



**Report of the Palliative Care, End-of-Life Care,  
And Pain Management Study Committee  
January 2009**

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*Senator Ed Flanagan*

*Senator Hinda Miller*

*Representative Bill Frank, Co-Chair*

*Representative Sandy Haas*

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***Part I. Statutory Authority and Responsibilities of End-of-Life Care,  
Palliative Care, and Pain Management Committee***

During the 2008 session of the Vermont General Assembly, the legislature enacted Act No. 166, creating a legislative study committee on end-of-life care, palliative care, and pain management. It required the study committee to collaborate with several state agencies and stakeholder groups to discuss and make recommendations on legislative and nonlegislative solutions for improving palliative care, end-of-life care, pain management, and access to these services for children. The act directed the study committee to consider (1) recommendations for improving ongoing coordination of activities based on available data and studies from existing sources; (2) how best to protect the interests of people with a terminal illness or who are receiving hospice care or suffering chronic pain; (3) how to advance the goal of improving health care services for children with painful or life-threatening medical conditions; (4) recommendations for improving methods of informing consumers about options in Vermont for end-of-life care, palliative care, and management of chronic pain, and about the importance of having an advance directive; and (5) any other issue the study committee determined to be necessary and appropriate.

## *Part II. Introduction*

Studies show that people want quality in dying as well as in life. A 2007 study conducted by Dr. Ira Byock, Director of the Palliative Care Service at Dartmouth Hitchcock Memorial Hospital, and his colleagues found that 96% of New Hampshire residents surveyed said it is very or extremely important to have clear and honest communication with doctors and health care providers. Ninety-four percent want their dignity respected, and 85% want to have their choices honored. On the other end of the spectrum, a mere 7% of survey participants said it was very or extremely important to be kept alive as long as possible. Asked where they would like to be when they die, 71% of the New Hampshire residents surveyed said they want to be at home, 15% in a hospice, 7% at the home of a friend or family member, 4% in an assisted living facility, and less than 1% in a hospital. Not one person chose a nursing home as the preferred place of death. A poll of Vermonters financed by the Cabot Creamery Cooperative found that 80.8% of Vermonters surveyed would choose to die at home, 0.5% in a hospice, 3.8% at the home of a friend or family member, 2.8% in an assisted living facility, 0.5% in a hospital, and 0.3% in a nursing home. Despite these preferences, however, of the 5,043 Vermonters who died in 2006, 39% died in a hospital, 28% in a nursing home, and 28% at their home or the home of a friend or family member. Information about and timely access and referrals to quality hospice and palliative care can ensure that more Vermont children and adults have satisfying end-of-life experiences.

Hospice and palliative care done well can provide excellent care and satisfaction for patients and their families. While the committee identified a number of areas in which care in Vermont can and should be improved, it also heard testimony from a number of dedicated providers, advocates, patients, and family members about the good work being done across the state. It is the committee's hope that with the implementation of the recommendations contained in this report, all Vermonters will have knowledge of and access to the care to which all are entitled.

### *Part III. Definitions*

As used in this report:

1. “Chronic pain” means an intractable pain state for which the cause of the pain cannot be removed or otherwise treated, and for which no relief or cure has been found. It includes pain continuing beyond the normal recovery time for the type of personal injury that precipitated, triggered, or otherwise predated the pain or pain disproportionate to the type of personal injury that precipitated, triggered or otherwise predated the pain.
2. “End-of-life” means that a patient has a life expectancy of less than one year.
3. “Hospice care” means end-of-life care provided by health care professionals and volunteers who give medical, psychological, social, and spiritual support in a variety of settings. The goal of hospice care is to help people who are dying to live their remaining days in peace, comfort, and dignity, and to support families during the patient’s life and with bereavement.
4. “Pain management” means the assessment of pain and, if appropriate, treatment to ensure the needs of persons who experience problems with pain are met.
5. “Palliative care” means patient- and family-centered care that optimizes quality of life.

## *Part IV. Findings and Recommendations*

### **A. Provider Education**

#### *Findings*

The committee finds that health care professionals in Vermont lack sufficient education and training in the areas of end-of-life care, palliative care, and pain management. There is not enough focus on these topics while students are in school, and Vermont's lack of requirements for continuing education means that most practitioners do not receive subsequent training in these areas. The committee heard testimony that many Vermonters would have acted differently and had better quality at the end of their lives if they had been better informed about their options.

Vermont is one of only six states without any requirement for continuing medical education for physicians. The other states are Colorado, Indiana, Montana, New York, and South Dakota. Vermont also does not require nurses to complete any continuing education, though it is important to note that many hospitals and other institutions impose their own continuing education requirements on the physicians and nurses who wish to practice there. Vermont does require doctors of osteopathy to complete a minimum of 30 hours of continuing education every two years as a condition of license renewal, but does not specify required content other than to require at least 40 percent of the hours to be osteopathic medical education (18 V.S.A. § 1836(c)). It also requires naturopathic physicians to complete continuing education, though the law leaves it up to the director of the Office of Professional Regulation to determine the number of hours, up to 30 in a two-year period (18 V.S.A. § 4130(b)). By rule, the director currently requires naturopathic physicians to complete 30 hours over the two-year renewal period, but specifies that any physician-level continuing medical education program is acceptable for all but those naturopaths with a special endorsement to practice naturopathic childbirth, whose continuing education courses must be presented under the auspices of one or more of a specified list of entities.

The Vermont Board of Pharmacy requires pharmacists to complete at least 30 hours of continuing education every two years and specifies only that "topics and formats of study shall include subject matter designed to maintain the professional competence of pharmacists licensed to practice and to improve their professional skills in order to protect the public health and safety." Vermont also imposes continuing education requirements on acupuncturists, chiropractors, dentists, marriage and family therapists, clinical mental health counselors, midwives, optometrists, psychologists, psychoanalysts, respiratory care practitioners, and clinical social workers. There are no continuing education requirements for physical therapists.

#### *Recommendations:*

1. Direct the Vermont Department of Health to work with the Palliative Care Service at Fletcher Allen Health Care (FAHC) and the licensing boards for physicians,

- osteopaths, naturopaths, nurses, pharmacists, and other health care professionals to determine how best to continue and expand education and training in end-of-life care, palliative care, and pain management for all health care professionals licensed in Vermont and how to turn such training into practice. Instruct them to create a system to identify providers who have and have not completed courses and other training in end-of-life care, palliative care, and pain management, and to institute a system of recordkeeping and accountability. Direct the licensing boards to require participation in programs that have demonstrated effectiveness as a condition of relicensure. Require the department and boards of licensing to begin implementation of the system by January 15, 2010, and to report to the General Assembly by the same date on the system's implementation and projected timeline.
2. By January 15, 2010, require the Vermont Board of Medical Practice to distribute to all health care professionals licensed by the State of Vermont information developed by the Department of Health on options for patients and families in need of end-of-life care, palliative care, and pain management, including the importance of timely and appropriate referrals.
  3. Some members of the study committee believe that continuing medical education, including training in effective palliative care, should be a prerequisite for relicensure of physicians in Vermont.

