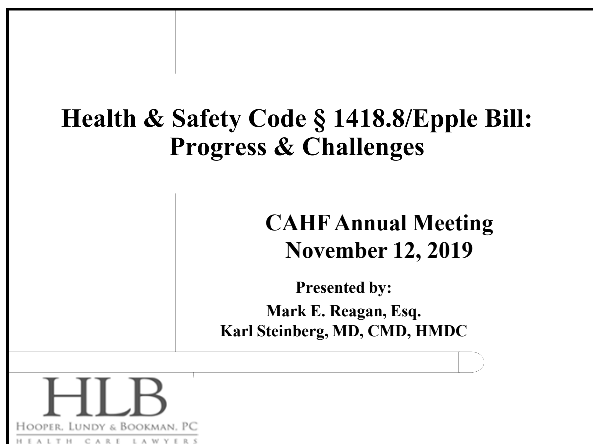

Overview

- Health & Safety Code § 1418.8 – Epple Bill (the Statute)
- The Court of Appeal Ruling in *CANHR v. Chapman/Smith* (Additions to the Statute)
- Challenges to Implementation
- Preparation and Planning
- Update on Superior Court Proceedings

Health and Safety Code § 1418.8

- CA law governing consent in SNFs
  - Proposed treatment or procedure. (Title 22, CCR § 72527(a)(4))
  - Administration of psychotherapeutic drugs, physical restrictions or prolonged use of a device that may lead to the inability to regain use of a normal bodily function. (Title 22, CCR § 72527(a)(5))
- Failure to obtain valid consent prior to initiating non-emergency treatment may constitute a battery [*Cobbs v. Grant* (1972) 8 Cal.3d 230]

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Health & Safety Code § 1418.8 – Epple Bill (The Statute) (1992)

- Health and Safety Code § 1418.8 allows the SNF IDTs to authorize medical treatment ordered by a physician for an incapacitated resident that requires informed consent if there is no:
  - Available family member willing to make health care decisions; or
  - Conservator of the person, or
  - Other person with legal authority to make health care decisions

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Interdisciplinary Team Process

- Attending physician determines lack of capacity.
  - If not clear, can obtain mental health consultation
- Attending physician determines that there is no person with legal authority to make health care decisions or no person who is willing to serve in a decision-making capacity (e.g., power of attorney, guardian, conservator or kin).
  - Facility should assist in looking for a surrogate

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Interdisciplinary Team Process

- Except in an emergency, facility holds interdisciplinary team review of the medical intervention that includes:
  - Review of physician's patient assessment;
  - Reason for proposed medical intervention;
  - Discussion of patient's desires if known (interviews with patient, family members, friends, review of medical records);

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Interdisciplinary Team Process

- Review of type of medical intervention;
- Probable impact on patient's condition with/without medical intervention;
- Alternative medical intervention considered or utilized and reason for discontinuance or inappropriateness; and
- Evaluation by interdisciplinary team of prescribed medical intervention ***at least quarterly*** and upon significant change in patient's medical condition;
- Also important to discuss any issues with "fluctuating" capacity.

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Interdisciplinary Team Process

- IDT must oversee care using team approach:
  - Participants include attending physician, RN with patient responsibility; and other appropriate staff depending on patient's needs
  - Must include a patient representative "where practicable" (e.g., family member or friend who won't/can't take full responsibility for health care decisions)
    [Note: Court of Appeal construed this as mandatory]

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Interdisciplinary Team Process

- All determinations and the reasons must be documented in the medical record.
- Not subject to administrative sanction if the physician or other health care provider believes in good faith that actions consistent with Health and Safety Code § 1418.8, desires of patient if known, or the best interests of the patient.

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Interdisciplinary Team Process

- Before proceeding with the intervention, facility must provide oral and written notice to the resident and written notice to "at least one competent person whose interests are aligned with the resident." [**Note: new requirement from Court of Appeal.]**

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Interdisciplinary Team Process

- "One competent person who might be willing and able to discuss the meaning of the notice to the resident."
- "The patient representative or the local ombudsman provided for in Section 1418.8, subdivision (e) and (a) could, for instance, receive such notice on the resident's behalf."

