SUMMARY OF HEALTH CARE DECISION STATUTES ENACTED IN 2016-2017

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From 2016 through 2017, states adopted the following legislation creating, modifying, and amending rights and procedures affecting health care decision-making. The statutes affect advanced directives, default surrogate laws, Physicians Orders for Life-Sustaining Treatment (POLST), and registries. These summaries are intended to offer selected highlights and do not fully describe the laws in their entirety.

Each piece of legislation is coded to indicate the potential areas of health care decision making affected by the statute. The coding system is:

AD = Advance Directives
DNR = Do Not Resuscitate Orders
DS = Default Surrogate
POLST = Physician's Orders for Life Sustaining Treatment, or its variants (e.g. MOLST, POST, MOST, and others).
Registry = State electronic registry for Advance Directives and/or POLST
PAD = Physician aid in dying legislation (also called physician-assisted suicide)

Alabama

(DNR)

2016 Alabama Laws Act 2016-96 (S.B. 138). Approved March 18, 2016. Effective June 1, 2016. Authorizes Portable Physician Do Not Attempt Resuscitation (DNAR) Orders, adding definitions and procedures to the state's advance directive statute. The DNAR form must be approved by the State Board of Health. The Act also provides statutory immunity for health care providers or facilities that issue or comply with a portable DNAR.

(PAD)

2017 Alabama Laws Act 2017-231 (H.B. 96). Approved May 4, 2017. Effective August 1, 2017. This bill established the Assisted Suicide Ban Act, prohibiting a person or a health care provider from providing aid in dying under certain conditions and provides civil and criminal penalties for violations of the Act.

Arizona

(Registry)

2017 Ariz. Legis. Serv. Ch. 154 (H.B. 2076) (WEST). Approved April 17, 2017 amending Arizona Revised Statute Sections 36-3295 and 36-3296, relating to the health care directives registry. Directs the Secretary of State to establish a process for health care providers to access the advanced directives central registry. Expanded the definition of "health care providers" to

[1] The author thanks legal intern Carissa Peterson for her invaluable assistance.

include emergency medical service providers and emergency service technicians providing emergency medical services.

Arkansas
(AD, DS)
2017 Arkansas Laws Act 974 (S.B. 676). Approved April 7, 2017. Effective July 31, 2017. Combines three advance directive statutes into two laws -- the existing Health Care Decision Act (Ark. Code Ann. §§ 20-6-101 to -118) and the existing Rights of the Terminally Ill Act (§§20-17-201 to -218), by repealing the separate Durable Power of Attorney for Health Care Act and merging its key elements into the health Care Decisions Act and amending and conforming other provisions of the original acts. Among the revisions, the Act:

- Adds "durable power of attorney for health care" to subchapter definitions. Defines "durable power of attorney for healthcare" as a written advance directive that identifies an agent who is authorized to make healthcare decisions on behalf of the principal.
- Adds "Living will" to subchapter definitions. "Living will" means a written advance directive describing the principal's individual instructions for health care to be provided or withheld if the principal subsequently lacks decision-making capacity.
- Provides a single uniform process for executing any form of advance directive – notarization or witnessing by 2 adults not related by blood, marriage, or adoption, and not entitled to any portion of the estate of the principal upon the principal's death.
- Replaces the requirement that a principal may only revoke the designation of an agent by a signed written statement or by personally informing the supervising healthcare provider with a more flexible requirement that a principal make revoke all or part of an advanced directive, living will, durable power of attorney for healthcare, or other document, at any time and in any manner that communicates an intent to revoke.
- Requires a healthcare provider, agent, guardian, or surrogate who is informed of a revocation promptly communicate the revocation to the supervising healthcare provider and any healthcare institution at which the patient is receiving care.
- Makes minor changes in the process for identifying a surrogate in the absence of an authorized decision-maker, and adds to the priority list of surrogates a close friend, defined as any adult who: (1) Has exhibited special care and concern for the principal; (2) Is familiar with the principal's personal values; (3) Is reasonably available; and (4) Is willing to serve.
- If no one is available to serve as surrogate, the existing law that permits the designated physician (now called supervising health care provider) to make decisions for the patient under specified criteria is modified slightly to require consultation and approval from either an institution's ethics officer or ethics committee.
- Adds that a default surrogate may make decisions regarding withdrawal of artificial nutrition and hydration if the action is authorized by a living will or other written advanced directive, or if certain medical criteria are certified by the supervising health care provider and a second independent physician.