## **B. Insurance and Other Health Coverage**

### *Finding*

Hospice and palliative care save money and provide better patient care than hospital care for patients at the end of life. The intensity of services provided in hospice and palliative care is lower than in standard hospital care, saving money to patients and insurers while providing increased comfort and quality of life to patients and their families. A 2007 study by Duke University found that hospice care reduced Medicare spending by an average of \$2,309 per person over traditional care. The study also showed that for seven in 10 hospice users, Medicare costs would have been further reduced if hospice had been used for a longer length of time. The patients in the study, which was conducted from 1993 to 2003, had a median length of hospice use of 15 days. The primary author, Duke Professor Don Taylor, reported that the results showed that the patients who used the hospice benefit for the last seven to eight weeks of life maximized cost savings to Medicare while allowing patients and their families to fully experience the benefits of hospice care, including bereavement counseling, palliative care, and respite for care-givers.

While there are few studies documenting the cost effectiveness of palliative and end-of-life care programs, the emerging data is encouraging. A study published earlier this year in the Archives of Internal Medicine analyzed data from eight hospitals with established palliative care programs and found the programs were associated with

significant cost savings. In the study, the palliative care patients who were discharged alive had an adjusted net savings of \$1,696 in direct costs per admission and \$279 in direct costs per day compared to patients receiving usual care. The palliative care patients who died had an adjusted net savings of \$4,908 in direct costs per admission and \$374 in direct costs per day. Much of the savings came from reductions in pharmacy, laboratory, and intensive care unit costs compared to usual care patients. Another study conducted at the Home Health Department of Kaiser Permanente and published in the October 2003 issue of the *Journal of Palliative Medicine* found that patients enrolled in palliative programs were more satisfied with the services they received; had fewer emergency room visits, hospital days, skilled nursing facility days, and physician visits than those in the comparison group; and averaged a 45% decrease in costs as compared to usual care patients. The study findings are consistent with Fletcher Allen Health Care's own internal impact analysis of its palliative care consultation service (PCS), which determined that there was a reduction in the length of hospital stay in the identified patient cohort as a result of the PCS program. There was no effect on overall mortality in these patients.

### ***Recommendation***

1. Require the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) to conduct a study of the costs of hospice and palliative care versus the costs of standard hospital care for patients in the last six to 12 months of life, focusing on the intensity of services provided.
2. Direct the Agency of Human Services to explore improvements to Medicaid hospice and palliative care when renegotiating Vermont's Section 1115 Global Commitment waiver.

### ***Finding***

Insurance and other health coverage for end-of-life care, palliative care, and pain management is insufficient and often inconsistent. Health insurance policies vary in terms of both cost and benefits depending on the plan. For example, in terms of cost, patients must often pay certain out-of-pocket costs (such as co-payments, deductibles, and/or coinsurance) as outlined by their insurance plans. Some insurance plans subject all benefits, including hospice, to a \$5,000 deductible followed by 30% coinsurance, for others, the patient may pay little more than a \$15 office visit co-pay. In terms of benefits, plans may also differ in the services provided, both between insurers and between an individual insurer's plans. The hospice benefit under most plans offered by BlueCross BlueShield of Vermont includes up to 100 hours per month of homemaker services, a service not available under MVP's plans. MVP's Catamount Health plan offers up to 210 days in a preferred hospital or hospice facility; up to two skilled nursing visits per day; up to 100 hours of home health aide visits for personal care services per month; up to five days or 120 hours of continuous care visits in the patient's home per month; up to eight social service visits before and after the patient's death; and up to 72 hours per month of respite care for the patient's family, with the patient responsible for deductibles



and co-insurance. But MVP's Vermont Individual Indemnity Plan specifies only that it "provides benefits" for medically necessary hospital inpatient services, physician services, and home health agency services provided pursuant to the patient's written hospice care plan, and that the patient is responsible for the difference between the provider's charge and MVP's allowable charge for each service.

### ***Recommendations***

Require the Hospice and Palliative Care Council of Vermont or a similar group to:

1. Develop a uniform set of best practices for hospice care, palliative care, and pain management for children and adults;
2. Identify effective insurance models in these areas; and
3. Create benchmarks for insurance coverage for hospice and palliative care and pain management, including alternative and complementary therapies where appropriate.

Once benchmarks have been established, require all health insurance policies sold in Vermont to offer at least the benchmark level of benefits.

### ***Finding***

Children make up less than one-half of one percent of hospice admissions, largely because the two main requirements of the Medicaid hospice benefit were designed for adults. These requirements are that the patient must (1) have less than six months left to live, which effectively excludes pediatric patients with life-limiting but not imminently terminal conditions from receiving interdisciplinary hospital services; and (2) forego any potentially curative treatment, which is very difficult for parents to agree to. With fewer children enrolling in hospice care, hospices lack comfort and expertise when a sick child needs hospice care.

### ***Recommendations***

1. Explore options for removing the barriers to pediatric hospice care. Possible avenues include direct funding of pediatric hospice care, as Massachusetts has done, or using a Medicaid waiver that would allow Medicaid funds to be used on a revenue-neutral basis for children who do not meet the traditional hospice requirements, as California has done. Negotiations for a Medicaid waiver may be done as part of the renegotiation of the state's Section 1115 Global Commitment waiver, which is up for renewal in 2010, or through other sections of the Medicaid code. Ensure the focus is also on the needs of families with children who are facing end-of-life situations.

2. Direct the University of Vermont's Medical School and the College of Nursing and Health Sciences to coordinate pediatric palliative and hospice care in consultation with the Hospice and Palliative Care Council of Vermont and other interested stakeholders.

