



House Bill 3162 (88th Texas Legislature; 2023)

HB 3162 makes broad changes to The Texas Advance Directives Act (“TADA”), specifically around statute affecting the ability for patients, or their decision-makers, to direct their care in situations where the TADA applies, decisions or conflicts around the provision of life-sustaining treatment (“LST”) or the dispute resolution process set forth in Sec. 166.046, Health and Safety Code, along with ancillary and related statute.

THA offers the following general explanation of the changes in HB 3162, and attempts to do so in a straightforward, neutral manner. The information that follows tracks **changes** to existing statute, in a section-by-section manner; other provisions of the TADA were unaffected by HB 3162.

THA is working on additional resources to assist hospitals in understanding and implementing these edits. THA membership will be notified when these resources become available. As always, please contact THA with any questions, concerns, or for additional information and detail on these issues.

1. What is HB 3162’s effective date?

HB 3162’s effective date is Sept. 1, 2023.

However, a review, consultation, disagreement, conduct or other action affected by the changes in statute which occurs **prior** to Sept. 1, 2023, is **governed by the statute existing prior** to the effective date.

Any review, consultation, disagreement, conduct, or other action affected by the changes in statute that occurs **on or after** Sept. 1, 2023, is **governed by the statute as modified by HB 3162.**

2. How does HB 3162 change current processes?

The last significant change to Chapter 166, Health and Safety Code, occurred in 2017. HB 3162 makes edits to a broader section of Ch. 166, as well as Ch. 313, Health and Safety Code. These edits are outlined below and will require review of existing policies and procedures concerning patient advance directives, do-not-resuscitate (DNR) orders and decisions related to care or interventions provided at the end of a patient’s natural life and other treatment decisions.

3. What major changes are included in HB 3162?

Among the other changes outlined below, the major changes effected by HB 3162 include:

- Extending the 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 seven days.
- Clarifying language regarding patients with disabilities, including how disabilities may affect the processes and decisions made under the TADA.
- Extending from 10 days to 25 days the period for continued attempts to transfer a patient, and the provision of patient care and interventions, 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.
- 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.
- Adding language to statute concerning the transfer of patients and, under certain circumstances, limited surgical interventions to help facilitate the patient's transfer.
- Clarifying the rights that a patient, or their decision-maker, have with regard to attending and participating in a meeting held pursuant to Sec. 166.046.
- 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.
- Aligning the decision-maker hierarchy in Chapter 313, Health and Safety Code, with Sec. 166.039.

HB 3162 contains 12 sections of edits to current statute, as follows:

4. Section 1 (pp. 1-2)

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.

5. Section 2 (pp. 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 below).

6. Section 3 (pp. 2-14)

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 it 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 seven days prior to a meeting, to discuss the patient's directive (unless this seven--day period is waived by written mutual agreement), which contains:
 - 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 five factors the committee is required to consider, as set forth in subsection (a-2) (described above); and,
 - The language codified in Section 166.0465.
- Clarify the patient's decision-maker is entitled to:
 - Attend and participate in the public portion of 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, 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 at 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, which 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 a part of the transfer effort;
 - If 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 meeting 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 into 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;
- After a denial of properly requested treatment, interventions, or LST, under Sec. 166.046, the attending or other physician responsible for the patient shall perform a tracheostomy or percutaneous endoscopic gastrostomy, if the following are satisfied:
 - In the attending physician's judgment, the procedure is reasonable and necessary to effect the patient's transfer under Sec. 166.046;
 - An authorized representative for the potential receiving facility (that has the ability to comply with the care or treatment request) has expressed the facility's likelihood of accepting transfer if the procedure is performed;
 - In the medical judgment of the physician who will operate on the patient, the procedure is:
 - Within the prevailing standard of medical care;

