Bureau of Disabilities Services

Practice Guidance

Clarifying Provider Expectations in Following an Individual's Designated Preferences for Cardiopulmonary Resuscitation (CPR)

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Guidance Version

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Applicability

This guidance is directed at BDS-enrolled case managers[1] and providers of HCBS waiver services, including personnel employed by an applicable provider.

Purpose

Individuals receiving home- and community-based services (HCBS) waiver services have the right to exercise self-determination and choice in their preferences for receipt of life-saving measures. This guidance document provides clarification to providers on existing requirements regarding Cardiopulmonary Resuscitation (CPR) training of staff and expectations for respecting individual choice in the receipt of life-saving measures.

Definitions

The following definitions apply throughout this document.

- "Case manager" means the personnel assigned to provide case management services, as defined in 455 IAC 2-4-10 and 460 IAC 6-3-9, inclusive of the term care manager.
- "Designated preference" or "designation" means a written declaration of an individual's preferences for life-saving measures, which takes the form of an out of hospital do not resuscitate (DNR) declaration[2] or physician order for scope of treatment (POST) form[3].
- "Individual" means a person who has been determined eligible for or is currently receiving BDS-operated HCBS waiver services in accordance with 455 IAC 2-4-20 or 460 IAC 13-3-10.
- "Life-saving measures" means interventions intended to prevent death and resuscitate or stabilize an individual, including but not limited to: cardiopulmonary resuscitation (CPR), first aid, abdominal thrusts to dislodge an airway obstruction, and medication administration.

[1] The term "case manager" is inclusive of care managers operating under the Health and Wellness and Traumatic Brain Injury HCBS waivers.
[2] IC 16-36-5
[3] IC 16-36-6

- "Service plan" means:
    - for an individual receiving services under the Family Supports or Community Integration and Habilitation waivers, the person-centered individualized support plan defined in 460 IAC 6-3-32.
    - for an individual receiving services under the Health and Wellness or Traumatic Brain Injury waivers, the person-centered support plan[4] defined in 455 IAC 1-5-2(8).

Practice Guidance

Current Provider Requirements on CPR Training

Under 460 IAC 6-15-2(b)(2)[5] and 455 IAC 2-14-1(b)(4)[6], BDS-enrolled providers must maintain records verifying that their personnel working with individuals have received up-to-date training on CPR techniques and possess a current certification from a recognized CPR certification entity.

This regulatory requirement applies to any personnel working with or providing direct care to individuals. In practice, this means:

- CPR training requirements are not limited to personnel designated by a provider as "direct care staff", "direct support professionals", or any other similarly constructed designation.
- The application of this requirement is not dependent on a provider's internal employee classification or job title structure.
- All personnel that work with or provide direct care to individuals must have up-to-date CPR training on file before rendering services directly to an individual
- Providers should establish internal policies and procedures to ensure any and all personnel that will provide services directly to an individual have up-to-date CPR training and that this training is reflected in personnel records.

Provider Expectations in Rendering CPR

As required by 460 IAC 6-15-2(b)(2) and 455 IAC 2-14-1(b)(4), a provider must maintain records that verify all personnel working with or providing direct care to an individual have up-to-date training on CPR techniques and possess a valid certificate of completion from an approved entity.

Since all personnel working directly with an individual are required to have up-to-date CPR training, personnel have the training necessary to render CPR to an individual in an emergent situation.

BDS expects personnel to render CPR to any individual in need of resuscitation unless:

- The individual has a valid designation indicating their preference that CPR not be rendered as a life-saving measure documented in their service plan, and
- The provider has informed personnel working with that individual of the individual's designated preference that CPR not be rendered as a life-saving measure.

[4] 455 IAC 1-5-2(8) uses the terminology "care plan" to refer to the person-centered support plan
[5] Applicable to providers of Family Support or Community Integration and Habilitation HCBS waiver services
[6] Applicable to providers of Health and Wellness or Traumatic Brain Injury HCBS waiver services

In practice, this means that providers should have policies and processes in place to ensure the provider personnel working with the individual are timely informed of an individual's designated preferences for life-saving measures.

