

No. 60. An act relating to hospice and palliative care.

(H.201)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS

The general assembly finds that:

(1) Despite the desire of more than 80 percent of Vermonters to die at home, 50 percent die in a hospital and 27 percent die in a nursing home.

Among those enrolled in hospice, 76 percent die at home. Doing an improved job in helping Vermonters to remain at home would better meet their desires.

(2) Current medical technology allows very ill patients to be kept alive far longer than was the case in the past.

(3) On average nationally, patients spend only two weeks in hospice care when they could benefit from much earlier referrals. Vermont has one of the lowest utilization rates of hospice in the country. In Vermont, per capita spending on hospice care by Medicare is well below the national average.

(4) Good palliative and hospice care is available in Vermont, but a better system needs to be in place to ensure access to that care. Financial pressures or insurance limitations sometimes contribute to the lack of access to palliative and hospice care.

(5) Hospice care helps to meet the needs of patients with advanced illness by providing palliative care, including effective pain and symptom management, as well as support for the emotional and spiritual needs of

patients and their caregivers. Hospice care allows patients to have a greater sense of control at the end of life.

(6) Presently, hospice care is limited to a patient with a physician certification of an illness with a prognosis of not more than six months' life expectancy. That patient must choose between curative and hospice care. Because individuals cannot receive both at the same time, they must forgo curative care to be eligible for hospice.

(7) When hospice benefits are extended from a six-month to a 12-month end-of-life prognosis and a patient can access treatment without being first required to discontinue curative therapy, a higher proportion of patients select hospice care. This results in significant increases in the use of hospice services and a decrease in the use of acute care services. Net medical costs have been shown to decrease by as much as 30 percent, and many patients live longer with a better quality of life and a dramatic increase in patient satisfaction.

(8) A national health insurance company has extended to all its members an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to 12 months, and members may access hospice without being first required to discontinue curative therapy because of the demonstrated effectiveness of the company's pilot project.

(9) Vermont is one of only six states that does not require any continuing medical education as a condition of physician licensure or renewal and health care professionals in Vermont lack sufficient education and training in the areas of end-of-life-care, palliative care, and pain management.

(10) In order to ensure continuity of care and seamless transitions between settings, the Clinician Order for Life Sustaining Treatment (COLST) form along with Do Not Resuscitate (DNR) orders should be standardized for all health care providers in the state.

* * * Enhanced Hospice Benefit * * *

Sec. 2. ENHANCED HOSPICE BENEFIT

(a) A health insurer operating in Vermont is encouraged to offer, issue, and administer a health insurance plan that provides insurance coverage for a terminal care management program and an “enhanced hospice access” benefit.

(b) The terminal care management program should include:

(1) nurse case managers trained to manage the care of patients with terminal illness;

(2) cases identified proactively through evaluation of hospitalizations, claims, and referrals; and

(3) a comprehensive assessment of a patient’s needs.

(c) Under the “enhanced hospice access” benefit, the definition of “terminal illness” should be expanded from six months’ life expectancy to 12 months,

and members may access hospice without being first required to discontinue curative therapy.

(d) As used in this section, “health insurance plan” means any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined in 18 V.S.A. § 9402. The term shall include the health benefit plan offered by the state of Vermont to its employees and any health benefit plan offered by any agency or instrumentality of the state to its employees. The term shall not include benefit plans providing coverage for specific disease or other limited benefit coverage unless so directed by the commissioner.

* * * Request for a Waiver * * *

Sec. 3. REQUEST FOR A WAIVER

By no later than July 1, 2012, the agency of human services shall include as a part of its application request for a demonstration project from the Centers for Medicare and Medicaid Services to integrate care for dual eligible individuals the additional proposal of allowing the state to provide for an “enhanced hospice access” benefit, whereby the definition of “terminal illness” is expanded from six months’ life expectancy to that of 12 months and participants may access hospice without being required to first discontinue

curative therapy. Also, by no later than July 1, 2013, the agency of human services shall submit a Global Commitment Medicaid waiver amendment to provide funding for the same enhanced hospice access benefit.

* * * Choices for Care * * *

Sec. 4. ENROLLMENT IN HOSPICE AND APPLICATION TO CHOICES
FOR CARE

(a) The department of disabilities, aging, and independent living shall revise its current policy to:

(1) allow individuals who have been admitted to hospice to apply for Choices for Care; and

(2) ensure that individuals who have been admitted to hospice are treated no differently from those individuals who first become enrolled in Choices for Care and then later are admitted to hospice.

