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

Aliases: POST

Purpose: The purpose of this policy is to provide a guideline to prehospital providers, who under certain circumstances may accommodate patients who do not wish to receive and/or may not benefit from certain interventions. This protocol is drafted in accordance with Public Act 154 of 2017. This protocol is intended to facilitate kind, humane, and compassionate service for patients who have executed a valid MI-POST under the law.

I. Definitions
   A. Attending health professional – means a physician, physician’s assistant, or certified nurse practitioner, who has primary responsibility for the treatment of a patient and is authorized to issue the medical orders on a POST form.
   B. Patient – means an adult with an advanced illness or means an adult with another medical condition that, despite available curative therapies or modulation, compromises his or her health so as to make death within 1 year foreseeable though not a specific or predicted prognosis.
   C. Guardian – means a person with the powers and duties to make medical treatment decisions on behalf of a patient to the extent granted by court order under section 5314 of the Estates and Protected Individuals Code, 1998 PS 386, MCL 700.5314.
   D. Patient Advocate – means an individual designated to make medical treatment decisions for a patient under Section 496 of the revised Probate Code, Act No. 642 of the Public Acts of 1978, being section 700.496 of the Michigan Compiled Laws.

II. Introduction - EMS providers who encounter an approved MI-POST in the field should be aware of the different levels of care in Sections A and B of the form.

III. Procedure for Use of Form
   A. Section A – Applies to only individuals who do NOT have a pulse and are not breathing upon arrival of EMS personnel or become pulseless or apneic during treatment.
      a. If Attempt Resuscitation is checked, provide treatment according to appropriate Cardiac Arrest protocol.
      b. If DO NOT attempt resuscitation is checked, refer to Dead on Scene or Determination of Death, Death in an Ambulance and Transport of Body protocol as appropriate.
   B. Section B – For patients who have a pulse and/or are breathing
      a. Comfort-Focused Treatment
         1. Patients should receive full palliative treatment for pain, dyspnea, hemorrhage, or other medical conditions (including medication by any route) according to applicable protocols.
2. Relief of choking caused by a foreign body is appropriate, but if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
3. Follow appropriate transport and destination protocols as needed.

b. Selective Treatment
   1. All patients receive comfort treatment plus:
   2. Treat medical conditions according to protocol including IV therapy, cardiac monitoring, medications, and non-invasive airway support.
   3. Do not use invasive airways (including supraglottic airways).

c. Full Treatment
   1. All patients receive comfort treatment, plus:
   2. Full treatment should be provided. This includes, but is not limited to, intubation, other invasive airways, and mechanical ventilation.

d. If no box is checked, Full Treatment is implied.

IV. MI POST Form
   A. An example form is contained in this protocol. The original form will generally be pink, but copies of the form are valid (paper or digital).
   B. The form must be dated within the last year. Note: reaffirmation dates should be counted as the most recent date, see Section G.
   C. The form must be signed by the attending health professional and the patient or the patient advocate/durable power of attorney for healthcare. A verbal order notation is valid for 72 hours.
   D. All previous versions of the form are valid, if all the above are true and there are no marks indicating a revocation on the form.
   E. The form is voluntary and may be revoked:
      a. By the patient, at any time when the patient can communicate their wishes.
      b. By the patient advocate/durable power of attorney for healthcare when it is considered to be consistent with the patient’s wishes or in the patient’s interest when the patient’s wishes are unknown.
      c. By the attending health professional when there is a condition change that makes the orders contained on the POST contrary to accepted healthcare standards.
   F. If there are issues with the form or the orders contained therein, contact Medical Control for direction.
**HIPAA PERMITS DISCLOSURE OF MI-POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

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

This MI-POST form is VOID if Patient Information or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C), does not void the form and implies full treatment for that section.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient Name (Last, First, Middle Initial)</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Date Form Prepared</th>
</tr>
</thead>
</table>

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, faxes, 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.

**MEDICAL ORDERS**

**A**

☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B)

☐ DO NOT attempt Resuscitation/CPR (DNR/No CPR, Allow Natural Death)

**B**

☐ 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.

