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. If there are issues with the form, the orders contained therein, or the circumstances of the situation are unclear, personnel may initiate treatment and contact Medical Control for direction.
   B. 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-Treatment Protocol.**
      b. If *DO NOT attempt resuscitation* is checked, refer to **Dead on Scene and Termination of Resuscitation-Procedure Protocol** or **Medical Examiner Notification and Body Disposition Protocol** as appropriate.
   C. Section B – For patients who have a pulse and/or are breathing
      a. Comfort-Focused Treatment box is selected:

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 box is selected:
   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 box is selected:
   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 10 calendar days.
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.

Protocol Source/References: **MCL** 333.20967, MCL 333.5679, **MCL 333.56**

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.

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