DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, MD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
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Testimony COMMENTING on HB1823 HD2 SD1
RELATING TO HEALTH.

SENATOR ROSALYN H. BAKER, CHAIR
SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

SENATOR KARL RHOADS, CHAIR
SENATE COMMITTEE ON JUDICIARY

Hearing Date: April 1, 2022 Room Number: Video & 016

Fiscal Implications: N/A.

Department Testimony: The role of the Department of Health (DOH) for chapter 327L, Hawaii Revised Statutes, or the "Our Care, Our Choice Act," is ministerial in function, which is to say that DOH's primary responsibility is the collection and dissemination of forms, data, and reports in aggregate, as required by law. DOH is compelled to collect data only on qualified patients who have followed through on every legally required step. As a result, DOH does not quantify the number of patients who expired prior to executing all the steps, however the anecdotal input from healthcare providers has been very consistent, that: 1) patients in rural communities struggle to find a participating provider (attending, consulting, and mental health), and 2) patients with grave health prognoses expire during the waiting period.

The department is in the process of evaluating forms for the collection period that ended on December 31, 2021. There are an estimated 70 patients who completed the medical aid in dying request process. In the 2020 annual report, there were 37 patients who qualified of which 32 ingested the medication causing their death. This is a consistent upward trend since enactment in 2019.

Offered Amendments: N/A.

Testimony of the Hawaii Medical Board

Before the
Senate Committee on Commerce and Consumer Protection
and
Senate Committee on Judiciary

Friday April 1, 2022
10:30 a.m.
Conference Room 16 and Videoconference

On the following measure:
H.B. 1823, H.D. 2, S.D. 1, RELATING TO HEALTH

Chair Baker, Chair Rhoads, and Members of the Committees:

My name is Ahlani Quiogue, and I am the Executive Officer of the Hawaii Medical Board (Board). The Board appreciates the intent of and offers comments on this bill only with respect to physician assistants.

The purposes of this bill are to: (1) authorize advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient; (2) require a prescribing provider to conduct an initial visit in-person; (3) amend the mandatory waiting period between oral requests and the provision of a prescription; and (4) prohibit the disclosure, discovery, or compelled production of information collected or retained pursuant to incidental or routine communication between the Department of Health and qualified patients or providers.

The Board appreciates the bill's intent to authorize physician assistants to practice medical aid in dying in accordance with their education, training, and scope of practice. The Board recognizes the important role physician assistants have in healthcare and believes this bill is a step in the right direction to serve the patients of Hawaii.

Thank you for the opportunity to testify on this bill.

Testimony of the Board of Nursing

Before the
Senate Committee on Commerce and Consumer Protection
and
Senate Committee on Judiciary
Friday April 1, 2022
10:30 a.m.
Conference Room 16 and Videoconference

On the following measure:
H.B. 1823, H.D. 2, S.D. 1, RELATING TO HEALTH

Chair Baker, Chair Rhoads, and Members of the Committees:

My name is Lee Ann Teshima, and I am the Executive Officer of the Board of Nursing (Board). The Board appreciates the intent and offers comments on this bill only with respect to advanced practice registered nurses (APRNs).

The purposes of this bill are to: (1) authorize advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient; (2) require a prescribing provider to conduct an initial visit in-person; (3) amend the mandatory waiting period between oral requests and the provision of a prescription; and (4) prohibit the disclosure, discovery, or compelled production of information collected or retained pursuant to incidental or routine communication between the Department of Health and qualified patients or providers.

The Board appreciates the bill's intent to authorize APRNs to practice medical aid in dying in accordance with their scope of practice and prescribing authority. APRNs are recognized as primary care providers who may practice independently based on their practice specialty. An APRN's education and training include, but are not limited to, a graduate-level degree in nursing and national certification that is specific to the APRN's practice specialty, in accordance with nationally recognized standards of practice.

The Board also appreciates that this bill's definition of "counseling" includes both a "psychiatric mental health nurse practitioner, or clinical nurse specialist" to consult with a patient to determine whether the patient is capable of making an informed decision regarding ending the patient's life. There are four categories of APRNs (nurse practitioner, clinical nurse specialist, certified nurse midwife and certified registered nurse anesthetist), and nurse practitioners or clinical nurse specialists whose practice specialty is in psychiatric mental health may provide consultative services in psychiatric mental health.

Thank you for the opportunity to testify on this bill.

HAWAIʻI STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Written Testimony Presented Before the Senate Committee on Commerce and Consumer Protection and Senate Committee on Judiciary

Friday April 1, 2022 at 10:30 AM
by
Laura Reichhardt, MS, AGNP-C, APRN
Director, Hawaiʻi State Center for Nursing
University of Hawaiʻi at Mānoa

Comments on HB 1823, HD2, SD1

Chairs Baker and Rhoads, Vice Chairs Chang and Keohokalole, members of the Senate Committee on Commerce and Consumer Protection, and members of the Senate Committee on Judiciary, thank you for the opportunity for the Hawaiʻi State Center for Nursing to provide **comments on HB 1823, HD2, SD1, only as it pertains to Section 2** of this measure which, if enacted, would enable Advanced Practice Registered Nurses (APRNs) to participate as an attending, consulting, and counseling provider in the Our Care, Our Choice Program.

Advanced Practice Registered Nurses have had a 75% increase in the number of in-state APRNs since 2011. Nearly 1,300 licensed APRNs reside in Hawaiʻi. APRNs are noted in national research to be more likely to provide care to underserved people and communities including rural areas, urban areas, to women, and to Medicaid recipients or uninsured people (Buerhaus et al., 2014). Currently, 30% of Hawaiʻi's APRNs reside on a Neighbor Island which also approximates with the percent of APRNs working in HSRA designated primary care shortage areas and medically underserved areas (Hawaiʻi State Center for Nursing, 2021).

The National Conference of State Legislatures notes that Nurse Practitioners, which are the most common type of APRNS in our state, "are prepared through advanced graduate education and clinical training to provide a range of health services, including the diagnosis and management of common as well as complex medical conditions to people of all ages" (scopeofpracticepolicy.org). NCSL also notes that in Hawaiʻi, APRNS are provided practice authority to the full extent of their education and certification, prescriptive authority, and that APRNs are identified as primary care providers.

Hawaiʻi adopted the national best practices for APRN regulation, the APRN Consensus Model (2008), which states that licensure, accreditation, and certification combined provide guidance on an APRN's scope of practice. Hawaiʻi's laws for APRNs ensure public safety during patient care through, authorize assessment, diagnosis, and prescriptive authority. APRNs have grown significantly in Hawaiʻi, with APRNs providing care in all regions in the state where people live.

Thank you for the opportunity to provide this information as it relates to your decision making on this measure.

The mission of the Hawaiʻi State Center for Nursing is that through collaborative partnerships, the Center provides accurate nursing workforce data for planning, disseminates nursing knowledge to support excellence in practice and leadership development; promotes a diverse workforce; and advocates for sound health policy to serve the changing health care needs of the people of Hawaiʻi.

ST. MICHAEL THE ARCHANGEL CHURCH
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Website: stmichaelparishkona.org

March 29, 2021

Senate Committees on Commerce and Consumer Protection and Judiciary

RE: HB1823 SD1 – Strongly Oppose

All life is precious and must be respected. This bill extends end of life counseling and ability to prescribe life ending medications to advanced practice registered nurses and physician assistants to those who wish to end their lives. The wish to forgo pain and suffering is understandable. None of us wish to watch our loved ones suffer. However, none of us have the right to be God. We only have the right to be compassionate and to do all we can to alleviate pain.

