Palliative Care and Quality of Life Interdisciplinary Advisory Council

May 10, 2018

1:00-4:00 PM

Clackamas Community College
Wilsonville Training Center, Room 211
29353 SW Town Center Loop
Wilsonville, Oregon 97070

AGENDA
PALLIATIVE CARE AND QUALITY OF LIFE INTERDISCIPLINARY ADVISORY COUNCIL
May 10, 2018
1:00-4:00 PM
Clackamas Community College
Wilsonville Training Center, Room 211
Wilsonville, Oregon
All times are approximate

I.	**Call to Order, Roll Call, Approval of Minutes** Introduction of new members	**1:00 PM**
II.	**Staff report – Darren Coffman** Pain Management Coordinator update HB 4135	**1:10 PM**
III.	**Health Facility Requirements – Maggie Klein**	**1:30 PM**
IV.	**Resource Identification on Website - Discussion**	**2:30 PM**
V.	**Oregon Partnership to Improve Dementia Care – Update**	**3:15 PM**
VI.	**Public comment**	**3:45 PM**
VII.	**Adjournment**	**4:00 PM**

MINUTES

Palliative Care and Quality of Life Interdisciplinary Advisory Council
Clackamas Community College
Wilsonville Training Center, Room 155
Wilsonville, Oregon
January 11, 2018

Members Present: Margaret Klein, Jennifer Levi, Jamie Newell, Catherine Kiel, Laura Mavity, Jennifer Neahring

Members Absent: Letha McCleod

Staff Present: Denise Taray

Also Attending: Leah Brandis (HealthInsight)

Call to Order

The meeting was called to order at 1:00 pm and roll was called.

Minutes Approval

MOTION: To approve the minutes of the October 19, 2017 meeting with addendum to the discussion on the barriers to palliative care. Adding "by not offering and supporting palliative care you are withholding treatment".
CARRIES 5-0, absent 2, member vacancies 2.

Staff Report

- Member Term updates
  - Delvin Zook - Expired
  - Kathy Perko - Expired
  - 7 applications received; pending OHA leadership review and Director appointment. Anticipate appointments by end of January or first part of February.

- EOLOR: End of Life Choices, Oregon – needs corrections to their website definition of Hospice and Palliative Care: Jennifer Levi will connect with the person responsible for the website to see if they would like input as to the palliative care content.

Community Palliative Care Survey Report/ Physician Palliative Care Survey Report

PCAC Project: Mapping Community Palliative Care in Oregon-
Survey Sent 2nd Round Nov 15th: 217/ 44 Undeliverable
Responses/ Report – total of 27 responses (12% response rate)

PCAC Project: Physician's Palliative Care Survey-
Survey out to 3,510 recipients
Responses/ Report – 255 Total Responses (7% response rate)

Barriers: internet securities/ firewalls, blocked emails
Both surveys closed January 2, 2018

Discussion:
These surveys, including the one sent out to social workers did not provide the feedback the council was anticipating. CAPC survey response is also small at this time.

Possible conclusion from the responses: additional education about what palliative care services are may be necessary. Confusion about what the differences are between hospice and palliative care.

Overall goal: improved access

Acknowledged that we just may not be able to gather enough data to complete a gap analysis. Consider redefining focus of the work to simply collect and add contact information to the PCAC website as a resource/ directory. Use website to allow providers to submit their palliative care services information to add to a directory. Use that mechanism to collect details or additional data from those respondents. Consider aligning with the work done already with the Oregon Hospice and Palliative Care Association. The palliative care portion of their website is limited at this time but interested in working together to bolster their resource information. It would be beneficial to have this on a website that has the capacity to maintain and update frequently. OHA PCAC website may only need to provide the information to direct users to the OR Hospice and Palliative Care Association. Question about whether or not a provider must be a member to be listed. PCAC may define what qualifies a services provider as a palliative care service. PCAC to share the survey worksheets and survey data with OR Hospice and Palliative Care Association to include as resources. Recommendations: separate the Hospice and Palliative Care into individual resource sites.

Action items:
Laura Mavity to follow up with Oregon Hospice and Palliative Care Association provider resource page and whether or not a palliative care service/ provider must be a member of their association in order to be included.

Oregon Partnership to Improve Dementia Care – Palliative Care Project Discussion
Leah Brandis: HealthInsight

105 nursing home collaborative to improve dementia care. Project is to put together/ develop a palliative care toolkit for patients with dementia to be used for care planning and promote having the appropriate conversations.
Proposed collaborative with PCAC and not duplicate any work which might go into this work. Include the toolkit on the PCAC website for accessibility. Additional opportunities to partnership on some educational videos and other training for staff in nursing facilities responsible for care conferences.
Jenni N. asks about how will it be determined who is appropriate for using the palliative care toolkit and to better define the population/ patient status for when it will be used.

The workgroup proposes including a screening tool to be used.

This project may align with the PCAC work to define health facilities palliative care requirement. Discussed the process of creating Admin Rules and establishing a Rules Advisory Committee.

PCAC Deliverable: Health facilities palliative care requirement
Oregon Partnership Deliverable: palliative care toolkit specific to patients with dementia

Discussed development of a webinar/ video: Oregon Partnership project with PCAC input to define palliative care. Jennifer Levi will send Leah resources that are already out there on this topic. Proposed webinar might be a way to survey participants directly during the presentation.

Action Items:
Leah will send out the toolkit sketch for PCAC member review. Denise will send out to PCAC members.
Denise to summarize previous PCAC discussions about the health facility requirement to bring forward with this project.
Denise to send out the updated OHP Statement of Intent for Palliative Care which may be used to define what a palliative care service should include.

Leah is also seeking a graduate intern project for the next 6-9 months.
Academic advisor: Jennifer Levi is available to preceptor and meet the MPH requirement
Project to support the work of developing the PCAC deliverable of the health facilities palliative care requirement. Will need to develop a position description for the process.
Denise to send Leah the application process with OHA/ DHS (check on previously submitted application done about a year ago)

Public Comment

There was no public comment at this time.

Other Discussion:
Legislation – Advance Directive bill
Action Item:
Denise to watch for any and send to council members

Adjournment

Meeting adjourned at 3:00 pm. Next meeting will be April 12, 2018 from 1:00-4:00 pm at Clackamas Community College Wilsonville Training Center, Room 155, Wilsonville, Oregon.

Enrolled
House Bill 4135

Sponsored by Representative KOTEK, Senators PROZANSKI, STEINER HAYWARD; Representatives GREENLICK, HOLVEY, KENY-GUYER, MARSH, POWER, SALINAS, Senators BEYER, DEMBROW, GELSER, MANNING JR, MONNES ANDERSON (Presession filed.)

CHAPTER .....

AN ACT

Relating to health care decisions; creating new provisions; amending ORS 97.953, 97.955, 97.959, 127.005, 127.505, 127.510, 127.515, 127.520, 127.525, 127.535, 127.545, 127.550, 127.555, 127.565, 127.625, 127.635, 127.640, 127.649, 127.658, 127.737, 127.760, 163.193 and 163.206; repealing ORS 127.531; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

FORM OF AN ADVANCE DIRECTIVE
(Series Placement)

SECTION 1. Sections 2 to 6 of this 2018 Act are added to and made a part of ORS 127.505 to 127.660.

(Advance Directive Adoption Committee)

SECTION 2. (1) The Advance Directive Adoption Committee is established within the division of the Oregon Health Authority that is charged with performing the public health functions of the state.

(2)(a) The committee consists of 13 members.

(b) One member shall be the Long Term Care Ombudsman or the designee of the Long Term Care Ombudsman.

(c) The other 12 members shall be appointed by the Governor as follows:

(A) One member who represents primary health care providers.

(B) One member who represents hospitals.

(C) One member who is a clinical ethicist affiliated with a health care facility located in this state, or affiliated with a health care organization offering health care services in this state.

(D) Two members who are health care providers with expertise in palliative or hospice care, one of whom is not employed by a hospital or other health care facility, a health care organization or an insurer.

(E) One member who represents individuals with disabilities.

(F) One member who represents consumers of health care services.

(G) One member who represents the long term care community.

(H) One member with expertise advising or assisting consumers with end-of-life decisions.

(I) One member from among members proposed by the Oregon State Bar who has extensive experience in elder law and advising individuals on how to execute an advance directive.

(J) One member from among members proposed by the Oregon State Bar who has extensive experience in estate planning and advising individuals on how to make end-of-life decisions.

(K) One member from among members proposed by the Oregon State Bar who has extensive experience in health law.

(3) The term of office of each member of the committee is four years, but a member serves at the pleasure of the appointing authority. Before the expiration of the term of a member, the appointing authority shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective for the unexpired term.

(4) A majority of the members of the committee constitutes a quorum for the transaction of business.

(5) Official action by the committee requires the approval of a majority of the members of the committee.

(6) The committee shall elect one of its members to serve as chairperson.

(7) The committee shall meet at times and places specified by the call of the chairperson or of a majority of the members of the committee, provided that the committee meets at least twice a year.

(8) The committee may adopt rules necessary for the operation of the committee.

(9) Members of the committee are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the Oregon Health Authority for purposes of the committee.

SECTION 3. (1) In accordance with public notice and stakeholder participation requirements prescribed by the Oregon Health Authority and section 4 of this 2018 Act, the Advance Directive Adoption Committee established under section 2 of this 2018 Act shall:

(a) Adopt the form of an advance directive to be used in this state; and

(b) Review the form not less than once every four years for the purpose of adopting changes to the form that the committee determines are necessary.

