HB 3162:

Changes to the Texas Advance Directives Act

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Texas Medical Association

Physicians Caring for Texans

Advance Directives Act
TX Health & Safety Code, Chapter 166

Texas statute allows for four types of end-of-life planning instruments:

- Directives to Physicians and Family or Surrogates;
- Medical Powers of Attorney;
- Out-of-Hospital Do Not Resuscitate ("DNR") Orders; and
- Facility DNR Orders.

- "Health care or treatment decision"
  - consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition, including such a decision on behalf of a minor.

- "Life-sustaining treatment"
  - treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

- "Terminal Condition"
  - Incurable condition
  - Caused by injury, disease or illness
  - Expected to result in death within 6 months, even with life-sustaining treatment

- "Irreversible Condition"
  - Condition, injury or illness that may be treated, but never eliminated
  - That leaves a person unable to care for or make decisions for themselves
  - That, without life-sustaining treatment, is fatal

Overview

HB 3162 makes broad changes to the Texas Advance Directives Act (TADA) found at Chapter 166, Health and Safety Code. Some of the changes to the TADA include:

- Extending the statutory period for notice to a patient, or their appropriate decision-maker, in advance of a meeting held pursuant to the dispute resolution process set forth in Section 166.046, from 48 hours to 7 days, and specifying certain information that must be included in the notice.
- Requiring an ethics or medical committee to consider the patient's well-being in conducting its review under Section 166.046 but prohibiting any judgment on the patient's quality of life, and enumerating specific considerations the committee must make related to the continuation of life-sustaining treatment – such as whether the treatment will prolong the natural process of dying or hasten the patient's death.
- Specifying and expanding the rights of persons participating in a committee meeting under Section 166.046, before, during, and after the meeting.
- Barring certain persons from participating in an executive session of a committee meeting.
- Clarifying language regarding patients with disabilities, as well as how such disabilities may affect the process and decisions made under the TADA. Specifically, during the review process under Section 166.046(b), an ethics or medical committee is prohibited from considering a patient's disability that existed before the patient 's current admission unless the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.

- Extending from 10 days to 25 days the statutory period for continued attempts to transfer a patient and the provision of care and interventions to a patient after the meeting held pursuant to the dispute resolution process set forth in Section 166.046 deems that ongoing care and interventions are medically inappropriate.
- Expanding and specifying new requirements related to attempts to transfer a patient.
- Clarifying that Section 166.046 applies only to care and treatment decisions for patients who are deemed incompetent or otherwise mentally or physically incapable of communication.
- Introducing a requirement for facilities to report certain data, within 180 days of initiating the dispute resolution process under Section 166.046 and requiring HHSC to publish aggregated data related to these reports.
- Adding language to statute concerning the transfer of patients and, under certain circumstances, limited surgical interventions to help facilitate the patient's transfer.
- Amending language in Chapter 166, Subchapter E, Health and Safety Code (“Facility DNR Orders”) to clarify and correct issues of concern made apparent since implementation in 2017, including those related to potential liability protection.

HB 3162 – Section 1

Adds new Section 166.0445 to the Health and Safety Code, which:

- Provides criminal and civil liability protection to a physician or other health care professional acting under the direction of a physician when participating in a medical procedure performed under Sec. 166.046(d-2) (further described below), EXCEPT:
  - this criminal liability protection is lost where the physician or health care professional:
    - acts with a specific malicious intent to cause the death of the patient; and,
    - that conduct significantly hastens the patient's death; and,
    - the hastening of the patient's death is not attributable to the risks associated with the medical procedure.

- A physician or other health care professional acting under the direction of a physician does not engage in unprofessional conduct by participating in a medical procedure performed under Sec. 166.046(d-2), unless the physician or health care professional acts with specific malicious intent to harm the patient.

HB 3162 – Section 2

Amends the heading to Section 166.046, Health and Safety Code, to clarify that Section 166.046 applies only to certain patients (further described in forthcoming slides).