### ***Finding***

Medicaid beneficiaries without a source of reliable transportation may face barriers to the treatment of their chronic pain if they have a pain contract with their provider. Medicaid patients are entitled to transportation to and from necessary medical services as a covered service under traditional, fee-for-service Medicaid, Primary Care Plus managed care Medicaid, and Dr. Dynasaur, but most of the transportation services brokers with which the Office of Vermont Health Access (OVHA) contracts require at least one day's advance notice. Section 3 of OVHA's Transportation Procedures Manual states that "[r]equests for Medicaid transportation must be submitted to the brokers with as much advance notice as possible, but with a minimum notice of 2 days (48 hours). Brokers will attempt to accommodate requests with as little notice as 24 hours whenever possible." Eligible Medicaid beneficiaries must also obtain prior authorization before receiving transportation to or from a medical service.

In order to protect against improper use of pain medication, many providers require their pain patients to sign a pain contract containing a random drug testing or other on-demand appointment provision. The provisions mean that the patient may be called at any time to come in for an immediate drug test or other appointment to ensure he or she is using the medication as prescribed and not abusing it in any way. A patient who is unable to come directly to the provider's office risks losing access to the medication and thus suffering with untreated pain.

### ***Recommendation***

Require OVHA to contract with brokers to provide transportation on short notice for beneficiaries with pain contracts so that they can attend mandatory drug testing and other required on-demand appointments, and direct OVHA to waive the prior authorization requirement for transportation to these appointments.

### ***Finding***

Most hospice care in Vermont is paid for by Medicare. According to the Visiting Nurse Association of Chittenden and Grand Isle Counties, which is the largest provider of hospice in the state, Medicare was the largest payer, accounting for 83% of the payer mix, followed by private insurance and other (12%) and Medicaid (5%). The per-day rates for Medicare coverage of hospice services are set at a flat rate that is expected to cover all services. The Medicaid rates for fiscal year 2009 match the Medicare rates. The current per-day rates, as determined by the Centers for Medicare and Medicaid Services (CMS) are as follows:

1. Routine home care, which includes all services needed to provide hospice care in the patient's home, prescription medications, supplies, transportation, emergency room visits, laboratory tests, blood transfusions, palliative radiation therapy, and bereavement services for the patient's family for one year following the patient's death: \$143.93 per day
2. Inpatient respite care, in which the patient receives care in a nursing home and gives respite to the family and which includes all nursing home services: \$148.02 per day
3. General inpatient care (hospitalization): \$639.08 per day
4. Continuous home care by a registered nurse, which is typically crisis care in the home: \$35 per hour

These rates are wholly insufficient to cover the costs accrued to hospice providers in providing and paying for all of these services. Hospice providers must negotiate with hospitals, nursing homes, and health care professionals for reduced rates in order to provide the services their patients need. Hospices also must frequently engage in fundraising activities in an effort to make up the difference between what Medicare or Medicaid pays and the cost of caring for their patients. While Medicaid often pays the same as Medicare, Vermont is not bound by what CMS pays, and OVHA could pay more for Medicaid beneficiaries.

### ***Recommendation***

Urge the Congressional delegation to encourage CMS to increase the hospice day rates to come closer to the actual costs accrued by hospice providers. Consider increasing the amount that OVHA pays for Medicaid beneficiaries.

### ***Finding***

When a patient is on Medicare or Medicaid hospice benefit, the patient must waive his or her right to Medicare or Medicaid payments for the duration of the election of hospice care for services provided under the hospice benefit. Federal regulations require a hospice to provide home health aide and homemaker services in an amount sufficient to meet the needs of the patient. These needs are determined by the hospice interdisciplinary team and must be noted as a part of the plan of care provided by the hospice. Because the hospice is required to provide home health aide and homemaker services, CMS guidance suggests that Choices for Care is duplicative of services required to be provided under hospice. To prevent duplication of services, it is up to the state to define the Medicaid personal care services benefit and to determine if the benefit is more extensive than the home health aide and homemaker benefit provided under the Medicare hospice program. In most instances, the Department of Disabilities, Aging, and Independent Living has determined that the home health aide and homemaker benefit provided under the Medicare program is sufficient to meet patient needs. As a result,

Choices for Care beneficiaries can be eligible for hospice benefits, but most hospice beneficiaries on Medicare and Medicaid are ineligible for Choices for Care benefits.

***Recommendation***

Investigate the feasibility of removing barrier to simultaneous eligibility.

**C. Providers**

***Finding***

A multidisciplinary approach is the best practice for end-of-life care, palliative care, and pain management, but the geographic distribution of providers around the state is a problem, especially for physical therapists practicing craniosacral therapy, postural restructuring, and other bodywork to deal with trauma; psychiatrists addressing chronic pain; psychologists and psychotherapists performing biofeedback; therapists practicing eye movement desensitization and reprocessing, somatic experience, and treatment for post-traumatic stress disorder; and other practitioners working in specialized fields.

***Recommendation***

Consider adopting a multidisciplinary approach to treatment. Look at the treatment and payment structures of existing state programs such as the Blueprint for Health and the Program of All-Inclusive Care for the Elderly (PACE), which use multidisciplinary teams to provide treatment for care coordination of chronic conditions (Blueprint) and interdisciplinary teams to cover and organize all medically necessary services for seniors at home and in the community, including at least all services covered by Medicare and Medicaid (PACE).

**D. Communication**

***Finding***

Open communication is the most important element of the relationship between providers and their patients. Lack of communication can lead to improper diagnoses, under- or overtreatment of conditions, frustration, and the breakdown of the doctor-patient relationship. Good communication can lead to improved outcomes. A 2000 *American Journal of Medicine* article entitled “An intensive communication intervention for the critically ill” found that intensive communication between patients, families, and critical care teams within 72 hours of a critical care admission significantly reduced the length of the hospital stay and reduced unnecessary invasive care. Providers and patients in Vermont identify communication as an area in need of improvement, both with each other and between providers. Patients also desire improved access to information so that they can make informed choices when selecting providers.

### ***Recommendation***

Encourage greater communication between providers and their patients. Encourage provider organizations to establish communications and referrals best practices for providers. Recommend that physicians contact pharmacists if they are deviating from the norm so that pharmacists are not surprised by prescriptions giving, for example, a large amount of an opioid to a patient. Open lines of communication between providers can facilitate improved health and comfort for patients. Patients should also have access to provider ratings or information on which providers have taken continuing medical education or other training in end-of-life care, palliative care, and pain management.

### **E. Legislation and Rulemaking**

#### ***Finding***

Vermont received a grade of B+ on the quality of its policies affecting pain treatment on the “Achieving Balance in State Pain Policy: Progress Report Card (Fourth Edition),” published in July 2008 by the Pain & Policy Studies Group at the University of Wisconsin School of Medicine and Public Health, in part because the report’s authors identified a piece of legislation as ambiguous and potentially confusing. 18 V.S.A. § 4234 refers to recommended individual therapeutic dosages for the sole purpose of calculating penalties for possessing, selling, or dispensing depressant, stimulant, or narcotic drugs. It directs the Vermont Board of Health to determine the recommended individual therapeutic dosage or its equivalent. The report found the language of the statute to be misleading and had concerns that it might lead to the improper belief that the dosages were intended to express actual recommendations for individual therapeutic dosages, rather than setting a benchmark dosage as a starting point for determining whether a penalty applies. 18 V.S.A. § 4234 reads as follows (emphasis added):

#### § 4234. DEPRESSANT, STIMULANT AND NARCOTIC DRUGS

##### (a) Possession.

(1) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, shall be imprisoned not more than one year or fined not more than \$2,000.00, or both.

(2) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-hundred times a ***recommended individual therapeutic dosage or its equivalent as determined by the board of health by rule*** shall be imprisoned not more than five years or fined not more than \$25,000.00, or both.

(3) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-thousand times a ***recommended individual therapeutic dosage or its equivalent as determined by the***

**board of health by rule** shall be imprisoned not more than ten years or fined not more than \$100,000.00, or both.

(4) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of ten-thousand times a **recommended individual therapeutic dosage or its equivalent as determined by the board of health by rule** shall be imprisoned not more than 20 years or fined not more than \$500,000.00, or both.

(b) Selling or dispensing.

(1) A person knowingly and unlawfully dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, shall be imprisoned not more than three years or fined not more than \$75,000.00, or both. A person knowingly and unlawfully selling a depressant, stimulant or narcotic drug, other than cocaine or heroin, shall be imprisoned not more than five years or fined not more than \$25,000.00, or both.

(2) A person knowingly and unlawfully selling or dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-hundred times a **recommended individual therapeutic dosage or its equivalent as determined by the board of health by rule** shall be imprisoned not more than ten years or fined not more than \$100,000.00, or both.

(3) A person knowingly and unlawfully selling or dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-thousand times a **recommended individual therapeutic dosage or its equivalent as determined by the board of health by rule** shall be imprisoned not more than 20 years or fined not more than \$500,000.00, or both.

### ***Recommendation***

The committee is concerned primarily with examining and improving practice in Vermont with respect to end-of-life care, palliative care, and pain management. While changing the language of this section will likely have no impact on practice, the committee nevertheless feels it sends a valuable message about the importance the committee places on improving Vermont's overall approach to providing the highest quality of care to its residents. Therefore, the committee recommends revising the language of this section to clarify the intent so that the benchmark dosage for penalty calculation cannot be confused with diagnostic recommendations to clinicians or pharmacists. The changes should be reflected in statute and in the Board of Health's rules. See proposed bill language in Appendix C.

### ***Finding***

The statutes relating to the scope of practice for physicians and surgeons (26 V.S.A. chapter 23) and other health care professionals, including naturopathic physicians (26

V.S.A. chapter 81), nurses (26 V.S.A. chapter 28), pharmacists (26 V.S.A. chapter 36), physical therapists (26 V.S.A. chapter 38), and physicians' assistants (26 V.S.A. chapter 31) do not include the treatment of pain, while the statutes relating to the scope of practice for osteopaths do. See 26 V.S.A. §1750(10) (emphasis added):

(10) "Practice of osteopathic medicine" means the *diagnosis, treatment, operation or prescription for* any human disease, *pain*, injury, deformity or other physical or mental condition, which practice is based in part upon educational standards and requirements which emphasize the importance of the neuromusculoskeletal structure and manipulative treatment in the maintenance and restoration of health.

***Recommendation***

Amend the statutes for the scope of practice for physicians and surgeons, naturopathic physicians, nurses, pharmacists, physical therapists, and physicians' assistants to include a statement regarding the treatment of pain. See an example of proposed bill language in Appendix D.

***Finding***

No central location exists to coordinate access to care and services for Vermonters in need of hospice care, palliative care, or pain management, or to identify gaps in services. As a result, many Vermont residents are unaware of the options for receiving these services, and patients and their families suffer unnecessarily as a result. This work may be able to be done by the existing offices of the Health Care Ombudsman and the Long-Term Care Ombudsman, by creating a new ombudsman's office, or by another entity.

***Recommendation***

Direct the offices of the Health Care Ombudsman and the Long-Term Care Ombudsman to collaborate with interested stakeholders to design the best way to coordinate services, help people access services, and identify gaps in access and services. Require them to report on their recommendations to the committees of jurisdiction by March 15, 2009.

***Finding***

The statutes on advance directives in chapter 231 of Title 18 do not allow for inclusion of do-not-resuscitate (DNR) or clinician orders for life-sustaining treatment (COLST) in the advance directive registry.

***Recommendation***

Amend 18 V.S.A. §§ 9701, 9709, and 9719 and other sections as needed to enable inclusion of DNR orders and COLST in the advance directive registry. See proposed bill language in Appendix E.

***Finding***

Existing bills of rights for hospital and nursing home patients do not adequately address the needs of Vermonters receiving hospice care or those suffering from chronic pain.

***Recommendation***

Expand existing patients' bills of rights or develop a new bill of rights to address the needs of Vermonters receiving hospice care or suffering from chronic pain. See proposed bill language in Appendix F.

**F. Improving Access and Quality*****Finding***

Vermonters are not sufficiently informed about their options for end-of-life care and palliative care. There is no coordinated system for referrals or treatment, with the result that most Vermonters do not know about the options available to them or to their families when faced with an end-of-life situation. Patients do not receive timely information about or referrals to hospice and palliative care, resulting in unnecessary pain and suffering.

***Recommendations***

1. Direct the Hospice and Palliative Care Council of Vermont to organize a group of interested stakeholders to work with the offices of Health Care Ombudsman and Long-Term Care Ombudsman to identify ways to improve the system of care for patients and their families at the end of life through the use of referrals, coordinated care, improved communication and outreach by providers and support organizations, increased access to services, higher quality of care, and other means.
2. Require the Vermont Department of Health to create public service announcements and conduct additional outreach to providers and the public on the importance and ease of creating an advance directive, including the availability of simple forms and the value of participating in the advance directive registry.

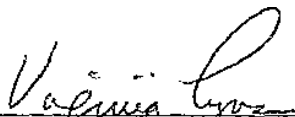


## **G. Annual Report Card**

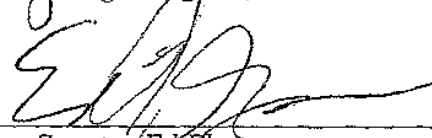
### ***Recommendation***


The committee does not feel that an annual report card requirement is appropriate at this time. Instead, the committee recommends that the standing committees monitor the quality and availability of end-of-life care, palliative care, and pain management services in Vermont, especially in light of any legislative or rules changes that may be implemented as a result of this report.

**2009 Report of the Palliative Care, End-of-Life Care,  
And Pain Management Study Committee to the Vermont  
General Assembly and the Governor of the State of  
Vermont**

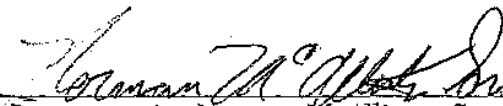
  
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Representative Sandy Haas

  
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Senator Hinda Miller

  
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Representative Norman McAllister, Sr.

*Part V. Appendices*

*Appendix A  
End-of-Life Care, Palliative Care, and Pain Management Committee  
Legislative Charge*

NO. 166. AN ACT RELATING TO END-OF-LIFE CARE AND PAIN MANAGEMENT.

(S.281)

It is hereby enacted by the General Assembly of the State of Vermont:

**Sec. 1. STUDY AND REPORT ON PALLIATIVE CARE, END-OF-LIFE CARE, AND PAIN MANAGEMENT**

(a) There is created a legislative study committee on palliative care, end-of-life care, and pain management. The study committee shall consist of three members of the house of representatives, appointed by the speaker of the house, and three members of the senate, appointed by the committee on committees. The study committee shall discuss and make recommendations on legislative and nonlegislative solutions for improving palliative care, end-of-life care, management of chronic pain, and access to these services for children, in collaboration with:

- (1) the department of health;
- (2) the department of disabilities, aging, and independent living;
- (3) the Vermont Program for Quality in Health Care;
- (4) the Hospice & Palliative Care Council of Vermont;
- (5) the Vermont health care ombudsman;
- (6) the Vermont long-term care ombudsman;
- (7) Patient Choices at End of Life – Vermont;
- (8) the Vermont Alliance for Ethical Healthcare;
- (9) the Community of Vermont Elders;
- (10) the Vermont Ethics Network;
- (11) the Vermont Health Care Association;
- (12) the Vermont Association of Hospitals and Health Systems;
- (13) the Vermont Medical Society;
- (14) the Vermont Coalition for Disability Rights;
- (15) the American Cancer Society;
- (16) AARP Vermont; and
- (17) other interested stakeholders.

(b) The study committee, at its first meeting, shall elect two legislative members as co-chairs. The legislative council and the joint fiscal office shall provide staff support to the study committee. Prior to the first meeting of the study committee, the legislative council staff shall collect from the department of health and the office of the attorney general existing data and background material relevant to the work of the committee.

(c) The study committee shall consider:

- (1) recommendations for improving ongoing coordination of activities directed toward improving palliative care, end-of-life care, and pain management services throughout the state based on available data and studies from existing sources;
  - (2) how best to protect the interests of persons who:
    - (A) have a terminal illness;
    - (B) are receiving hospice care; or
    - (C) are suffering chronic pain;
  - (3) how to advance the goal of improving health care services for children with painful or life-threatening medical conditions, including:
    - (A) the current availability of insurance coverage for pediatric palliative care services and treatment for chronic pain; and
    - (B) avenues for increasing children's access to care;
  - (4) recommendations for improving methods of informing consumers about options in this state for end-of-life care, palliative care, and management of chronic pain, and about the importance of having an advance directive; and
  - (5) such other issues as the study committee determines to be necessary and appropriate.
- (d) No later than January 15, 2009, the study committee shall provide a written report on its findings and recommendations, including the appropriateness of an annual report card and future activities, to the house committees on human services and on health care and the senate committee on health and welfare.
- (e) The study committee shall meet no more than four times and legislative members of the study committee shall be entitled to receive per diem compensation and reimbursement of expenses as provided in section 406 of Title 2.

Approved: May 22, 2008

*Appendix B*  
*Recommendations Not Implemented*

The committee received a number of recommendations from interested stakeholders that it felt had merit but was unable to recommend for implementation at the time that the committee completed its work. Those recommendations and the party or parties suggesting the action are listed below.

Education

- Create an endowed chair at the UVM Medical School similar to the Nursing School's endowed chair in palliative care and ethics (Dr. Allan Ramsay, MD)
- Increase palliative care training for primary care doctors (Dr. Ramsay)
- Use Global Commitment funds for the UVM Medical School to target funding provider education in pain management and palliative and end-of-life care (Deborah Lisi-Baker, Vermont Center for Independent Living (VCIL))
- Require all health care professionals to participate periodically in training on pain, pain management, and palliative care, including the encouragement of pain management; training in the proper use of opiates; making pain management a professional requirement; training on the difference between physical dependence, analgesic tolerance, and addiction; training about improper pain management resulting in liability; and training about the consequences of "firing" patients with legitimate pain needs due to pain contract infractions (Trinka Kerr, Vermont Health Care Ombudsman)

Insurance/Medicaid Coverage

- Improve insurance coverage for alternative and complementary therapies (Dr. Brian Erickson, MD; Dr. Bill Warnock, Doctor of Naturopathic Medicine)
- Require insurers to cover acupuncture treatment (Dr. Erickson)
- Increase reimbursement rates for hospice providers (Deborah Lisi-Baker, VCIL)

Providers

- If money is available, do a pilot project to allow hospice care for a patient on palliative chemotherapy (Dr. Ramsay)
- Consider incentives to enhance physician and nursing competence in end-of-life care, such as higher reimbursement for demonstrated levels of education, outcomes (Monica Knorr/Tuck Rainwater, Patient Choices at End of Life Vermont)

Legislation and Rulemaking

- Relax certificate of need requirements for hospices to encourage competition and outreach; use explicit standards instead (Dr. Ira Byock, MD)
- Create a loan repayment program for palliative care programs for doctors, nurses, advanced practice registered nurses, and others (Madeleine Mongan, Vermont Medical Society (VMS))

- Provide loan forgiveness for doctors and nurses seeking graduate level (fellowship) training in end-of-life and palliative care (Dr. Ramsay)
- Provide scholarships to nurses interested in pursuing advanced studies in palliative and end-of-life care (Deborah Lisi-Baker, VCIL)
- Develop outcome criteria to measure quality end-of-life services (Christina Melvin, MS, APRN)
- Provide funding to the University of Vermont for the initiation of a graduate nursing program (Master's Degree) in palliative care (Christina Melvin)
- Provide nurse scholarships to assist nurses interested in pursuing graduate education in palliative care nursing (Christina Melvin)
- Look into getting a Medicare demonstration project grant or waiver (Peter Cobb, Vermont Assembly of Home Health Agencies; Deborah Lisi-Baker, VCIL)
- Create a standard definition of palliative care and standardized expectations for delivery of such care (Jackie Majoros, Vermont Long-Term Care Ombudsman)
- Ensure access to a palliative care consultation where appropriate (Rep. Sandy Haas)
- Establish a statewide standardization for referrals in any setting (nursing home, Respite House, hospital, etc.) as FAHC does, so that it is not up to a doctor or nurse to order a palliative care consult, it just gets triggered upon the occurrence of a certain event (Patty Launer)
- Require all facilities to adopt a palliative care best practice – look to hospice program for model – and address implementation (could require as part of certification/recertification (Jackie Majoros)
- Clarify in statutes and regulations under what circumstances providers could have liability for prescribing controlled substances, including for the under-treatment of pain (Trinka Kerr)
- Increase funding for Vermont hospices and disperse it regionally (VCIL)

#### Improving Access and Quality

- Vermont Hospice and Palliative Care Council should get more involved in quality improvement and look at collective approaches to challenges (Dr. Byock)
- Assemble a task force of pediatric palliative care experts to examine the specific needs of children and families living with life-threatening diseases and make recommendations to improve care (Christina Melvin)
- Consider a collaborative project for chronic pain management similar to the Maternal-Child Nursing Competence Validation Model (Margaret Luce)
- Require an annual report card that looks at the percentage of patients dying in hospice care versus hospital care, including capacity, performance, and benchmarks (Stephen Kiernan)
- Create an ongoing Commission on End-of-Life Care (Stephen Kiernan)
- Include palliative care indicators in Vermont's quality programs for the state health plan and Medicaid programs (Dr. Ramsay)
- Look at hospitals' finances and the impact of palliative care and hospice care on hospitals' bottom lines (Sen. Hinda Miller)

- Institute a code of ethics and conduct for all nursing homes, residential care facilities, and other institutions for supports for palliative care, hospice care, and pain management, including requirement that all providers consider palliative care to be a part of treatment (Sen. Ginny Lyons, Jackie Majoros)
- Require OVHA to provide all beneficiaries and providers with information about their rights to pain management and palliative care and how to access that care (Trinka Kerr)
- Identify data sources and/or gaps for current end-of-life care practice in Vermont, including palliative care versus treatment care, hospice referrals, patient consultations on options, terminal sedations, and voluntarily stopping eating and drinking (Monica Knorr/Tuck Rainwater)
- Establish a locus of responsibility for end-of-life care improvements in Vermont (Monica Knorr/Tuck Rainwater)
- Create a centralized position or organization that focuses on end-of-life care and the coordination and improvement of activities around the state (VPQHC)

*Appendix C*  
*Proposed Amendments to 18 V.S.A. § 4234*

Sec. 1. 18 V.S.A. § 4234 is amended to read:

§ 4234. DEPRESSANT, STIMULANT AND NARCOTIC DRUGS

(a) Possession.

(1) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, shall be imprisoned not more than one year or fined not more than \$2,000.00, or both.

(2) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-hundred times a ~~recommended individual therapeutic~~ benchmark unlawful dosage or its equivalent as determined by the board of health by rule shall be imprisoned not more than five years or fined not more than \$25,000.00, or both.

(3) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-thousand times a ~~recommended individual therapeutic~~ benchmark unlawful dosage or its equivalent as determined by the board of health by rule shall be imprisoned not more than ten years or fined not more than \$100,000.00, or both.

(4) A person knowingly and unlawfully possessing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of ten-thousand times a ~~recommended individual therapeutic~~ benchmark unlawful dosage or its equivalent as determined by the board of health by rule shall be imprisoned not more than 20 years or fined not more than \$500,000.00, or both.



(b) Selling or dispensing.

(1) A person knowingly and unlawfully dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, shall be imprisoned not more than three years or fined not more than \$75,000.00, or both. A person knowingly and unlawfully selling a depressant, stimulant or narcotic drug, other than cocaine or heroin, shall be imprisoned not more than five years or fined not more than \$25,000.00, or both.

(2) A person knowingly and unlawfully selling or dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-hundred times a ~~recommended individual therapeutic~~ benchmark unlawful dosage or its equivalent as determined by the board of health by rule shall be imprisoned not more than ten years or fined not more than \$100,000.00, or both.

(3) A person knowingly and unlawfully selling or dispensing a depressant, stimulant or narcotic drug, other than heroin or cocaine, consisting of one-thousand times a ~~recommended individual therapeutic~~ benchmark unlawful dosage or its equivalent as determined by the board of health by rule shall be imprisoned not more than 20 years or fined not more than \$500,000.00, or both.

Sec. 2. RULEMAKING

The board of health shall amend, by rule, all references to the recommended individual therapeutic dosage as specified in Sec. 1 of this act.

Sec. 3. EFFECTIVE DATE

This act shall take effect upon passage.

*Appendix D*  
*Example of language adding treatment of pain to scope of practice statutes*  
*Proposed Amendments to 26 V.S.A. § 4121 (naturopathic physicians)*

Sec. 1. 26 V.S.A. § 4121 is amended to read:

§ 4121. DEFINITIONS

As used in this chapter:

\* \* \*

(8) "Naturopathic medicine" or "the practice of naturopathic medicine" means a system of health care that utilizes education, natural medicines and natural therapies to support and stimulate a patient's intrinsic self-healing processes and to prevent, diagnose and treat human health conditions, ~~and injuries,~~ and pain. In connection with such system of health care, an individual licensed under this chapter may:

(A) Administer or provide for preventative and therapeutic purposes nonprescription medicines, topical medicines, botanical medicines, homeopathic medicines, counseling, hypnotherapy, nutritional and dietary therapy, naturopathic physical medicine, naturopathic childbirth, therapeutic devices, barrier devices for contraception, and prescription medicines authorized by this chapter or by the formulary established under subsection 4125(c) of this title.

(B) Use diagnostic procedures commonly used by physicians in general practice, including physical and orificial examinations, electrocardiograms, diagnostic imaging techniques, phlebotomy, clinical laboratory tests and examinations, and physiological function tests.

