SUMMARY OF HEALTH CARE DECISION STATUTES ENACTED IN 2015-2016

ABA Commission on Law and Aging

From 2015 through mid-2016, 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, 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.

Arizona – DNR
2015 Ariz. Legis. Serv. Ch. 318 (H.B. 2545) (WEST). Approved by the Governor April 14, 2015, amending Arizona Revised Statute Section 36-3251, providing additions and revisions relating to pre-hospital medical care directives. Adds "direct care staff person" to the list of health care providers who may comply with a prehospital medical care directive.

California – PAD
2015 Cal. Legis. Serv. 2nd Ex. Sess. Ch.1 (A.B. 15) (WEST), filled with Secretary of State, October 5, 2015, amends the Health and Safety Code relating to end of life to enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The Act establishes procedures for making these requests, including forms to request aid-in-dying and requirements for documentation in the individual's medical record of, among other things, all oral and written requests for an aid-in-dying drug.

Connecticut – AD (durable power of attorney)
2016 Conn. Legis. Serv. P.A. 16-40 (S.B. 142) (WEST). Approved May 27, 2016, adds a short form statutory power of attorney to the Connecticut Uniform Power of Attorney Act.

- The Act includes new provisions concerning the agent's discretionary powers with respect to executing a written document regarding the disposition of the principal's body upon death. Disposition includes cremation, incineration, dispositions of cremains, burial, method of interment, alkaline hydrolysis and cryogenic preservation. These decisions can be made by the agent unless there is express language that does not bestow disposition power.

Delaware – POLST (DMOST)
2015 Delaware Laws Ch. 18 (H.B. 64) (WEST), Approved May 28, 2015, amends Title 16 of the Delaware code adding definitions, provisions and powers relating to "Delaware Medical Orders for Scope of Treatment Act."

- Delaware's enacts POLST legislation and outlines the purpose of providing individuals the autonomy for implementing orders of life sustaining treatment.
- Outlines duties for the agent of the patient including the parameters for the decision of whether to provide, withhold or withdraw life sustaining procedures which are not to depend on the patient's pre-existing long-term mental or physical disability.
- Adds the powers and duties of the Department of Health and Social Services, Department of State and the Delaware Health Information Network.
- Provides a new section on the obligation to treat a patient who has completed a DMOST form, mandatory elements of DMOST and modification and revocation of DMOST forms.
- Adds civil and criminal penalties for failing to act in accordance with certain requirements of the chapter.

Florida – AD, DS
2015 Fla. Sess. Law Serv. Ch. 2015-153 (C.S.C.S.C.S.H.B. 889) (WEST). Approved by the Governor June 11, 2015, amends the Florida statute by adding definitions, provisions, and designations of a health care surrogate in sections FL ST 765.101, 02, 04, 05, 1103, 1105, 202, 203, 2035, 2038, 204, 404.

- Authorizes individuals to designate a "surrogate" (Florida's current term for an appointed health care agent) to make health care decisions or receive health information, or both, without the necessity for a determination of incapacity under this chapter. In other words, this permits an immediately effective health care powers of attorney.
- Recognizes the importance of having a surrogate authorized to receive health care information by including that purpose in the definition of a surrogate designation and by adding a definition of "Health care" and "Health information."
- Revises the optional statutory form for appointing a health care surrogate.
- Authorizes the designation of a health care surrogate for a minor and provides an optional statutory form for that purpose.
  Replaces references to "attending or treating physician" with "primary physician" defined as "a physician designated by an individual or the individual's surrogate, proxy, or agent under a durable power of attorney … to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not

reasonably available, a physician who undertakes the responsibility." The primary physician has the primary authority to determine the capacity/incapacity of the principal and diagnoses of terminal condition or persistent vegetative state; a duty to provide information concerning pain management and palliative care to the individual or surrogate; and authority to seek expedited judicial. If an attending physician determines that the principal lacks capacity, the hospital in which the attending physician made such a determination must notify the principal's primary physician of the determination.

Illinois – AD

2015 Ill. Legis. Serv. P.A. 99-328 (S.B. 159) (WEST). Approved August 10, 2015, amends the Illinois Power of Attorney Act sections 4-5.1, 4-10, and 4-12 to allow a health care power of attorney that is effective on the incapacity of the principal to be immediately effective for purposes of access to the principal's medical and mental health records.

- The immediately effective power allows the health care agent to share medical records with others as needed, to communicate with the principal's personal physician(s) and other health care providers, and to require an opinion of the physician as to whether the principal lacks the ability to make decisions for himself or herself.

Indiana – AD

2015 Ind. Legis. Serv. P.L. 81-2015 (S.E.A. 355) (WEST), approved April 29, 2015, amends the health care consent provision in Indiana Code Title 16, Article 36.