(POLST)
2017 Arkansas Laws Act 504 (S.B. 356). Approved March 15, 2017. Effective July 31, 2017. Creates the Arkansas Physician Order for Life-Sustaining Treatment (POLST) Act and provides for the use of a physician order for life-sustaining treatment form.

- The General Assembly found that the physician order for life-sustaining treatment form is a complement to an Advanced Directive, if existing, by taking an individual's intentions and converting them into a medical order.
- Provides that the standardized form is to be prescribed by the State Board of Health and outlines the elements of the form.
- Outlines the hallmarks of the POLST form, provides guidance on how to complete the form on behalf of patients who lacks capacity and the process for reviewing and revising an executed POLST form.
- Indicates the relationship the POLST form is to have with Advanced Directives – the POLST form does not replace an advanced directive and a good faith effort must be made to locate and incorporate an advanced directive into the form. Outlines steps to be followed when the advanced directive and POLST form conflict with one another.
- Provides that healthcare providers, facilities, and their agents are not subject to civil or criminal liability for complying with a POLST form or failing to comply where good faith determinations are made under enumerated circumstances. Provides religious and moral exceptions to compliance.
- The signing of a POLST form is voluntary. A person or entity cannot require an individual to execute a POLST form as a condition of being insured for, or receiving, healthcare services.
- Creates criminal penalties for failing to act in accordance with certain requirements of the chapter (e.g., "undue influence" by providing financial incentives for completing the form).
- Provides the form that the State Board of Health is to adopt.

Colorado
(PAD)
2016 Colo. Legis. Serv. Init. Pet. 145 (WEST). Passed by Colorado voters on November 8, 2016, by 65 to 35 percent. Effective December 16, 2016.
Modeled upon the Oregon Death with Dignity law, the law:

- Establishes process by which competent, terminally ill (6 month prognosis) adult resident of DC can obtain a physician's prescription to end their life, based upon an informed and voluntary decision.
- Requires confirmation that the individual is not suffering from psychiatric or psychological condition causing impaired judgment.
- Requires (1) an initial oral request, followed by (2) a written request on an approved form witnessed by 2 qualified witnesses, and then (3) a 2nd oral request (no sooner than 15 days after the first).
- Provides for counseling of patients requesting aid in dying.
- Authorizes dispensing the prescription either directly to the patient by physician, or through a pharmacy. Both have reporting requirements to the department of public health.
- Defines its effect on contracts, wills, insurance and annuity policies and requires that they not be conditioned upon or affected by the making or rescinding of a request for medication or by a patient ingesting covered medication.
- Establishes terms for immunity from criminal and civil liabilities.

- Establishes penalties and provides an opt-out provision for health care providers.
- Provides for claims by the government against the individual's estate if costs are incurred from a patient terminating his or her life pursuant to the legislation in a public place

(DS)
2016 Colo. Legis. Serv. Ch. 170 (H.B. 16-1101) (WEST). Approved May 18, 2016. Effective August 10, 2016. Amends the state's Proxy Decision-Makers for Medical Treatment Article, §15-18.5 of Colo. Rev. Statutes to add a medical decision-making procedure for patients with no available proxy decision-maker. The law provides that an attending physician may designate another willing physician to make health care treatment decisions as a patient's proxy decision-maker if:

- After making reasonable efforts, the attending physician or his or her designee cannot locate any interested persons, or no interested person is willing and able to serve as proxy decision-maker;
- The attending physician has obtained an independent determination of the patient's lack of decisional capacity by another physician; by an advanced practice nurse who has collaborated about the patient with a licensed physician either in person, by telephone, or electronically; or by a court;
- The attending physician or his or her designee has consulted with and obtained a consensus on the proxy designation with the medical ethics committee of the health care facility where the patient is receiving care; and
- The identity of the physician designated as proxy decision-maker is documented in the medical record.

The law also specifies decision-making criteria and procedures, including ethics committee concurrence and/or a second consulting physician concurrence for certain decisions.

Connecticut
(POLST)
2017 Conn. Legis. Serv. P.A. 17-70 (S.B. 938) (WEST). Approved June 27, 2017. Effective October 1, 2017. Authorizes the state–wide adoption of the medical orders for life–sustaining treatment program (MOLST).

