18101602D

SENATE BILL NO. 222

Offered January 10, 2018

Prefiled January 3, 2018

A BILL to amend and reenact §§ 32.1-127 and 54.1-2990 of the Code of Virginia, relating to medically or ethically inappropriate care not required.

Patron—Edwards

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-127 and 54.1-2990 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities. For purposes of this paragraph, facilities in which five or more first trimester abortions per month are performed shall be classified as a category of "hospital";

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition,

and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is a registered sex offender, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or

resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.); ~~and~~

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that (i) requires, for any refusal to admit a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and (ii) prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician*; and*

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, provided that the patient or his agent, the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

§ 54.1-2990. Medically unnecessary health care not required; procedure when physician refuses to comply with an advance directive or a designated person's health care decision; mercy killing or euthanasia prohibited.

A. *As used in this section:*

"Health care provider" has the same meaning as in § 8.01-581.1.

"Life-sustaining treatment" means any ongoing health care that utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function, including hydration, nutrition, maintenance medication, and cardiopulmonary resuscitation.

B. Nothing in this article shall be construed to require a physician to prescribe or render health care to a patient that the physician determines to be medically or ethically inappropriate. ~~However, in such a case, if the physician's~~ *A determination of the medical or ethical inappropriateness of proposed health*

care shall be based solely on the patient's medical condition and not on the patient's age or other demographic status, disability, or diagnosis of persistent vegetative state, except to the extent that such factors relate to the patient's medical condition.

In cases in which a physician's determination *that proposed health care, including life-sustaining treatment, is medically or ethically inappropriate* is contrary to the request of the patient, the terms of a patient's advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order, the physician *or his designee* shall *document the physician's determination in the patient's medical record,* make a reasonable effort to inform the patient or the patient's agent or person with decision-making authority pursuant to § 54.1-2986 of such determination and the reasons ~~for the determination~~ *therefor in writing, and provide a copy of the hospital's written policies regarding review of decisions regarding the medical or ethical appropriateness of proposed health care established pursuant to subdivision B 21 of § 32.1-127.*

If the conflict remains unresolved, the physician shall make a reasonable effort to transfer the patient to another physician ~~who~~ *or facility that* is willing to comply with the request of the patient, the terms of the advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order *and shall cooperate in transferring the patient to the physician or facility identified*. The physician shall provide the patient or his agent or person with decision-making authority pursuant to § 54.1-2986 a reasonable time of not less than ~~fourteen~~ *14* days *after the date on which the decision regarding the medical or ethical inappropriateness of the proposed treatment is documented in the patient's medical record in accordance with the hospital's written policy developed pursuant to subdivision B 21 of § 32.1-127* to effect such transfer. During this period, *(i)* the physician shall continue to provide any life-sustaining ~~care~~ *treatment* to the patient ~~which~~ *that* is reasonably available to such physician, as requested by the patient or his agent or person with decision-making authority pursuant to § 54.1-2986*, and (ii) the hospital in which the patient is receiving life-sustaining treatment shall facilitate prompt access to the patient's medical record pursuant to § 32.1-127.1:03*.

If, at the end of the 14-day period, the conflict remains unresolved despite compliance with the hospital's written policy established pursuant to subdivision B 21 of § 32.1-127 and the physician has been unable to identify another physician or facility willing to provide the care requested by the patient, the terms of the advance directive, or the decision of the agent or person authorized to make decisions pursuant to § 54.1-2986 to which to transfer the patient despite reasonable efforts, the physician may cease to provide the treatment that the physician has determined to be medically or ethically inappropriate. However, artificial nutrition and hydration may be withdrawn or withheld only if, on the basis of physician's reasonable medical judgment, providing such artificial nutrition and hydration would (a) hasten the patient's death, (b) be harmful or medically ineffective in prolonging life, or (c) be contrary to the clearly documented wishes of the patient, the terms of the patient's advance directive, or the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986 regarding the withholding of artificial nutrition or hydration. In all cases, care directed toward the patient's pain and comfort shall be provided.

~~B. For purposes of this section, "life-sustaining care" means any ongoing health care that utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, including hydration, nutrition, maintenance medication, and cardiopulmonary resuscitation.~~

C. Nothing in this section shall require the provision of health care that the physician is physically or legally unable to provide~~,~~ or health care that the physician is physically or legally unable to provide without thereby denying the same health care to another patient.

D. Nothing in this article shall be construed to condone, authorize, or approve mercy killing or euthanasia~~,~~ or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

E. A health care provider who complies with the requirements of this section shall be presumed to have complied with the standard of care set forth in § 8.01-581.20, absent clear and convincing evidence of gross negligence or willful misconduct, and shall not be subject to criminal prosecution or disciplinary action related to actions taken or not taken in accordance with this section, absent gross negligence or willful misconduct. Any person who provides information to any medical review committee reviewing the medical and ethical appropriateness of the proposed health care in accordance with the provisions of this section and the policy established pursuant to subdivision B 21 of § 32.1-127 or who makes any finding, opinion, or conclusion as part of such medical review committee shall be immune from civil liability for any act done for, or any utterance or communication made to, such medical review committee unless such act, utterance, or communication was the result of gross negligence or willful misconduct.