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Interdisciplinary Team Process

- "Anyone recognized by the Probate Code to pursue judicial relief for the resident, even if they are not available to serve as a surrogate decisionmaker, might suffice."
- Referenced Probate Code § 3203 – some likely apply
  - Spouse, relative, friend, or "interested person"
  - Public guardian or county officer designated by local Board of Supervisors

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Health and Safety Code § 1418.8

- Specific Circumstances
  - All treatments and procedures (other than routine nursing care)
  - Psychotherapeutic Medications (See CDPH Anti-Psychotic Tool)
  - End-of-Life Care
    - Hospice Referrals/Comfort Care
    - Potentially Life-Sustaining Treatment/DNR orders
- Decisions made under § 1418.8 to be revisited quarterly by IDT and additional notice if <u>new</u> interventions
  - Includes increase in dosage of psychotropics

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Related Patients Rights Provision

- Cal. Code Regs, Title 22, § 72527(c)
  - If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. <u>The patient's incapacity shall be determined</u> by a court in accordance with state law or <u>by the patient's physician's unless the physician's determination is **disputed** by the patient or patient's representative.</u>

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Probate Code Process

- In the absence of § 1418.8, only option is to utilize Probate Code judicial process.
- Probate Code § 3201 provides for a process to gain judicial approval of proposed treatments and providers for incapacitated, unbefriended patients.
- Challenges from Probate Code § 3201 process from a timeliness and resource perspective.
- Rarely used in clinical practice, especially in nursing homes

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Challenges to the IDT Process

- CANHR Litigation Against CDPH.
- Attacks on IDT Process/Health and Safety Code § 1418.8.
- Found unconstitutional by Alameda Superior Court in 2015.
  - Lack of notice that resident found to lack capacity
  - Cannot be used for antipsychotics (other psych meds OK)
  - Cannot be used for "withdrawing or withholding life-sustaining treatment" (but hospice OK)

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Challenges to the IDT Process

- Reversed by Court of Appeal July 2019 but added several new mandates for the use of § 1418.8.
- If mandates cannot be met, the proposed treatments/procedures cannot be provided.
- Applies to both existing and new residents.
- Transfer to hospital?

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Court of Appeal Decision

- Requires SNF to do more than has ever been the case.
- No medical intervention is precluded from coverage of Health & Safety Code § 1418.8/Epple Bill, including the use of antipsychotics, hospice and comfort care (withdrawing/withholding potentially life-sustaining treatment).

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New Requirements on Capacity and Applicability of Health & Safety Code § 1418.8/Epple Bill

- Notice must be given orally and in writing to the resident, and in writing to at least one competent person whose interests are aligned with the resident
  - Any determination of incapacity – notice must be given to the resident immediately following a physician's determination of incapacity with an opportunity for judicial review before treatment begins

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New Requirements on Capacity and Applicability of Health & Safety Code § 1418.8/Epple Bill

- Any determination that no surrogate decision-maker for the resident is available
- Any medical intervention proposed by the attending physician
- The fact that a decision will be made by the IDT on a proposed medical intervention
- The resident's right to have a patient representative participate in IDT decision-making
- The resident's right to judicial review of IDT decisions under § 1418.8, subdivision.

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New Requirements on Capacity and Applicability of Health & Safety Code § 1418.8/Epple Bill

- Except in an emergency, the IDT's decision on implementing treatment must be postponed until after notice has been given and the resident has had an opportunity to seek judicial review
  - Not specified as to how much time to wait
  - Likely to be construed to be a reasonable amount of time under the circumstances

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New Requirements on Capacity and Applicability of Health & Safety Code § 1418.8/Epple Bill

- Other than the resident, to whom should the written notice be directed?
  - Family member or friend? Patient representative?
  - Long Term Care Ombudsman.
- Development of standard form? CAHF model?