(2) Except as otherwise provided by ORS 127.505 to 127.660, the form of an advance directive adopted pursuant to this section is the only valid form of an advance directive in this state.

(3) At a minimum, the form of an advance directive adopted under this section must contain the following elements:

(a) A statement about the purposes of the advance directive, including:

(A) A statement about the purpose of the principal's appointment of a health care representative to make health care decisions for the principal if the principal becomes incapable;

(B) A statement about the priority of health care representative appointment in ORS 127.635 (2) in the event the principal becomes incapable and does not have a valid health care representative appointment;

(C) A statement about the purpose of the principal's expression of the principal's values and beliefs with respect to health care decisions and the principal's preferences for health care;

(D) A statement about the purpose of the principal's expression of the principal's preferences with respect to placement in a care home or a mental health facility; and

(E) A statement that advises the principal that the advance directive allows the principal to document the principal's preferences, but is not a POLST, as defined in ORS 127.663.

(b) A statement explaining that to be effective the advance directive must be:

(A) Accepted by signature or other applicable means; and

(B) Either witnessed and signed by at least two adults or notarized.

(c) A statement explaining that to be effective the appointment of a health care representative or an alternate health care representative must be accepted by the health care representative or the alternate health care representative.

(d) A statement explaining that the advance directive, once executed, supersedes any previously executed advance directive.

(e) The name, date of birth, address and other contact information of the principal.

(f) The name, address and other contact information of any health care representative or any alternate health care representative appointed by the principal.

(g) A section providing the principal with an opportunity to state the principal's values and beliefs with respect to health care decisions, including the opportunity to describe the principal's preferences, by completing a checklist, by providing instruction through narrative or other means, or by any combination of methods used to describe the principal's preferences, regarding:

(A) When the principal wants all reasonably available health care necessary to preserve life and recover;

(B) When the principal wants all reasonably available health care necessary to treat chronic conditions;

(C) When the principal wants to specifically limit health care necessary to preserve life and recover, including artificially administered nutrition and hydration, cardiopulmonary resuscitation and transport to a hospital; and

(D) When the principal desires comfort care instead of health care necessary to preserve life.

(h) A section where the principal and the witnesses or notary may accept by signature or other means, including electronic or verbal means, the advance directive.

(i) A section where any health care representative or any alternate health care representative appointed by the principal may accept the advance directive by signature or other means, including electronic or verbal means.

(4)(a) In adopting the form of an advance directive under this section, the committee shall use plain language, such as "tube feeding" and "life support."

(b) As used in this subsection:

(A) "Life support" means life-sustaining procedures.

(B) "Tube feeding" means artificially administered nutrition and hydration.

(5) In adopting the form of an advance directive under this section, the committee shall use the components of the form for appointing a health care representative or an alternate health care representative set forth in section 5 of this 2018 Act.

(6) The principal may attach supplementary material to an advance directive. In addition to the form of an advance directive adopted under this section, supplementary material attached to an advance directive under this subsection is a part of the advance directive.

(7) The Oregon Health Authority shall post the form of an advance directive adopted under this section on the authority's website.

SECTION 4. (1) In addition to the requirements prescribed by the Oregon Health Authority under section 3 (1) of this 2018 Act, the form of an advance directive adopted pursuant to section 3 of this 2018 Act may not take effect until the form has been ratified by the Legislative Assembly during an odd-numbered year regular session of the Legislative Assembly in the manner required for the passage of bills by Article IV, section 25 (1), of the Oregon Constitution, and by the Governor in the manner required for the passage of bills by Article V, section 15b, of the Oregon Constitution.

(2) For purposes of this section, the Advance Directive Adoption Committee established under section 2 of this 2018 Act shall submit the form of an advance directive adopted under section 3 of this 2018 Act to an interim committee of the Legislative Assembly related to the judiciary on or before September 1 of an even-numbered year following the date on which the committee adopts the form. Upon receiving the form, the interim committee shall file a proposed legislative measure with the Legislative Counsel requesting a measure by which the Legislative Assembly and the Governor may ratify the form.

(Form for Appointing Health Care Representative and Alternate Health Care Representative)

SECTION 5. A form for appointing a health care representative and an alternate health care representative must be written in substantially the following form:

FORM FOR APPOINTING HEALTH CARE REPRESENTATIVE AND ALTERNATE HEALTH CARE REPRESENTATIVE

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative.

• If you have completed a form appointing a health care representative in the past, this new form will replace any older form.

• You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

• If you become too sick to speak for yourself and do not have an effective health care representative appointment, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2).

1. ABOUT ME.

Name: _____ Date of Birth: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

2. MY HEALTH CARE REPRESENTATIVE.

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____
E-mail: _____
3. MY SIGNATURE.
My signature: _____ Date: _____
4. WITNESS.
COMPLETE EITHER A OR B WHEN YOU SIGN.
A. NOTARY:
State of _____
County of _____
Signed or attested before me on _____, 2____, by _____.

_____
Notary Public - State of Oregon
B. WITNESS DECLARATION:
The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternate health care representative, and I am not the person's attending health care provider.
Witness Name (print): _____
Signature: _____
Date: _____
Witness Name (print): _____
Signature: _____
Date: _____
5. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.
I accept this appointment and agree to serve as health care representative.
Health care representative:
Printed name: _____
Signature or other verification of acceptance: _____
Date: _____
First alternate health care representative:
Printed name: _____
Signature or other verification of acceptance: _____
Date: _____
Second alternate health care representative:
Printed name: _____
Signature or other verification of acceptance: _____
Date: _____

(Temporary Form for Advance Directive)

SECTION 6. (1) In lieu of the form of an advance directive adopted by the Advance Directive Adoption Committee under section 3 of this 2018 Act, on or before January 1, 2022, a principal may execute an advance directive that is in a form that is substantially the same as the form of an advance directive set forth in this section.

(2) Notwithstanding section 3 (2) of this 2018 Act, the form of an advance directive set forth in this section is a valid form of an advance directive in this state.

(3) The form of an advance directive executed as described in subsection (1) of this section is as follows:

ADVANCE DIRECTIVE
(STATE OF OREGON)

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative. If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

• If you have completed an advance directive in the past, this new advance directive will replace any older directive.

• You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

• If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

• In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME.

Name: _____ Date of Birth: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

2. MY HEALTH CARE REPRESENTATIVE.

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work)_____ (Cell)_____

Address: _____

E-mail: _____

3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE.

If you wish to give instructions to your health care representative about your health care decisions, initial one of the following three statements:

___ To the extent appropriate, my health care representative must follow my instructions.

___ My instructions are guidelines for my health care representative to consider when making decisions about my care.

___ Other instructions: _____

4. DIRECTIONS REGARDING MY END OF LIFE CARE.

In filling out these directions, keep the following in mind:

• The term "as my health care provider recommends" means that you want your health care provider to use life support if your health care provider believes it could be helpful, and that you want your health care provider to discontinue life support if your health care provider believes it is not helping your health condition or symptoms.

• The term "life support" means any medical treatment that maintains life by sustaining, restoring or replacing a vital function.

• The term "tube feeding" means artificially administered food and water.

• If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

• You will receive care for your comfort and cleanliness no matter what choices you make.

A. Statement Regarding End of Life Care. You may initial the statement below if you agree with it. If you initial the statement you may, but you do not have to, list one or more conditions for which you do not want to receive life support.

___ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below.

B. Additional Directions Regarding End of Life Care. Here are my desires about my health care if my health care provider and another knowledgeable health care provider confirm that I am in a medical condition described below:

a. Close to Death. If I am close to death and life support would only postpone the moment of my death:

INITIAL ONE:

___ I want to receive tube feeding.

___ I want tube feeding only as my health care provider recommends.

___ I DO NOT WANT tube feeding.

INITIAL ONE:

___ I want any other life support that may apply.

___ I want life support only as my health care provider recommends.

___ I DO NOT WANT life support.

b. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONE:

___ I want to receive tube feeding.

___ I want tube feeding only as my health care provider recommends.

___ I DO NOT WANT tube feeding.

INITIAL ONE:

___ I want any other life support that may apply.

___ I want life support only as my health care provider recommends.

___ I DO NOT WANT life support.

c. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONE:

___ I want to receive tube feeding.

___ I want tube feeding only as my health care provider recommends.

___ I DO NOT WANT tube feeding.

INITIAL ONE:

___ I want any other life support that may apply.

___ I want life support only as my health care provider recommends.

___ I DO NOT WANT life support.

d. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

INITIAL ONE:

___ I want to receive tube feeding.

___ I want tube feeding only as my health care provider recommends.

___ I DO NOT WANT tube feeding.

INITIAL ONE:

___ I want any other life support that may apply.

___ I want life support only as my health care provider recommends.

___ I DO NOT WANT life support.

C. Additional Instruction. You may attach to this document any writing or recording of your values and beliefs related to health care decisions. These attachments will serve as guidelines for health care providers. Attachments may include a description of what you would like to happen if you are close to death, if you are permanently unconscious, if you have an advanced progressive illness or if you are suffering permanent and severe pain.

5. MY SIGNATURE.

My signature: _____ Date: _____

6. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of _____

County of _____

Signed or attested before me on _____, 2____, by _____.