\* \* \*

*Appendix E*  
*Proposed Amendments to 18 V.S.A. chapter 231*

Sec. 1. 18 V.S.A. § 9701 is amended to read:

§ 9701. DEFINITIONS

As used in this chapter:

\* \* \*

(6) “Clinician orders for life sustaining treatment” or “COLST” means a clinician’s order or orders for treatment such as intubation, mechanical ventilation, transfer to hospital, antibiotics, artificially administered nutrition, or another medical intervention. A COLST order is designed for use in outpatient settings and health care facilities and may include a DNR order that meets the requirements of Section 9708 of this title.

~~(6)(7)~~ "Commissioner" means the commissioner of the department of health.

~~(7)(8)~~ "Do-not-resuscitate order" or "DNR order" means a written order of the principal's clinician directing health care providers not to attempt resuscitation.

~~(8)(9)~~ "DNR identification" means a document, bracelet, other jewelry, wallet card, or other means of identifying the principal as an individual who has a DNR order.

~~(9)(10)~~ "Emergency medical personnel" shall have the same meaning as provided in section 2651 of Title 24.

~~(10)(11)~~ "Guardian" means a person appointed by the probate court who has the authority to make medical decisions pursuant to subdivision 3069(b)(5) of Title 14.

~~(11)(12)~~ "Health care" means any treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services

provided pursuant to a clinician's order, and services to assist in activities of daily living provided by a health care provider or in a health care facility or residential care facility.

~~(12)~~(13) "Health care decision" means consent, refusal to consent, or withdrawal of consent to any health care.

~~(13)~~(14) "Health care facility" shall have the same meaning as provided in subdivision 9432(7) of this title.

~~(14)~~(15) "Health care provider" shall have the same meaning as provided in subdivision 9432(8) of this title and shall include emergency medical personnel.

~~(15)~~(16) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, codified at 42 U.S.C. § 1320d and 45 C.F.R. §§ 160-164.

~~(16)~~(17) "Informed consent" means the consent given voluntarily by an individual with capacity after being fully informed of the nature, benefits, risks, and consequences of the proposed health care, alternative health care, and no health care.

~~(17)~~(18) "Interested individual" means:

(A) the principal's spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneficiary, or clergy person; or

(B) any adult who has exhibited special care and concern for the principal and who is personally familiar with the principal's values.

~~(18)~~(19) "Life sustaining treatment" means any medical intervention, including nutrition and hydration administered by medical means and antibiotics, which is intended to extend life and without which the principal is likely to die.

~~(19)~~(20) "Nutrition and hydration administered by medical means" means the provision of food and water by means other than the natural ingestion of food or fluids by

eating or drinking. Natural ingestion includes spoon feeding or similar means of assistance.

~~(20)~~(21) "Ombudsman" means an individual appointed as a long-term care ombudsman under the program contracted through the department of aging and independent living pursuant to the Older Americans Act of 1965, as amended.

~~(21)~~(22) "Patient's clinician" means the clinician who currently has responsibility for providing health care to the patient.

~~(22)~~(23) "Principal" means an adult who has executed an advance directive.

~~(23)~~(24) "Principal's clinician" means a clinician who currently has responsibility for providing health care to the principal.

~~(24)~~(25) "Probate court designee" means a responsible, knowledgeable individual independent of a health care facility designated by the probate court in the district where the principal resides or the county where the facility is located.

~~(25)~~(26) "Procurement organization" shall have the same meaning as in subdivision 5238(10) of this title.

~~(26)~~(27) "Reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of a principal's health care needs, and willing and able to act in a timely manner considering the urgency of the principal's health care needs.

~~(27)~~(28) "Registry" means a secure, web-based database created by the commissioner to which individuals may submit an advance directive, COLST, DNR order, combination of these documents, or information regarding the location of ~~an advance directive~~ one or more of these documents, that is accessible to principals and

agents and, as needed, to individuals appointed to arrange for the disposition of remains, procurement organizations, health care providers, health care facilities, residential care facilities, funeral directors, crematory operators, cemetery officials, probate court officials, and the employees thereof.

~~(28)~~(29) "Residential care facility" means a residential care home or an assisted living residence as those terms are defined in section 7102 of Title 33.

~~(29)~~(30) "Resuscitate" or "resuscitation" includes chest compressions and mask ventilation; intubation and ventilation; defibrillation or cardioversion; and emergency cardiac medications provided according to the guidelines of the American Heart Association's Cardiac Life Support program.

~~(30)~~(31) "Suspend" means to terminate the applicability of all or part of an advance directive for a specific period of time or while a specific condition exists.

Sec. 2. 18 V.S.A. § 9709 is amended to read:

§ 9709. OBLIGATIONS OF HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, RESIDENTIAL CARE FACILITIES, AND HEALTH INSURERS REGARDING PROTOCOLS AND NONDISCRIMINATION

(a) Every health care provider, health care facility, and residential care facility shall develop protocols:

\* \* \*

(3) within 120 days of the commissioner announcing the availability of the registry, to ensure that the provider or facility checks the registry at the time any individual without capacity is admitted or provided services to determine whether the individual has an advance directive, COLST, DNR order, or a combination of these documents;

\* \* \*

(b) Every health care facility and residential care facility shall develop written protocols to ensure that:

\* \* \*

(3) A patient with an advance directive, COLST, DNR order, or combination of these documents is encouraged and helped to submit ~~the advance directive~~ such documents or a notice of the advance directive to the registry.

\* \* \*

Sec. 3. 18 V.S.A. § 9719 is amended to read:

§ 9719. OBLIGATIONS OF STATE AGENCIES

\* \* \*

(b)(1) Within one year of the effective date of this chapter, the commissioner shall develop and maintain a registry to which a principal may submit his or her advance directive, including a terminal care document and a durable power of attorney, as well as clinician orders for life sustaining treatment and do-not-resuscitate orders. The rules shall describe when health care providers, health care facilities, and residential care facilities may access ~~an advance directive~~ documents in the registry. In no event shall the information in the registry be accessed or used for any purpose unrelated to decision-making for health care or disposition of remains, except that the information may be used for statistical or analytical purposes as long as the individual's identifying information remains confidential.

(2)(A) Within one year of the effective date of this chapter, the commissioner shall adopt rules pursuant to chapter 25 of Title 3 on the process for securely submitting,

revoking, amending, replacing, and accessing the information contained in the registry. The rules shall provide for incorporation into the registry of notifications of amendment, suspension, or revocation under subsection 9704(c) of this title and revocations of appointment under subsection 9704(d) of this title.

(B) The commissioner shall provide to any individual who submits an advance directive, clinician orders for life sustaining treatment, do-not-resuscitate order, or combination of these documents to the registry a sticker that can be placed on a driver's license or identification card indicating that the holder has ~~an advance directive~~ one or more documents in the registry.

