Michigan law a DNR may be enacted to:
- provide that certain actions be taken and certain actions not be taken with respect to such an order;
 - provide for the revocation of a do-not-resuscitate order;
 - prohibit certain persons and organizations from requiring the execution of such an order as a condition of receiving coverage, benefits, or services
 - prohibit certain actions by certain insurers;
 - exempt certain persons from penalties and liabilities; and
 - prescribe liabilities.

Please refer to the DNR orders procedures in this policy.

2. CMHPSM employees, contractual staff and volunteers can only honor the DNR order is if the recipient is enrolled in a licensed hospice setting.
3. CMHPSM and its staff along with contractual agencies in accordance with Michigan Law, is not subject to civil or criminal liability for either of the following:
- a. Attempting to resuscitate an individual who has executed a do-not-resuscitate order or on whose behalf an order has been executed, if the person or organization has no actual notice of the order.
 - b. Failing to resuscitate an individual who has revoked a do-not-resuscitate order or on whose behalf a do-not-resuscitate order has been revoked, if the person or organization does not receive actual notice of the revocation.

- c. A person or organization is not subject to civil or criminal liability for withholding resuscitative procedures from a declarant in accordance with this act.
4. All CMHPSM employees, contract staff and volunteers are to be aware of special issues related to end of life planning for recipients, their families and support networks. These may include, but are not limited to, the following:
 - a. Advocating appropriate medical attention, including palliative care, through making referrals to the recipient's Primary Care Physician. This may include asking the recipient/guardian to consider talking with their physician about Hospice Care.
 - b. Discussing with the recipient/guardian, and family when applicable, whether supportive counseling about end-of-life issues might be helpful.
 - c. Discussing with the recipient/guardian and family when applicable, whether staff can help facilitate contact with a local religious community of the recipient's choice to receive treatment by spiritual means.
 - d. While respecting the wishes of the recipient/guardian and within the limits of the laws requiring confidentiality of recipient information, providing information and referral to family and friends of the recipient which will help them cope with the recipient's situation.
 - e. Providing information about more tangible affairs such as making out a living will and/or the appointment of a patient advocate to make decisions as the end nears, organ donation, collecting/donating property, funeral expenses, etc.
 - f. Identifying, when possible, the person legally responsible to provide consent for an autopsy upon the recipient's death, and preparing to discuss the benefit of and request for an autopsy with that person. Staff shall seek any necessary technical and supportive assistance with this task, given its sensitive nature, to assure being properly prepared prior to the death of the recipient.
5. If a recipient is enrolled in a licensed hospice program, CMHPSM will ensure that all staff, students or volunteers who regularly work with that recipient will receive appropriate in-servicing by hospice staff, or a hospice trained staff, on special needs and issues related to that recipient's care.
6. All CMHPSM staff, students, volunteers and contractual staff of CMHPSM and/or its providers, will immediately contact the appropriate emergency response number should a recipient appear to require emergency care:
 - a. If the recipient is not enrolled in a licensed hospice program, all covered staff, students and volunteers must see that 911 is called and initiate CPR/First Aid until the emergency responders arrive to take over. If staff has reason to believe that the recipient may have filed a Do-Not-Resuscitate Order with their Primary Care Physician, they will provide the Emergency responders with the recipient's Primary Care Physician's phone number. If a recipient wears a "Do-Not-Resuscitate" identification bracelet, as provided for in the MDNRPA, the PCP's number will be on

the bracelet. The Emergency responders are empowered by the MDNRPA to determine what action to take next.

- b. If the recipient is enrolled in a licensed hospice program, the Michigan Do-Not-Resuscitate Procedure Act allows for an emergency call to be placed to an enrolled recipient's licensed hospice provider, rather than to 911, and prior to attempting CPR, if a recipient appears to suffer cessation of both spontaneous respiration and circulation. **For any other emergency (accidents, falls, illness, etc) staff will seek emergency care as usual.**

7. The CMHSPM will ensure that the recipient's paper and electronic record reflects the most current DNR order. It is the recipients' responsibility to provide CMHSPM staff with any revisions, revocations (where allowed by law), or updates to their DNR order.

