KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Advanced Directives				POLICY #: 5.07-P	
DEPARTMENT: Member Services					
Effective Date: 03/2003	Review/Revised Date: 12/20/2016	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 12/20/16

Chief Medical Officer — Date 12/20/16

Chief Operating Officer — Date 12/20/16

Administrative Director of Health Services — Date 10/16/16

Director of Provider Relations — Date 12/15/16

Director of Marketing and Member Services — Date 12/15/12

POLICY:
Kern Health Systems (KHS) and the providers of KHS will follow all requirements of 42 CFR 422.128 and 42 CFR 438.6(i) respecting advance directives. KHS will comply with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.[1]

KHS members 18 years of age or older have the right to formulate advance directives. Neither KHS nor its contracted providers will condition the provision of care or otherwise discriminate against a member based on whether or not the individual has executed an advance directive.[2]

Advance Health Care Directives allow KHS members to choose a personal representative and or outline acceptable future healthcare for a time when the member may be unable to choose or communicate directly.

DEFINITIONS:

Advance Directive[3]	A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

PROCEDURE:

1.0 CONSCIECENTIOUS OBJECTION[4]

KHS does not limit the implementation of advance directives as a matter of conscience. Conscientious objections raised by individual physicians must comply with all state and federal regulations.

2.0 PROVIDER POLICIES AND PROCEDURES

Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, providers of personal care services, and hospices must maintain written policies and procedures concerning advance directives as required by the California Code of Regulations Title 42 Section 489.102.

3.0 DOCUMENTATION

All adult and emancipated minor current medical records must include evidence to whether the KHS member was offered information or has executed an advance health care directive[5]. An *Advance Directive Acknowledgement* (See Attachment A) must be maintained in the provider's medical record.

Attachment:

- ❖ Attachment A – Advance Directive Acknowledgement

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[1] **Revision 2016-11:** Policy titles updated. **Revision 2006-02:** Reviewed against DHS Contract 03-76165 (Effective 5/1/2004).
[1] 42 CFR 422.128 (b)(1)(ii)(G)
[2] 42 CFR 422.128 (b)(1)(ii)(F)
[3] 42 CFR 489.100 definition required by 42 CFR 422.128 (a)
[4] 42 CFR 422.128 (b)(1)(ii)
[5] 42 CFR 422.128 (b)(1)(ii)(E); California Probate Code §4701

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____
HOME PHONE NUMBER: _____ CHART NUMBER: _____

PLEASE READ THE FOLLOWING TWO STATEMENTS.

PLACE YOUR INITIALS AFTER EACH STATEMENT

1. I HAVE BEEN OFFERED WRITTEN MATERIALS ABOUT MY RIGHT TO ACCEPT OR REFUSE MEDICAL TREATMENTS. _____

2. I UNDERSTAND THAT I AM NOT REQUIRED TO HAVE AN ADVANCE DIRECTIVE IN ORDER TO RECEIVE MEDICAL TREATMENT AT THIS HEALTH CARE FACILITY. _____

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

_____ I HAVE EXECUTED AN ADVANCE DIRECTIVE FOR HEALTH CARE.

_____ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE FOR HEALTH CARE.

SIGNED: _____ DATE: _____

WITNESS: _____ DATE: _____

TRANSLATED BY: _____ DATE: _____

RECONOCIMIENTO DEL PODER LEGAL MÉDICO POR ADELANTADO

NOMBRE: _____ FECHA DE NACIMIENTO: _____
NÚMERO DE SEGURO SOCIAL: _____
NÚMERO DE TELÉFONO EN CASA: _____
NÚMERO DE EXPEDIENTE: _____

POR FAVOR LEA SIGUIENTES DOS DECLARACIONES.

ESCRIBA SUS INICIALES DESPUÉS DE CADA DECLARACIÓN

1. A MI SE ME OFRECIÓ MATERIAL POR ESCRITO SOBRE MI DERECHO DE ACEPTAR O RECHAZAR TRATAMIENTO MÉDICO _____
2. YO ENTIENDO QUE NO ESTOY REQUERIDO A TENER UN PODER LEGAL MÉDICO POR ADELANTADO PARA PODER RECIBIR TRATAMIENTO MÉDICO EN ESTE ESTABLECIMIENTO_____

POR FAVOR MARQUE UNA DE LAS SIGUIENTES DECLARACIONES

_____ YO HE HECHO UN PODER LEGAL POR ADELANTADO PARA CUIDADO MÉDICO

_____ YO NO HE HECHO UN PODER LEGAL POR ADELANTADO PARA CUIDADO MÉDICO

FIRMA: _____ FECHA: _____

TESTIGO: _____ FECHA: _____

TRADUCIDO POR: _____ FECHA: _____