HB 3162 – Section 3

Amends Section 166.046, Health and Safety Code, to:

- Limit applicability of Section 166.046 to health care and treatment for a patient deemed incompetent or otherwise mentally or physically incapable of communication.
- Require an ethics or medical committee that reviews a physician's refusal to honor a directive or health care or treatment decision, pursuant to this section, to consider the patient's well-being and not make any judgment on the patient's quality of life.
- If the committee is determining whether life-sustaining treatment requested in the directive or health care or treatment decision is medically inappropriate, require the committee to consider:
  - Will the provision of LST prolong the natural process of dying or hasten the patient's death?
  - Will the provision of LST result in substantial, irremediable, and objectively measurable physical pain that is not outweighed by the benefit of providing the treatment?
  - Is the provision of LST medically contraindicated such that the provision of the LST seriously exacerbates life-threatening medical problems not outweighed by the benefit of providing the LST?
  - Is the provision of LST consistent with the prevailing standard of care?
  - Is the provision of LST contrary to the patient's clearly documented desires?
- State that a committee decision based on any of the considerations listed above is not a judgment on the patient 's quality of life.

- Require written notice, provided at least 7 days prior to a meeting to discuss the patient's directive (unless this 7-day period is waived by written mutual agreement), of the following:
  - Any applicable ethics or medical committee policies and procedures, including any adopted pursuant to subsection (b-1);
  - The statutory rights codified in subdivisions (3)(A)-(D);
  - The date, time, and location of the meeting;
  - The work contact information of the facility's personnel who is responsible for overseeing the reasonable effort to transfer the patient to another physician or facility willing to comply with the patient's directive;
  - The 5 factors the committee is required to consider, as set forth in subsection (a-2) (described above); and,
  - The language codified in Section 166.0465.
- After such written notice is provided, the patient's attending physician must make a reasonable effort to transfer the patient, with the facility's personnel assisting in arranging the transfer.

- Clarify the patient's decision-maker is entitled to:
  - Attend and participate in the meeting scheduled by the committee;
  - During the meeting, receive a written document with the first name, first initial of the last name, and title of each committee member participating in the meeting;
  - Subject to a policy created under subsection (b-1):
    - Be accompanied at the meeting by the patient's:
      - Spouse;
      - Parents;
      - Adult children; and,
      - No more than 4 additional individuals as selected by the patient's decision-maker, including:
        - A legal counsel;
        - A physician;
        - A health care professional; or
        - A patient advocate.
    - Have an opportunity, during the open portion of the meeting, to either directly or through another individual attending through the patient's decision-maker's direction:
      - Explain the justification for the health care or treatment decision made by or on behalf of the patient;
      - Respond to information relating to the patient, that is submitted or presented during the open portion of the meeting; and,
      - State any concerns regarding compliance with Sections 166.046 and 166.0465, including an opinion that one or more of the patient's disabilities are not relevant to the committee's determination on the medical appropriateness of the medical or surgical intervention.
  - After the committee's deliberation and decision, receive written notice of:
    - If applicable, the committee's reasoning for affirming that LST is medically inappropriate;
    - The patient's major medical conditions as identified by the committee, including any disability considered in reaching the decision;
      - The notice is not required to specify whether any medical condition qualifies as a disability;
    - A statement that the committee has complied with subsection (a-2) and Sec. 166.0465; and,
    - The facilities contacted before the meeting, as part of transfer efforts;
      - Where a contacted facility provided a reason for the denial of the transfer request, the reason for denial must be provided.

- Provide a copy or electronic access to the patient's medical record related to the treatment received by the patient in the facility for the period of the patient's current admission to the facility, including all reasonably available diagnostic results and reports related to the medical record;
- Allow a facility to adopt and implement a written policy for meetings held pursuant to Sec. 166.046, that is reasonable and necessary to:
  - Facilitate information sharing and discussion of the patient's medical status and treatment requirements.
    - This may include provisions related to:
      - attendance, confidentiality, and timing regarding agenda items.
  - Preserve the meeting's effectiveness, including provisions that the meeting is not a legal proceeding and the ability for the committee to enter executive session.
- Prevent the following from attending or participating in executive sessions:
  - Physicians or health care professionals providing care or treatment to the patient;
  - The patient's decision-maker;
  - Anyone attending the meeting on behalf of the patient or the patient's decision-maker;
- To the extent the facility or the patient's decision-maker intends to include legal counsel at the meeting, such party shall make good faith efforts to provide the other with notice of such intent at least 48 hours before the meeting;