(b) The revised policy set forth in subdivisions (a)(1) and (2) of this section will be for a one-year trial period beginning July, 1, 2011, and ending June 30, 2012.

(c) To assess the revised policy, the department of disabilities, aging, and independent living, with the Vermont Assembly of Home Health and Hospice Agencies, shall develop mutually agreed-upon evaluative measures, including:

(1) the number of patients receiving hospice services;

(2) the number of patients receiving both hospice and Choices for Care;

(3) the fiscal implications of the change in policy;

(4) length of stay on hospice;

(5) length of stay in Choices for Care;

(6) the length of time to obtain Choices for Care services once the application process is initiated; and

(7) the number of patients found ineligible for Choices for Care.

(d) The department of disabilities, aging, and independent living shall provide the house committee on human services and the senate committee on health and welfare with an interim report on the utilization and effectiveness of the revised policy by no later than January 31, 2012.

* * * Inclusion of Palliative Care, Hospice, and End-of-Life Pain

Management in the Blueprint for Health * * *

Sec. 5. 18 V.S.A. § 701 is amended to read:

§ 701. DEFINITIONS

For the purposes of this chapter:

(1) “Blueprint for Health” or “Blueprint” means the state’s program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

(2) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year

or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care and pain and symptom management. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, hyperlipidemia, dementia, and chronic pain.

(3) “Chronic care information system” means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

(4) “Chronic care management” means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for licensed health care practitioners and their patients, and a plan of care emphasizing, on an ongoing basis and with the goals of improving overall health and meeting patients’ needs:

(A) prevention of complications utilizing evidence-based practice guidelines;

(B) patient empowerment strategies, ~~and~~;

(C) evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health; and

(D) advance care planning, palliative care, pain management, and hospice services, as appropriate.

* * *

Sec. 6. 18 V.S.A. § 703(d) is amended to read:

(d) The model for care coordination and management shall include the following components:

* * *

(5) Education for patients on health care decision-making, including education related to advance directives, palliative care, ~~and hospice care,~~ and timely referrals to palliative and hospice care, when appropriate.

* * *

* * * Continuing Medical Education * * *

Sec. 7. 26 V.S.A. § 1400 is amended to read:

§ 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL EDUCATION

(a) Every person licensed to practice medicine ~~and surgery~~ by the board shall apply biennially for the renewal of his or her license. ~~One~~ At least one month prior to the date on which renewal is required, the board shall send to each licensee a license renewal application form and notice of the date on

which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee. The board shall register the applicant and issue the renewal license. Within one month following the date renewal is required, the board shall pay the license renewal fees into the medical practice board special fund ~~and shall file a list of licensees with the department of health.~~

(b) A licensee applying for renewal of an active license to practice medicine shall have completed continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and which shall be in effect for the renewal of licenses to practice medicine expiring after August 31, 2014. The board shall require a minimum of ten hours of continuing medical education by rule. The training provided by the continuing medical education shall be designed to ensure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields for which patient referrals may be appropriate. The board shall require evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to ensure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

(c) A licensee applying for renewal of an active license to practice medicine shall have practiced medicine within the last three years as defined in section 1311 of this title or have complied with the requirements for updating knowledge and skills as defined by board rules.

(d) A licensee shall demonstrate that the requirements for licensure are met.

(e) A licensee shall promptly provide the board with new or changed information pertinent to the information in his or her license and license renewal applications at the time he or she becomes aware of the new or changed information.

~~(b)(f) A person who practices medicine and surgery and who fails to renew his or her license in accordance with the provisions of this section shall be deemed an illegal practitioner and shall forfeit the right to so practice or to hold himself or herself out as a person licensed to practice medicine and surgery in the state until reinstated by the board, but nevertheless a person who was licensed to practice medicine and surgery at the time of his induction, call on reserve commission or enlistment into the armed forces of the United States, shall be entitled to practice medicine and surgery during the time of his service with the armed forces of the United States and for 60 days after separation from such service~~ physician while on extended active duty in the uniformed services of the United States or as a member of the national guard, state guard, or reserve component who is licensed as a physician at the time of

an activation or deployment shall receive an extension of licensure up to 90 days following the physician's return from activation or deployment, provided the physician notifies the board of his or her activation or deployment prior to the expiration of the current license and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application for renewal of the license.