_____

Notary Public - State of Oregon

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternate health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____

Date: _____

Witness Name (print): _____

Signature: _____

Date: _____

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____
Date: _____
Second alternate health care representative:
Printed name: _____
Signature or other verification of acceptance: _____
Date: _____

APPOINTING HEALTH CARE REPRESENTATIVES AND EXECUTING ADVANCE DIRECTIVES

SECTION 7. ORS 127.510 is amended to read:

127.510. [*(1) A capable adult may designate in writing a competent adult to serve as attorney-in-fact for health care. A capable adult may also designate a competent adult to serve as alternative attorney-in-fact if the original designee is unavailable, unable or unwilling to serve as attorney-in-fact at any time after the power of attorney for health care is executed. The power of attorney for health care is effective when it is signed, witnessed and accepted as required by ORS 127.505 to 127.660 and 127.995. The attorney-in-fact so appointed shall make health care decisions on behalf of the principal if the principal becomes incapable.*]

[*(2) A capable adult may execute a health care instruction. The instruction shall be effective when it is signed and witnessed as required by ORS 127.505 to 127.660 and 127.995.*]

(1) A capable adult may execute an advance directive. The advance directive is effective when it is signed by the principal and witnessed or notarized as required by ORS 127.505 to 127.660.

(2)(a) A capable adult may use an advance directive or the form set forth in section 5 of this 2018 Act to appoint a competent adult to serve as the health care representative for the capable adult. A health care representative appointed under this paragraph shall make health care decisions for the principal if the principal becomes incapable.

(b) A capable adult may use an advance directive or the form set forth in section 5 of this 2018 Act to appoint one or more competent adults to serve as alternate health care representatives for the capable adult. For purposes of ORS 127.505 to 127.660, an alternate health care representative has the rights and privileges of a health care representative appointed under paragraph (a) of this subsection, including the rights described in ORS 127.535. An alternate health care representative appointed under this paragraph shall make health care decisions for the principal if:

(A) The principal becomes incapable; and

(B) The health care representative appointed under paragraph (a) of this subsection is unable, unwilling or unavailable to make timely health care decisions for the principal.

(c) For purposes of paragraph (b) of this subsection, the health care representative appointed under paragraph (a) of this subsection is unavailable to make timely health care decisions for the principal if the health care representative is not available to answer questions for the health care provider in person, by telephone or by another means of direct communication.

(d) An appointment made under this section is effective when it is accepted by the health care representative.

(3) Unless the period of time that an advance directive **or a form appointing a health care representative** is [*to be*] effective is limited by the terms of the advance directive **or the form appointing a health care representative**, the advance directive [*shall continue*] **or the form appointing a health care representative continues** in effect until:

(a) The principal dies; or

(b) The advance directive **or the form appointing a health care representative** is revoked, suspended or superseded pursuant to ORS 127.545.

(4) Notwithstanding subsection (3) of this section, if the principal is incapable at the expiration of the term of the advance directive **or the form appointing a health care representative**, the advance directive **or the form appointing a health care representative** continues in effect until:

(a) The principal is no longer incapable;

(b) The principal dies; or

(c) The advance directive **or the form appointing a health care representative** is revoked, suspended or superseded pursuant to the provisions of ORS 127.545.

(5) A health care provider shall make a copy of an advance directive [*and*]**, a copy of a form appointing a health care representative and a copy of** any other instrument a part of the principal's medical record when a copy of [*that*] **the advance directive, form appointing a health care representative or** instrument is provided to the principal's health care provider.

(6) Notwithstanding subsections (3)**(a)** and (4)**(b)** of this section, **an advance directive remains in effect with respect to** an anatomical gift, as defined in ORS 97.953, [*made on an advance directive is effective*] **after the principal dies**.

SECTION 8. ORS 127.515 is amended to read:

127.515. (1) An advance directive **or a form appointing a health care representative** may be executed by a resident or nonresident adult of this state in the manner provided by ORS 127.505 to 127.660 [*and 127.995*].

[*(2) A power of attorney for health care must be in the form provided by Part B of the advance directive form set forth in ORS 127.531, or must be in the form provided by ORS 127.530 (1991 Edition).*]

[*(3) A health care instruction must be in the form provided by Part C of the advance directive form set forth in ORS 127.531, or must be in the form provided by ORS 127.610 (1991 Edition).*]

[*(4) An advance directive must reflect the date of the principal's signature. To be valid, an advance directive must be witnessed by at least two adults as follows:*]

[*(a) Each witness shall witness either the signing of the instrument by the principal or the principal's acknowledgment of the signature of the principal.*]

[*(b) Each witness shall make the written declaration as set forth in the form provided in ORS 127.531.*]

[*(c) One of the witnesses shall be a person who is not:*]

[*(A) A relative of the principal by blood, marriage or adoption;*]

[*(B) A person who at the time the advance directive is signed would be entitled to any portion of the estate of the principal upon death under any will or by operation of law; or*]

[*(C) An owner, operator or employee of a health care facility where the principal is a patient or resident.*]

[*(d) The attorney-in-fact for health care or alternative attorney-in-fact may not be a witness. The principal's attending physician at the time the advance directive is signed may not be a witness.*]

[*(e) If the principal is a patient in a long term care facility at the time the advance directive is executed, one of the witnesses must be an individual designated by the facility and having any qualifications that may be specified by the Department of Human Services by rule.*]

(2) An advance directive or a form appointing a health care representative must reflect the date of the principal's signature or other method of accepting the advance directive or the form appointing a health care representative. To be valid, an advance directive or a form appointing a health care representative must be:

(a) Witnessed and signed by at least two adults; or

(b) Notarized by a notary public.

(3) If an advance directive or a form appointing a health care representative is validated under subsection (2)(a) of this section, each witness must witness:

(a) The principal signing the advance directive or the form appointing a health care representative; or

(b) The principal acknowledging the signature of the principal on the advance directive or the form appointing a health care representative, or the principal acknowledging any other method by which the principal accepted the advance directive or the form appointing a health care representative.

(4) For an advance directive or a form appointing a health care representative to be valid under subsection (2)(a) of this section, the witnesses may not, on the date the advance directive or the form appointing a health care representative is signed or acknowledged:

(a) Be the principal's attending physician or attending health care provider.

(b) Be the principal's health care representative or alternate health care representative appointed under ORS 127.510.

(5) If an advance directive or a form appointing a health care representative is validated under subsection (2)(a) of this section, and if the principal is a patient in a long term care facility at the time the advance directive or the form appointing a health care representative is executed, one of the witnesses must be an individual who is designated by the facility and qualified as specified by the Department of Human Services by rule.

[*(5)*] **(6)** Notwithstanding [*subsections (2) to (4)*] **subsection (2)** of this section, an advance directive **or a form appointing a health care representative that is** executed by an adult who [*at the time of execution resided in another state,*] **resides in another state at the time of execution, and that is executed** in compliance with [*the formalities of execution required by*] the laws of that state, the laws of the state where the principal [*was*] **is** located at the time of **the** execution or the laws of this state, is validly executed for the purposes of ORS 127.505 to 127.660 [*and 127.995 and may be given effect in accordance with its provisions, subject to the laws of this state*].

DEFINITIONS

SECTION 9. ORS 127.505 is amended to read:

127.505. As used in ORS 127.505 to 127.660 and 127.995:

(1) "Adult" means an individual who**:**

(a) Is 18 years of age or older[*, who*]**; or**

(b) Has been adjudicated an emancipated minor**,** or [*who*] is **a minor who is** married.

[*(2) "Advance directive" means a document that contains a health care instruction or a power of attorney for health care.*]

(2)(a) "Advance directive" means a document executed by a principal that contains:

(A) A form appointing a health care representative; and

(B) Instructions to the health care representative.

(b) "Advance directive" includes any supplementary document or writing attached by the principal to the document described in paragraph (a) of this subsection.

(3) "Appointment" means [*a power of attorney for health care*] **a form appointing a health care representative**, letters of guardianship or a court order appointing a health care representative.

(4)**(a)** "Artificially administered nutrition and hydration" means a medical intervention to provide food and water by tube, mechanical device or other medically assisted method.

(b) "Artificially administered nutrition and hydration" does not include the usual and typical provision of nutrition and hydration, such as the provision of nutrition and hydration by cup, hand, bottle, drinking straw or eating utensil.

(5) "Attending health care provider" means the health care provider who has primary responsibility for the care and treatment of the principal, provided that the powers and duties conferred on the health care provider by ORS 127.505 to 127.660 are within the health care provider's scope of practice.

[*(5)*] **(6)** "Attending physician" means the physician who has primary responsibility for the care and treatment of the principal.

[*(6) "Attorney-in-fact" means an adult appointed to make health care decisions for a principal under a power of attorney for health care, and includes an alternative attorney-in-fact.*]

[*(7) "Dementia" means a degenerative condition that causes progressive deterioration of intellectual functioning and other cognitive skills, including but not limited to aphasia, apraxia, memory, agnosia and executive functioning, that leads to a significant impairment in social or occupational function and that represents a significant decline from a previous level of functioning. Diagnosis is by history and physical examination.*]

(7) "Capable" means not incapable.

(8) "Form appointing a health care representative" means:

(a) The portion of the form adopted under section 3 of this 2018 Act used to appoint a health care representative or an alternate health care representative;

(b) The portion of the form set forth in section 6 of this 2018 Act used to appoint a health care representative or an alternate health care representative; or

(c) The form set forth in section 5 of this 2018 Act.

[*(8)*] **(9)** "Health care" means diagnosis, treatment or care of disease, injury and congenital or degenerative conditions, including the use, maintenance, withdrawal or withholding of life-sustaining procedures and the use, maintenance, withdrawal or withholding of artificially administered nutrition and hydration.