- When inquiring about a potential transfer, the facility must make a good faith effort to inquire if a facility denying the request would be more likely to approve the transfer if a tracheostomy or percutaneous endoscopic gastrostomy were performed on the patient;
- If the patient's advance directive or the patient's decision-maker is requesting LST that the attending physician has decided and the committee has affirmed is medically inappropriate, the attending or other physician responsible for the patient shall perform each medical procedure — which is defined in Sec. 166.046 to mean only a tracheostomy or percutaneous endoscopic gastrostomy — that satisfies all of the following:
  - In the attending physician's judgment, the procedure is reasonable and necessary to help effect the patient's transfer under Sec. 166.046
  - An authorized representative for the potentially receiving facility (with the ability to comply with the care or treatment request) has expressed the potentially receiving facility is more likely to accept transfer if the procedure it performed;
  - In the medical judgment of the physician who would perform the procedure, performing the procedure is:
    - Within the prevailing standard of medical care; and
    - Not medically contraindicated or medically inappropriate under the circumstances;
  - In the medical judgment of the physician who would perform the procedure, the physician has the training and experience to perform the procedure;
  - The physician who would perform the procedure has medical privileges at the facility and is authorized to perform the procedure at the facility;
  - The facility has determined it has the resources for the performance of the procedure on the patient; and,
  - The patient's decision-maker provides consent for the procedure, on behalf of the patient

- If the patient's advance directive or the patient's decision-maker is requesting LST that the attending physician has decided and the committee has affirmed is medically inappropriate, notice must be provided as follows:
  - A delay notice – that is, a written notice that the 25-day timeframe will not begin until the first calendar day after a tracheostomy or percutaneous endoscopic gastrostomy required by Section 166.046(d-2)(1) is performed unless, before the procedure is performed, another written notice of an earlier first day is provided due to one or more conditions described by that subdivision are no longer satisfied – is required where:
    - At the time the committee's written decision is provided, the conditions precedent for a tracheostomy or , as set forth in Sec. 166.046, are met; or
    - At the time the committee's written decision is provided, the conditions precedent for a tracheostomy or percutaneous endoscopic gastrostomy, as set forth in Sec. 166.046, are met – EXCEPT for consent on behalf of the patient – and such consent is provided within 24 hours of request.
  - A start notice – that is, written notice indicating the 25-day timeframe will begin on the first calendar day after the date the notice is provided – is required where:
    - At the time the committee's written decision is provided, the conditions precedent for a tracheostomy or percutaneous endoscopic gastrostomy, as set forth in Sec. 166.046 – other than consent on behalf of the patient – are NOT met; or
    - At the time the committee's written decision is provided, the condition precedent for a tracheostomy or percutaneous endoscopic gastrostomy, as set forth in Sec. 166.046, are met – EXCEPT for consent on behalf of the patient – and such consent is NOT provided within 24 hours of request; or
    - A delay notice is initially provided, but the conditions previously met are no longer satisfied prior to the tracheostomy or percutaneous endoscopic gastrostomy being performed – in which case, a statement that one or more of the conditions are no longer satisfied must accompany this start notice.
  - Once the 25-day period codified in Section 166.046, Health and Safety Code, is initiated, it may not be suspended or stopped for any reason. Section 166.046 does not require a tracheostomy or after the expiration of the 25-day period. This does not limit a court's ability to extend the applicable time period pursuant to Section 166.046(g).

Process for Resolving Intractable Conflict

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	Hospitals could consider:
Policy / Procedure	• Whether to write or revise institutional policy. • How to structure the policy so that steps in the process are clear. • What type of language (specific vs. broad) to use in the policy. • Whether to include attachments or addendums to the policy.
Education	• Whether to provide education to stakeholders. • What type of educational materials will meet educational needs. • How to utilize existing mechanisms (e.g., councils) to provide education. • Who will be responsible for education.

Implementation	• Whether to create:
	  • Standardized forms (e.g., notices)
	  • Compliance tools
	  • Algorithms
	• Whether the institutional process will include additional steps.
	• What rules, if any, are necessary for the ethics committee review meeting.

HB 3162 – Section 4

Adds Section 166.0465, Health and Safety Code, regarding patients with disabilities. New Section 166.0465 defines “disability ”as found in the ADA Act (1990), in 42 USC Sec. 12102.

This new section requires that a committee convened in accordance with Sec. 166.046, may not consider a patient’s disability that existed prior to the current admission, unless the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.