~~(e)~~(g) Any person who allows a license to lapse by failing to renew the same in accordance with the provisions of this section may be reinstated by the board by payment of the renewal fee and the late renewal penalty, and if applicable, by completion of the continuing medical education requirement as established in subsection (b) of this section and any other requirements for licensure as required by this section and board rule.

Sec. 8. BOARD REPORT ON CONTINUING MEDICAL EDUCATION

The state board of medical practice, as established under 26 V.S.A. § 1351, shall report to the house committee on human services and the senate committee on health and welfare by no later than January 15, 2017, on the implementation and overall impact of the continuing medical education requirement, set forth in 26 V.S.A. § 1400(b).

* * * DNR/COLST * * *

Sec. 9. 18 V.S.A. § 9701 is amended to read:

§ 9701. DEFINITIONS

* * *

(8) “Do-not-resuscitate order” or “DNR order” means a written order of the ~~principal’s~~ patient’s clinician directing health care providers not to attempt resuscitation.

(9) “DNR identification” means a ~~document, bracelet, other jewelry, wallet card, or other~~ necklace, bracelet, or anklet ~~method~~ of identifying the ~~principal~~ patient as an individual who has a DNR order.

* * *

(15) “Health care provider” shall have the same meaning as provided in ~~subdivision~~ section 9432(8) of this title and shall include emergency medical personnel.

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Sec. 10. 18 V.S.A. § 9708 is amended to read:

§ 9708. AUTHORITY AND OBLIGATIONS OF HEALTH CARE
PROVIDERS, HEALTH CARE FACILITIES, AND RESIDENTIAL
CARE FACILITIES REGARDING DO-NOT-RESUSCITATE
ORDERS AND CLINICIAN ORDERS FOR LIFE SUSTAINING
TREATMENT

(a) As used in this section, “DNR/COLST” shall mean a do-not-resuscitate order (“DNR”) and a clinician order for life sustaining treatment (“COLST”) as defined in section 9701 of this title.

(b) A DNR order and a COLST shall be issued on the department of health’s “Vermont DNR/COLST form” as designated by rule by the department of health.

(c) Notwithstanding subsection (b) of this section, health care facilities and residential care facilities may document DNR/COLST orders in the patient’s medical record in a facility-specific manner when the patient is in their care.

(d) A ~~do-not-resuscitate (“DNR”)~~ DNR order must:

- (1) be signed by the patient’s clinician;
- (2) certify that the clinician has consulted, or made an effort to consult, with the patient, and the patient’s agent or guardian, if there is an appointed agent or guardian;

(3) include either:

(A) the name of the patient, agent, guardian, or other individual giving informed consent for the DNR and the individual's relationship to the patient; or

(B) certification that the patient's clinician and one other named clinician have determined that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest; and

(4) if the patient is in a health care facility or a residential care facility, certify that the requirements of the facility's DNR protocol required by section 9709 of this title have been met.

(e) A COLST must:

(1) be signed by the patient's clinician;

(2) include the name of the patient, agent, guardian, or other individual giving informed consent for the COLST and the individual's relationship to the patient.

(f) The department of health shall promulgate by rule by March 1, 2012, criteria for individuals who are not the patient, agent, or guardian, but who are giving informed consent for a DNR/COLST order. The rules shall include the following:

(1) other individuals permitted to give informed consent for a DNR/COLST order who shall be a family member of the patient or a person with a known close relationship to the patient;

(2) parameters for how decisions should be made, which shall include at a minimum the protection of a patient's own wishes in the same manner as in section 9711 of this title; and

(3) access to a hospital's internal ethics protocols for use when there is a disagreement over the appropriate person to give informed consent.

(g) A patient's clinician issuing a DNR/COLST order shall:

(1) place a copy of the completed DNR/COLST order in the patient's medical record; and

(2) provide instructions to the patient as to the appropriate means of displaying the DNR/COLST order.

~~(b)~~(h) A clinician who issues a DNR order ~~may~~ shall authorize issuance of a DNR identification to the ~~principal~~ patient. Uniform minimum requirements for DNR identification shall be determined by rule by the department of health no later than March 1, 2012.

~~(e)~~(i) Every health care provider, health care facility, and residential care facility shall honor a DNR/COLST order or a DNR identification unless the provider or facility:

(1) believes in good faith, after consultation with the agent or guardian where possible and appropriate, that:

(A) the ~~principal~~ patient wishes to have the DNR/COLST order revoked; or

(B) the ~~principal~~ patient with the DNR identification is not the individual for whom the DNR order was issued; and

(2) documents the basis for ~~that~~ the good faith belief in the ~~principal's~~ patient's medical record.