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New Mandates for Patient Representatives

- Every IDT must include a patient representative. The representative must be:
  - Unaffiliated with the nursing home
  - Not in the employ of the nursing home
  - Independent of nursing home staff
  - Able to take responsibility for understanding and articulating the best approximation possible of the patient's perspective

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New Mandates for Patient Representatives

- "[T]he role of the patient representative is to take responsibility for understanding and articulating the best approximation possible of the patient's perspective."
- "Where a patient, although incompetent to make medical decisions, nonetheless is able to articulate coherent ideas about his or her current circumstances, it is the task of the patient representative to bring that information into the IDT's decision-making process." *(emphasis added)*

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New Requirements for Patient Representatives

- "Where the patient's attitudes and personal background are not known, the patient representative provides, at minimum, the perspective of an individual unaffiliated with the nursing home, who can be vigilant as to when judicial intervention is required." *(emphasis added)*

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New Requirements for Patient Representatives

- "The representative does not perform the role of the surrogate and the resident is provided virtual representation through the IDT as a body." *(emphasis added)*
- "We consider it necessary to have a patient representative participate on *every* IDT as an element of the due process." *(emphasis added)*

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New Requirements for Patient Representatives

- ". . . the nursing home must designate some person not employed by the nursing home – and thus independent of nursing home staff – to act as patient representative." *(emphasis added)*
- "Where no appropriate friend or family member is identified, the nursing home must enlist the local ombudsman, public guardian or equivalent county officer to serve (See Prob. Code, § 3203)." *(emphasis added)*
  - *Not clear if anyone outside these parameters can serve*

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New Requirements for Patient Representatives

- "Where a patient, although incompetent to make medical decisions, nonetheless is able to articulate coherent ideas about his or her current circumstances, it is the task of the patient representative to bring that information into the IDT's decision-making process."

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Challenges to Implementation

- New requirements apply to all residents covered by Health and Safety Code § 1418.8/Epple Bill – not just new residents!
- Written and verbal notice to resident/representative and other individual "whose interests are aligned with the resident"
  - Development of forms?
  - To whom should the notice be sent?
    - Family member or friend? Patient representative?
    - Long-Term Care Ombudsman?

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Challenges to Implementation

- Reasonable period of time to wait and see if the judicial review initiated – what does that mean?
- Examples.

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Challenges to Patient Representation Requirement

- Is there a family member or friend with a prior relationship?
- If not, who can function in that capacity?
- Who may qualify as a "friend"?

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Challenges to Patient Representation Requirement

- Long-Term Ombudsman has refused to serve
  - Sent letter on September 16th stating that federal law precludes functioning as a "surrogate" – we disagree
  - Court of Appeal stated not a "surrogacy" situation
- Public Guardian has indicated it does not have resources to function as patient representatives
- Other options?

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Challenges to Patient Representation Requirement

- CDPH may create temporary funding stream (2 - 3 years) to "stand up" the system
  - Federal CMP Fund
  - May still take 4-6 months

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Challenges to Patient Representation Requirement

- Are there immediate solutions to this problem?
- Are there "friends" from the religious or non-profit world willing to serve?
- Local hospital bioethics committee/community representative?
- What are the privacy/confidentiality ramifications of that?

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Any Challenges/Obstacles Preferred by Either HIPAA or CMIA?

- Personal Health Information ("PHI") may be used and disclosed under HIPAA for treatment purposes.
- The disclosure and use of an incapacitated patient's health information by the IDT, including the patient representative, would qualify for treatment purposes under HIPAA.

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Any Challenges/Obstacles Preferred by Either HIPAA or CMIA?

- "Treatment means the provision, coordination, or management of health care and related services by one or more health care providers <u>with a third party</u>, consultation between health care providers relating to a patient, or the referral of a patient for health care from one health care provider to another." *(emphasis added)*

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Any Challenges/Obstacles Preferred by Either HIPAA or CMIA?

- Confidentiality of California Medical Information Act ("CMIA") allows disclosure of medical information under California law to providers of health care, contractors, or other health care professionals or facilities for purposes of treatment of the patient.