[*(9)*] **(10)** "Health care decision" means consent, refusal of consent or withholding or withdrawal of consent to health care, and includes decisions relating to admission to or discharge from a health care facility.

[*(10)*] **(11)** "Health care facility" means a health care facility as defined in ORS 442.015, a domiciliary care facility as defined in ORS 443.205, a residential facility as defined in ORS 443.400, an adult foster home as defined in ORS 443.705 or a hospice program as defined in ORS 443.850.

[*(11) "Health care instruction" or "instruction" means a document executed by a principal to indicate the principal's instructions regarding health care decisions.*]

(12)**(a)** "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the [*law*] **laws** of this state to administer health care in the ordinary course of business or practice of a profession[*, and includes a health care facility*].

(b) "Health care provider" includes a health care facility.

(13) "Health care representative" means:

[*(a) An attorney-in-fact;*]

(a) A competent adult appointed to be a health care representative or an alternate health care representative under ORS 127.510.

(b) A person who has authority to make health care decisions for a principal under the provisions of ORS 127.635 (2) or (3)[*; or*]**.**

(c) A guardian or other person, appointed by a court to make health care decisions for a principal.

(14) "Incapable" means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician **or attending health care provider**, a principal lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. [*"Capable" means not incapable.*]

(15) "Instrument" means an advance directive, [*acceptance,*] **form appointing a health care representative,** disqualification, withdrawal, court order, court appointment or other document governing health care decisions.

[*(16) "Life support" means life-sustaining procedures.*]

[*(17)*] **(16)(a)** "Life-sustaining procedure" means any medical procedure, pharmaceutical, medical device or medical intervention that maintains life by sustaining, restoring or supplanting a vital function.

(b) "Life-sustaining procedure" does not include routine care necessary to sustain patient cleanliness and comfort.

[*(18)*] **(17)** "Medically confirmed" means the medical opinion of the attending physician **or attending health care provider** has been confirmed by a second physician **or second health care provider** who has examined the patient and who has clinical privileges or expertise with respect to the condition to be confirmed.

[*(19)*] **(18)** "Permanently unconscious" means completely lacking an awareness of self and external environment, with no reasonable possibility of a return to a conscious state, and that condition has been medically confirmed by a neurological specialist who is an expert in the examination of unresponsive individuals.

[*(20)*] **(19)** "Physician" means an individual licensed to practice medicine by the Oregon Medical Board or a naturopathic physician licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

[*(21) "Power of attorney for health care" means a power of attorney document that authorizes an attorney-in-fact to make health care decisions for the principal when the principal is incapable.*]

[*(22)*] **(20)** "Principal" means:

(a) An adult who has executed an advance directive;

(b) A person of any age who has a health care representative;

(c) A person for whom a health care representative is sought; or

(d) A person being evaluated for capability [*who will have*] **to whom** a health care representative **will be assigned** if the person is determined to be incapable.

[*(23)*] **(21)** "Terminal condition" means a health condition in which death is imminent irrespective of treatment, and where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death of the principal.

[*(24) "Tube feeding" means artificially administered nutrition and hydration.*]

TECHNICAL AMENDMENTS

SECTION 10. ORS 127.005 is amended to read:

127.005. (1) When a principal designates another person as an agent by a power of attorney in writing, and the power of attorney does not contain words that otherwise delay or limit the period of time of its effectiveness:

(a) The power of attorney becomes effective when executed and remains in effect until the power is revoked by the principal;

(b) The powers of the agent are unaffected by the passage of time; and

(c) The powers of the agent are exercisable by the agent on behalf of the principal even though the principal becomes financially incapable.

(2) The terms of a power of attorney may provide that the power of attorney will become effective at a specified future time, or will become effective upon the occurrence of a specified future event or contingency such as the principal becoming financially incapable. If a power of attorney becomes effective upon the occurrence of a specified future event or contingency, the power of attorney may designate a person or persons to determine whether the specified event or contingency has occurred, and the manner in which the determination must be made. A person designated by a power of attorney to determine whether the principal is financially incapable is the principal's personal representative for the purposes of ORS 192.553 to 192.581 and the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164.

(3) If a power of attorney becomes effective upon the principal becoming financially incapable and either the power of attorney does not designate a person or persons to make the determination as to whether the principal is financially incapable or none of the designated persons is willing or able to make the determination, a determination that the principal is financially incapable may be made by any physician. The physician's determination must be made in writing.

(4) All acts done by an agent under a power of attorney during a period in which the principal is financially incapable have the same effect, and inure to the benefit of and bind the principal, as though the principal were not financially incapable.

(5) If a conservator is appointed for a principal, the agent shall account to the conservator, rather than to the principal, for so long as the conservatorship lasts. The conservator has the same power that the principal would have to revoke, suspend or terminate all or any part of the power of attorney.

(6) This section does not apply to [*powers of attorney for health care executed under*] ORS 127.505 to 127.660 [*and 127.995*].

SECTION 11. ORS 127.520 is amended to read:

127.520. (1) Except as provided in ORS 127.635 or as may be allowed by court order, the following persons may not serve as health care representatives:

(a) If unrelated to the principal by blood, marriage or adoption:

(A) The attending physician **or attending health care provider of the principal,** or an employee of the attending physician **or attending health care provider of the principal**; or

(B) An owner, operator or employee of a health care facility in which the principal is a patient or resident, unless the health care representative was appointed before the principal's admission to the facility; or

(b) A person who is the principal's parent or former guardian [*and*] **if**:

(A) At any time while the principal was under the care, custody or control of the person, a court entered an order:

(i) Taking the principal into protective custody under ORS 419B.150; or

(ii) Committing the principal to the legal custody of the Department of Human Services for care, placement and supervision under ORS 419B.337; and

(B) The court entered a subsequent order that:

(i) The principal should be permanently removed from the person's home, or continued in substitute care, because it was not safe for the principal to be returned to the person's home, and no subsequent order of the court was entered that permitted the principal to return to the person's home before the principal's wardship was terminated under ORS 419B.328; or

(ii) Terminated the person's parental rights under ORS 419B.500 and 419B.502 to 419B.524.

(2) A principal, while not incapable, may petition the court to remove a prohibition [*contained*] **described** in subsection (1)(b) of this section.

(3) A capable adult may disqualify any other person from making health care decisions for the capable adult. The disqualification must be in writing and signed by the capable adult. The disqualification must specifically designate those persons who are disqualified.

(4) A health care representative whose authority has been revoked by a court is disqualified.

(5) A health care provider who has actual knowledge of a disqualification may not accept a health care decision from [*a*] **the** disqualified [*individual*] **person**.

(6) A person who has been disqualified from making health care decisions for a principal, and who is aware of that disqualification, may not make health care decisions for the principal.

SECTION 12. ORS 127.525 is amended to read:

127.525. [*For an appointment under a power of attorney for health care to be effective, the attorney-in-fact must accept the appointment in writing. Subject to the right of the attorney-in-fact to withdraw, the acceptance imposes a duty on the attorney-in-fact to make health care decisions on behalf of the principal at such time as the principal becomes incapable. Until the principal becomes incapable, the attorney-in-fact may withdraw by giving notice to the principal. After the principal becomes incapable, the attorney-in-fact may withdraw by giving notice to the health care provider.*] **For an appointment of a health care representative or an alternate health care representative in a form appointing a health care representative to be effective, the health care representative or the alternate health care representative must accept the appointment as described in ORS 127.510. Subject to the right of the health care representative or the alternate health care representative to withdraw, the acceptance imposes a duty on the health care representative or the alternate health care representative to make health care decisions on behalf of the principal as described in ORS 127.510. Until the principal becomes incapable, the health care representative or the alternate health care representative may withdraw by giving notice to**

the principal. After the principal becomes incapable, the health care representative or the alternate health care representative may withdraw by giving notice to the health care provider.

SECTION 13. ORS 127.535 is amended to read:

127.535. (1) [*The*] **A** health care representative has [*all the*] authority over the principal's health care that the principal would have if **the principal were** not incapable, subject to the limitations of the appointment and ORS 127.540 and 127.580. A health care representative who is known to [*the*] **a** health care provider to be available to make health care decisions has priority over any person other than the principal to act for the principal [*in all*] **with respect to** health care decisions. A health care representative has authority to make a health care decision for a principal only when the principal is incapable.

(2) A health care representative is not personally responsible for the cost of health care provided to the principal solely because the health care representative makes health care decisions for the principal.

(3) Except to the extent **that** the right is limited by the appointment or [*any*] **by** federal law **or regulation**, a health care representative for an incapable principal has the same right as the principal to receive information regarding the proposed health care, to receive and review medical records and to consent to the disclosure of medical records. The right of the health care representative to receive [*this*] information **as described in this section** is not a waiver of any evidentiary privilege or any right to assert confidentiality with respect to others.

(4) In making health care decisions, [*the*] **a** health care representative has a duty to act consistently with the desires of the principal as expressed in the principal's advance directive, or as otherwise made known by the principal to the health care representative [*at any time*]. If the principal's [*desires*] **preferences** are unknown, [*the*] **a** health care representative has a duty to act in [*what*] **a manner that** the health care representative in good faith believes to be **in** the best interests of the principal.

(5) ORS 127.505 to 127.660 do not authorize a health care representative or health care provider to withhold or withdraw life-sustaining procedures or artificially administered nutrition and hydration [*in any situation*] if the principal manifests an objection to the health care decision. If the principal objects to [*such a*] **the** health care decision, the health care provider shall proceed as though the principal [*were*] **is** capable [*for the purposes of*] **with respect to** the health care decision [*objected to*].