HB1823 puts pressure on more medical professionals to take on the role of God. Do not allow HB1823 become low. Vote no when HB1823 when it comes to your committees on May 1.

Humbly,

Shirley David
Pastoral Council Chair

HB-1823-SD-1
Submitted on: 3/29/2022 4:10:57 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Michael Golojuch Jr	Testifying for Stonewall Caucus of the Democratic Party of Hawaii	Support	Written Testimony Only

Comments:

Aloha Senators,

The Stonewall Caucus of the Democratic Party of Hawaiʻi (formerly the LGBT Caucus) Hawaiʻi's oldest and largest policy and political LGBTQIA+ focused organization fully supports HB 1823 HD 2 SD 1.

We hope you all will support this important piece of legislation.

Mahalo nui loa,

Michael Golojuch, Jr.
Chair and SCC Representative
Stonewall Caucus for the DPH

March 29, 2022

Lana`i Kina`ole Inc.
PO Box 630805
Lanai City HI 96763

Re: SD1 amendments to law HB1823 HD2

Attention Senator Baker, Senator Rhodes and Senator Keohokalole,

Please accept this as written testimony to advocate on behalf of Lana`i residents who seek MAiD access. The law HB1823 HD2 version is preferred over the HB1823 HD2 SD1 version because of the new barriers to care the SD1 version will create, particularly for people on neighbor islands. Changes need to be made to remove barriers to accessing such care i.e., shorten the wait time to be in line with other states, allow mid-level practitioners to order the medications for their clients if they are the designated Primary Care Provider (PCP), etc.

Adding more stringent requirements, e.g., SD1 amendments requiring a face-to-face psychiatrist visit, will diminish, particularly a neighboring island client's, access to care unnecessarily so. I have taken care of four clients this year alone who have sought MAiD, there are already so many cumbersome steps in the process, wait times, visits, revisits, psychological visit, shortage of providers, etc. Only one has received the medication and was not able to use it by the time it was received because of the cumbersome process that already exists. We do not need to add more unless we are adding something for a reason that benefits the client and the safety of access to the service for the client and the providers. Please note requiring a face to face with a specialist, with this specialty shortage may eliminate MAiD as an option for the client. Additionally, it will likely require off island travel for Lana`i residents if they can get a timely appointment and travel coordinated. They don't feel well, they are dying, flights are delayed, the planes to and from Lana`i are unbearably small and difficult to get in and out of for a healthy person and flights frequently are unavailable and expensive – nonsense! We need to work to accommodate their wishes, as long as we are staying within the parameters of the law.

We have proven that telemedicine is adequate for care even during a pandemic. Requiring a client to see another provider face to face during such a sensitive time may exclude the client from being able to utilize the law, as it was created and to allow the client to choose death on their terms (to a degree) over lengthy transitioning which can include suffering when faced with a terminal illness.

I beg of you to reconsider the purpose of the law and manage requirements in a meaningful and sensible manner, if care can be provided as needed and within the parameters of the law. Ultimately changes need to make sense.

Valerie Janikowski RN, BSN
Lana`i Kina`ole Inc.
Program Administrator

Testimony of Sam Trad, Hawai'i State Director, Compassion & Choices
Supportive Testimony Regarding HB 1823 HD2 SD1

Good morning Chairs Rosalyn H. Baker and Karl Rhoads, Vice Chairs Stanley Chang and Jarrett Keohokaloleand Members of the Committees. My name is Sam Trad and I am the Hawai'i State Director for Compassion & Choices, the nation's oldest and largest nonprofit organization working to improve care, expand options and empower everyone to chart their own end-of-life journey.

Thank you for passing the Our Care, Our Choice Act, which has provided peace of mind to the terminally ill over the last three years it has been in effect; and thank you for your consideration of HB 1823 HD2 SD1. We are here today and pleased to offer our support for these crucial amendments to the Our Care, Our Choice Act.

This legislation is based on the suggested amendments the Department of Health has made to the legislature. One year into implementation of the Hawai'i Our Care, Our Choice Act (OCOCA), the Department of Health conducted an analysis of the implementation of the law by soliciting input from the medical community. A subsequent report to the legislature[1] found that while compassionately implemented, some of the well intentioned regulatory requirements outlined in the Act are creating unintended barriers and unnecessary burdens in care. Coupled with the state's well-known severe physician shortage, which has only worsened with the COVID-19 pandemic[2][3] and is especially dire on neighbor islands,[4][5] these collective barriers have made it very difficult for terminally ill patients seeking to access medical aid in dying. Unfortunately, many individuals died with needless suffering while attempting to navigate the process. In fact, we know from local healthcare systems that at least 21 eligible patients who

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[1] Report to the Thirtieth Legislature, Our Care, Our Choice Act Annual Report, Reporting Period 2019, Hawai'i Department of Health. Accessed at: https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf

[2] University of Hawai'i System Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project, November 2021. Accessed at: https://www.ahec.hawaii.edu/workforce-page/

[3] Hawai'i doctor shortage worsens during pandemic, June 15, 2021. Accessed at: https://www.kitv.com/video/hawaii-doctor-shortage-worsens-during-pandemic/article_887db62f-c8ee-5f02-95b5-01d7102395b0.html

[4] Hawai'i's doctor shortage has worsened after the COVID-19 pandemic, Jan 7, 2021. Accessed at: https://www.khon2.com/coronavirus/hawaiis-doctor-shortage-has-worsened-after-covid-19-pandemic/

[5] Physician shortage takes a troubling turn for the worse, John A. Burns School of Medicine University of Hawaiʻi at Mānoa, September 10th, 2019. Accessed at: https://jabsom.hawaii.edu/hawaii-doctor-shortage-takes-a-troubling-turn-for-the-worse/

wanted the option of medical aid in dying died during the mandatory waiting period, unable to have the peaceful end of life experience they wanted.[6]

Holding true to the intent of the Our Care, Our Choice Act - to ensure that all terminally ill individuals have access to the full range of end of-life care options - the bill before you seeks to ensure eligible patients can access medical aid in dying by amending the law to:

- Reduce the current mandatory minimum 20 day waiting period between oral requests to 15 days.
- Allow the attending provider the authority to waive the mandatory minimum waiting period if the eligible patient is unlikely to survive the waiting period (the patient must still go through the qualifying process).
- Allow qualified Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) to support patients in the option of medical aid in dying by acting as the attending provider, consulting provider and/or mental health counselor.

All of these amendments will reduce unnecessary burdens terminally ill Hawaiʻi residents face when trying to access medical aid in dying.

*However, the bill also seeks to amend the law to require that an attending provider make the initial determination of whether a patient is eligible for medical aid in dying under the OCOCA in person. Unlike the other amendments in the bill, this amendment creates an additional roadblock for patients who wish to access medical aid in dying and there is no evidence supporting it. It can be very difficult to schedule an in person visit and terminally ill patients don't always have time to get through the process if the first visit must be in person. Hawaiʻi has a robust telehealth system that makes it easier for dying patients to see their providers. This amendment would reverse important progress that telehealth has made. This amendment is also a new addition to the version of this bill that the House passed out and would force the bill to go to conference.