(j) A DNR/COLST order executed prior to July 1, 2011 shall be a valid order if the document complies with the statutory requirements in effect at the time the document was executed or with the provisions of this chapter.

(k) A health care provider shall honor in good faith an out-of-state DNR order, orders for life sustaining treatment, or out-of-state DNR identification if there is no reason to believe that what has been presented is invalid.

~~(d)~~(l) A DNR order precludes efforts to resuscitate only in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient.

* * * STUDY ON DNR/COLST ORDER INFORMED CONSENT * * *

SEC. 11. STUDY ON DNR/COLST ORDER INFORMED CONSENT

(a) The DNR/COLST order informed consent committee is created and shall be convened by the commissioner of health to study criteria to be used for

rules concerning individuals who are giving informed consent for a DNR/COLST order issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian.

(b) The committee shall consist of the following members or their designees:

(1) The commissioners of health; Vermont health access; and disabilities, aging, and independent living;

(2) one representative each from the Vermont Medical Society, the Vermont Ethics Network, the Vermont Association of Hospitals and Health Systems, Vermont Program for Quality in Health Care, the Hospice and Palliative Care Council of Vermont, the Vermont Center for Independent Living, Vermont Area Agencies on Aging, Vermont Assembly of Home Health and Hospice Agencies, and the Vermont Health Care Association;

(3) the long term care ombudsman; and

(4) the state health care ombudsman.

(c) The committee shall make recommendations on the criteria to be used for rules concerning individuals who are giving informed consent for a DNR/COLST order to be issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian. The committee's recommendations shall include:

(1) which individual or individuals who are not the patient, the patient's agent, or the patient's guardian, but who shall be a family member of the patient or a person with a known close relationship to the patient, are permitted to give informed consent for a DNR/COLST order;

(2) how decisions regarding who is the appropriate person to be giving informed consent for a DNR/COLST order are to be made, which shall include at a minimum the protection of a patient's own wishes in the same manner as set forth in 18 V.S.A. § 9711,

(3) the use of a hospital's internal ethics protocols when there is a disagreement over who is the appropriate person to give informed consent for a DNR/COLST order; and

(4) an examination of the relationship between the wishes expressed in an advance directive and the DNR/COLST order.

(d) The committee shall report by December 1, 2011 to the Vermont health access oversight committee, the chair of the house committee on human services, and the chair of the senate committee on health and welfare on its findings and recommendations.

Sec. 12. 18 V.S.A. § 9709 is amended to read:

§ 9709. OBLIGATIONS OF HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, RESIDENTIAL CARE FACILITIES, AND HEALTH INSURERS REGARDING PROTOCOLS AND NONDISCRIMINATION

(a) As used in this section, “DNR/COLST” shall mean do-not-resuscitate orders (“DNR”) and clinician orders for life sustaining treatment (“COLST”) as defined in section 9701 of this title.

(b) Every health care provider, health care facility, and residential care facility shall develop protocols:

(1) to ensure that a principal’s advance directive, including any amendment, suspension, or revocation thereof, and DNR/COLST order, if any, are promptly available when services are to be provided, including that the existence of the advance directive, amendment, suspension, revocation, or DNR/COLST order is prominently noted on any file jacket or folder, and that a note is entered into any electronic database of the provider or facility;

(2) for maintaining advance directives received from individuals who anticipate future care but are not yet patients of that provider or facility;

(3) ~~within 120 days of the commissioner announcing the availability of the registry,~~ to ensure that the provider or facility checks the registry at the

time any individual without capacity is admitted or provided services to determine whether the individual has an advance directive;

* * *

~~(b)~~(c) Every health care facility and residential care facility shall develop written protocols to ensure that:

* * *

(4) DNR/COLST orders are issued, revoked, and handled pursuant to the same process and standards that are used for each patient receiving health care.

(5) Upon transfer or discharge from the to another facility, a copy of any advance directive, DNR order, ~~and clinician order for life sustaining treatment~~ is or COLST order shall be transmitted with the principal ~~or, if or~~ patient. If the transfer is to a health care facility or residential care facility, ~~is~~ any advance directive, DNR order, or COLST order shall be promptly transmitted to the subsequent facility, unless the sending facility has confirmed that the receiving facility has a copy of ~~any the~~ advance directive, DNR order, or clinician order for life sustaining treatment COLST order.