(6) An [*instrument that would be a valid*] advance directive **or form appointing a health care representative that would be valid** except that the [*instrument is not a form described in ORS 127.515, has*] **advance directive or form appointing a health care representative is** expired, is not properly witnessed or otherwise fails to meet the formal requirements of ORS 127.505 to 127.660 shall constitute evidence of the patient's desires and interests.

(7) A health care representative is a personal representative for the purposes of ORS 192.553 to 192.581 and the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164.

SECTION 14. ORS 127.545 is amended to read:

127.545. (1) An advance directive or a health care decision by a health care representative may be revoked:

(a) If the advance directive or health care decision involves the decision to withhold or withdraw life-sustaining procedures or artificially administered nutrition and hydration, at any time and in any manner by which the principal is able to communicate the intent to revoke; or

(b) At any time and in any manner by a capable principal.

(2) Revocation is effective upon communication by the principal to the **principal's** attending physician**,** [*or*] **attending** health care provider[*, or to the*] **or** health care representative. If the revocation is communicated **by the principal** to the **principal's** health care representative, and the principal is incapable and is under the care of a health care provider known to the **health care**

representative, the health care representative must promptly inform the **principal's** attending physician or **attending** health care provider of the revocation.

(3) Upon learning [*of the revocation, the health care provider or attending physician shall*] **about a revocation of a health care decision, an attending physician or attending health care provider must** cause the revocation to be made a part of the principal's medical records.

[*(4) Execution of a valid power of attorney for health care revokes any prior power of attorney for health care. Unless the health care instruction provides otherwise, execution of a valid health care instruction revokes any prior health care instruction.*]

(4) Unless the advance directive provides otherwise:

(a) Execution of an advance directive revokes any prior advance directive; and

[*(5)*] **(b)** [*Unless the advance directive provides otherwise,*] The directions [*as*] **with respect** to health care decisions in [*a valid*] **an** advance directive supersede:

[*(a)*] **(A)** Any directions contained in a previous court appointment or advance directive; and

[*(b)*] **(B)** Any prior inconsistent expression of [*desires*] **preferences** with respect to health care decisions.

[*(6) Unless the power of attorney for health care provides otherwise, valid appointment of an attorney-in-fact for health care supersedes:*]

(5) Unless the form appointing a health care representative provides otherwise:

(a) Execution of a form appointing a health care representative revokes any prior form appointing a health care representative;

(b) Valid appointment of a health care representative or an alternate health care representative under ORS 127.510 supersedes:

[*(a)*] **(A)** Any power of a guardian or other person appointed by a court to make health care decisions for the protected person; and

[*(b)*] **(B)** Any other prior appointment or designation of a health care representative[.]**; and**

[*(7) Unless the power of attorney for health care expressly provides otherwise, a power of attorney for health care is suspended:*]

(c) A form appointing a health care representative is suspended:

[*(a)*] **(A)** If [*both the attorney-in-fact and the alternative attorney-in-fact*] **the appointed health care representative and all appointed alternate health care representatives** have withdrawn; or

[*(b)*] **(B)** If the [*power of attorney*] **form appointing a health care representative** names the principal's spouse as [*attorney-in-fact*] **the health care representative or an alternate health care representative**, a petition for dissolution or annulment of marriage is filed and the principal does not reaffirm the appointment [*in writing*] after the filing of the petition.

[*(8)(a)*] **(6)(a)** If the principal has both a valid [*health care instruction*] **advance directive** and a valid [*power of attorney for health care*] **form appointing a health care representative**, and if the directions reflected in those documents are inconsistent, the document last executed governs to the extent of the inconsistency.

(b) If the principal has both a valid [*health care instruction*] **advance directive**, or a valid [*power of attorney for health care*] **form appointing a health care representative**, and a declaration for mental health treatment made in accordance with ORS 127.700 to 127.737, and if the directions reflected in those documents are inconsistent, [*the directions contained in*] the declaration for mental health treatment governs to the extent of the inconsistency.

[*(9)*] **(7)** Any reinstatement of an advance directive **or a form appointing a health care representative** must be in writing.

SECTION 15. ORS 127.550 is amended to read:

127.550. (1) A health care decision made by [*an individual*] **a person** who is authorized to make the decision under ORS 127.505 to 127.660 [*and 127.995*] is effective immediately and does not require judicial approval.

(2) A petition may be filed under ORS 127.505 to 127.660 [*and 127.995 for any*] **for** one or more of the following purposes:

(a) Determining whether a principal is incapable.

(b) Determining whether an appointment of [*the*] **a** health care representative or [*a health care instruction*] **the execution of an advance directive** is valid or has been suspended, reinstated, revoked or terminated.

(c) Determining whether the acts or proposed acts of [*the*] **a** health care representative breach any duty of the **health care** representative and whether those acts should be enjoined.

(d) Declaring that [*an individual*] **a person** is authorized to act as a health care representative.

(e) Disqualifying [*the*] **a** health care representative upon a determination of the court that the health care representative has violated, **has** failed to perform or is unable to perform the duties under ORS 127.535 (4).

(f) Approving any health care decision that by law requires court approval.

(g) Determining whether the acts or proposed acts of [*the*] **a** health care representative are clearly inconsistent with the [*desires*] **preferences** of the principal as made known to the health care representative, or where the [*desires*] **preferences** of the principal are unknown or unclear, whether the acts or proposed acts of the health care representative are clearly contrary to the best interests of the principal.

(h) Declaring that a [*power of attorney for health care is*] **form appointing a health care representative is suspended or** revoked upon a determination by the court that the [*attorney-in-fact*] **appointed health care representative** has made a health care decision for the principal that authorized anything illegal. A suspension or revocation of a [*power of attorney*] **form appointing a health care representative** under this paragraph shall be in the discretion of the court.

(i) Considering any other matter that the court determines needs to be decided for the protection of the principal.

(3) A petition may be filed by any of the following:

(a) The principal.

(b) [*The*] **A** health care representative.

(c) The spouse, parent, sibling or adult child of the principal.

(d) An adult relative or adult friend of the principal who is familiar with the desires of the principal.

(e) The guardian of the principal.

(f) The conservator of the principal.

(g) The attending physician or **attending** health care provider of the principal.

(4) A petition under this section shall be filed in the circuit court in the county in which the principal resides or is located.

(5) [*Any of the determinations*] **A determination** described in this section may be made by the court as a part of a protective proceeding under ORS chapter 125 if a guardian or temporary guardian has been appointed for the principal, or if the petition seeks the appointment of a guardian or a temporary guardian for the principal.

SECTION 16. ORS 127.555 is amended to read:

127.555. (1) If there is more than one physician **or health care provider** caring for a principal, the principal shall designate one physician **or one health care provider** as the attending physician **or the attending health care provider**. If the principal is incapable, the health care representative for the principal shall designate the attending physician **or the attending health care provider**.

(2) Health care representatives, and persons who are acting under a reasonable belief that they are health care representatives, [*shall not be*] **are not** guilty of any criminal offense, or subject to civil liability, or in violation of any professional oath, affirmation or standard of care for any action taken in good faith as a health care representative.

(3) A health care provider acting or declining to act in reliance on the health care decision made in an advance directive **or in a document that the health care provider reasonably believes to be an advance directive**, made by an attending physician **or attending health care provider** under ORS 127.635 (3), or made by a person who the **health care** provider believes is the health care representative for an incapable principal, is not subject to criminal prosecution, civil

liability or professional disciplinary action on [*the*] grounds that the health care decision is unauthorized unless the **health care** provider:

(a) Fails to satisfy a duty that ORS 127.505 to 127.660 [*and 127.995*] place on the **health care** provider;

(b) Acts without medical confirmation as required under ORS 127.505 to 127.660 [*and 127.995*];

(c) Knows or has reason to know that the requirements of ORS 127.505 to 127.660 [*and 127.995*] have not been satisfied; or

(d) Acts after receiving notice that:

(A) The authority or decision on which the **health care** provider relied is revoked, suspended, superseded or subject to other legal infirmity;

(B) A court challenge to the health care decision or the authority relied on in making the health care decision is pending; or

(C) The health care representative has withdrawn or has been disqualified.

(4) The immunities provided by this section do not apply to:

(a) The manner of administering health care pursuant to a health care decision made by the health care representative or by [*a health care instruction*] **an advance directive**; or

(b) The manner of determining the health condition or incapacity of the principal.

(5) A health care provider who determines that a principal is incapable is not subject to criminal prosecution, civil liability or professional disciplinary action for failing to follow that principal's direction except for a failure to follow a principal's manifestation of an objection to a health care decision under ORS 127.535 (5).

SECTION 17. ORS 127.565 is amended to read:

127.565. (1) In following [*a health care instruction*] **an advance directive** or the decision of a health care representative, a health care provider shall exercise the same independent medical judgment that the health care provider would exercise in following the decisions of the principal if the principal were capable.

(2) [*No*] **A** person [*shall*] **may not** be required [*either*] to execute or to refrain from executing an advance directive **or to appoint or to refrain from appointing a health care representative** as a [*criterion*] **condition** for insurance. [*No*] **A** health care provider [*shall*] **may not** condition the provision of health care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive **or has appointed a health care representative**.