<u>Expediting and/or reducing the mandatory minimum waiting period as they now do in Oregon, California and New Mexico</u>

Hawaiʻi currently has the longest mandatory waiting period (20 days) between the first and second oral requests for medical aid in dying, of the 11 authorized U.S. jurisdictions. Hawaiʻi physicians have said that their eligible terminally ill patients are suffering terribly at the end of

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[6] Susan Amina, NP, Kaiser HI, OCOCA panel on 1.13.21; Michelle Cantillo R.N., Advance Care Planning Coordinator, HPH, OCOCA panel on 1.13.21.

life and are not surviving the 20-day mandatory waiting period between oral requests.[7] Internal data from Kaiser Hawai'i and Hawai'i Pacific Health show that a significant number of eligible patients do not survive the long waiting period.

This experience matches what we have seen from data and experience throughout the other authorized jurisdictions which have less restrictive measures in place than currently exist in Hawai'i. In 2019, in response to the evidence compiled over 21 years of practice, the Oregon legislature amended its law in an attempt to find a better balance between safeguards intended to protect patients and access to medical aid in dying. The amended law (SB579) gives doctors the ability to waive the current mandatory minimum 15-day waiting period between the two required oral requests and to waive the 48-hour waiting period after the required written request before the prescription can be provided, if they determine and attest that the patient is likely to die while waiting.[8] The similar amendment to the OCOCA before you now is a direct result of evidence and data in Hawai'i that clearly demonstrates the need for easier access for eligible terminally ill patients facing imminent death.[9]

Last year, California amended their waiting period from 15 days to 48 hours, because data from healthcare systems in California showed that approximately 30% of eligible patients who want medical aid in dying do not survive the minimum 15 day waiting period.[10] Additionally, New Mexico's medical aid-in-dying law, which went into effect last year, only requires one written request and one 48 hour waiting period between receiving and filling the prescription.[11]

<u>Expanding the Definition of Provider to include those who have it within their current scope of practice: Advanced Practice Registered Nurses (APRN) and Physician Assistants (PAs)</u>

- Hawai'i is one of 25 states that give advanced practice registered nurses (APRNs) authority to independently carry out all medical acts consistent with their education and

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[7] 'Like a Christmas Present': Hawaii's Medical Aid in Dying Law Eased Patient's Anxiety, The Civil Beat, Jul 1, 2019. Accessed at: https://www.civilbeat.org/2019/07/a-palpable-sense-of-relief-hawaiis-medical-aid-in-dying-law-eased-patients-anxiety/

[8] Senate Bill 579, 80th Oregon Legislative Assembly--2019 Regular Session. Accessed at: https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB579

[9] Report to the Thirty-First Legislature, Our Care, Our Choice Act Annual Report, Reporting Period 2020, Hawai'i Department of Health. Accessed at: https://health.hawaii.gov/opppd/files/2021/06/2020-Annual-OCOCA-report-6.30.21.pdf

[10] Characterizing Kaiser Permanente Southern California's Experience With the California End of Life Option Act in the First Year of Implementation. JAMA Internal Medicine, H.Q. Nguyen, E.J. Gelman, T.A.Bush, J.S. Lee, M.H.Kanter (2018). Accessed at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2665731

[11] Elizabeth Whitefield End of Life Options Act, Ch. 24, art. 7C NMSA 1978. Accessed at: https://nmonesource.com/nmos/nmsa/en/item/4384/index.do#!b/a7C

training, including prescribing all forms of medication, including controlled substances.[12]

- Physician Assistants may perform all duties and responsibilities delegated to them by their supervising physician and within the scope of practice and prescribing authority for PAs under existing Hawaiʻi law.
- However, by not including APRNs and PAs within the definition of "provider," the Our Care, Our Choice Act unnecessarily prohibits them from providing high quality health care and support to patients who want the option of medical aid in dying. Amending the law to explicitly allow APRNs and PAs to participate as providers under the Our Care, Our Choice Act is generally consistent with their scope of practice and would help address the disparity in access to participating providers, particularly in rural areas and neighbor islands.
- For example, Ron Meadow, who lived on the Big Island, was terminally ill and eligible for the Our Care, Our Choice Act, spent his final weeks searching for a physician who would support him in the option of medical aid in dying, so he could end his suffering. Sadly, by the time he found a physician it was too late and Ron died in pain in exactly the way he did not want. Allowing APRNs and PAs to support patients in medical aid in dying will provide patients, like Ron, with more options to access this compassionate option.
- Additionally, other jurisdictions are recognizing that restricting the definition of "provider" to physicians for the purposes of medical aid in dying creates an unnecessary barrier to access. For example, in 2021 New Mexico passed aid-in-dying legislation authorizing APRNs and PAs to serve as either the attending or consulting provider.[13]

Requiring that the attending provider make the initial determination of eligibility for medical aid in dying in person

Hawaiʻi law already requires that providers have an in-person consultation with a patient prior to prescribing opiates.[14] Currently, all medical aid in dying medications available in the United States contain some form of opiate, so providers are already required to have at least one in-person consultation with patients prior to prescribing medical aid in dying. Notably, this

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[12] American Association of Nurse Practitioners, 2021 Nurse Practitioner State Practice Environment. Accessed at: https://storage.aanp.org/www/documents/advocacy/State-Practice-Environment.pdf

[13] Elizabeth Whitefield End of Life Options Act, Ch. 24, art. 7C NMSA 1978. Accessed at: https://nmonesource.com/nmos/nmsa/en/item/4384/index.do#!b/a7C

[14] HRS §45301.3(c)

amendment would place additional burdens on patients, particularly those in more rural areas, to secure an in-person visit with an attending provider in order to fulfill the requirements of an initial request, even if the provider and patient have a long-standing relationship that otherwise fulfills the in-person requirement for opiate prescriptions under Hawai'i law. Under the current law, a provider may require the initial determination be in person if they believe it is medically necessary, without having it mandated by the state. This amendment does nothing to increase patient safety, it simply makes patient access to medical aid in dying through telehealth more difficult by directing when the in-person visit between the patient and provider must occur. Because of the reasons mentioned above, we recommend that the committee strike this amendment from the bill.

Every eligible patient who wants the peace of mind that the Our Care, Our Choice Act provides should be able to benefit from it no matter which island they live on. These smart amendments will remove barriers to patients, especially in rural areas and on neighbor islands, so that they can have the compassionate option of medical aid in dying. Thank you for your time and attention to this matter.

Sincerely,

Sam Trad
Hawai'i State Director
Compassion & Choices

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

Committee on Judiciary
Senator Kari Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

From: Michelle Cantillo, RN, Advance Care Planning Coordinator, Hawaiʻi Pacific Heath

RE: HB1823, HD2, SD1 Relating to Health –Medical Aid in Dying, Our Care, Our Choice Act. Authorizes advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient. Requires a prescribing provider to conduct an initial visit in-person. Amends the mandatory waiting period between oral requests and the provision of a prescription.

I, Michelle Cantillo, RN, Advance Care Planning Coordinator representing Hawaii Pacific Health (HPH) am writing to express HPH support of HB1823, HD2, SD1. This bill allows more providers to voluntarily participate in medical aid in dying and will help terminally ill patients to grant their dying wishes as their time is limited. HPH supports this bill with the recommendation to remove "Requires a prescribing provider to conduct an initial visit in-person."

Since January 1, 2019, there have only been a limited amount of physicians who are willing to be an attending physician for Medical Aid in Dying. At HPH, there are less than 15 physicians who are willing to participate in writing the aid-in-dying prescription! Currently this is one percent (1%) of physicians who are willing to be an attending physician at our 4 hospitals (1505 physicians on medical staff).