- Not medically contraindicated or medically inappropriate under the circumstances;
- In the medical judgment of the physician performing the procedure on the patient, the physician has the training and experience needed to perform the procedure;
- The physician who will perform the procedure on the patient has medical privileges at the facility and is authorized to perform the medical procedure at that facility;
- The facility has determined it has the resources necessary for the performance of the medical procedure on the patient; and
- The patient's decision-maker provides consent for the procedure on behalf of the patient.
- After a decision rendered by the committee affirms the original decision to withdraw or withhold requested care, notice must be provided as follows:
 - A delay notice, indicating the 25-day time frame will not begin, is required where:
 - 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; 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 provided within 24 hours of request.
[NOTE: HB 3162 is silent on the timeline and process for undertaking any required medical procedure and subsequent attempts to transfer the patient. Each facility should determine their best practices, policies and procedures when caring for patients, but THA suggests making best efforts to safely, appropriately and effectively expedite the procedure and any transfer efforts.]
 - A start notice, indicating the 25-day time frame will begin, 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, 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.
 - A delay notice is initially provided, but the conditions previously met are no longer satisfied prior to the tracheostomy or percutaneous endoscopic gastrostomy;
 - A statement describing the conditions 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. A medical procedure is not required by law after the expiration of the 25-day period. A court may still extend the applicable time period, pursuant to law.**

7. Section 4 (pp. 14)

Adds Section 166.0465, Health and Safety Code, and language regarding patients with disabilities. This new section defines “disability” as found in the Americans with Disabilities Act (1990), in 42 USC Sec. 12102, which, in part, reads as follows:

The term “disability” means, with respect to an individual—

(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment (please refer to the Act).

This new section requires that, during a review pursuant to Sec. 166.046, the committee 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.

8. Section 5 (pp. 14-20)

Amends the statutory form required under Sec. 166.046 to align with changes discussed herein, including the limitation to patients deemed incompetent or otherwise mentally or physically incapable of communication, and the seven- and 25-day timeframes (pre- and post-committee meeting, respectively).

9. Section 6 (pp. 20-26)

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 the Texas Health and Human Services Commission (HHSC), containing the following:

- The number of days between the patient’s admission and the date that 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 facility;
- 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 setting that is not a health care 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 decision-maker 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;
- Patient's sex, 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.

HHSC will develop a form for this reporting via rulemaking. The information collected 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.

10. Section 7 (pp. 26-28)

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 decision-makers 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 among the attending physician, the patient’s decision-maker, 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 notice requirements.

11. Section 8 (pp. 28-30)

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

- Clarifying issues around concerns with notice requirements;
- Requiring notice to a patient that regains competency if a certain type of order has been issued;

Clarifying that good faith is required in the attempt to provide notice as required by the subsections governing these DNR orders.

12. Section 9 (pp. 30-32)

Amends Section 166.204 (“In-patient DNR orders”) by clarifying the requirement for revocation of an order in certain situations, including revocation where the:

- Underlying advance directive is properly revoked under applicable law;
- Patient’s appropriate decision-maker 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 decision-maker
- 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 decision-maker, and another 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);
- the order was originally issued based on an agreement amongst the attending physician, the patient’s decision-maker, and another physician not involved in the direct care of the patient or a part of the medical or ethics committee; or,
- in the physician’s judgment, the patient’s death is no longer imminent “within minutes to hours.”

13. Section 10 (pp. 32)

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

The inclusion of that term in this subchapter was a concern raised by member hospitals; this change should reduce confusion in the interpretation and use of the procedures set forth in the subchapter.

14. Section 11 (pp. 33-34)

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

- That specific intent to violate the subchapter, with an actual 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 wishes of the patient or the patient’s decision-maker.

15. Section 12 (pp. 34-35)

Amends Section 313.004, Health and Safety Code by aligning the patient decision-maker hierarchy therein with the hierarchy found in Section 166.039, Health and Safety Code. This includes:

- 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 if the patient does not have a legal guardian, an agent under a medical power of attorney or a person listed in the decision-making hierarchy who is reasonably available after a reasonably diligent inquiry.

Please forward any questions to [Carrie Kroll](#) or [Cesar J. Lopez](#).