H.201

SHORT FORM

Introduced by Representatives Frank of Underhill, Batchelor of Derby, Burditt of West Rutland, Donahue of Northfield, French of Randolph, Haas of Rochester, McFaun of Barre Town, Mrowicki of Putney, Pugh of South Burlington, Trieber of Rockingham and Woodward of Johnson

Referred to Committee on

Date:

Subject: Health; human services; palliative care; hospice care

Statement of purpose: This bill proposes to require the use of a standard form for out-of-hospital do-not-resuscitate (DNR) orders; require the department of health to create a standard identifier for individuals who have an out-of-hospital DNR order; require that the department of disabilities, aging, and independent living (DAIL) revise its policies to allow individuals enrolled in hospice to enroll in choices for care; create a group to study expanding hospice access and benefits; and require continued medical education on hospice and palliative care for physicians.

An act relating to hospice and palliative care

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

~~(TEXT OMITTED IN SHORT-FORM BILLS)~~

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

The department of Vermont health access shall request and apply for a demonstration project or waiver from the Centers for Medicare and Medicaid Services to allow for the state to obtain federal Medicaid matching funds to provide for an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to 12 months, and participants may access hospice without being first required to discontinue curative therapy.

Sec. 3. REQUEST FOR A WAIVER

The department of Vermont health access shall request and apply for a demonstration project or waiver from the Centers for Medicare and Medicaid Services to allow for the state to obtain federal Medicaid matching funds to provide for an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to 12 months' and participants may access hospice without being required to first discontinue curative therapy. The department shall also request and apply for a Medicare demonstration project or waiver from the Centers for Medicare and Medicaid Services 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 Assembly of Home Health Agencies, Inc., 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 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)(1) As a condition of renewal of a license to practice medicine and surgery, the licensee, during the preceding two-year period, shall have completed a minimum of four hours of continuing medical education in the field of palliative care, hospice, end-of-life care, and management of chronic pain. Licensees may be exempt if the licensee does not engage in direct patient care or provide patient consultations.

(2) The continuing medical education requirement in the field of palliative care, hospice, end-of-life care, and management of chronic pain shall meet minimum criteria as established by rule, by the board, by August 31, 2012, and shall be effective for the renewal of licenses to practice medicine and surgery expiring after August 31, 2014.

(b) A licensee for renewal of an active license to practice medicine and surgery shall have completed a minimum of ten hours of continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and shall be in effect for the renewal of licenses to practice medicine and surgery expiring after August 31, 2014. The training provided by the continuing medical education shall be designed to assure 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 to 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 assure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

~~(b)~~(c) 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 or her 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 or her service with the armed forces of the United States and for 60 days after separation from such service.

~~(c)~~(d) 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 required continuing medical education requirement as established in subdivision (b)(1) of this section.

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

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(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.

* * *

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. A uniform DNR identification

shall be determined by rule by the department of health no later than March 1, 2012.

~~(c)~~(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 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)~~(k) 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.

Sec. 11. 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 facility~~,~~:

(A) A copy of any advance directive, DNR order, and ~~clinician order for life sustaining treatment is~~ COLST order shall be transmitted with the principal or patient ~~or, if. If~~ the transfer is to a health care facility or residential care facility, ~~is~~ any advance directive, DNR order, and 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 advance directive, DNR order, or ~~clinician order for life sustaining treatment~~ COLST order.

(B) 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 as outlined in subsection 9708(b) of this title.

~~(c)~~(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. 12. 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. 13. EFFECTIVE DATE

This act shall take effect on passage.