☐ Selective Treatment – 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 (CPAP, 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 advance interventions as medically indicated.

Likely to involve transportation to the hospital. May include intensive care.

**C**

**ADDITIONAL ORDERS:** Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, nutrition, long-term life-support, medications, and blood products.

☐

☐

☐

**SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER (NP) OR PHYSICIAN ASSISTANT (PA)**

My signature below indicates that these orders are medically appropriate given the patient’s current medical condition and reflect to the best of my knowledge the patient’s goals for care.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (print)</td>
<td>Phone #</td>
</tr>
</tbody>
</table>

**COMPLETE BELOW IF ORDERS ARE ISSUED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT**

| Name of collaborating Physician (print) | Phone # |

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**
Michigan
PROCEDURES
MICHIGAN PHYSICIAN ORDERS
FOR SCOPE OF TREATMENT (MI-POST)

Initial Date: 10/26/2018
Revised Date:   

Section 7-25

HIPAA PERMITS DISCLOSURE OF MI-POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Patient First Name:</th>
</tr>
</thead>
</table>

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 Healthcare (DPOAH)
- [ ] Court-appointed Guardian

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

INFORMATION OF LEGALLY AUTHORIZED REPRESENTATIVE

Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAH or Court-appointed Guardian

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone #</th>
<th>Alternate Phone #</th>
</tr>
</thead>
</table>

INDIVIDUAL ASSISTING WITH COMPLETION OF MI-POST FORM

<table>
<thead>
<tr>
<th>Preparer’s Name (print)</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preparer’s Signature</th>
<th>Organization</th>
<th>Phone #</th>
</tr>
</thead>
</table>

TO REAFFIRM OR REVOKE THIS FORM

This MI-POST form can be reaffirmed or revoked at any time, if any of the following has occurred, the form must be revoked or reaffirmed by the patient or patient representative and the Attending Health Care Provider within the time frame indicated from the time the event occurred, or the form 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 care provider
- 1 week from a change in the patient’s place of care, level of care, or care setting; or any unexpected change in the patient’s medical condition

Reaffirming this MI-POST form indicates there are no changes and requires signatures with dating of reaffirmation below. If treatment changes are desired, revocation of this MI-POST form is required, and a new MI-POST form should be completed. Write “revoked” over the signatures of the patient or patient representative; and the signature(s) of the Attending Healthcare Provider, in Sections D and G, if used, on this MI-POST form

- 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.

If a section was previously blank (Sections A, B or C) and is later completed, follow the procedures for reaffirming. If a new form is not completed, full treatment and resuscitation will be provided.

<table>
<thead>
<tr>
<th>Reaffirmation #1</th>
<th>Date of Reaffirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Provider Name</td>
<td>Patient/Representative Name</td>
</tr>
<tr>
<td>Healthcare Provider Signature</td>
<td>Patient/Representative Signature</td>
</tr>
<tr>
<td>Reaffirmation #2</td>
<td>Date of Reaffirmation</td>
</tr>
<tr>
<td>Healthcare Provider Name</td>
<td>Patient/Representative Name</td>
</tr>
<tr>
<td>Healthcare Provider Signature</td>
<td>Patient/Representative Signature</td>
</tr>
<tr>
<td>Reaffirmation #3</td>
<td>Date of Reaffirmation</td>
</tr>
<tr>
<td>Healthcare Provider Name</td>
<td>Patient/Representative Name</td>
</tr>
<tr>
<td>Healthcare Provider Signature</td>
<td>Patient/Representative Signature</td>
</tr>
<tr>
<td>Reaffirmation #4</td>
<td>Date of Reaffirmation</td>
</tr>
<tr>
<td>Healthcare Provider Name</td>
<td>Patient/Representative Name</td>
</tr>
<tr>
<td>Healthcare Provider Signature</td>
<td>Patient/Representative Signature</td>
</tr>
</tbody>
</table>

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

MCA: 
MCA Board Approval Date: Click here to enter text. 
MCA Implementation Date: Click here to enter text. 
Protocol Source/References: