CHAPTER 218
(CORRECTED COPY)

AN ACT concerning Practitioner Orders for Life-Sustaining Treatment forms, amending P.L.2011, c.145 and P.L.2014, c.68, and supplementing Title 45 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 6 of P.L.2014, c.68 (C.26:2H-5.29) is amended to read as follows:

C.26:2H-5.29 Construction of act relative to advance care directive.

6. a. Nothing in this act shall be construed to interfere with the rights of an agent operating under a valid advance directive pursuant to the provisions of the "New Jersey Advance Directives for Health Care Act," P.L.1991, c.201 (C.26:2H-53 et al.), the "New Jersey Advance Directives for Mental Health Care Act," P.L.2005, c.233 (C.26:2H-102 et al.), or the “Practitioner Orders for Life-Sustaining Treatment Act," P.L.2011, c.145 (C.26:2H-129 et al.).

b. A patient may designate a caregiver in an advance directive.

2. Section 1 of P.L.2011, c.145 (C.26:2H-129) is amended to read as follows:

C.26:2H-129 Short title.

1. Sections 1 through 13 of this act shall be known and may be cited as the “Practitioner Orders for Life-Sustaining Treatment Act."

3. Section 2 of P.L.2011, c.145 (C.26:2H-130) is amended to read as follows:

C.26:2H-130 Findings, declarations to practitioner orders for life-sustaining treatment (POLST) forms.

2. The Legislature finds and declares that:

a. Pursuant to the "New Jersey Advance Directives for Health Care Act," P.L.1991, c.201 (C.26:2H-53 et seq.), this State has statutorily recognized the right of an adult with decision-making capacity to plan ahead for health care decisions through the execution of advance directives and designate a surrogate decision-maker, and to have the wishes expressed in those documents respected, subject to certain limitations, in order to ensure that the right to control decisions about one's own health care is not lost if a patient loses decision-making capacity and is no longer able to participate actively in making his own health care decisions;

b. The Physician Orders for Life-Sustaining Treatment or Practitioner Orders for Life-Sustaining Treatment, or POLST, form complements an advance directive by converting a person's wishes regarding life-sustaining treatment, such as those set forth in an advance directive, into a medical order;

c. The POLST form: contains immediately actionable, signed medical orders on a standardized form; includes medical orders that address a range of life-sustaining interventions as well as the patient's preferred intensity of treatment for each intervention; is typically a brightly colored, clearly identifiable form; and is recognized and honored across various health care settings;

d. The use of a POLST form is particularly appropriate for persons who have a compromised medical condition or a terminal illness, and the experience in other states has

shown that the use of the POLST form helps these patients to have their health care preferences honored by health care providers;

e. The use of POLST forms can overcome many of the problems associated with advance directives, which in many cases are designed simply to name an individual to make health care decisions for the patient if the latter becomes incapacitated or otherwise lack specificity in regard to the patient's health care preferences, and are often locked away in file drawers or safe deposit boxes and unavailable to health care providers when the need arises to ensure that the patient's wishes are followed;

f. A completed POLST form is signed by, and more readily available than an advance directive to, the patient's attending physician, physician assistant, or advanced practice nurse, and provides a specific and detailed set of instructions for a health care professional or health care institution to follow in regard to the patient's preference for the use of various medical interventions;

g. To date, at least the following states, or communities within these states, have established programs providing for the use of the POLST form that have been endorsed by the National POLST Paradigm Task Force or are in the process of developing such programs: Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming; and

h. The right and preference of New Jerseyans to have their health care preferences respected would be better served by the use of the POLST form in this State to augment the use of advance directives, and the enactment of this act will conduce to that end.

4. Section 3 of P.L.2011, c.145 (C.26:2H-131) is amended to read as follows:

C.26:2H-131 Definitions relative to POLST forms.

3. As used in sections 1 through 12 of this act:

"Advance directive" means an advance directive for health care as defined in section 3 of P.L.1991, c.201 (C.26:2H-55).

"Advanced practice nurse" or "APN" means a person who is certified as an advanced practice nurse pursuant to P.L.1991, c.377 (C.45:11-45 et seq.).

"Commissioner" means the Commissioner of Health.

"Decision-making capacity" means a patient's ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of that decision, and alternatives to any proposed health care, and to reach an informed decision.

"Department" means the Department of Health.

"Emergency care" means the use of resuscitative measures and other immediate treatment provided in response to a sudden, acute, and unanticipated medical crisis in order to avoid injury, impairment, or death.

"Emergency care provider" means an emergency medical technician, paramedic, or member of a first aid, ambulance, or rescue squad.

"Health care decision" means a decision to accept, withdraw, or refuse a treatment, service, or procedure used to diagnose, treat, or care for a person's physical or mental condition, including life-sustaining treatment.

"Health care institution" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a psychiatric facility as defined in section 2 of P.L.1987, c.116 (C.30:4-27.2), or a State developmental center listed in R.S.30:1-7.

"Health care professional" means a health care professional who is licensed or otherwise authorized to practice a health care profession pursuant to Title 45 or 52 of the Revised Statutes and is currently engaged in that practice.

"Life-sustaining treatment" means the use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery, or therapy that uses mechanical or other artificial means to sustain, restore, or supplant a vital bodily function, and thereby increase the expected life span of a patient.

"Patient" means a person who is under the care of a physician, physician assistant, or APN.

"Patient's representative" means an individual who is designated by a patient or otherwise authorized under law to make health care decisions on the patient's behalf if the patient lacks decision-making capacity.

"Physician" means a person who is licensed to practice medicine and surgery pursuant to chapter 9 of Title 45 of the Revised Statutes.

“Physician Assistant” means a health professional who meets the qualifications under P.L.1991, c.378 (C.45:9-27.10 et seq.) and holds a current, valid license issued pursuant to section 4 of P.L.1991, c.378 (C.45:9-27.13).

" Practitioner Orders for Life-Sustaining Treatment form" or "POLST form" means a standardized printed document that is uniquely identifiable and has a uniform color, which:

a. is recommended for use on a voluntary basis by patients who have advanced chronic progressive illness or a life expectancy of less than five years, or who otherwise wish to further define their preferences for health care;

b. does not qualify as an advance directive;

c. is not valid unless it meets the requirements for a completed POLST form as set forth in this act;

d. provides a means by which to indicate whether the patient has made an anatomical gift pursuant to P.L.2008, c.50 (C.26:6-77 et al.);

e. is intended to provide direction to emergency care personnel regarding the use of emergency care, and to a health care professional regarding the use of life-sustaining treatment, with respect to the patient, by indicating the patient's preference concerning the use of specified interventions and the intensity of treatment for each intervention;

f. is intended to accompany the patient, and to be honored by all personnel attending the patient, across the full range of possible health care settings, including the patient's home, a health care institution, or otherwise at the scene of a medical emergency; and

g. may be modified or revoked at any time by a patient with decision-making capacity or the patient's representative in accordance with the provisions of section 7 of this act.

"Resuscitative measures" means cardiopulmonary resuscitation provided in the event that a patient suffers a cardiac or respiratory arrest.

5. Section 4 of P.L.2011, c.145 (C.26:2H-132) is amended to read as follows:

C.26:2H-132 Encouragement of public awareness, understanding of POLST form.

4. It shall be the public policy of this State to encourage public awareness and understanding of the Practitioner Orders for Life-Sustaining Treatment form as a means of enabling patients in this State to indicate their preferences for health care through the use of

a completed POLST form as a complementary measure to the use of an advance directive, or in lieu of an advance directive if the patient has not executed such a document, in accordance with the provisions of this act.

6. Section 6 of P.L.2011, c.145 (C.26:2H-134) is amended to read as follows:

C.26:2H-134 Treatment of patient in accordance with POLST form.