- Provides that the Commissioner of Public Health shall establish a state-wide program to implement the use of medical orders for life-sustaining treatment by health care providers. Patient participation in the program shall be voluntary.
- Establishes a MOLST advisory council. The advisory council shall meet at least annually to be updated on the status of the program and advise the department on matters related to improving the program.
- The Commissioner of Public Health shall adopt regulations for the program to ensure that:
    - MOLSTs are transferrable among, and recognized by, various types of health care institutions subject to any limitations set forth in federal law;
    - Any procedures and forms developed for recording MOLST require the signature of the patient or the patient's legally authorized representative and a witness on the MOLST and the patient or the patient's legally authorized representative is

given the original order immediately after signing such order and a copy of such order is immediately placed in the patient's medical record;

- Prior to requesting the signature of the patient or the patient's legally authorized representative on such order, the physician, advanced practice registered nurse or physician assistant writing the medical order discusses with the patient or the patient's legally authorized representative the patient's goals for care and treatment and the benefits and risks of various methods for documenting the patient's wishes for end-of-life treatment, including medical orders for life-sustaining treatment; and,
- Each physician, advanced practice registered nurse or physician assistant that intends to write a MOLST receives training concerning: (A) The importance of talking with patients about their personal treatment goals; (B) methods for presenting choices for end-of-life care that elicit information concerning patients' preferences and respects those preferences without directing patients toward a particular option for end-of-life care; (C) the importance of fully informing patients about the benefits and risks of an immediately effective MOLST; (D) awareness of factors that may affect the use of MOLST, including, but not limited to, advanced health care directives, race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence; and (E) procedures for properly completing and effectuating MOLST.

District of Columbia
(PAD)
2016 District of Columbia Laws 21-182 (Act 21-577). Approved December 19, 2016. Effective February 18, 2017. The "Death with Dignity Act of 2016" –

- Establishes process by which competent, terminally ill (6 month prognosis) adult resident of DC can obtain a physician's prescription to end their life, based upon an informed and voluntary decision.
- Requires confirmation that the individual is not suffering from psychiatric or psychological condition causing impaired judgment.
- Requires (1) an initial oral request, followed by (2) a written request on an approved form witnessed by 2 qualified witnesses, and then (3) a 2nd oral request (no sooner than 15 days after the first).
- Provides for counseling of patients including the importance of family notification.
- Authorizes dispensing the prescription either directly to the patient by physician, or through a pharmacy. Both have reporting requirements to the department of public health.
- Defines its effect on contracts, wills, insurance and annuity policies and requires that they not be conditioned upon or affected by the making or rescinding of a request for medication or by a patient ingesting covered medication.
- Establishes terms for immunity from criminal and civil liabilities.
- Establishes penalties and provides an opt-out provision for health care providers.
- Provides for claims by the government against the individual's estate if costs are incurred from a patient terminating his or her life pursuant to the legislation in a public place

Idaho
(AD)

2017 Idaho Laws Ch. 273 (S.B. 1090). Approved April 6, 2017. Effective July 1, 2017. An Act amending Idaho's Medical Consent and Natural Death Act.

- Revises provisions regarding revocation of an advance directive. Adds that an advanced directive may be revoked by any other action that clearly manifests the maker's intent to revoke the advance directive. Provides the maker of the revoked living will and durable power of attorney for health care advance directive is responsible for notifying his health care provider of the revocation. A health care provider who does not have actual knowledge of the revocation is entitled to rely on an otherwise apparently valid advance directive as though it had not been revoked.
- Revises provisions regarding suspension of an advance directive. Provides that a suspension may be accomplished by any other action that clearly manifests the maker's intent to suspend the advance directive. Provides that a health care provider who does not have actual knowledge of the suspension is entitled to rely on an otherwise apparently valid advance directive as though it had not been suspended.
- Revises provisions regarding presumed consent to resuscitation. Provides that there is a presumption in favor of consent to CPR unless: (a) CPR is contrary to the person's advance directive and/or POST; (b) The person's surrogate decision-maker has communicated the person's unconditional wishes not to receive CPR; (c) The person's surrogate decision-maker has communicated the person's conditional wishes not to receive CPR and those conditions have been met; (d) The person has a proper POST identification device; or (e) The attending health care provider has executed a DNR order consistent with the person's prior expressed wishes or the directives of the legally authorized surrogate decision-maker.

Maryland – AD, Registry

2016 Maryland Laws. Ch. 510 (H.B. 1385). Approved May 10, 2016. Effective October 1, 2016. An act concerning public health, advance directives, procedures, information sheet, and of electronic advance directives.