(3) No existing or future policy of insurance [*shall be*] **is** legally impaired or invalidated in any manner by actions taken under ORS 127.505 to 127.660 [*and 127.995*]. [*No person shall*] **A person may not** be discriminated against in premium or contract rates because of the existence or absence of an advance directive or appointment of a health care representative.

(4) Nothing in ORS 127.505 to 127.660 [*and 127.995*] is intended to impair or supersede any conflicting federal statute.

SECTION 18. ORS 127.625 is amended to read:

127.625. (1) [*No health care provider shall be*] **A health care provider is not** under any duty, whether by contract, [*by*] statute or [*by any*] other legal requirement**,** to participate in the withdrawal or withholding of life-sustaining procedures or of artificially administered nutrition or hydration.

(2) If a health care provider is unable or unwilling to carry out [*a health care instruction*] **an advance directive** or the decisions of the health care representative, the following provisions apply:

(a) The health care provider shall promptly notify the health care representative, if [*there is*] **the principal has appointed** a health care representative;

(b) If the authority or decision of the health care representative is in dispute, the health care representative or **health care** provider may seek the guidance of the court in the manner provided in ORS 127.550;

(c) If the **health care** representative's authority or decision is not in dispute, the **health care** representative shall make a reasonable effort to transfer the principal to the care of another physician or health care provider; and

(d) If there is no health care representative for an incapable patient, and the health care decisions are not in dispute, the health care provider shall, without abandoning the patient, either discharge the patient or make a reasonable effort to locate a different **physician or** health care provider and authorize the transfer of the patient to that **physician or health care** provider.

SECTION 19. ORS 127.635 is amended to read:

127.635. (1) Life-sustaining procedures that would otherwise be applied to a principal who is incapable and who does not have an appointed health care representative or applicable valid advance directive may be withheld or withdrawn in accordance with subsections (2) and (3) of this section if the principal has been medically confirmed to be in one of the following conditions:

(a) A terminal condition;

(b) Permanently unconscious;

(c) A condition in which administration of life-sustaining procedures would not benefit the principal's medical condition and would cause permanent and severe pain; or

(d) An advanced stage of a progressive illness that will be fatal, and the principal is consistently and permanently unable to communicate by any means, to swallow food and water safely, to care for the principal's self and to recognize the principal's family and other people, and it is very unlikely that the principal's condition will substantially improve.

(2) If a principal's condition has been determined to meet one of the conditions set forth in subsection (1) of this section, and the principal does not have an appointed health care representative or applicable valid advance directive, the principal's health care representative shall be the first of the following, in the following order, who can be located upon reasonable effort by the health care facility and who is willing to serve as the health care representative:

(a) A guardian of the principal who is authorized to make health care decisions, if any;

(b) The principal's spouse;

(c) An adult designated by the others listed in this subsection who can be so located, if no person listed in this subsection objects to the designation;

(d) A majority of the adult children of the principal who can be so located;

(e) Either parent of the principal;

(f) A majority of the adult siblings of the principal who can be located with reasonable effort; or

(g) Any adult relative or adult friend.

(3) If none of the persons described in subsection (2) of this section is available, then life-sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending physician **or attending health care provider**.

(4)(a) Life-sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending physician **or attending health care provider** at the request of a person designated the health care representative under subsections (2) and (3) of this section only after the person has consulted with concerned family and close friends and, if the principal has a case manager, as defined by rules adopted by the Department of Human Services, after giving notice to the principal's case manager.

(b) A case manager who receives notice under paragraph (a) of this subsection shall provide the person giving the case manager notice with any information in the case manager's possession that is related to the principal's values, beliefs and preferences with respect to the withholding or withdrawing of life-sustaining procedures.

(5) Notwithstanding subsection (2) of this section, a person who is the principal's parent or former guardian may not withhold or withdraw life-sustaining procedures under this section if:

(a) At any time while the principal was under the care, custody or control of the person, a court entered an order:

(A) Taking the principal into protective custody under ORS 419B.150; or

(B) Committing the principal to the legal custody of the Department of Human Services for care, placement and supervision under ORS 419B.337; and

(b) The court entered a subsequent order that:

(A) The principal should be permanently removed from the person's home, or continued in substitute care, because it was not safe for the principal to be returned to the person's home, and no subsequent order of the court was entered that permitted the principal to return to the person's home before the principal's wardship was terminated under ORS 419B.328; or

(B) Terminated the person's parental rights under ORS 419B.500 and 419B.502 to 419B.524.

(6) A principal, while not incapable, may petition the court to remove a prohibition contained in subsection (5) of this section.

SECTION 20. ORS 127.640 is amended to read:

127.640. Before withholding or withdrawing life-sustaining procedures or artificially administered nutrition and hydration under the provisions of ORS 127.540, 127.580 or 127.635, the attending physician **or attending health care provider** shall determine that the conditions of ORS 127.540, 127.580 and 127.635 have been met.

SECTION 21. ORS 127.649 is amended to read:

127.649. (1) Subject to the provisions of ORS 127.652 and 127.654, all health care organizations shall maintain written policies and procedures, applicable to [*all capable adults who are receiving*] **each capable adult individual who receives** health care by or through the health care organization, that provide for:

(a) Delivering to [*those individuals*] **the individual** the following information and materials, in written form, without recommendation:

(A) Information on the rights of the individual under [*Oregon law*] **the laws of this state** to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute [*advance directives*] **an advance directive or a form appointing a health care representative**;

(B) Information on the policies of the health care organization with respect to the implementation of the rights of the individual under [*Oregon law*] **the laws of this state** to make health care decisions;

[*(C) A copy of the advance directive set forth in ORS 127.531, along with a disclaimer on the first line of the first page of each form in at least 16-point boldfaced type stating "You do not have to fill out and sign this form."; and*]

(C) Materials necessary to execute an advance directive or a form appointing a health care representative; and

(D) The name of a person who can provide additional information concerning [*the forms for*] advance directives **and forms appointing a health care representative**.

(b) Documenting in a prominent place in the individual's medical record whether the individual has executed an advance directive **or a form appointing a health care representative**.

(c) Ensuring compliance by the health care organization with [*Oregon law relating to advance directives*] **the laws of this state governing advance directives and forms appointing a health care representative**.

(d) Educating the staff and the community on issues relating to advance directives **and forms appointing a health care representative**.

(2) A health care organization [*need not furnish a copy of an advance directive to an individual*] **does not need to deliver materials described in subsection (1)(a)(C) of this section** if the health care organization has reason to believe that the individual [*has received a copy of an advance directive in the form set forth in ORS 127.531 within*] **has received materials described in subsection (1)(a)(C) of this section during** the preceding 12-month period or has previously executed an advance directive **or a form appointing a health care representative**.

SECTION 22. ORS 127.737 is amended to read:

127.737. [*(1)*] ORS 127.525, 127.550, 127.565, 127.570, 127.575 and 127.995 apply to a declaration for mental health treatment.

[*(2) For purposes of this section only, a declaration shall be considered a power of attorney for health care, without regard to whether the declaration appoints an attorney-in-fact.*]

SECTION 23. ORS 127.760 is amended to read:

127.760. (1) As used in this section:

(a) "Health care instruction" means a document executed by a patient to indicate the patient's instructions regarding health care decisions[*, including an advance directive or power of attorney for health care executed under ORS 127.505 to 127.660*].

(b) "Health care provider" means a person licensed, certified or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(c) "Hospital" has the meaning given that term in ORS 442.015.

(d) "Mental health treatment" means convulsive treatment, treatment of mental illness with psychoactive medication, psychosurgery, admission to and retention in a health care facility for care or treatment of mental illness, and related outpatient services.

(2)(a)(A) A hospital may appoint a health care provider who has received training in health care ethics, including identification and management of conflicts of interest and acting in the best interest of the patient, to give informed consent to medically necessary health care services on behalf of a patient admitted to the hospital in accordance with subsection (3) of this section.

(B) If a person appointed under subparagraph (A) of this paragraph is the patient's attending physician or naturopathic physician licensed under ORS chapter 685, the hospital must also appoint another health care provider who meets the requirements of subparagraph (A) of this paragraph to participate in making decisions about giving informed consent to health care services on behalf of the patient.

(b) A hospital may appoint a multidisciplinary committee with ethics as a core component of the duties of the committee, or a hospital ethics committee, to participate in making decisions about giving informed consent to medically necessary health care services on behalf of a patient admitted to the hospital in accordance with subsection (3) of this section.

(3) A person appointed by a hospital under subsection (2) of this section may give informed consent to medically necessary health care services on behalf of and in the best interest of a patient admitted to the hospital if:

(a) In the medical opinion of the attending physician or naturopathic physician, the patient lacks the ability to make and communicate health care decisions to health care providers;

(b) The hospital has performed a reasonable search, in accordance with the hospital's policy for locating relatives and friends of a patient, for a health care representative appointed under ORS 127.505 to 127.660 or an adult relative or adult friend of the patient who is capable of making health care decisions for the patient, including contacting social service agencies of the Oregon Health Authority or the Department of Human Services if the hospital has reason to believe that the patient has a case manager with the authority or the department, and has been unable to locate any person who is capable of making health care decisions for the patient; and

(c) The hospital has performed a reasonable search for and is unable to locate any health care instruction executed by the patient.

(4) Notwithstanding subsection (3) of this section, if a patient's wishes regarding health care services were made known during a period when the patient was capable of making and communicating health care decisions, the hospital and the person appointed under subsection (2) of this section shall comply with those wishes.