HB 3162 – Section 5

Amends the statutory form required under Sec. 166.046 to align with changes made to Sec. 166.046 by HB 3162, including the limitation on applicability to patients deemed incompetent or otherwise mentally or physically incapable of communication, and the 7- and 25-day timeframes (pre- and post-committee meeting, respectively).

HB 3162 – Section 6

Adds a new Section 166.054 that governs reporting requirements related to the ethics or medical committee processes. Within 180 days from the date written notice is provided under Sec. 166.046(b)(1) (initiating the committee meeting process), a health care facility shall prepare and submit a report to HHSC, containing the following:

- The number of days between the patient's admission and the date notice of the committee meeting was provided;
- Whether the committee met to review the case, pursuant to Sec. 166.046, and, if so, the number of days between the provision of notice and the date the meeting was held;
- Whether the patient was:
  - Transferred to a physician within the same facility who was willing to comply with the patient's directive or health care or treatment decision made on the patient's behalf;
  - Transferred to a different health care facility; or,
  - Discharged to a private residence or other, non-health care facility

- Whether the patient died while receiving LST at the facilty;
- Whether LST was withheld or withdrawn after the expiration of the 25-day period codified in Sec. 166.046 and, if so, the disposition of the patient after the withholding or withdrawal of LST, as selected from:
  - The patient died at the facility;
  - The patient currently remains a patient at the facility;
  - The patient was transferred to a different health care facility; or,
  - The patient was discharged to a private residence or other non-health care setting or facility
- The patient age group, which is limited to:
  - 17 years of age or younger;
  - 18 years of age, or older, and younger than 66 years of age; or,
  - 66 years of age or older

- The health insurance coverage status of the patient, selected from:
  - Private health insurance coverage;
  - Public health insurance coverage; or,
  - Uninsured
- Patient's sex;
- Patient's race;
- Whether the facility was notified and can reasonably verify any public disclosure of contact information for facility personnel, physicians or health care professionals that provide care at the facility, or member of the medical or ethics committee, in connection with the patient's stay;
- Whether the facility was notified and can reasonably verify any public disclosure, by facility personnel, of contact information of the patient's immediate family members or patient's decisionmaker in connection with the patient's stay;

HHSC shall ensure submitted information is kept confidential, subject to the requirement to publish annual reports containing the following aggregate information, or withhold such information for as many annual cycles as needed to appropriately aggregate the following:

- The total number of written notices provided under Sec. 166.046;
- The average number of days between admission and provision of notice;
- The total number of committee meetings held under Sec. 166.046;
- The average number of days between the provision of notice and the meeting date;
- The number of patients transferred or discharged;
- The number of patients who died while receiving LST;
- The total number of patients for whom LST was withdrawn or withheld upon the completion of the 25-day period;
- The number of cases where a disclosure of personal information was reported to HHSC;

- If at least 10 reports are submitted the preceding year, or have accumulated at least 10 reports from the years that did not meet this threshold:
  - Patient's sec, race, age group, and insurance coverage – in the categories described above;
  - For patients where LST was removed, whether the patient died, was transferred, discharged, or remains at the facility

By rule, HHSC will develop a form for this reporting. This information is not admissible in a civil or criminal proceeding where the health care professional or facility is a defendant. This information is not available for use in any disciplinary action.

HB 3162 – Section 7

Amends Section 166.203 (“Facility DNR orders”) by:

- allowing any physician providing direct care to the patient to issue an order in compliance with certain directions from the patient or their decisionmaker;
- clarifying that an out-of-hospital DNR order may be used as the basis for an order;
- allowing directions from other appropriate decisionmakers appointed by an advance directive to be the basis for an order;
- clarifying that a patient’s death must be imminent, “within minutes to hours,” for certain orders that may only be issued by an attending physician;
- allowing for an order where there is agreement amongst the attending physician, the patient’s decisionmaker, and another physician not directly involved in the patient’s care or a part of the medical or ethics committee;
- allowing for issuance and entry of an order in the patient medical record in a format acceptable to the facility (e.g., electronic records); and
- clarifying issues around concerns with notice requirements.

Facility Do-Not-Resuscitate Orders

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	Hospitals could consider:
Policy / Procedure	• Whether to create or revise the institutional policy. • How to structure the policy so that the legal requirements are clear. • Whether to include amendments or attachments to the institutional policy.
Education	• What type of education is necessary (e.g., algorithms v. announcement). • Who is the target audience to receive education. • Whether to develop a packet of education materials for other facilities. • How to utilize existing mechanisms for education. • Whether to create enduring educational materials.

