HOUSE BILL 214

J1 7lr1055

By: **Delegates Morhaim and Frush**
Introduced and read first time: January 29, 2007
Assigned to: Health and Government Operations

Committee Report: Favorable
House action: Adopted
Read second time: February 14, 2007

CHAPTER _____

AN ACT concerning

Health Care Decisions Act – "Patient's Plan of Care" Form – Renaming

FOR the purpose of renaming the "Patient's Plan of Care" form under the Health Care Decisions Act to be the "Instructions on Current Life–Sustaining Treatment Options" form; and generally relating to the renaming of the "Patient's Plan of Care" form.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 5–602(f), 5–608.1, and 19–344(f)(5)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 5–619(b)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)
(As enacted by Chapter 223 of the Acts of the General Assembly of 2006)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

5–602.

(f) (1) It shall be the responsibility of the declarant to notify the attending physician that an advance directive has been made. In the event the declarant becomes comatose, incompetent, or otherwise incapable of communication, any other person may notify the physician of the existence of an advance directive.

(2) An attending physician who is notified of the existence of the advance directive shall promptly:

(i) If the advance directive is written, make the advance directive or a copy of the advance directive a part of the declarant's medical records; or

(ii) If the advance directive is oral, make the substance of the advance directive, including the date the advance directive was made and the name of the attending physician, a part of the declarant's medical records.

(3) If the care of a declarant is transferred from one health care provider to another, the transferring health care provider may prepare **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form in accordance with § 5–608.1 of this subtitle.

(4) If the transferring health care provider prepares **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form in accordance with § 5–608.1 of this subtitle, the transferring health care provider shall:

(i) Take reasonable steps to ensure that the **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form is consistent with any applicable decision stated in the advance directive of a declarant; and

(ii) Transmit the **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form to the receiving health care provider simultaneously with the transfer of the declarant.

5–608.1.

(a) The Office of the Attorney General shall develop **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form suitable for summarizing the plan of care for an individual, including the aspects of the plan of care related to:

(1) The use of life–sustaining procedures; and

(2) Transfer to a hospital from a nonhospital setting.

(b) The **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form is voluntary and shall be consistent with:

(1) The decisions of:

(i) The patient if the patient is a competent individual; or

(ii) If the patient is incapable of making an informed decision, a health care agent or surrogate decision maker as authorized by this subtitle; and

(2) Any advance directive of the patient if the patient is incapable of making an informed decision.

(c) The **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form:

(1) May be completed by a health care provider under the direction of an attending physician;

(2) If the attending physician has a reasonable basis to believe that the **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form satisfies the requirements of subsection (b) of this section, shall be signed by the attending physician;

(3) Shall be signed by:

(i) The patient if the patient is a competent individual; or

(ii) If the patient is incapable of making an informed decision, a health care agent or surrogate decision maker as authorized by this subtitle;

(4) If signed by the patient in accordance with item (3)(i) of this subsection, shall include contact information for the patient's health care agent;

(5) If signed by a health care agent or surrogate decision maker in accordance with item (3)(ii) of this subsection, shall include contact information for the health care agent or surrogate decision maker;

(6) Shall be dated;

(7) Shall include a statement that the form may be reviewed, modified, or rescinded at any time;

(8) Shall designate under which conditions the form must be reviewed or modified, including promptly after the patient becomes incapable of making an informed decision; and

(9) Shall contain a conspicuous statement that the original form shall accompany the individual when the individual is transferred to another health care provider or discharged.

(d) A health care provider shall review any **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form received from another health care provider as part of the process of establishing a plan of care for an individual.

(e) The Office of the Attorney General, in developing the **[**"Patient's Plan of Care"**]** **"INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form in accordance with subsection (a) of this section, shall consult with:

(1) The Department;

(2) Religious groups and institutions with an interest in end–of–life care;

(3) One or more representatives from the community of individuals with disabilities; and

(4) Any other group the Office of the Attorney General identifies as appropriate for consultation.

5–619.

(b) (1) "Advance directive" has the meaning stated in § 5–601 of this subtitle.

(2) "Advance directive" includes **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form developed under § 5–608.1 of this subtitle.

19–344.

(f) (5) (i) A facility shall offer a resident, upon admission, the opportunity for the preparation of **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form in accordance with § 5–608.1 of this article.

(ii) If a facility prepares **[**a "Patient's Plan of Care"**]** **AN "INSTRUCTIONS ON CURRENT LIFE–SUSTAINING TREATMENT OPTIONS"** form in accordance with subparagraph (i) of this paragraph, the form shall remain conspicuously in the front of a resident's medical records.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2007.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.