- Provides an important patient's rights clarification that, "Notwithstanding any other provision of law, in the absence of a validly executed or witnessed advance directive, any authentic expression made by an individual while competent of the individual's wishes regarding health care for the individual shall be considered."
- The Act provides a repeal and restructuring of the Maryland Advance Directive Registry system.
- To facilitate the use of cloud-based technology for electronic advance directives, the Department of Health and Mental Hygiene (Department) is required to contract with an electronic advance directives service to connect with health care providers at the point of care through the State-designated health information exchange. The electronic advance directives service must be approved by the Maryland Health Care Commission and the Department and meet the technology, security, and privacy standards set by the Maryland Health Care Commission. Also see 2017 enactment below: 2017 Maryland Laws Ch. 667 (H.B. 188).
- Allows the State-designated health information exchange to accept as valid an unwitnessed electronic advance directive in the form of a video record or file if the video

record or file is dated and stored in an electronic file by an electronic advance directives service recognized by the Maryland Health Care Commission.

- Requires the Maryland Health Care Commission to develop criteria for recognizing electronic advance directives services that are authorized to connect to the State-designated health information exchange. The State-designated health information exchange must ensure that electronic advance directives services do not have access to information stored on the State-designated health information exchange.
- Requires the information sheet on advance directives (that the Department produces under current law) to also include information to: (i) Educate the public on the use of electronic advance directives; (ii) Encourage the use of electronic advance directives; (iii) Provide information about developing an electronic advance directive; (iv) Describe how electronic advance directives are made available at the point of care;(v) Indicate that the use of an electronic advance directive is not required; and (vi) Indicate that individuals do not have to pay to have their electronic advance directives honored.
- Requires the State-designated health information exchange to include the advance directive information sheet in the exchange's consumer publications, on its website, and to provide it at the request of an applicant.
- The Department is also required to: (1) Encourage the use of electronic advance directives; (2) Carry out appropriate educational and outreach efforts to increase public awareness of electronic advance directives; and (3) Encourage the following persons and entities to engage in outreach efforts regarding electronic advance directives:
    - The Maryland Department of Aging;
    - County ombudspersons;
    - Local health departments;
    - Senior living facilities;
    - Academic institutions;
    - Religious organizations;
    - Hospitals; and
    - Other similar persons or entities.

<u>Maryland</u>
(AD)
2017 Maryland Laws Ch. 657 (H.B. 498). Approved May 25, 2017. Effective October 1, 2017. An Act amending the Health Care Decisions Act - Advance Directives and Surrogate Decision Making - Disqualified Individuals.

- Disqualifies individuals from acting as health care agents if (1) they are the subject of any protective order for which the declarant is a subject of relief under that order, or (2) they are the spouse of the declarant and there is an executed separation agreement or a filed application for divorce (unless the declarant has indicated otherwise).

(AD)
2017 Maryland Laws Ch. 667 (H.B. 188). Approved May 25, 2017. Effective July 1, 2017. An Act amending the Health Care Decisions Act relating to electronic advanced directives.

- Provides that a witness is not required for an electronic advance directive if the declarant's identity has been authenticated in accordance with guidelines specified by the National Institute of Standards and Technology.

- Provides that an individual shall submit an electronic advance directive that is not witnessed to an electronic advance directives service that is recognized by the Maryland Health Care Commission.

Missouri
(Registry)
2017 Mo. Legis. Serv. S.B. 50 (VERNON'S) (West's No. 40) and S.B. 501 (VERNON'S) (West's No. 51). Approved July 10 and 14, 2017. Effective August 28, 2017. Authorizes a state "Advance Health Care Directives Registry" to be created by contract with a third party.

- Any document and any revocation of a document submitted for filing in the registry must be submitted electronically at an intake point (defined as any licensed health care provider or licensed attorney) and signed electronically with a unique identifier, such as a social security number, a driver's license number, or another unique government-issued identifier. Submission requires a fee not to exceed ten dollars.
- The Department of Health and Senior Services is authorized to promulgate regulations regarding access and other matters.

Montana
(DS)
2017 Montana Laws Ch. 285 (S.B. 92). Approved and effective May 4, 2017. An act allowing for appointment of proxy decision-makers for adult patients who lack decisional capacity related to medical treatment and have no appointed or otherwise authorized decision-maker.