(5) A person appointed under subsection (2) of this section may not consent on a patient's behalf to:

(a) Mental health treatment;

(b) Sterilization;

(c) Abortion;

(d) Except as provided in ORS 127.635 (3), the withholding or withdrawal of life-sustaining procedures as defined in ORS 127.505; or

(e) Except as provided in ORS 127.580 (2), the withholding or withdrawal of artificially administered nutrition and hydration, as defined in ORS 127.505, other than hyperalimentation, necessary to sustain life.

(6) If the person appointed under subsection (2) of this section knows the patient's religious preference, the person shall make reasonable efforts to confer with a member of the clergy of the patient's religious tradition before giving informed consent to health care services on behalf of the patient.

(7) A person appointed under subsection (2) of this section is not a health care representative as defined in ORS 127.505.

SECTION 24. ORS 97.953 is amended to read:

97.953. As used in ORS 97.951 to 97.982:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Agent" means [*an*]:

[*(a) Attorney-in-fact as that term is defined in ORS 127.505; or*]

(a) A health care representative or an alternate health care representative appointed under ORS 127.510; or

(b) **An** individual expressly authorized to make an anatomical gift on the principal's behalf by any record signed by the principal.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research or education.

(4) "Body part" means an organ, an eye or tissue of a human being. The term does not include the whole body.

(5) "Decedent" means a deceased individual whose body or body part is or may be the source of an anatomical gift, and includes a stillborn infant or a fetus.

(6)(a) "Disinterested witness" means a witness other than:

(A) A spouse, child, parent, sibling, grandchild, grandparent or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift; or

(B) An adult who exhibited special care and concern for the individual.

(b) "Disinterested witness" does not include a person to whom an anatomical gift could pass under ORS 97.969.

(7) "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement, symbol or designation on a driver license, identification card or donor registry.

(8) "Donor" means an individual whose body or body part is the subject of an anatomical gift.

(9) "Donor registry" means a centralized database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

(10) "Driver license" means a license or permit issued under ORS 807.021, 807.040, 807.200, 807.280 or 807.730, regardless of whether conditions are attached to the license or permit.

(11) "Eye bank" means an organization licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of human eyes or portions of human eyes.

(12) "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health or welfare of an individual. "Guardian" does not include a guardian ad litem.

(13) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state or a subdivision of a state.

(14) "Identification card" means the card issued under ORS 807.021, 807.400 or 807.730, or a comparable provision of the motor vehicle laws of another state.

(15) "Know" means to have actual knowledge.

(16) "Minor" means an individual who is under 18 years of age.

(17) "Organ procurement organization" means an organization designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.

(18) "Parent" means a parent whose parental rights have not been terminated.

(19) "Physician" means an individual authorized to practice medicine under the law of any state.

(20) "Procurement organization" means an eye bank, organ procurement organization or tissue bank.

(21) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a body part that could be medically suitable for transplantation, therapy, research or education. The term does not include an individual who has made a refusal.

(22) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(23) "Recipient" means an individual into whose body a decedent's body part has been or is intended to be transplanted.

(24) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(25) "Refusal" means a record that expressly states an intent to prohibit other persons from making an anatomical gift of an individual's body or body part.

(26) "Sign" means, with the present intent to authenticate or adopt a record:

(a) To execute or adopt a tangible symbol; or

(b) To attach to or logically associate with the record an electronic symbol, sound or process.

(27) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands or any territory or insular possession subject to the jurisdiction of the United States.

(28) "Technician" means an individual determined to be qualified to remove or process body parts by an appropriate organization that is licensed, accredited or regulated under federal or state law. The term includes an enucleator.

(29) "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

(30) "Tissue bank" means a person that is licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of tissue.

(31) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

SECTION 25. ORS 97.955 is amended to read:

97.955. (1) Subject to ORS 97.963, a donor may make an anatomical gift of a donor's body or body part during the life of the donor for the purpose of transplantation, therapy, research or education.

(2) An anatomical gift may be made in the manner provided in ORS 97.957 by:

(a) The donor, if the donor is an adult or if the donor is a minor and is:

(A) Emancipated; or

(B) Authorized under ORS 807.280 to apply for an instruction driver permit because the donor is at least 15 years of age;

(b) An agent of the donor, unless the [*power of attorney for health care*] **form appointing a health care representative, as defined in ORS 127.505,** or other record prohibits the agent from making an anatomical gift;

(c) A parent of the donor, if the donor is an unemancipated minor; or

(d) The donor's guardian.

SECTION 26. ORS 97.959 is amended to read:

97.959. (1) Except as provided in subsection (7) or (8) of this section, an anatomical gift made under ORS 97.957 may be amended or revoked only by the donor in accordance with the provisions of this section and may not be amended or revoked by any other person otherwise authorized to make, amend or revoke a gift under ORS 97.963 or 97.967.

(2) A donor or other person authorized to amend or revoke an anatomical gift under subsection (7) or (8) of this section may amend or revoke an anatomical gift by:

(a) A record signed by:

(A) The donor;

(B) The other person; or

(C) Subject to subsection (3) of this section, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(b) A later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(3) A record signed pursuant to subsection (2)(a)(C) of this section must:

(a) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(b) State that it has been signed and witnessed as required in this subsection.

(4) A donor or other person authorized to revoke an anatomical gift under subsection (7) or (8) of this section may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(5) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(6) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (4) of this section.

(7) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or body part.

(8) An agent or guardian of a donor may amend or revoke an anatomical gift only if:

(a) The agent or guardian made the gift under ORS 97.955 (2)(b) or (d); or

(b) [*The power of attorney for health care*] **The form appointing a health care representative, as defined in ORS 127.505,** or other record appointing the agent expressly authorizes the agent to amend or revoke anatomical gifts.

SECTION 27. ORS 163.193 is amended to read:

163.193. (1) A person commits the crime of assisting another person to commit suicide if the person knowingly sells, or otherwise transfers for consideration, any substance or object, that is capable of causing death, to another person for the purpose of assisting the other person to commit suicide.

(2) This section does not apply to a person:

(a) Acting pursuant to a court order, an advance directive or [*power of attorney for health care*] **a form for appointing a health care representative** pursuant to ORS 127.505 to 127.660 or a POLST, as defined in ORS 127.663;

(b) Withholding or withdrawing life-sustaining procedures or artificially administered nutrition and hydration pursuant to ORS 127.505 to 127.660; or

(c) Acting in accordance with the provisions of ORS 127.800 to 127.897.

(3) Assisting another person to commit suicide is a Class B felony.

SECTION 28. ORS 163.206 is amended to read:

163.206. ORS 163.200 and 163.205 do not apply:

(1) To a person acting pursuant to a court order, an advance directive or a [*power of attorney for health care*] **form for appointing a health care representative** pursuant to ORS 127.505 to 127.660 or a POLST, as defined in ORS 127.663;

(2) To a person withholding or withdrawing life-sustaining procedures or artificially administered nutrition and hydration pursuant to ORS 127.505 to 127.660;

(3) When a competent person refuses food, physical care or medical care;

(4) To a person who provides an elderly person or a dependent person who is at least 18 years of age with spiritual treatment through prayer from a duly accredited practitioner of spiritual treatment as provided in ORS 124.095, in lieu of medical treatment, in accordance with the tenets and practices of a recognized church or religious denomination of which the elderly or dependent person is a member or an adherent; or

(5) To a duly accredited practitioner of spiritual treatment as provided in ORS 124.095.

TEMPORARY PROVISION RELATED TO MEMBERSHIP OF ADVANCE DIRECTIVE ADOPTION COMMITTEE

SECTION 29. Notwithstanding the term of office specified by section 2 of this 2018 Act, of the members first appointed by the Governor to the Advance Directive Adoption Committee:

(1) Four shall serve for a term ending January 1, 2021.

(2) Four shall serve for a term ending January 1, 2022.

(3) Four shall serve for a term ending January 1, 2023.

REPEAL

SECTION 30. ORS 127.531 is repealed.

SAVINGS CLAUSES AND APPLICABILITY

SECTION 31. ORS 127.658 is amended to read:

127.658. [*(1) ORS 127.505 to 127.660 and 127.995 do not impair or supersede any power of attorney for health care, directive to physicians or health care instruction in effect before November 4, 1993.*]

[*(2) Any power of attorney for health care or directive to physicians executed before November 4, 1993, shall be governed by the provisions of ORS 127.505 to 127.660 and 127.995, except that:*]

[*(a) The directive to physicians or power of attorney for health care shall be valid if it complies with the provisions of either ORS 127.505 to 127.660 and 127.995 or the statutes in effect as of the date of execution;*]

[*(b) The terms in a directive to physicians in the form prescribed by ORS 127.610 (1991 Edition) or predecessor statute have those meanings given in ORS 127.605 (1991 Edition) or predecessor statute in effect at the time of execution; and*]

[*(c) The terms in a power of attorney for health care in the form prescribed by ORS 127.530 (1991 Edition) have those meanings given in ORS 127.505 in effect at the time of execution.*]

[*(3) A health care organization, as defined in ORS 127.646, that on November 4, 1993, has printed materials with the information and forms which were required by ORS 127.649, prior to November 4, 1993, may use such printed materials until December 1, 1993.*]

(1) ORS 127.505 to 127.660 as enacted, the repeal of any statute that was a part of ORS 127.505 to 127.660 and subsequent amendments to the provisions of ORS 127.505 to 127.660 do not impair or supersede any advance directive, form appointing a health care representative or directive to physicians executed in accordance with:

(a) The provisions of ORS 127.505 to 127.660; or

(b) The provisions of ORS 127.505 to 127.660 or any other statute governing an advance directive, a form appointing a health care representative or a directive to physicians that was in effect on the date that the advance directive, the form appointing a health care representative or the directive to physicians was executed.