HPH providers have been educated on Medical Aid in Dying bill since this law passed and there are processes in place to help support patients and their physicians. However, as an Advance Care Planning nurse coordinator and with only one percent of our physicians willing, it has been challenging for me and other nurse navigators or social workers to find physicians for our terminally ill patients who are in support of this law. Department of Health has data that shows there is a physician shortage in both primary care and specialty areas especially outer islands. At HPH, 83% of patients requesting Medical Aid in Dying have cancer with metastases. Hawaii has a lack of oncologists on island and we currently use locum oncologists in Kaua'i. HPH is in the process of hiring however replacement takes a couple of months for their credentialing. We have no physicians willing to write the aid-in-dying prescription on Kaua'i, thankfully participating Oahu physicians can do telehealth for these outer island patients.

The current oncologists are stretched very thin and priority are given for new patient consults and ensuring all patients are able to be assessed in a reasonable time. For the few oncologists who do try to help qualified terminally ill patients, they have to fit them in their already busy schedules and have voiced concerns why there is a lack of support from other physicians.

HPH recommends the removal of “requires a prescribing provider to conduct an initial visit in-person”. During the pandemic it was a blessing for these terminally ill patients, many of whom has decreasing mobile function to have telehealth conducted with their providers. Our Oahu providers are very willing to help outer island patients via a telehealth visit. It is very impractical for a prescribing physician to travel to outer island to do an in-person first oral consult. Per the law, the first oral request may start with another participating physician once patient qualifies. If this law is passed with the amendment, this can make the process even longer for the patient who may have challenges finding an attending prescribing physician.

HPH is thankful for the few Oahu participating physicians who will voluntarily consult if patient’s current physicians are not willing to participate in the law. Many of the Advanced Practice Registered Nurses (APRN) at HPH have expressed their support for this bill. With training, our APRNs or PAs will continue to work closely with physicians and collaborate on how best to help support patients requesting medical aid in dying.

At HPH, many patients do not meet the 20 day window after their first oral request. In the past three years, 60 patients have completed their 1st oral request and 45 of those patients went on to complete their 2nd oral request. Many of these patients had a rapid decline and expired while waiting. HPH is in favor of waiving the mandatory waiting period and decrease the time from 20 days to 15 days. Our providers are very skilled at assessing their patients and can determine when it is appropriate to provide an expedited pathway for those qualified terminally ill patients who are not expected to survive the mandatory waiting period.

The state passed this law in 2018 to ensure that all terminally ill individuals will have access to the full-range of end-of-life options. Three years later, data has shown that the state of Hawaii needs to improve access. Let’s make this law better for our dying patients.

HPH urges you to support HB1823, HD2, SD1 and remove the amendment for in-person first oral request. Thank you for the consideration of our testimony.

Mahalo,
Michelle Cantillo, RN, ACP Coordinator
Hawai’i Pacific Health
michelle.cantillo@hawaiipacifichealth.org
808-535-7874

TESTIMONY OF EVAN OUE ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) WITH COMMENTS TO HB 1823 HD2 SD1

Date: Friday April 1, 2022

Time: 10:30 a.m.

My name is Evan Oue and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ) with **COMMENTS and PROPOSING AMENDMENTS** to HB 1823 HD2 SD1, Relating to Health. HAJ is concerned with HB 1823 as it prohibits certain medical records pertaining to euthanasia from discovery in civil cases.

Specifically, the measure amends HRS Section 327L-14(c) to state "Information collected pursuant to this ~~[section]~~ <u>chapter</u> by the department or <u>retained as the result of incidental or routine communication with providers and qualified patients</u> shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding." HAJ is concerned with this provision because it could have the unintended consequence of preventing the discovery of relevant and important information in a civil case, just because the information was sent to the department. For example, if a patient's medical record was sent to the department, then it could be argued that the patient could not obtain their own medical record in discovery.

In order to avoid such an absurd result, HAJ recommends adding the following sentence to HRS Section 327L-14 to make clear that information sent to the department remains discoverable from entities other than the department and is not precluded from discovery by virtue of the fact it was collected by the department:

> "<u>Original sources of information, documents, or records collected pursuant to this chapter by the department or retained as the result of incidental or routine communication with providers and qualified patients shall not be construed as being</u>

> immune from discovery or use in any civil, criminal, administrative or proceeding merely because they were collected or retained by the department. Litigants may seek to obtain the information, documents, or records in discovery from parties other than the department."

This additional language tracks an existing statute with a similar purpose, HRS Section 624-25.5 (2012), pertaining to medical peer review. Thank you for allowing us to testify regarding this measure. Please feel free to contact us should you have any questions or desire additional information.

ALOHACARE

To: The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice-Chair
Senate Committee on Commerce and Consumer Protection

The Honorable Karl Rhoads, Chair
The Honorable Jarrett Keohokalole, Vice-Chair
Senate Committee on Judiciary

From: Peggy Mierzwa, Community and Government Relations

Hearing: Friday, April 1, 2022

RE: **HB1823 HD2, SD1 Relating to Health -Support**

AlohaCare appreciates the opportunity to provide testimony in **support** of **HB1823 HD2, SD1.** This measure will authorize Advanced Practice Registered Nurses (APRN) and Physician Assistants (PAs), in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority. The measure will also authorize advance practice registered nurses with psychiatric or clinical nurse specialization or physician assistants, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient. In addition to those changes, this measure will also ease the waiting periods to better serve patients who are terminally ill in a timely manner.

Founded in 1994 by the community health centers, AlohaCare is a community-rooted, non-profit health plan serving 80,000 Medicaid and dual-eligible health plan members on all islands. We are the only health plan in Hawaii that exclusively serves Medicaid beneficiaries. Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating for access to quality health care for all. We believe that health is about supporting whole-person care.

Hawaii has struggled with a shortage of physicians for decades. This shortage means that in a variety of medical circumstances, residents, particularly those who reside on neighbor islands, are unable to access timely health care near their home, or even their home island. Addressing this shortage is not a one-solution approach. The Legislature has several measures before them this year ranging from scope of practice to telehealth bills that will help to increase patient's access to care.

This measure will increase patients' access to care by allowing APRNs and PAs to practice to the full scope of their licensure. It will give them the authority to prescribe as well as fully practice in alignment with their licensure allowances under the Our Care, Our Choice Act. APRNs and PAs can increase access to care. AlohaCare supports increasing equitable access to care through this measure for the residents of Hawaii. Our members and all residents need to have timely access to important health care and procedures.

We support allowing healthcare professionals to practice to the full scope of their licensure. We believe this approach helps to address gaps in care found throughout the state.

Mahalo for this opportunity to testify in **support of HB1823 HD2 SD1**.

HAWAII MEDICAL ASSOCIATION
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SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

SENATE COMMITTEE ON THE JUDICIARY
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

Date: April 1, 2022
From: Hawaii Medical Association
Elizabeth England MD, Vice Chair, HMA Legislative Committee
Elizabeth Ann Ignacio MD, Chair, HMA Legislative Committee

Re: HB1823 HD2 SD1, Our Care, Our Choice Act; Advanced Practice Registered Nurses; Physician Assistants; Mandatory Waiting Period; Information
Position: Offering Comments

The Our Care Our Choice Act allows terminally ill patients the opportunity to control the manner of their death. The primary goals of medical aid in dying (MAiD) are to increase patient autonomy, allowing individuals the right to control the circumstances of their death when it is otherwise inevitable, and to decrease suffering in the setting of a terminal disease[1]. Our comments on this proposed legislation are only intended to address issues around the implementation of MAiD in order to ensure that even the most vulnerable patients in our community receive quality care and services.