(6) For a patient for whom DNR/COLST orders are documented in a facility-specific manner, any DNR/COLST orders to be continued upon discharge, during transport, or in another setting shall be documented on the

Vermont DNR/COLST form issued pursuant to 18 V.S.A. § 9708(b) or on the form as prescribed by the patient's state of residence.

~~(e)~~(d) Every hospital shall designate an adequate number of individuals to explain the nature and effect of an advance directive to patients as required by subsection 9703(e) of this title.

~~(d)~~(e) No health care provider, health care facility, residential care facility, health insurer as defined in section 9402 of this title, insurer issuing disability insurance, or self-insured employee welfare benefit plan shall charge an individual a different rate or require any individual to execute an advance directive or to obtain a DNR/COLST order or DNR identification as a condition of admission to a facility or as a condition of being insured for or receiving health care or residential care. No health care shall be refused except as provided herein because an individual is known to have executed an advance directive.

Sec. 13. 18 V.S.A. § 9713 is amended to read:

§ 9713. IMMUNITY

(a) No individual acting as an agent or guardian shall be subjected to criminal or civil liability for making a decision in good faith pursuant to the terms of an advance directive, or DNA order, or COLST order and the provisions of this chapter.

(b)(1) No health care provider, health care facility, residential care facility, or any other person acting for or under such person's control shall, if the provider or facility has complied with the provisions of this chapter, be subject to civil or criminal liability for:

(A) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNA order, a COLST order, a DNR identification ~~of the principal~~, the consent of a principal or patient with capacity or of the principal's or patient's agent or guardian, or a decision or objection of a principal or patient; or

(B) relying in good faith on a suspended or revoked advance directive, suspended or revoked DNR order, or suspended or revoked COLST order, unless the provider or facility knew or should have known of the suspension or revocation.

(2) No funeral director, crematory operator, cemetery official, procurement organization, or any other person acting for or under such person's control, shall, if the director, operator, official, or organization has complied with the provisions of this chapter, be subject to civil or criminal liability for providing or withholding its services in good faith pursuant to the provisions of an advance directive, whether or not the advance directive has been suspended or revoked.

(3) Nothing in this subsection shall be construed to establish immunity for the failure to follow standards of professional conduct and to exercise due care in the provision of services.

(c) No employee shall be subjected to an adverse employment decision or evaluation for:

(1) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNR order, a COLST order, a DNR identification ~~of the principal~~, the consent of the ~~principal's~~ principal or patient with capacity or principals or patient's agent or guardian, a decision or objection of a principal or patient, or the provisions of this chapter. This subdivision shall not be construed to establish a defense for the failure to follow standards of professional conduct and to exercise due care in the provision of services;

(2) relying on an amended, suspended, or revoked advance directive, unless the employee knew or should have known of the amendment, suspension or revocation; or

(3) providing notice to the employer of a moral or other conflict pursuant to subdivision 9707(b)(3) of this title, so long as the employee has provided ongoing health care until a new employee or provider has been found to provide the services.

Sec. 14. 18 V.S.A. § 9719 is amended to read:

§ 9719. OBLIGATIONS OF STATE AGENCIES

(a) No later than ~~July 1, 2006~~ March 1, 2012, and from time to time thereafter, the commissioner, in consultation with all appropriate agencies and organizations, shall adopt rules pursuant to chapter 25 of Title 3 to effectuate the intent of this chapter. The rules shall cover at least one optional form of an advance directive with an accompanying form providing an explanation of choices and responsibilities, ~~the form and content of clinician orders for life sustaining treatment, the Vermont DNR/COLST form as outlined in subsection 9708(b) of this title,~~ the use of experimental treatments, ~~a model DNR order which meets the requirements of subsection 9708(a) of this title,~~ a DNR identification, revocation of a DNR identification, and consistent statewide emergency medical standards for DNR/COLST orders and advance directives for patients and principals in all settings. The commissioner shall also provide, but without the obligation to adopt a rule, optional forms for advance directives for individuals with disabilities, limited English proficiency, and cognitive translation needs.

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Sec. 15. EFFECTIVE DATE

This act shall take effect on passage, except for Sec. 7, 26 V.S.A. § 1400(c), which shall take effect 60 days after the adoption of the maintenance of licensure rule for physicians.

Approved: June 1, 2011