(2) An advance directive, a form appointing a health care representative or a directive to physicians executed before, on or after the operative date specified in section 34 of this 2018 Act shall be governed by the provisions of ORS 127.505 to 127.660 or any other statute that is in effect on the date on which:

(a) The issue giving rise to adjudication occurs; or

(b) The advance directive, the form appointing a health care representative or the directive to physicians was executed.

SECTION 32. The amendments to ORS 127.510 by section 7 of this 2018 Act apply to appointments made before, on or after the operative date specified in section 34 of this 2018 Act.

SECTION 33. **(1) The amendments to ORS 127.515 by section 8 of this 2018 Act apply to advance directives and forms appointing a health care representative that are executed on or after the operative date specified in section 34 of this 2018 Act.**

(2) Sections 1 to 6 of this 2018 Act, the amendments to statutes by sections 7 to 28 and 31 of this 2018 Act and the repeal of ORS 127.531 by section 30 of this 2018 Act do not effect the validity of an advance directive executed on or after the operative date specified in section 34 of this 2018 Act if the principal relied in good faith on a provision of ORS 127.505 to 127.660 as in effect immediately before the operative date specified in section 34 of this 2018 Act.

OPERATIVE DATE

SECTION 34. **(1) Sections 1 to 6 of this 2018 Act, the amendments to statutes by sections 7 to 28 and 31 of this 2018 Act and the repeal of ORS 127.531 by section 30 of this 2018 Act become operative on January 1, 2019.**

(2) The Advance Directive Adoption Committee and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the committee and the authority to exercise, on and after the operative date specified in subsection (1) of this section, all the duties, powers and functions conferred on the committee and authority by sections 1 to 6 of this 2018 Act, the amendments to statutes by sections 7 to 28 and 31 of this 2018 Act and the repeal of ORS 127.531 by section 30 of this 2018 Act.

UNIT CAPTIONS

SECTION 35. **The unit captions used in this 2018 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2018 Act.**

EFFECTIVE DATE

SECTION 36. **This 2018 Act takes effect on the 91st day after the date on which the 2018 regular session of the Seventy-ninth Legislative Assembly adjourns sine die.**

Passed by House February 16, 2018

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate February 27, 2018

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2018

Approved:

.....M.,....., 2018

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2018

.....
Dennis Richardson, Secretary of State

Health Facility Palliative Care Requirement

Health Facility Palliative Care Programs

Monitoring is beyond the scope of this council and there are evaluative mechanism in place through the health facility survey process. The council may be better positioned to identify the elements of a palliative care program and provide support rather than evaluation to the health facilities. The council would be able to encourage the use of best practices when building palliative care programs. The council may consider education targeted at state surveyors on what is an acceptable palliative care program and what is acceptable care planning for palliative care.

Revised the language of the Council Objectives from "Create a system for monitoring health facilities compliance with SB 608(5) and institute a mechanism for effecting meaningful change in the areas where facilities actions can be improved"…" to "Support health facilities compliance with SB 608(5) and institute a mechanism for effecting meaningful change in areas where delivery of palliative care programs can be improved."

Palliative Care and Health Facilities in Oregon Administrative Rules

The council shall consult with and advise the director on:

(a) Matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in this state; and
(b) The implementation of ORS 413.273 (Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities).

A health facility shall:

(a) Establish a system for identifying patients or residents who could benefit from palliative care;
(b) Provide information to patients, residents and their families about palliative care; and
(c) Coordinate with a patients or residents primary care provider, if practicable, to facilitate the access of patients and residents with serious illnesses to appropriate palliative care. [2015 c.789 §5]

Requirement of ORS 413.273(2)

Key Elements:
Emphasis should be for primary palliative care approach in which the primary care provider has the conversation with patient about advanced directives and goals of care to identify surrogate decision maker, advance care planning and completion of POLST if applicable.

A Health Facilities Palliative care requirement should not be met as a "requirement of documents" and should be a "coordination of care requirement".

Health facilities should have a policy about palliative care that includes the following elements:

- Staff education to improve knowledge of advanced care planning and goals of care
- Available information for patients on palliative care resources within community

- Mechanism to identify patients with serious illness who would benefit from palliative care
- Opportunity and mechanism for patients to engage in advance care planning, to include:
    - Identification of a surrogate decision maker and/or health care representative
    - Identification to establish desired goals of care
- Program to facilitate palliative care between patient, primary care provider and health facility to manage or mediate symptoms to meet goals of care

Health Facilities Requirements: Implementation & Regulation

Regulatory process to review for compliance and assure the statute has been met.

- Consider authority of regulatory boards or state survey processes already in place
- Define elements a regulatory body would consider to meet the requirement for palliative care
    - This will need to be addressed in Rule Making (OARs)
    - Definition of elements of a palliative care program (model of care)
        - To include the process of identifying the patient for palliative care services

Palliative Care and Quality of Life Interdisciplinary Advisory Council

2015 Oregon Revised Statutes

Chapter 413: Oregon Health Authority

Health Care Practices (Palliative Care)

413.270 Advisory council

(1) The Palliative Care and Quality of Life Interdisciplinary Advisory Council is established in the Oregon Health Authority consisting of nine members appointed by the Director of the Oregon Health Authority.

(2) The council shall consult with and advise the director on:

(a) Matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in this state; and
(b) The implementation of ORS 413.273 (Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities).

(3) The members of the council must include:

(a) Individuals with collective expertise in interdisciplinary palliative care provided in a variety of settings and to children, youths, adults and the elderly;
(b) Individuals with expertise in nursing, social work and pharmacy;
(c) Members of the clergy or individuals who have professional spiritual expertise; and
(d) At least two board-certified physicians or nurses with expertise in palliative care.

(4) The term of office of each member is three years but a member serves at the pleasure of the director. Before the expiration of the term of a member, the director shall appoint a successor whose term begins on January 1, next following. A member is eligible for reappointment. If there is a vacancy for any cause, the director shall make an appointment to become immediately effective for the unexpired term.

(5) The council shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the council determines.

(6) A majority of the members of the council constitutes a quorum for the transaction of business.

(7) The council shall meet at least twice every year at a place, day and hour determined by the council. The council may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

(8) A member of the council is not entitled to compensation but in the discretion of the director may be reimbursed from funds available to the authority for actual and necessary travel and other expenses incurred by the member in the performance of the members official duties in the manner and amount provided in ORS 292.495 (Compensation and expenses of members of state boards and commissions).

(9) The authority shall provide staff support to the council. [2015 c.789 §1]

Note: 413.270 (Advisory council) to 413.273 (Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities) were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

Note: Section 3, chapter 789, Oregon Laws 2015, provides:

Sec. 3. Notwithstanding the term of office specified in section 1 of this 2015 Act [413.270 (Advisory council)], of the members first appointed to the Palliative Care and Quality of Life Interdisciplinary Advisory Council:

(1) Three shall serve for terms ending December 31, 2017.

(2) Three shall serve for terms ending December 31, 2018.

(3) Three shall serve for terms ending December 31, 2019. [2015 c.789 §3]

413.271 Palliative care information and resources

(1) The Oregon Health Authority shall publish on its website information and resources, including links to external resources, about palliative care. This may include, but is not limited to:

(a) Continuing educational opportunities for health care providers;
(b) Information about palliative care delivery in the home and in primary, secondary and tertiary care facilities;
(c) Best practices for and cultural competency in the delivery of palliative care;
(d) Consumer education materials; and
(e) Referral information for culturally competent palliative care.

(2) The authority shall consult with the Palliative Care and Quality of Life Interdisciplinary Advisory Council in carrying out this section. [2015 c.789 §4]

Note: See first note under 413.270 (Advisory council).

Palliative Care and Quality of Life Interdisciplinary Advisory Council

2015 Oregon Revised Statutes

413.273 Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities

(1) As used in this section and ORS 413.270 (Advisory council) and 413.271 (Palliative care information and resources):

(a) Appropriate means consistent with applicable legal, health and professional standards, a patients clinical and other circumstances, and the patients known wishes and beliefs.

(b) Health facility includes:

(A) Hospitals and long term care facilities licensed under ORS 441.025 (License issuance); and

(B) Residential facilities licensed under ORS 443.415 (License applications).

(c) Medical care means professional services for a patient that are provided, requested or supervised by a physician, nurse practitioner or physician assistant.

(d)(A) Palliative care means patient-centered and family-centered medical care that optimizes a patients quality of life by anticipating, preventing and treating the suffering caused by serious illness and involves addressing the patients physical, social and spiritual needs and facilitating the patients autonomy, access to information and choice.

(B) Palliative care includes, but is not limited to:

(i) Discussing a patients goals for treatment;

(ii) Discussing the treatment options that are appropriate for the patient; and

(iii) Comprehensive pain and symptom management.

(e) Serious illness means any illness, physical injury or condition that substantially impairs a patients quality of life for more than a short period of time.

(2) A health facility shall:

(a) Establish a system for identifying patients or residents who could benefit from palliative care;

(b) Provide information to patients, residents and their families about palliative care; and

(c) Coordinate with a patients or residents primary care provider, if practicable, to facilitate the access of patients and residents with serious illnesses to appropriate palliative care. [2015 c.789 §5]

Note: See first note under 413.270 (Advisory council).