- Changes the article's language from authorizing "an individual" to take certain actions – such as consenting to health care for another – to authorizing "a representative" (as defined by the article) to take those actions.
- Defines "representative" to mean any of the following:
    - an individual at least 18 years of age, a corporation,
    - a trust,
    - a limited liability company,
    - a partnership,
    - a business trust,
    - an estate,
    - an association,
    - a joint venture,
    - a government or political subdivision,
    - an agency,
    - an instrumentality, or
    - any other legal or commercial entity.

Kentucky – POLST (MOST)

2015 Kentucky Laws Ch. 3 (S.B. 77). Approved March 12, 2015, amends the Medical Orders Scope of Treatment Act (MOST) providing definitions and additions to the MOST requirements for patients.

- This section adds the term "medical order for scope of treatment."
- Creates a new section for MOST operations, procedures and requirements for patients.

- The new section addresses the completion of a medical order for scope of treatment directing medical interventions with respect to adult decisional capacity, an adult's legal surrogate or a responsible party.
- The form is titled "MOST" and must include the patient name, DOB, the effective date of the form including the statement "Form must be reviewed at least annually," and the statements, "HIPAA permits disclosure of MOST to other health care professionals as necessary" and "This document is based on this person's medical condition an wishes. Any section not completed indicates a preference for full treatment for that section."

Maryland – AD, Registry

2016 Maryland Laws. Ch. 510 (H.B. 1385). Approved May 10, 2016, is 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.
- 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.

Maryland – AD

2015 Maryland Laws. Ch. 412 (H.B. 293). Approved May 12, 2015, make certain changes to the state's guardianship law and modifies revocation provisions for advance directives, providing for what is sometimes referred to as a Ulysses clause, specifically:

> "A declarant, knowingly and voluntarily, may elect in an advance directive to waive the right under paragraph (1) of this subsection to revoke any part or all of the advance directive, including the appointment of an agent, during a period in which the declarant has been certified incapable of making an informed decision under §5-602(e) of this subtitle.

Nevada – AD

2015 Nevada Laws Ch. 337 (A.B. 128). Approved by the Governor June 4, 2015, providing definitions and forms relating to the creation of powers of attorney for health care by persons with intellectual disabilities.

- Existing state law provides an example of a form for a power of attorney for health care. (NRS 162A.860). This Act provides a statutory form for a power of attorney for health care for adults with intellectual disabilities and a form for end-of-life decisions for adults with intellectual disabilities.

Pennsylvania – AD

2016 Pa. Legis. Serv. Act 2016-79 (S.B. 1104) (PURDONS). Approved July 8, 2016, amending 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

2015 Tex. Sess. Law Serv. Ch. 435 (H.B. 3074) (VERNON'S). Approved June 12, 2015, amends Texas Health and Safety Code relating to advance directives.

- Changes "artificial nutrition and hydration" to "artificially administered nutrition and hydration."
- Revises the existing procedures for review by an ethics or medical committee when there is a disagreement about medical treatment to require:
    - That the patient or person responsible for decision-making receive a copy of the portion of the patient's medical record related to the treatment received by the patient in the facility for the shorter of the current admission or the preceding 30 days; and also receive a copy of all of the patient's reasonably available diagnostic results and reports.
    - Where the patient wanted treatment that was considered medically inappropriate and the ethics committee affirmed that conclusion, existing law provides a 10 day window to enable the patient to find another facility, after which the disputed treatment can be stopped. However, a new provision requires that treatment to enhance pain management and reduce suffering be continued after the 10–day period. This includes the provision of artificially administered nutrition and hydration, unless, based on reasonable medical judgment, providing artificially administered nutrition and hydration would:
        (1) hasten the patient's death,
        (2) be medically contraindicated such that the provision of the treatment seriously exacerbates life-threatening medical problems not outweighed by the benefit of the provision of the treatment,
        (3) result in substantial irremediable physical pain not outweighed by the benefit of the provision of the treatment,
        (4) be medically ineffective in prolonging life, or
        (5) be contrary to the patient's or surrogate's clearly documented desires.

<u>Vermont</u>- DS, DNR, POLST (COLST)

2016 Vermont Laws No. 136 (S. 62). Signed May 25, 2016, authorize 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.

- "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 - AD

2015 Virginia Laws Ch. 109 (H.B. 1657). Approved March 16, 2015, an act to amend and reenact section 54.1-2984 of the code of Virginia relating to advance directives; directions for prolonging procedures during pregnancy.

- Provides the option for an individual to provide specific instructions in the advance directive form to address the situation in which she is pregnant and in a terminal condition.