Patients who have completed MAiD in Oregon and Washington were more likely to have some level of college education, have public or private medical insurance, be Caucasian, and over the age of 65[4]. These findings suggest that traditionally vulnerable populations are not the primary recipients of MAiD. It is important to note that these studies are largely observational, and additional research is needed. To ensure that this is the decision of a competent individual with no elements of coercion or under-/untreated psychiatric disease, the patient is required to have an evaluation by a counselor[2]. Hawaii adds an additional protection by mandating a mental health evaluation be performed by a counselor, though definition of “counselor” is not clarified[3].

The gravity of this decision deserves robust research and careful layers of protection. There is evidence that depression may play a role in a patient’s decision to participate in MAiD, raising concerns regarding determination of patient decision-making capacity. Patients requesting MAiD in Oregon were more likely to have higher levels of depression and hopelessness than their counterparts with similar advanced disease[5]. Additionally, cases of elderly abuse and patients exhibiting concerning suicidal behavior prior to participation are reported[6].

Hawaii patients deserve the highest standard of care, particularly in matters of life and death. HMA respectfully submits the following recommendations that are consistent with the intention of the Our Care Our Choice Act and ensure the safety of our most vulnerable patients:

1. Require that the providers prescribing the terminal prescription for MAiD perform a formal decision-making capacity evaluation following the standards of evaluations completed by Psychiatrists, outlined in American Psychiatric Association resource document as follows:
    a. "A DC (decision capacity) assessment should start with a full psychiatric interview, as several psychiatric diagnoses are associated with greater impairment in DC. Such workup includes a thorough history, interview, focused physical examination, laboratory testing, additional imaging and procedures where needed, and discussions with hospital staff and family members, if relevant and available.
    b. Cognitive assessments such as MMSE or MoCA, with additional testing as indicated (e.g., Hamilton Depression Rating Scale, Young Mania Rating Scale, Positive and Negative Symptoms Scale, neuropsychological testing) should be performed for any DC evaluation, since cognitive impairment is highly associated with DC impairment.
    c. Assumptions should not be made that all patients with psychiatric illnesses, including neurocognitive disorders, lack DC, nor that patients on psychiatric commitment order necessarily lack DC.
    d. Efforts should be made to determine underlying factors contributing to decisional incapacity, and to correct any reversible factors in efforts to restore DC."[7]
2. Mandate that the Department of Health publish the data requested in the Our Care Our Choice Act §14 (D)(1-8) in an annual report available to the public.[3]
3. Require that the patient's primary provider assess for the possibility of coercion, as outlined in the Maine Death With Dignity Act, Sec. 1. 22 MRSA c. 418, §2140(6)(E): "Confirm that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is feeling coerced or unduly influenced"[8].

Thank you for allowing the Hawaii Medical Association to offer comments on this measure.

Continued

REFERENCES

1. Harris, D., Richard, B., & Khanna, P. (2006, August). *Assisted dying: The ongoing debate*. Postgraduate medical journal. Retrieved March 18, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585714/
2. "States with Legal Physician-Assisted Suicide - Euthanasia - ProCon.Org." *Euthanasia*, https://euthanasia.procon.org/states-with-legal-physician-assisted-suicide/. Accessed 18 Mar. 2022.
3. *A BILL FOR AN ACT*. (n.d.). Retrieved March 20, 2022, from https://health.hawaii.gov/opppd/files/2018/11/OCOC-Act2.pdf.
4. *Predictors of Pursuit of Physician-Assisted Death - ScienceDirect*. (n.d.). Retrieved March 20, 2022, from https://www.sciencedirect.com/science/article/pii/S0885392414003984.
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6. Steinbock B. The case for physician assisted suicide: not (yet) proven.*Journal of Medical Ethics* 2005;**31:**235-241.
7. Resource Document on Decisional Capacity Determinations in Consultation-Liaison Psychiatry: A Guide for the General Psychiatrist Approved by the Joint Reference Committee, June 2019 APA Operations Manual. Prepared by: James A. Bourgeois, OD, MD; Maria Tiamson-Kassab, MD; Kathleen A. Sheehan, MD; Diana Robinson, MD; Mira Zein, MD on behalf of the Council on Consultation-Liaison Psychiatry
8. *PATIENT-DIRECTED CARE 2020 ANNUAL REPORT*. (n.d.). Retrieved March 20, 2022, from https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Patient-Directed%20Care%20%28Death%20with%20Dignity%29%20Annual%20Report%20--%204-2021.pdf.

HB-1823-SD-1
Submitted on: 3/31/2022 7:37:46 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Charles F Miller	Testifying for Hawaii Society of Clincal Oncology	Support	Written Testimony Only

Comments:

Good morning and Aloha Chairs Baker and Rhoads,

I have supported and testified in favor of HB1823, including at all recent committee hearings. However the recent addition to the bill during the Health Committee hearing, requiring an in-person visit by the attending physician will completely abrogate all of the other amendments in the bill if this requirement remains in place.

I have served as the Director of Kaiser Hawaii's Aid in Dying Program since the Our Care, Our Choice Act(OCOCA) became law. I have consulted on over 125 patients who requested medical aid in dying(MAID) and this experience has shown and taught me that requiring an in-person visit will dramatically reduce access to the law.

There are two very important reasons why i believe this is true. First, many, if not most patients who request MAID are too ill to make a last visit to see a physician in person. A third of my patients died in less than 20 days from their first request for MAID. Many patients who would like to use the OCOCA will simply give up the request rather than suffer through the stress of another doctor's visit. Second, very few physicians have the time or ability to do home visits for these patients who are so terminally ill. I have personally used telhealth visits for msny, many patients over the last two years during the pandemic and everyone of them was completely satisfied with this type of doctor-patient interaction.

It is my belief that the OCOCA should be easily and readily available to all Hawaii residents who request it. If the requirement for an in-person visit remains it will reverse all of the other amendments in HB1823 meant to increase access to the law. I urge you to remove the in persn requirement fom the bill. Please do not hesitate to contact me if you have questions or wish to discuss this issue further.

Aloha,

Charles F Miller, MD, FACP, FASCO

Board of Directors, Hawaii Society of Clinical Oncology

Director, Kaiser Hawaii Medical Aid in Dying Program

Hawai'i Association of Professional Nurses (HAPN)

HAWAII ASSOCIATION of
PROFESSIONAL NURSES

To: The Honorable Senator Rosalyn Baker, Chair of the Senate Committee on Commerce and Consumer Protection and The Honorable Senator Karl Rhoads, Chair of the Senate Committee on Judiciary

From: Hawaii Association of Professional Nurses (HAPN)
Subject: HB1823 HD2 SD1 – Relating to Health

Hearing: April1st, 2022, 2022, 10:30a.m.

Aloha Senator Baker, Chair; Senator Chang, Vice Chair, and CPN Committee Members; and Senator Rhoads, Chair; Senator Keohokalole, Vice Chair and JDC Committee Members,

Thank you for the opportunity to submit testimony regarding HB1823 HD2 SD1. HAPN is in **strong support with amendments** of placing choice in the hands of patients with whom we work every day, which includes patient choice in who their provider is when making a decision of this magnitude. We have reviewed the recommendations made by the Department of Health to include Advanced Practice Registered Nurses (APRN) to practice medical aid in dying in accordance with their scope of practice. We also support reducing the mandatory waiting period and allowing the provider to waive this waiting period as they deem appropriate after evaluation and discussion with the patient about their options.