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Any Challenges/Obstacles Preferred by Either HIPAA or CMIA?

- CMIA permits medical information to be disclosed when disclosure is specifically authorized by law.
- Also applicable to HIPAA.
- There are also definitions of "personal representative" (Probate Code § 58) or "patient representative" (Health & Safety Code § 123105(a), which may also be helpful.

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Medically Ineffective Care

- Medically ineffective, medically non-beneficial, formerly called "futile" treatment/care
- Probate Code § 4735 provides that:

  "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

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Medically Ineffective Care

- Applicable to Epple population?
- If so, how?
- Examples.
  - Tube feeding in residents with advanced dementia
  - CPR in frail elders or those with terminal illness

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Practicalities

- Be very cautious
  - Admissions – is there a decisionmaker?
  - Compliance – how much time is reasonable?
  - Is there a patient representative?
  - Risk of abuse litigation under Elder and Dependent Adult Civil Protection Act. (Welfare & Institutions Code § 15657. *et seq.*)
- But to the extent possible, do what's right by your resident

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Are You Prepared? Taking the Necessary Steps

- Undertake all required steps for existing and prospective residents covered by Health and Safety Code §1418.8/Epple Bill
- Identify before admission if the patient has an advance directive, and if so, get a copy of it.

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Are You Prepared? Taking the Necessary Steps

- If no advance directive, strongly encourage and assist potential resident to formulate one (yes, call in the ombudsman) – especially for long-term residents
- Make a concerted effort to find a decisionmaker who is willing to speak for the resident before resorting to § 1418.8.
- If none, it will be necessary to locate a patient representative.

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Are You Prepared? Taking the Necessary Steps

- Identify if the resident has capacity or lacks capacity to make health care decisions, per physician. Make sure it is clearly documented in the medical record and known to facility staff.
  - Update periodically – make sure physician documents initial status and changes in decisional capacity
  - Does the resident have "fluctuating capacity"?
  - Remember: Capacity may vary by complexity of the decision being considered, variability in resident cognition (good days and bad days with dementia)

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Are You Prepared? Taking the Necessary Steps

- Maintain open lines of communication with the resident and any family members/friends concerning consent issues.
- If resident has capacity, discuss end-of-life wishes in detail and document discussions—and revisit these discussions regularly

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Recommendations

- Address any and all consent issues with the attending physician and/or medical director; obtain mental health consultation when needed.
- Draft policies and procedures to ensure compliance with laws/regulatory requirements.
- When a resident has early dementia but still has capacity, consider executing a **POLST** even if resident not otherwise **POLST**-appropriate (in the last year of life, etc.).

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Recommendations

- Written notice – form development?
- Appointment of patient representative – form development?
- IDT proceedings – form development?

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Recommendations

- Make sure that compliance with Interdisciplinary Team Meetings held pursuant to Health and Safety Code § 1418.8 (or alternative approach) is well documented in the medical record.
  - Consider drafting a form to memorialize the proceedings of the meeting.
  - Include a resident representative on IDT (now mandatory)
  - Recap all IDT treatment decisions quarterly
  - Consider having two MDs present when significant treatment decisions being discussed.

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Recommendations

- Make sure to notify resident representative when a resident is deemed to lack capacity if Epple is going to be invoked (before actually convening Epple IDT).
- Continually educate staff on policies and procedures regarding consent issues.
- Create and implement a process for monitoring compliance with consent issues.
- Consult legal counsel when necessary.
- Bioethics resources may also be helpful.

- **STAY TUNED!!**

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Thank You!

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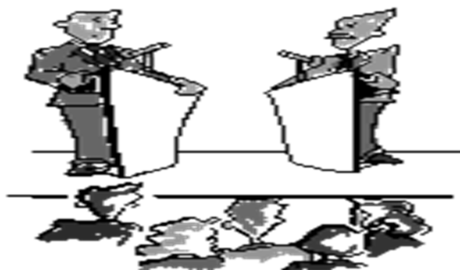
QUESTIONS?



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