6. a. A health care professional, health care institution, or emergency care provider shall treat a patient who has a completed POLST form in accordance with the information contained therein, except as otherwise provided in this act.

b. A POLST form shall be deemed to be completed, and therefore valid for the purposes of this act if it:

(1) contains information indicating a patient's health care preferences;

(2) has been voluntarily signed by a patient with decision-making capacity, or by the patient's representative in accordance with the patient's known preferences or in the best interests of the patient;

(3) includes the signature of the patient's attending physician, physician assistant, or APN and the date of that signature; and

(4) meets any other requirements to be deemed valid for the purposes of this act.

c. A document executed in another state, which meets the requirements of this act for a POLST form, shall be deemed to be completed and valid for the purposes of this act to the same extent as a POLST form completed in this State.

7. Section 7 of P.L.2011, c.145 (C.26:2H-135) is amended to read as follows:

C.26:2H-135 Modification, supersedure of POLST form.

7. a. If the goals of care of a patient with a completed POLST form change, the patient's attending physician, physician assistant, or APN may, after conducting an evaluation of the patient and after obtaining informed consent from the patient or, if the patient has lost decision-making capacity, the patient's representative in accordance with subsection d. of this section, issue a new order that modifies or supersedes the completed POLST form consistent with the most current information available about the patient's health status and goals of care.

b. A patient with decision-making capacity, may, at any time, modify or revoke the patient's completed POLST form or otherwise request alternative treatment to the treatment that was ordered on the form.

c. If the orders in a patient's completed POLST form regarding the use of any intervention specified therein conflict with the patient's more recent verbal or written directive to the patient's attending physician, physician assistant, or APN, then the physician, physician assistant, or APN shall honor the more recent directive from the patient in accordance with the provisions of subsection e. of this section.

d. The POLST form shall provide the patient with the choice to authorize the patient's representative to revoke or modify the patient's completed POLST form if the patient loses decision-making capacity. If the patient so authorizes the patient's representative, the patient's representative may, at any time after the patient loses decision-making capacity and after consultation with the patient's attending physician or APN, request the physician, physician assistant, or APN to modify or revoke the completed POLST form, or otherwise request alternative treatment to the treatment that was ordered on the form, as the patient's

representative deems necessary to reflect the patient's health status or goals of care. If the patient does not authorize the patient's representative to revoke or modify the patient's completed POLST form, the patient's representative may not revoke or modify the patient's completed POLST form.

e. A verbal or written request by a patient or the patient's representative to modify or revoke a patient's completed POLST form, in accordance with the provisions of this section, shall be effectuated once the patient's attending physician, physician assistant, or APN has signed the POLST form attesting to that request for modification or revocation.

8. Section 8 of P.L.2011, c.145 (C.26:2H-136) is amended to read as follows:

C.26:2H-136 Procedure in event of disagreement.

8. a. In the event of a disagreement among the patient, the patient's representative, and the patient's attending physician, physician assistant, or APN concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of a completed POLST form to the patient's course of treatment, the parties:

(1) may seek to resolve the disagreement by means of procedures and practices established by the health care institution, including, but not limited to, consultation with an institutional ethics committee, or with a person designated by the health care institution for this purpose; or

(2) may seek resolution by a court of competent jurisdiction.

b. A health care professional involved in the patient's care, other than the attending physician, physician assistant, or APN, or an administrator of a health care institution may also seek to resolve a disagreement concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of a completed POLST form to the patient's course of treatment in the same manner as set forth in subsection a. of this section.

C.45:9-27.25b Continuing medication education to include programs on end-of-life care; rules, regulations.

9. a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician assistant, as a condition of biennial renewal pursuant to section 4 of P.L.1991, c.378 (C.45:9-27.13), include two credits of educational programs on topics related to end-of-life care. The continuing medical education requirement in this subsection shall be subject to the provisions of section 16 of P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

b. The State Board of Medical Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of this section.

10. This act shall take effect immediately.

Approved August 9, 2019.