We have some significant concerns with the amendment that changes the process of seeking these services to an "in-person" appointment for the initial determination. This is not a requirement for usual and standard care in the era of increased telehealth utilization. Requiring in-person appointments to review this option would significantly impact the patient and pose an undue hardship to those who may be bedbound or have significant mobility concerns that could additionally impact their family/support team in getting them to this in person appointment. The current laws in our state dictate that an in-person visit is required before prescribing a controlled substance. We request the statement for in-person evaluation be removed as providers across the state have to complete in-person assessments prior to prescribing a controlled substance.

This is a multi-professional bill working toward increasing access to care. This access to care has gotten worse over the years due to many reasons, but most notably the decline in the number of providers to improve access. Research for physicians and APRNs in Hawaii show that there will be even steeper declines in the number of providers to provide general access in the coming years.

HAPN's mission, to be the voice of APRNs in Hawaii, has been the guiding force that propelled us to spearhead the advancement of patients' access to healthcare as well as supporting the recognition of the scope of practice for APRNs in Hawaii which led us to full practice authority. We have worked to improve the physical and mental health of our communities. As our ability to provide close care with our patients progressed, we also opened up our own clinics to provide the care our patients deserve. As a result, the current law requires that a patient remove themselves from the excellent care their APRN has provided them over the years to discuss this end-of-life option with physicians who may not have the same patient-provider relationship.

APRNs have played an important role in the healthcare of our communities, and we will continue to be by our patients' side as they make many different healthcare decisions throughout their lives. There have been clear indications that patients on our rural islands have been having difficulty finding healthcare professionals to support them in their legal right: https://www.hawaiitribune-herald.com/2020/11/15/opinion/aid-in-dying-shouldnt-be-this-difficult-in-east-hawaii/. We support the recommendations from our partners at the Department of Health in their assessment and evaluation of this issue.

Thank you for the opportunity to share the perspective of HAPN with your committee. Thank you for your enduring support of the nursing profession in the Aloha State.

Respectfully,
Dr. Jeremy Creekmore, APRN
HAPN President

Dr. Bradley Kuo, APRN
HAPN Legislative Committee, Chair
HAPN Past President

hawaii family forum

Submitted Online: March 31, 2022

HEARING: Friday, April 1, 2022

TO: Senate Committee on Commerce & Consumer Protection
Sen. Rosalyn Baker, Chair
Sen. Stanley Chang, Vice-Chair

Senate Committee on Judiciary
Sen. Karl Rhoads, Chair
Sen. Jarrett Keohokalole, Vice-Chair
FROM: Eva Andrade, President

RE: Opposition to HB1823 HD2 SD1 Relating to Health

Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawaii. We oppose this bill that chips away at the safeguards that were put in place when the “Our Care, Our Choice” law went into effect.

Waiving the mandatory waiting period for qualified patients not expected to survive the mandatory waiting period is very dangerous. Doctors can only give their best professional “guess” on patient survival. What if they are wrong? Removing the original “safeguard” of the waiting period, we believe, would open the door to abuse and/or coercion. The 2021 Oregon report showed that 3.3% of patients outlived the prognosis [ii].

We also have strong concerns regarding the Department of Health’s request to stop the release or “the disclosure or discovery of information collected or retained pursuant to incidental or routine communication between the Department of Health and qualified patients or providers.” While not unusual to protect identities of patients and even providers, we are leary of provisions that completely insulates the information from disclosure pursuant to a subpoena, for example. That is excessive. What happens if a patient’s family believes a provider coerced a patient into requesting physician-assisted suicide or short-cut the process? Families would have few avenues to adequately investigate that under this provision.

We expressed our strong opposition when the Our Care Our Choice Act was passed in 2018 because we were (and still are) very concerned about abuse of the law, primarily against frail elders and other vulnerable patients. At that time, to alleviate our concerns, the introduction to the bill stated that the “rigorous safeguards will be the strongest of any state in the nation and will protect patients and their loved ones from any potential abuse [ii].” Therefore, we are disheartened to see that these safeguards are already being removed or modified.

Although there are those in the community that are receptive to the general concept of assisted suicide, we believe that when the public learns about the dangers of assisted suicide, especially for those who are poor, elderly, disabled, or without access to good medical care, their views shift against the practice. Rather than expand the law, we should continue to provide (and promote) education on available access to palliative care and hospice services.

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[i] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDI GNITYACT/Documents/year23.pdf (accessed 03/15/21)

[ii] https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.HTM

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The Hawaiian Islands Association
for Marriage and Family Therapy
(HIAMFT)
We know systems.
We know relationships.
We know FAMILY MATTERS.

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

DATE: April 1, 2022 10:30 AM. - VIA VIDEO CONFERENCE – Room 16

Testimony in Support to Add Marriage & Family Therapists as Eligible Counselors

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT) strongly supports HB1823 HD2 SD1, which would give advanced practice registered nurses, psychiatric mental health nurse practitioners, and physician assistants the authority to engage in certain medical aid in dying services. These services have been previously limited to physicians, psychiatrists, psychologists, and social workers.

While HIAMFT strongly supports this bill, we believe **it can be strengthened to further achieve the purpose and intent of Our Care, Our Choice legislation by adding Marriage and Family Therapists (MFTs) to the corps of healthcare professionals allowed to provide "counseling" services** outlined in Hawaii Revised Statutes section 321L-1 to determine if a patient is capable, and has received adequate treatment for depression or other conditions that may impact his or her ability to make informed aid-in-dying decisions.

In the senate companion to this bill, SB2680 SD1, the Senate Committee on Health added MFTs to those authorized to provide "counseling" because of their expertise in mental health counseling and family systems. In this vein, we also ask that language be added to require physician assistants – added in the HD1 of this measure – who would also be authorized to provide "counseling" services, also have the requisite training in mental health.

Marriage and Family Therapists are one of five core mental health professions (along with psychiatrists, psychologists, social workers and advanced practice psychiatric nurses) identified by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) of the US Government. Additional information can be obtained in *The Mental Health Workforce: A Primer* (April 20, 2018). They are trained to diagnose and treat mental health issues, such as but not limited to, anxiety, depression, substance abuse, alcoholism, relationship/marital problems, child-parent problems, ADD/ADHD, and schizophrenia.

Perhaps most germane to this measure, MFTs are specifically trained to attend to a patient's primary relationship networks that may become resources for well-being. With a relational and systemic focus, MFTs use a perspective that considers the full context of a patient's situation. This perspective is particularly important when working with critically serious issues like the intentional ending of one's life.

Moreover, MFTs are specifically trained to understand and help patients discuss all aspects of family life and other interpersonal dynamics. In working with a dying patient, that person may be concerned about one or more family members, pets, or others within their personal family "system." Therapy may represent a last opportunity for saying good-bye or the possibility of healing and forgiveness for both the dying patient and various family and/or other community members.

Accordingly, we ask that Marriage and Family Therapists be added to the professionals authorized to provide "counseling" services on page 5, lines 3- 10 of this bill as follows:

> "Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, [~~or~~] clinical social worker licensed pursuant to chapter 467E, advanced practice registered nurse with a psychiatric or clinical nurse specialization licensed under chapter 457, a physician assistant **with mental health training** licensed under section 453-5.3, or **marriage and family therapist licensed pursuant to chapter 451J** and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions [~~which~~]that may interfere with the patient's ability to make an informed decision pursuant to this chapter."

Thank you for the opportunity to provide strong support and suggested amendment for this important bill.