- Requires the provider to make reasonable efforts to locate and notify as many interested persons as practicable to inform them of the patient's incapacity and ask that a lay proxy decisionmaker be selected for the patient.
- "Interested persons" are defined as: (a) spouse; (b) parent; (c) adult child, sibling, or grandchild; or (d) close friend.
- Interested persons who are informed of the patient's lack of decisional capacity must make reasonable efforts to reach a consensus as to who among them will make medical treatment decisions on behalf of the patient.
- An attending physician may designate another physician or advance practice nurse to make health care treatment decisions as a patient's proxy decision-maker if:
    - no interested person is willing or available to serve as proxy decision-maker;
    - the lack of decisional capacity has been confirmed by a 2nd health care provider;
    - a medical ethics committee approves the designation;
    - the designated proxy is documented in the medical record.
- Specifies decision-making criteria and procedures, including ethics committee concurrence and second consulting physician concurrence for certain decisions.

Nevada
(AD)
2017 Nevada Laws Ch. 154 (S.B. 50). Approved and effective May 26, 2017. An Act establishing a procedure for a person to execute an advance directive for psychiatric care to direct any provider of health care on how he or she wishes psychiatric care to be provided if he or she is incapable of making decisions concerning such care or communicating such decisions. (Appointment of a agent is already available under the existing statute).

- "Psychiatric care" is defined as "the provision of psychiatric services and psychiatric treatment and the administration of psychotropic medication."
- Provides a sample form that may be used by a person wishing to execute an advance directive for psychiatric care.
- The directive must be signed by the principal, or another at the principal's direction, and attested by two witnesses. Neither of the witnesses may be:
  (a) The attending physician or provider of health care;
  (b) An employee of the attending physician or provider of health care;
  (c) An owner or operator of a medical facility in which the principal is a patient or resident or an employer of such an owner or operator; or
  (d) A person appointed as an attorney-in-fact by the advance directive.
- The directive becomes effective upon execution and remains valid for a period of 2 years after the date of its execution unless revoked.
- Implementation requires a finding by the principal's attending physician or a licensed psychologist and by another physician, a physician assistant, a licensed psychologist, psychiatrist, or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing that the principal's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that s/he lacks the capacity to refuse or consent to psychiatric care.
- Provides that an advance directive for psychiatric care validly executed pursuant to the laws of another state is valid in this State.
- Outlines the circumstances under which a physician or other provider of health care may decline to comply with an advance directive for psychiatric care and in such cases requires the provider to "take all reasonable steps as promptly as practicable to transfer the psychiatric care of the principal to another physician or provider of health care."
- Includes immunity provisions and the opportunity to register such an advance directive with the Secretary of State for deposit in the Registry of Advance Directives for Health Care.

Nevada
(POLST, DS)
2017 Nevada Laws Ch. 104 (A.B. 199). Approved May 24, 2017. Effective July 1, 2017.
Amends the state's Physician Orders for Life-Sustaining Treatment law to:

- Authorize physician assistants or advanced practice registered nurses to make certain determinations related to a POLST and to sign it.
- Changes the name of the form from "Physician Orders…" to "Provider Orders for Life-sustaining Treatment."
- Provides for consent to POLST forms by default surrogates in a priority order similar to the existing default surrogate provision in the state's living will statute (§449.626) but adds close friend to the list of surrogates as follows:
  - Spouse
  - Adult child
  - Parent
  - Adult sibling
  - Nearest adult relative

    - "An adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient."
- Amend existing provisions regarding certain conflicts between a POLST form and DNR identification bracelets by requiring the health care provider to honor a POLST form ordering the provision of life-resuscitating treatment if the POLST form is executed after a DNR identification was issued to the patient.

(AD, POLST)
2017 Nevada Laws Ch. 318 (S.B. 227). Approved June 2, 2017. Effective January 1, 2018. Authorizes an advanced practice registered nurse to sign medical orders, certifications, and verifications that require physician signature, if he or she is qualified to do so; and requires the State Board of Nursing to adopt regulations specifically providing for when an advanced practice registered nurse is qualified to provide his or her signature. The provision affects multiple situations from certification of death or disability and competency to stand trial, to certification of terminal condition and decisional incapacity for purposes of implementing an advance directive and signing of Physician Orders for Life-Sustaining Treatment.

North Dakota
(AD)
2017 North Dakota Laws Ch. 189 (S.B. 2151). Approved April 4, 2017. Effective August 1, 2017. Minimally edited the optional health care directive form to replace "doctor(s)" with "health care provider(s)." Edited the making an anatomical gift section by providing an "opt-out" section.