Implementation	• Whether to update:
	  • Informed consent forms
	  • Existing mechanisms for documentation in the EMR.
	• What process is needed, if any, for the identification of a second physician.
	• How to ensure accessibility of educational materials for physicians.

HB 3162 – Section 8

Amends Section 166.204 (“Facility DNR orders”) by:

- clarifying issues around concerns with notice requirements;
- requiring notice to a patient that regains competency if a certain type of order has been issued;
- providing liability protection relating to required DNR notices for a person who makes a good faith determination that the circumstances in which a notice must be provided have not been met.

HB 3162 – Section 9

Amends Section 166.205 (“Facility DNR orders”) by clarifying requirement for the revocation of an order in certain situations, including revocation where the:

- underlying advance directive is properly revoked under applicable law;
- patient’s appropriate decisionmaker expresses a desire to revoke an order that was issued based on:
  - the decisionmaker’s directions; or
  - if the authorized decisionmaker has changed, based on the directions of the prior decisionmaker;
- patient’s attending physician desired to revoke the order, and:
  - the underlying order was issued pursuant to the patient’s oral or written directions, or the patient’s advance directive, and there is agreement amongst the attending physician, the patient’s decisionmaker, and other physician not involved in the direct care of the patient or a part of the medical or ethics committee;
  - the underlying decision to issue the order was based on a decision by concurring physicians under Sec. 166.039(e); or,
  - the order was originally issued based on an agreement amongst the attending physician, the patient’s decisionmaker, and other physician not involved in the direct care of the patient or a part of the medical or ethics committee; or,
  - in the attending physician’s judgment, the patient’s death is no longer imminent “within minutes to hours.”

HB 3162 – Section 10

Amends Section 166.206 (“Facility DNR orders”) by removing references to “attending physician.”

HB 3162 – Section 11

Amends Section 166.209 (“Facility DNR orders”) by clarifying thresholds for penalties, including:

- Clarifying that specific intent to violate the subchapter, plus a violation of the subchapter, is the standard;
- Clarifying that an offense under this section is subject to the sections providing liability protections; and,
- Providing protection where the offending act or omission was undertaken on the basis of a reasonable belief the act or omission was in compliance with the patient’s or the patient’s decisionmaker’s wishes.

HB 3162 – Section 12

- Amends Section 313.004, Health and Safety Code by amending the patient decisionmaker hierarchy to align with the hierarchy in Section 166.039, Health and Safety Code. The amendments include:

- Removing the ability for clergy to take part in the decision-making process; and,
- Including the ability for a non-treating physician to take part in the decision-making process.

Revisions to the Consent to Medical Treatment Act

HB 3162 also amends the Consent to Medical Treatment Act (Chapter 313, Health and Safety Code) to more closely align its decision-making hierarchy with the TADA (Sec. 166.039, Health and Safety Code). Chapter 313 governs treatment decisions made on behalf of an adult patient of a home and community support services agency or in a hospital or nursing home, or an adult inmate of a county or municipal jail who is comatose, incapacitated, or otherwise mentally or physically incapable of communication – and only applies if the patient does not have a legal guardian or an agent under a medical power of attorney who is reasonably available after a reasonably diligent inquiry.

It also removes from the surrogate decision-making hierarchy "the individual clearly identified to act for the patient by the patient before the patient became incapacitated or a member of the clergy."

Finally, under a new subsection added to Section 313.004, if the patient does not have a legal guardian, an agent under a medical power of attorney, or a person listed in the hierarchy listed in Subsection (a) (*i.e.*, spouse, adult children, parents, or nearest living relative who is reasonably available after a reasonably diligent inquiry), another physician who is not involved in the medical treatment of the patient may concur with the proposed treatment.

Statutory Surrogate Hierarchy

	Hospitals could consider:
Policy / Procedure	• Whether to develop or revise the institutional policy for decision-making.
Education	• What type of educational materials will meet educational needs. • How to utilize existing mechanisms (e.g., councils) to provide education. • Who will be responsible for education.

Implementation	• Whether to update:
	  • Informed consent forms
	  • Documentation within the EMR (e.g., attestation)
	• Whether to create a process for identifying a second physician.
	• What other ancillary health care professionals should be involved.
	• Whether a routine ethics consultation is needed.

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