Sincerely,

John Souza J LMFT, DMFT

Dr. John Souza, Jr., LMFT, DMFT, President
The Hawaiian Islands Association for Marriage and Family Therapy

NASW, HAWAI'I CHAPTER
National Association of Social Workers

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

DATE: April 1, 2022 10:30 AM. - VIA VIDEO CONFERENCE – Room 16

Testimony in Support on **HB1823 HD2 SD1 RELATING TO HEALTH** with comments

The National Association of Social Workers – Hawai'i (NASW- HI) **supports HB1823 HD2 SD1**, giving psychiatric mental health nurse practitioners, clinical nurse specialists, and physician assistants the authority to engage in certain medical aid in dying services, as well as reduce the waiting time for patients to be eligible for the program.

These services have been previously limited to physicians, psychiatrists, psychologists, and clinical social workers. NASW- HI supports the addition of qualified APRNs and physician assistants to the cadre of medical and mental health professionals to provide services through this program; however, **we would like the bill to clarify that the physician assistants providing "counseling" services are appropriately trained in mental health.**

Just as the Senate Health Committee did in SB2680, the companion of this bill, NASW-HI also would also like to see **Licensed Marriage and Family Therapists added to the professionals authorized to provide "counseling"** services in Hawaii Revised Statutes Section 3217L-1 – as they have specialized mental health training in the relational aspects of a dying patient's family and community. Accordingly, we ask that Marriage and Family Therapists be added to the professionals authorized to provide "counseling" services on page 5, lines 3- 10 as:

> "Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, [~~or~~] clinical social worker licensed pursuant to chapter 467E, advanced practice registered nurse with a psychiatric or clinical nurse specialization licensed under chapter 457, a physician assistant **with mental health training** licensed under section 453-5.3, or **marriage and family therapist licensed pursuant to chapter 451J** and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions [~~which~~]that may interfere with the patient's ability to make an informed decision pursuant to this chapter."

There currently is a significant shortage of providers. As the baby boomer generation ages, provider shortages and access to care in this area will only exacerbate.

Thank you for the opportunity to provide this testimony in support.

Sincerely,

Sonja, MSW, LCSW

Sonja Bigalke-Bannan, MSW, LCSW
Executive Director,
National Association of Social Workers- Hawai'i Chapter

LATE

Hawaii Association
HANA
of Nurse Anesthetists

April 1, 2022

Aloha Chairs Baker and Rhoads and members of the committees!

We are writing to comment on HB 1823, HD2, SD1, relating to health. This bill authorizes advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient. We are in support of advanced practice registered nurses and thank the legislature for seeking appropriate opportunities to address the significant medical and healthcare needs in our state.

The Hawaii Association of Nurse Anesthetists is a professional organization for Certified Registered Nurse Anesthetists (CRNAs) in the state of Hawaii. It is affiliated with the American Association of Nurse Anesthesiology (AANA) and is dedicated to promoting the CRNA profession and advancing the art and science of anesthesia by:

- Developing and promoting educational and practice standards that support and enhance cost-effective, quality anesthesia care for the patients, payers, and physicians we serve.
- Providing patient education and information about anesthesia and related healthcare services.
- Monitoring and maintaining active presence in state and national CRNA practice and healthcare legislative issues by working with lawmakers, regulatory agencies, and those who shape healthcare policy.
- Promoting partnerships with the community and liaisons with other healthcare professions to integrate and promote practice and healthcare quality issues.
- Providing continuing education information for our members and other CRNAs.

We wish to serve as a resource to policy leaders and look forward to working with legislators to understanding issues related to nurse anesthesia during the legislative session and the interim.

Mahalo for the opportunity to testify.

TESTIMONY ON BEHALF OF HAWAII PSYCHIATRIC MEDICAL ASSOCIATION

To: Chairs Rosalyn Baker and Karl Rhoads; Vice Chairs Stanley Chang and Jarrett Keohokalole, and Members of the Committees of Commerce and Consumer Protection and the Judiciary

From: Dr. Denis Mee-Lee, Legislative Committee Chair, Hawaii Psychiatric Medical Association

Time: 10:30 am, April 1, 2022

Re: HB 1823, HD2 SD1

Position: **COMMENTS**

LATE

Dear Chairs Baker and Rhoads, Vice Chairs Chang and Keohokalole and Members of the Committees:

HPMA thanks the committee for the opportunity to offer comments on HB 1823, HD 2 SD1. HPMA is a state medical organization whose physician members advocate for safe, quality care of our patients by those appropriately trained. HPMA represents more than 130 psychiatrists in Hawaii. We thank the Senate Health Committee for adopting one of our amendments calling for an in person evaluation. Still, we note:

- HB 1823, HD2 SD1 would make Hawaii only the **2nd state in the nation** to allow APRNs to provide Aid in Dying and the **1st in the nation to allow PAs** to participate in lethal prescriptions.
- The State of Oregon is now becoming known for **"Suicide Tourism."** [i]
- The Disability Rights Education and Defense Fund has documented numerous Oregon and Washington State **Assisted Suicide Abuses and Complications including criminal convictions.[ii]**
- According to the Journal of the American Medical Association on Assisted Suicide in Washington and Oregon: of 2558 patients, rates of complications rates were reported for 1557 (60.87%); **the complication rate was unknown in the remaining 39.13%. unreported deaths**.[iii]

HPMA respectfully urges prudent restraint regarding expansion of Aid in Dying. If the Committee wishes to pass this measure, we would respectfully request consideration of the following amendments to Hawaii Revised Statutes §327L-1 et. Seq., the Our Life, Our Choice Act, to protect our patients.

1. The first amendment would require that all participating providers to be both licensed and certified:

[§327L-1] Definitions."Consulting provider" means a physician licensed **[and certified]** pursuant to chapter 453 who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
"Counseling" means one or more consultations, which may be provided through Telehealth, as necessary between a psychiatrist licensed **[and certified]** under chapter 453, psychologist licensed **[and certified]** under chapter 465, or clinical social worker licensed **[and certified]** pursuant to

chapter 467E and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from under treatment or no treatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter.

2. The following amendment would require the participating provider to attest to knowledge of the mandatory reporting requirements and would allow for mandatory additional training or supervision of those who are noncompliant.

HRS§327L-12(7):A statement by the attending provider indicating that all requirements under this chapter have been met **[An attestation, under penalty of perjury, that the attending provider has met all requirements under this chapter]** and indicating the steps taken to carry out the request, including identification of the medication prescribed. [L 2018, c 2, pt of §3].

3. This amendment would allow the department to provide a pertinent licensing board with information necessary to the investigation of noncompliant providers.

[§327L-14](c) Reporting requirements.Information collected pursuant to this section by the department shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

4. The following amendments would require the department to create standards for training in the recognition of mental illness, the evaluation of decision-making capacity, and detection of elder exploitation or abuse.

[§327L-14](e) On or before July 1, 2022, the department shall promulgate regulations for the training and **certification of licensed physicians, advanced practice registered nurses, clinical nurse specialists, physician assistants, psychologists, marriage and family therapists, and licensed clinical social workers who participate under the Act.** The regulations shall specify that the individual is **trained to recognize signs and symptoms of mental illness, which affect decision-making capacity, as well as the assessment of coercion or undue influence, to include:**

(1) The vulnerability of the patient, including (A) incapacity and illness

(B) Intellectual disability or cognitive impairment (C) education(D) social isolation€ social dependency

(2) The nature of the patient’s relationship with a primary caregiver, household members, or other influential individuals, including controlling access to the patient’s daily needs and medication, interactions with others, access to needed information or services, and the use of affection, excessive persuasion, or intimidation to initiate changes in

personal or property rights€ other factors relevant to the detection of elder exploitation or abuse (this should be especially important to the Kupuna Council).