D. Crisis Planning

1. An adult recipient of the CMHSP has the right to enact a Crisis Plan in accordance with agency procedures. This is a non-legal binding document that a recipient may complete that explains certain details related to a recipients life that may be addressed should there be a crisis. A crisis may be in the form of but not limited to an environmental crisis, psychiatric crisis, or death of a guardian. Please refer to the Individual Crisis Planning procedure of this policy.
2. The recipient's paper and electronic record **must** include a copy of the current Individual Crisis Plan if the recipient has delegated any responsibilities in the plan to a CMHSP staff person. If the CMHSP has no designated responsibilities in the Individual Crisis Plan, a copy of the Individual Crisis Plan will be included in the paper and electronic record at the recipient's request. It is the recipients' responsibility to provide CMHSPM staff with any revisions, revocations, or updates to their crisis plan.

V. EXHIBITS

- A. Advanced Directives/End of Life Brochure
- B. Crisis Plan Template

VI. REFERENCES

- A. Balanced Budget Act (specifically 42CFR422.128) MCL 333.20106 MCL 700.5506
- B. Michigan Estates and Protected Individuals Code, PA 386 of 1998, MCL 700.5501-5513, 700.5515, and 700.5520

- C. Public Health Code section 20106, PA 368 of 1978, article 17, Michigan Do-Not-Resuscitate Procedure Act, PA 193 of 1996, MCL 333.1051-1067
- D. PA 194 of 1996, MCL 400.703-706 and 400.726a
- E. Michigan Patient Self Determination Act, PA 312 of 1990
- F. CMHSPM Policy on Confidentiality and Access to Clinical Records
- G. CMHSPM Policy on Religious Freedom & Treatment by Spiritual Means
- H. Opinion #6986 State of MI, Office of Attorney General, re: “Application of Michigan Do-Not-Resuscitate Procedure Act to Adult Foster Care Facilities”.
- I. Opinion #7009, State of MI, Office of Attorney General, re: “Application of Michigan Do-Not-Resuscitate Procedure Act to Persons Under 18 Years of Age”.

VII. PROCEDURES

WHO	DOES WHAT
CMHSP Staff	<ul style="list-style-type: none"> 1. Identifies materials to be distributed to CMHSP recipients at initial and annual PCP meeting. 2. Updates materials to reflect changes in legislation regarding advanced directives and affiliation policy.
CMHSP Staff	<ul style="list-style-type: none"> 1. Informs supervisor of any reason why they may not be able to honor a DNR or Advance Directive due to a conflict of interest, religious or medical reason.

A. Provision of Information

WHO	DOES WHAT
Case Manager/Supports Coordinator/Organizational Designee	<ul style="list-style-type: none"> 1. Provides all adult recipients with written information on crisis planning, and the advance directives policy and applicable state laws at time of initial PCP and at least annually thereafter. This information will also inform recipients that complaints concerning non-compliance with advance directive policy requirements may be filed.

B. Advance Directive - Psychiatric

WHO	DOES WHAT
Case Manager/Supports Coordinator/Organizational Designee	<ul style="list-style-type: none"> 1. Notifies all adult recipients of their right to execute a psychiatric advance directive initially and annually.
Recipient	<ul style="list-style-type: none"> 1. Requests to enact a psychiatric advance directive.

Case Manager/Supports
Coordinator/Organizational Designee

1. Assists the recipient as needed with materials to complete a psychiatric advance directive or referrals to organizations that assist recipients in completing psychiatric advance directives.

Recipient

1. Informs the CMHSP that they have a psychiatric advance directive and provides the CMHSP staff a copy of the document.
2. If the recipient makes any changes or terminates the psychiatric advance directive, notifies CMHSP staff immediately.

Case Manager/Supports
Coordinator/Organizational Designee

1. Includes the psychiatric advance directive and any changes/terminations in the recipient's record and includes it in the Person Centered Plan as a health and safety goal.
2. If recipient is in a psychiatric crisis, Informs healthcare professionals that the recipient has a psychiatric advanced directive where necessary and in accordance with state and federal confidentiality laws.

C. Advance Directive – Medical/Durable Power of Attorney- Health Care

WHO

DOES WHAT

Adult Recipient

1. Indicates to Case Manager/Supports Coordinator a desire to enact a Durable Power of Attorney-Health Care, Medical Advance Directive.

Case Manager/Supports Coordinator/
Organizational Designee

1. Notifies all adult recipients of their right to execute a Durable Power of Attorney-Health Care, and/or Advance Directive.
2. Upon request, assists adult recipient with either obtaining a DPOA-Health Care Form, or information regarding estate planning attorneys.

Recipient

1. Informs the CMHSP that they have a Durable Power of Attorney-Health Care, and/or Advance Directive and provides the CMHSP staff a copy of the document.