(c)(1) Within one year of the effective date of this chapter, the commissioner shall provide on the department's public website information on advance directives and the registry to appropriate state offices. The commissioner shall also include information on advance directives, and on the registry and the optional forms of an advance directive.

(2) Within one year of the effective date of this chapter, the commissioner of motor vehicles shall provide motor vehicle licenses and identity cards, as soon as existing licenses or cards have been depleted, which allow the license holder or card holder to indicate that he or she has an advance directive, clinician orders for life sustaining treatment, do-not-resuscitate order, or combination of these documents and whether ~~it is~~ they are in the registry.

#### Sec. 4. EXPANSION OF ADVANCE DIRECTIVE REGISTRY

(a) No later than July 1, 2010, the commissioner of health shall take steps necessary to expand the advance directive registry to include clinician orders for life sustaining



treatment and do-not-resuscitate orders and make available registry stickers in order to implement 18 V.S.A. § 9719(b), as amended by section 3 of this act.

(b) In order to implement the provisions of 18 V.S.A. § 9719(c)(2), as amended by section 3 of this act, as soon supplies of existing motor vehicle licenses and identity cards have been depleted, the commissioner of motor vehicles shall provide licenses and cards that enable the license or card holder to indicate that he or she has an advance directive, clinician orders for life sustaining treatment, do-not-resuscitate order, or combination of these documents.

*Appendix F*  
*Proposed Hospice Care, Palliative Care, and Pain Management Patients'*  
*Bill of Rights*

Sec. 1. 18 V.S.A. chapter 42A is added to read:

CHAPTER 42A. HOSPICE CARE, PALLIATIVE CARE, AND PAIN  
MANAGEMENT PATIENTS' BILL OF RIGHTS

§ 1871. HOSPICE CARE, PALLIATIVE CARE, AND PAIN MANAGEMENT  
PATIENTS' BILL OF RIGHTS

(a) A patient who is dying has the right to be informed by a physician of all available options related to terminal care; to be able to select any, all, or none of such options; and to expect and receive supportive care for the specific option or options chosen. The options shall include:

(1) hospice care;

(2) adequate doses of medication to control pain and other symptoms related to dying;

(3) the option by which the dying process can be shortened by the voluntary stopping of eating and drinking all food and liquid; and

(4) the use of terminal sedation, if all other forms of palliative care fail to produce a satisfactory degree of relief from the patient's physical and emotional suffering.

(b) A patient suffering from severe chronic intractable pain has the right to request or reject the use of any or all modalities in order to relieve his or her severe chronic intractable pain.

(b) A patient who suffers from severe chronic intractable pain has the right to choose opiate medications to relieve severe chronic intractable pain without first having to

submit to an invasive medical procedure, which is defined as surgery, destruction of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or other device, as long as the prescribing physician acts in conformance with standards of medical practice in this state.

(c) A patient's physician may refuse to prescribe opiate medication for a patient who requests treatment for severe chronic intractable pain, but such physician shall inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

(d) A physician who uses opiate therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain, as long as that prescribing is in conformance with standards of medical practice in this state.

(e) A patient may voluntarily request that his or her physician provide an identifying notice of the prescription for purposes of emergency treatment or law enforcement identification.

(f) Nothing in this section shall be deemed to:

(1) Limit any reporting or disciplinary requirements applicable to licensed physicians and surgeons who violate prescribing practices established by the state board of medical practice; or

(2) Limit the applicability of any federal statute or federal regulation or any other statute or regulation of this state concerning regulation of dangerous drugs or controlled substances.

*Appendix G*  
*2008 Witness List*

Jackie Majoros, Long Term Care Ombudsman  
 Madeleine Mongan, Vermont Medical Society  
 Bea Grause, VAHHS  
 Frances Keeler, Director of the Division of License & Protection, DDAIL  
 Patricia Launer, RN, VPQHC, Quality Improvement Adviser  
 Kelly Stoddard, Director of Govt. Relations & Advocacy, American Cancer Society  
 Betsy Davis, COVE  
 Lynne Vitzthum, Vermont Coalition for Disability Rights  
 Mary Claire Carroll, Vermont Coalition for Disability Rights  
 Tuck Rainwater, Patient Choices at End of Life – Vermont  
 Dr. Carmer Van Buren, Patient Choices at End of Life – Vermont  
 Linda Purdy, Assistant Attorney General  
 Dr. Brian Erickson, Fletcher Allen Pain Medicine Center  
 Dr. Zail Berry, Geriatric Medicine  
 Dr. David Clauss, Vermont Medical Practice Board  
 Dr. Todd Mandell, Medical Advisor, Vermont Department of Health, ADAP Division  
 Dr. Ed Haak, Director, Emergency Medicine, Northwestern Medical Center  
 Deborah Lisi- Baker, Executive Director, VCIL  
 Dr. Bill Warnock, Doctor of Naturopathic Medicine  
 Julie Eaton, Vermont Board of Pharmacy  
 Trinka Kerr, Vermont Health Care Ombudsman  
 Dr. Robert McCauley, Interim Director of Clinical Ethics, Fletcher Allen Health Care and  
 Clinical Assistant Professor of Pediatrics, University of Vermont  
 John Pierce, Consumer  
 Jean E. Mankowski-Upham, Consumer  
 Margaret Luce, Vermont State Nurses' Association  
 Liz Schneider, Medical Director for Vermont and New Hampshire, MVP Health Care  
 Joshua Slen, Director, OVHA  
 Diane Nealy, Pharmacy Clinical Account Manager, OVHA  
 Dr. Stephen Perkins, Medical Director, Blue Cross Blue Shield of Vermont  
 Meika Zilberberg, MS, Program Coordinator, VT Prescription Monitoring Program  
 Dr. Donald Swartz, Medical Director, VDH  
 Dr. Ira Byock, Dartmouth Hitchcock Medical Center  
 Diana Peirce, Central Vermont Home Health and Hospice  
 Angel Collins, Director of End-of-Life Care Services, VNA  
 Christina Melvin, Professor of Nursing, UVM  
 Tom Walsh, Consumer, Londonderry, VT  
 Karina Lapala, Student, Johnson State College  
 Stephen Kiernan, MA, MFA, Journalist, Author of "Last Rights," Lecturer  
 Dr. Allan Ramsay, Medical Director, Palliative Care Services, Fletcher Allen Health Care  
 Jennifer Carbee, Legislative Council  
 Nolan Langweil, Joint Fiscal Office