

**Arizona Department of Health Services
Division of Behavioral Health Services
Magellan Health Services of Arizona, Edition**

Section 3.12 Advance Directives

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3.12.1 Introduction

An advance directive is a written set of instructions developed by an adult person in the event the person becomes incapable of making decisions regarding his or her health treatment. An advance directive instructs others regarding the person's wishes, if he/she becomes incapacitated, and can include the appointment of a friend or relative to make health care decisions for the person. A person prepares an advance directive when capable, and the directive is followed when the person is incapable of making treatment decisions. This section outlines the requirements of health care providers with regard to advance directives.

3.12.2 Terms

Definitions for terms are located online at <http://www.azdhs.gov/bhs/definitions/index.php> and <http://magellanofaz.com/for-providers/provider-manual/definitions.aspx>. The following terms are referenced in this section:

Advance Directive

Health Care Power of Attorney

Incapacitated Person

Mental Health Care Power of Attorney

3.12.3 Procedures

3.12.3-A. What does a health care power of attorney do?

A health care power of attorney gives an adult person the right to designate another adult person to make health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult person if/when she or he is found incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the health treatment of the adult person at the time the health care power of attorney is executed.

3.12.3-B. What does a mental health care power of attorney do?

A mental health care power of attorney gives an adult person the right to designate another adult person to make mental health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult person if/when she or he is found incapable of

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making these types of decisions. The designee, however, must not be a mental health care provider directly involved with the health treatment of the adult person at the time the mental health care power of attorney is executed.

3.12.3-C. What are some of the power and duties of the designee(s)?

The designee:

- May act in this capacity until his or her authority is revoked by the adult person or by court order;
- Has the same right as the adult person to receive information and to review the adult person's medical records regarding proposed health treatment and to receive, review, and consent to the disclosure of medical records relating to the adult person's treatment;
- Must act consistently with the wishes of the adult person as expressed in the mental health care power of attorney or health care power of attorney. If, however, the adult person's wishes are not expressed in a mental health care power of attorney or health care power of attorney and are not otherwise known by the designee, the designee must act in good faith and consent to treatment that she or he believes to be in the adult person's best interest; and
- May consent to admitting the adult person to a level 1 health facility licensed by the Arizona Department of Health Services if this authority is expressly stated in the mental health care power of attorney or health care power of attorney.

See [A.R.S. § 36-3283](#) for a complete list of the powers and duties of an agent designated under a mental health care power of attorney.

3.12.3-D. What must be provided to an adult person at the time of enrollment?

At the time of enrollment, all adult persons, and when the individual is incapacitated or unable to receive information, the enrollee's family or surrogate, must receive information regarding (see [42 C.F.R. § 422.128](#)):

- The person's rights, in writing, regarding advance directives under Arizona State law;
- A description of the applicable state law (summarized in 3.12.7-A and 3.12.7-B above); and information regarding the implementation of these rights;
- The person's right to file complaints directly with AHCCCS; and
- Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum, should:
 - Clarify institution-wide conscientious objections and those of individual physicians;
 - Identify state legal authority permitting such objections; and
 - Describe the range of medical conditions or procedures affected by the conscience objection.

If an enrollee is incapacitated at the time of enrollment, providers may give advance directive information to the enrollee's family or surrogate in accordance with state law. Providers must

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also follow up when the person is no longer incapacitated and ensure that the information is given to the person directly.

3.12.3-E. How do I help an adult person develop an advance directive?

Providers must assist adult persons who are interested in developing and executing an advance directive. They must also maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. The T/RBHA can offer the following resources:

- [Advance Directive Form](#)
- [Advance Directive Resource Sheet](#)

For additional resources about Advance Directives, contact Magellan Customer Service at 1-800-564-5465.

3.12.3-F. What else must health care providers do regarding advance directives?

Healthcare providers must:

- Document in the adult person's clinical record whether or not the adult person was provided the information and whether an advance directive was executed;
- Not condition provision of care or discriminate against an adult person because of his or her decision to execute or not to execute an advance directive;
- Provide a copy of a person's executed advanced directive, or documentation of refusal, to the acute care primary care provider (PCP) for inclusion in the person's medical record; and
- Provide education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advance directives executed by person's to whom they are assigned to provide services

3.12.4 References

The following citations can serve as additional resources for this content area:

[42 C.F.R. § 422.128](#)

[42 C.F.R. § 438.6](#)

[42 C.F.R. § 438.10\(g\) \(2\)](#)

[42 C.F.R. § 489.100](#)

[42 C.F.R. § 489.102\(a\)](#)

[A.R.S. § 36-3221](#)

[A.R.S. § 36-3281](#)

[A.R.S. § 36-3283](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[ADHS/TRBHA IGAs](#)

[Section 3.6, Member Handbooks](#)

[Section 4.2, Behavioral Health Medical Record Standards](#)

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[Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers, and Medicare Providers](#)