WHO

Case Manager/Supports
Coordinator/Organizational Designee

DOES WHAT

- 2. If the recipient makes any changes or terminates the Durable Power of Attorney-Health Care, and/or Advance Directive, notifies CMHSP staff immediately.
- 1. Documents in recipient’s record whether or not the recipient has a Durable Power of Attorney-Health Care, and/or Advance Directive.
- 2. Includes any changes/terminations in the recipient’s record.

D. End of Life Care including Do Not Resuscitate Orders

WHO

Recipient

DOES WHAT

- 1. Provides Case Manager/ Supports Coordinator with a copy of the most current DNR order.
- 2. Immediately notifies Case manager/Supports Coordinator of revocation of or changes to most current DNR order.
- 3. If the DNR order is changed, the recipient must provide a new copy to the case manager/supports coordinator.
- 4. If the DNR order is revoked, the recipient must notify the Case Manager verbally or in writing.

Case Manager/Supports Coordinator/
Organizational Designee

- 1. Ensures that the recipient’s paper and electronic record reflects only the most current DNR order. All previous/revoked DNR orders must immediately be marked as outdated.
- 2. An “X” shall be drawn over the paper copy of a revoked order, and the revocation date shall be documented on the order.
- 3. Provides all contractual direct staff with a copy of the recipient’s most current DNR order.
- 4. Immediately notifies direct care staff and/or hospice staff of any revocation of or changes to the recipient’s most current DNR order.

WHO

Case Manager/Supports Coordinator/
Organizational Designee or contractual
staff

DOES WHAT

5. Immediately provides direct care staff and/or hospice staff with a copy of an updated/revised DNR order.
1. **If the recipient is in the care of a licensed setting, supported living or respite setting, and an incident occurs the staff present will contact 911, inform dispatch of the DNR order, and initiate CPR/First Aid until the emergency responders arrive to take over medical attention.**
2. If staff has reason to believe that the recipient may have filed a Do-Not-Resuscitate Order with their Primary Care Physician, they will provide the Emergency responders with the recipient's Primary Care Physician's phone number.
3. **If the recipient IS under the care of a licensed hospice agency and appears to suffer cessation of both spontaneous respiration and circulation, AND**
4. **Is at their residence/group home at the time of the incident:** Place an emergency call to the recipient's licensed hospice provider prior to contacting 911 and attempting CPR.
5. **Is in the community at the time of the incident:** Follow normal emergency procedures, which includes immediately contacting 911, attempting CPR and notifying the recipient's licensed hospice provider.
6. **For any other emergency (accidents, falls, illness, etc) staff will seek emergency care as usual.**

E. Crisis Planning

A crisis plan is a recipient driven document in which the recipient decides what issues to address in a crisis, which people will be enlisted for support during the crisis, and who will get a copy of the plan. This is a non-legal binding document and is used for primarily instructional purposes to communicate a recipient's needs/wishes if they are in crisis.

WHO

DOES WHAT

Case Manager/Supports Coordinator/
Organizational Designee

1. At the time of the recipient’s assessment, PCP pre-planning or at other times if requested, will provide informational materials (brochure) about what crisis planning entails, examples of crisis plans and explanations of the process.

Recipient

1. Determines whether or not to complete a crisis plan.
2. Determines what format to use if a crisis plan is to be completed.
3. Determines how the plan will be written (independently, with family or friend, CMHSP staff)

Case Manager/Supports Coordinator/
Organizational Designee

4. Determines who will receive a copy of the crisis plan.
1. Assist recipient to identify supports to implement the plan if asked by the recipient.
2. If CMHSP staff is included as supports to implement the crisis plan, make a recommendation for the recipient to forward a copy of the plan and the PCP should reflect that a crisis plan is part of the recipient’s record.
3. Obtain any Releases of Information needed to implement the Crisis Plan.
4. Document involvement in the Crisis Plan.
5. If CMHSP staff is NOT included in the Crisis Plan, but the recipient forwards a copy of the plan to CMHSP, it will be filed in the recipient’s record under the correspondence section.

Recipient

1. Notifies all people who are listed as supports in the crisis plan of their role in implementing the plan.
2. Notify all people that are listed as supports in the Crisis Plan if the plan changes.
3. If a crisis occurs, inform the person who is to initiate the plan.

Case Manager/Supports Coordinator/
Organizational Designee

1. Documents involvement in the plan once the crisis occurs.