Documenting an Individual's Designated Preference for Life-Saving Measures

As provided for in state law, an individual may designate their preferences for life-saving measures through one of the following methods:

- An Out of Hospital Do Not Resuscitate (DNR) declaration that follows the format[7] of state form SF 49559 and is completed in accordance with IC 16-36-5,
- A Physician Orders for Scope of Treatment (POST) form documented on state form SF 55317 and completed in accordance with IC 16-36-6, or
- An Advance Directive that includes a valid DNR or POST document.

A copy of the designation should be provided to all members of the individual's Individualized Support Team (IST), including but not limited to:

a. the individual's HCBS waiver case manager;
b. the individual's HCBS waiver service providers;
c. providers of nonwaiver services as desired by the individual,
d. health care coordination provider;
e. primary care provider;
f. medical specialists providing care or services.

Please refer to the Appendices for more detailed information on DNR and POST designations.

Individual Preferences Regarding Life-Saving Care

All individuals receiving BDS-administered HCBS waiver services must be allowed to exercise their right to designate their preferences regarding life-saving measures, including their preferences for the receipt of CPR.

It is important to note the following:

1. All valid DNR and POST designations are voluntary and reflect personal choice.
2. Individuals have the right to cancel or amend these designations at any time, should they choose to do so.
3. When an individual cancels or amends a designation on life-saving measures, the individual (or their legal representative) must provide all members of the individual's IST with written documentation of changes to their designation so that the individual's current designated preferences can be documented in the service plan.
    - The individual may provide this written documentation in physical or electronic format and may request assistance from the case manager to distribute the current designated preferences to the other members of the IST.

[7] A valid DNR may be executed on SF 49559 or in a separate document that uses the same wording and format as SF 49559

Case Management Requirements in Facilitating and Documenting an Individual's Preferences

Case managers hold the following responsibilities regarding facilitating conversations on an individual's designated preferences for life-saving measures and documenting those preferences:

1. Case managers shall facilitate and document a discussion with the individual and the individual's Individual Support Team regarding the individual's designated preferences for life-saving measures.
    a. A conversation shall occur at minimum, annually, during the annual service plan meeting, and this should be documented within the service plan as an addendum;
    b. If an individual gives notice of terminal illness, the case manager will facilitate an IST meeting with all parties to discuss future medical care and treatment planning, including an individual's desire to designate preferences for life-saving measures;
    c. Should an individual express a desire to execute a Health Care Power of Attorney, the case manager will facilitate an IST meeting to discuss the need for legal consultation and services;
    d. Should an individual revoke or amend their designations surrounding end-of-life planning, resuscitation, or care and treatment planning, the case manager will facilitate an IST meeting to discuss the individual's current designated preferences.
2. Upon receipt of an individual's designated preferences for life-saving measures, the case manager will ensure:
    a. The designation included all necessary documentation and required forms, with appropriate signatures;
        i. Upon validation, documentation should be added as a case note and addendum to the individual's service plan;
        ii. A notification will be sent to all members of the IST;
        iii. The validated document shall be added to the individual's BDS Portal Document Library for reference;
3. In the event the individual cancels or amends a designation, the identified case manager shall document the change within a case note, as well as within the individual's service plan and ensure that all members of the IST are informed of the individuals' updated designated preferences for life-saving measures.

Appendices

Appendix A: Reminders on Out of Hospital Do Not Resuscitate (OH-DNR) Declarations

1. The OH-DNR declaration form is a legally recognized state form completed by an individual to express their preferences regarding cardio-pulmonary resuscitation administration, and other life-prolonging measures.
    - The declaration and intent to execute the OH-DNR form must be made voluntarily, in written communication
    - The form should be signed by the individual, in the presence of at least two competent witnesses
    - Following the signature, the attending physician will verify the individual meets the statutory criteria to quality for an OH-DNR and issue an OH-DNR Order.
2. The OH-DNR Declaration should be shared with the individual medical care providers, medical specialists, and providers of home and community-based services
    - This form shall travel with the individual to ensure adherence and observation of medical care and treatment.
3. The OH-DNR Declaration form is a voluntary declaration that may be cancelled at individual's discretion at any time.
    - In the event of cancellation, the individual or other applicable parties must clearly indicate their request to all relevant parties to ensure proper acknowledgment and implementation.