Oregon
(AD)
2017 Oregon Laws Ch. 135 (H.B. 2393). Approved May 24, 2017. Effective January 1, 2018. Amends the "Medical Care and Treatment—Terminally Ill Persons" section of the Oregon Health Care Decisions Act.

- Specifies case manager's duties if they receive notice that person for whom case manager provides services will have life-sustaining procedures withheld or withdrawn.
- A case manager shall provide any information in the case manager's possession that is related to the principal's values, beliefs and preferences with respect to the withholding or withdrawing of life-sustaining procedures.

Pennsylvania
(AD)
2016 Pa. Legis. Serv. Act 2016-79 (S.B. 1104) (PURDONS). Approved and effective July 8, 2016. Amends Title 20 of Pa. Consolidated Statutes.

- Expands the range of decisions over which an agent under a health care power of attorney has authority by adding to the definition of "health care decision" at § 5422:
    - Admission to a medical, nursing, residential or similar facility, or entering into agreements for the individual's care.
    - Making anatomical gifts, or after the death of the individual, disposing of the remains or consenting to autopsies.

- Clarifies that a health care power of attorney cannot be revoked by a guardian of the person unless the court authorizes the guardian to revoke.

Texas
(AD)
2017 Tex. Sess. Law Serv. Ch. 995 (H.B. 995) (VERNON'S). Approved June 15, 2017. Effective January 1, 2018. An Act relating to the form and revocation of medical powers of attorney.

- Expands the revocation by "divorce" provision of the medical power of attorney to include revocation if the agent's marriage to the principal is "dissolved, annulled, or declared void." Existing law that allows the principal to provide otherwise in the medical power of attorney remains unchanged.
- Moves the separate mandatory Disclosure Statement that the principal was required to sign into the statutory medical power of attorney form itself, so that a separate signature is not needed.

Vermont-
(DS, DNR, POLST)
2016 Vermont Laws No. 136 (S. 62). Approved May, 25, 2016. Effective January 1, 2018. Authorizes a "surrogate" (interested persons) to make decisions about DNR orders and Clinician Orders for Life-Sustaining Treatment" (DNR/COLST) when the patient lacks decisional capacity and there is no authorized guardian or appointed agent. COLST is Vermont's version of POLST.

- "Interested individual" is defined as:
  (A) the principal's or patient's spouse, adult child, parent, adult sibling, adult grandchild, or clergy person; or
  (B) any adult who has exhibited special care and concern for the principal or patient and who is personally familiar with the principal's or patient's values.
- A surrogate can be designated by the patient by personally informing the patient's clinician who must document the designation in the medical record.
- If the patient cannot designate a surrogate, then the patient's clinician must make a reasonable attempt to notify all reasonably available interested individuals of the need for a surrogate to make a decision regarding DNR/COLST. The group of interested individuals must agree on who will act as surrogate.
- The surrogate must be willing to provide or withhold informed consent for a DNR/COLST order for the patient in accordance with the patient's wishes and values, if known; and willing and available to consult with the patient's clinician
- If the interested individuals are unable to agree on the designation of a surrogate, an interested person may file a petition for guardianship.
- A surrogate cannot act if the patient objects, "even if the patient lacks capacity."

Virginia
(DNR, POLST)
2017 Virginia Laws Ch. 179 (H.B. 2153). Approved February 23, 2017. Effective July 1, 2017. An Act to amend and reenact § 54.1-2987.1 of the Code of Virginia, relating to Durable Do Not Resuscitate Orders and Reciprocity.

- Added a new provision that provides a Durable Do Not Resuscitate Order or other order regarding life-prolonging procedures executed in accordance with the laws of another state in which such order was executed shall be deemed to be valid and given effect as provided in this article.

(AD)

2017 Virginia Laws Ch. 747 (H.B. 1747) and 2017 Virginia Laws Ch. 752 (S.B. 1242). Approved March 24, 2017. Effective July 1, 2018. Amends Virginia's Health Care Decisions Act to include Qualified Advance Directive Facilitators.

- Defines "qualified advance directive facilitator" as a person who has successfully completed a training program approved by the Department of Health for providing assistance in completing and executing a written advance directive.
- Establishes requirements for training programs for qualified advance directive facilitators.
- Provides that distribution of a form for an advance directive that meets the requirements of § 54.1-2984 ("Suggested Form of Written Advance Directives") and the provision of ministerial assistance to a person regarding the completion or execution of such form shall not constitute the unauthorized practice of law.