

## **Introduction to advance directives and palliative and hospice care**

### **Definitions**

**Advance directive** - a written record that may include appointment of an agent, identification of a preferred primary care clinician, instructions on health care desires or treatment goals, an anatomical gift, disposition of remains, and funeral goods and services. The term includes documents designated under prior law as a durable power of attorney for health care or a terminal care document. (18 V.S.A. § 9701)

- Combines what were formerly known as a health care power of attorney and a living will
- Can file advance directive with the Vermont Advance Directive Registry, which is accessible by hospitals and other providers  
<http://healthvermont.gov/vadr/register.aspx>

**Clinician order for life-sustaining treatment (COLST)** – a clinician’s order for treatment such as intubation, mechanical ventilation, transfer to hospital, antibiotics, artificially administered nutrition, or another medical intervention. A COLST order is designed for use in outpatient settings and health care facilities and may include a DNR order. (18 V.S.A. § 9701)

**Do-not-resuscitate (DNR) order** – a written order of the patient's clinician directing health care providers not to attempt resuscitation. (18 V.S.A. § 9701)

**Hospice care** – a program of care and support provided by a Medicare-certified hospice provider to help an individual with a terminal condition to live comfortably by providing palliative care, including effective pain and symptom management. Hospice care may include services provided by an interdisciplinary team that are intended to address the physical, emotional, psychosocial, and spiritual needs of the individual and his or her family. (18 V.S.A. § 9410)

**Palliative care** – interdisciplinary care given to improve the quality of life of patients and their families facing the problems associated with a serious medical condition. Palliative care through the continuum of illness involves addressing physical, cognitive, emotional, psychological, and spiritual needs and facilitating patient autonomy, access to information, and choice. (18 V.S.A. § 2)

### **Legislative History**

#### **2005 – Advance directive law (Act 55)**

- Added advance directive chapter (18 V.S.A. chapter 231)
- Purpose of chapter is that the state of Vermont recognizes the fundamental right of an adult to determine the extent of health care the

individual will receive, including treatment provided during periods of incapacity and at the end of life. This chapter enables adults to retain control over their own health care through the use of advance directives, including appointment of an agent and directions regarding health care and disposition of remains. During periods of incapacity, the decisions by the agent shall be based on the express instructions, wishes, or beliefs of the individual, to the extent those can be determined.

**2009 - An act relating to palliative care (Act 25)**

- Created Patients' Bill of Rights for Palliative Care and Pain Management (18 V.S.A. chapter 42A)
- Directed the Secretary of Human Services to report on the programmatic and cost implications of a Medicaid and SCHIP waiver amendment allowing Vermont to provide children on Dr. Dynasaur who have life-limiting illnesses to receive concurrent palliative services and curative care
- Added advance care planning and palliative care to the Blueprint for Health
- Required the Department of Health to begin reporting biennially in 2011 on the number of people who died in a variety of settings, including emergency rooms, other hospital settings, their own homes, nursing homes, and hospice facilities, as well as whether each decedent received hospice care within the last 30 days of life
  - Beginning in 2013, report to include deaths in hospital ICUs, intensive care facilities, and residential care homes
- Created Palliative Care and Pain Management Task Force

**2011 - An act relating to hospice and palliative care (Act 60)**

- Encouraged health insurers to offer health insurance plans that provide coverage for a terminal care management program and an enhanced hospice access benefit
  - terminal care management program would include specially trained nurse case managers, cases identified proactively through evaluation of hospitalizations, claims, and referrals
  - enhanced hospice access would expand the definition of a terminal illness from a six months' life expectancy to 12 months and allow members to access hospice services without being first required to discontinue curative therapy
- Directed Agency of Human Services to seek approval from Centers for Medicare and Medicaid Services for the enhanced hospice access benefit for dual eligibles and for a Global Commitment waiver amendment to provide funding for enhanced hospice access
- Directed Department of Disabilities, Aging, and Independent Living to revise its policy for a one-year trial period to allow people who have been admitted to hospice to apply for Choices for Care and to ensure

that people who have been admitted to hospice are treated no differently from people who enroll in Choices for Care first and are later admitted to hospice

- Required a minimum of 10 hours of continuing medical education for physicians and directed the Board of Medical Practice to 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
- Required the Department of Health to create a DNR/COLST form and specified the requirements for a COLST
- Required the Department of Health to adopt rules specifying the criteria for individuals who are not the patient, agent, or guardian but are giving informed consent for a DNR/COLST order (date has been delayed)

**2014 - An act relating to consent for admission to hospice care and for DNR/COLST orders (Act 127)**

- Allows a family member or person with a known close relationship to a patient to elect hospice care on the patient's behalf if the patient does not have an agent or guardian or the agent or guardian is unavailable.