Reset Form

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER
State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION
Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below. **I declare:** My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death. I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain. I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration. **I understand the full import of this declaration**
Signature of declarant
Printed name of declarant
City and state of residence
The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*
Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER
I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.
Signature of attending physician

Printed name of attending physician	Medical license number	Date *(month, day, year)*

Form Made Fillable by eForms

Appendix C: Elements of the Physicians Order of Scope of Treatment (POST) Form

1. The POST form is a legally recognized state form completed with an individual's medical professional that includes:
    - An individual's medical conditions
    - Preferences regarding:
    - Medical Interventions
    - Medical Treatments
    - Resuscitation and Life-prolonging efforts
    - Nutrition
    - Hydration
2. An individual seeking the completion of a POST form shall meet with their health care professional to discuss their health conditions, treatment and care options, and wishes.
    - If the individual has a legal representative, or an elected/appointment medical proxy, that individual shall additionally be included in the facilitation of the conversation when applicable.
    - The individual's health care professional shall complete the POST form, for review by the individual, and when applicable the individual's representative or proxy;
3. For the validation of the POST form, both the individual and the health care professional are required to sign the form.
    - If the individual has a legal representative, or elected/appointed proxy, these parties are also required to sign the POST form for validation.
4. The POST form should be shared with the individual's medical care providers, medical specialists, and providers of home and community-based services
    - This form shall travel with the individual to ensure adherence and observation of medical care and treatment.
5. The POST form is a voluntary declaration that may be cancelled at individual discretion at any time.
    - In the event of cancellation, the individual or other applicable parties must clearly indicate their request to all relevant parties to ensure proper acknowledgment and implementation.

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)
State Form 55317 (R6 / 6-23)
Indiana Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment. It should be filled out based on a discussion about the patient's current medical condition and preferences. It is voluntary and a patient may not be required to complete a POST form. The POST should be reviewed whenever the patient's condition changes. A patient may ask the health care provider to void the POST form at any time. If the patient lacks decisional capacity, the legal representative or proxy (if there is no legal representative) may complete POST on behalf of the patient and/or ask the health care provider to void POST. Any section left blank implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name (required)	Patient First Name (required)	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing. (required)

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY: In order for the POST form to be effective, the patient, legal representative, or proxy must sign and date the form below.
E	**SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY** My signature below indicates that the physician, advanced practice registered nurse, or physician assistant (or their designee) discussed with me the above orders and the selected orders correctly represent the decisions made during this discussion.

Signature ***(required)***	Print Name ***(required)***	Date *(mm/dd/yyyy)* ***(required)***

F	**CONTACT INFORMATION FOR LEGAL REPRESENTATIVE OR PROXY IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative or proxy.

Relationship of representative or proxy identified in Section E if patient does not have capacity	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:

(A) the individual is a qualified person; and

(B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person, representative, or proxy has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.

(2) An advanced chronic progressive frailty.

(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:

(A) there can be no recovery; and

(B) death will occur from the condition within a short period without the provision of life prolonging procedures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G	**DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:** ☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Power of Attorney ☐ Proxy
H	**SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT** My signature below indicates that I or my designee have discussed with the patient, patient's representative, or proxy the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA ***(required)***	Print Treating Physician / APRN / PA Name ***(required)***	Date *(mm/dd/yyyy)* ***(required)***

Physician / APRN / PA office telephone number	Physician / APRN / PA License Number	Health Care Professional preparing form if other than the physician / APRN / PA

I	**APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As a patient you have the option to appoint a representative to serve as your health care representative pursuant to IC 16-36-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the IDOH web site at https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/ .