5. The following amendment would require the department to annually compare PDMP prescriptions written under the act with mandatory reports submitted to the department, in order to detect non compliant health care providers. Noncompliant providers would be referred to the pertinent licensing boards for investigation and additional education or discipline.

[§327L-14](f)The department shall annually compare reports submitted under this act to prescription data contained in the Hawaii Prescription Drug Monitoring Program per the requirements of §329-101 et. Seq. A licensed and certified provider who is found to be out of compliance with the reporting requirements of §327L-14 of this Act shall be in violation of the Hawaii Medical Practice Act §453-1 et. Seq. or the appropriate provider's licensure law.

6. This amendment creates a duty for both physicians and dispensing pharmacists to ensure that the patient receiving the prescription is a qualified patient. It would also require prescriptions—which would include compounded formulas of multiple medications—to be flagged and registered in the PDMP.

HRS§329-38 Prescriptions.(a)(2) No schedule II narcotic controlled substance may be prescribed or dispensed for more than a thirty-day supply, except where such substances come in a single unit dose package that exceeds the thirty-day limit or where a terminally ill patient is certified by a physician to exceed the thirty-day limit;

[(A) The pharmacist shall record on the prescription document on file whether the medications are prescribed under the Our Care, Our Choice Act. Both the pharmacist and the prescribing provider have a corresponding responsibility to assure that the controlled substance is for a terminally ill patient.]

HPMA thanks the Committees for the opportunity to testify on HB 1823 HD2 SD1, and urges restraint or amendments to protect our Kupuna and Hawaii's vulnerable patients.

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[i] https://www.usnews.com/news/politics/articles/2022-03-28/oregon-ends-residency-rule-for-medically-assisted-suicide

[ii] https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/

[iii] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692

TO: SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
AND SENATE COMMITTEE ON JUDICIARY

RE: HB 1823, HD2, SD1 RELATING TO HEALTH.
Authorizes advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient. Requires a prescribing provider to conduct an initial visit in-person. Amends the mandatory waiting period between oral requests and the provision of a prescription. Prohibits the disclosure, discovery, or compelled production of information collected or retained pursuant to incidental or routine communication between DOH and qualified patients or providers. Effective 7/1/2060. (SD1)

FOR HEARING ON Friday, April 1, 2022

FROM:
Kenneth R. Conklin, Ph.D.
46-255 Kahuhipa St. Apt. 1205
Kane'ohe, HI, 96744
Tel. 808.247.7942

TESTIMONY IN SUPPORT

I write this testimony as an elderly man with a Ph.D. in Philosophy who has spent a lifetime reading, meditating, thinking, writing, and teaching about the nature of human life, including the inevitability of death. As further evidence of my thoughtfulness about this topic: I am registered with the willed body program of the UH John A. Burns School of Medicine. In my medical advance directive and in my Will I have described my own preference for final disposal of my remains after they have been used for transplantation and/or teaching anatomy through dissection.

Approximately 1971, as a professor at Emory University, the School of Nursing asked me to teach a course for students seeking a masters degree in Nursing to further their careers as teachers of nursing. One topic I focused on was the stages of dying as described by psychiatrist Elizabeth

Kubler-Ross in her then-newly-published book "On Death and Dying." Of course I used some writings by existentialist philosophers who believe that facing the inevitability of death, especially if it is likely to happen soon, focuses the mind. Even ordinary choices we make in everyday life might include an awareness that in choosing one path, we are experiencing on a small scale those same stages of dying because the possibilities of the other paths not chosen are dying.

I was deeply impressed by the intelligence and sincerity of the nurses in my class, and their determination to take as much time as needed to help each patient not only with medical issues but especially with emotional and spiritual concerns of patients with terminal illnesses.
Full-fledged medical doctors are experts in their specialties, but often lacking in empathy and compassion. They have limited time to spend with individual patients, and there are too few of them to meet the demands of too many patients.

If I'm looking for a cure then I want an expert medical doctor even if their bedside manner is lousy. But if there is no cure then I want a nurse to tell me what is likely to happen with my body, give me the hands-on help I need, and hold my hand as I face the inevitable. A certified physicians assistant or advanced-practice nurse has the medical expertise to communicate effectively with the doctor while also having empathy and compassion that come from years of prolonged caregiving to individuals in hospitals, nursing homes, or family homes.

How often have we heard the slogan "My body, my choice." It took many years of struggle before the legislature finally passed the Our Care, Our Choice Act in 2018. This bill further empowers my choice by shortening the mandatory waiting period between giving notice of my intention and receiving the means to carry it out. It also provides the possibility of further shortening that waiting period in especially urgent situations of unbearable pain and imminent death. This bill further empowers the effectiveness of my choice by expanding the number and accessibility of the medical professionals authorized to provide me with the prescription and the drugs I need.

HB-1823-SD-1
Submitted on: 3/28/2022 8:24:46 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
jacqueline gardner	Individual	Support	Written Testimony Only

Comments:

SUPPORT the aid in dying bill for advanced practice nurses

No patient should have to meet a new provider for this service

HB-1823-SD-1
Submitted on: 3/28/2022 8:41:12 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Bob Gahol	Individual	Support	Written Testimony Only

Comments:

I am submitting my written testimony in strong support of HB 1823 HD 2 SD1. In Hawaii, Advanced Practice Registered Nurses (APRNs) have completed the required education and board certification to practice independently. As licensed, independent practitioners, they practice autonomously and coordinate with health care professionals and other individuals. Due to the shortage of physicians in the state, especially in the neighboring islands, APRNs are extremely important in meeting the healthcare needs of our citizens. Therefore, they should also be given the authority to administer medical aid in dying, including counseling qualified patients. The passing of this bill promotes patient-centered care and will significantly assist patients and their families through the death and dying process. Thank you.

HB-1823-SD-1
Submitted on: 3/29/2022 7:12:12 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Caroline Kunitake	Individual	Support	Written Testimony Only

Comments:

Dear Chair Baker, Vice Chair Chang, Committee on Commerce and Consumer Protection, Chair Rhoads, Vice Chair Keohokalole and Committee on Judiciary,

I am submitting testimony in support of HB1823 HD2 SD1.

I firmly believe that medical aid in dying needs to be accessible to more people, especially on the neighbor islands where there is a shortage of primary care physicians. It is not fair that someone who lives in a less populated county or district will be unable to access the current law on medical aid in dying because they are unable to find a physician (not a registered nurse practioner) willing to perform medical aid in dying. Nurse practioners, who take less time to train and have less school loans compared to physicians, will be able to provide medical aid in dying services once the laws are changed to expand their legal scope of practice.

Physician are reluctant to permanently live in rural areas due to lack of city amenities, competitive private schools for their children, social events and products/services that high earning professionals can afford in a big city. If a physician does not have relatives or a spouse with relatives in the rural area, they often feel socially isolated when living in a rural community.

Due to the shortage of physicians in rural areas, a new primary care physican who moves into the rural area may be reluctant to be responsible for a proportionately high patient case load with serious medical complications. In other words, this primary care doctor will be treating patients who have never received any medical care, have little to no access to medical specialists and/or no income to pay for drugs and medical treatments. Most physicans will choose to work with healthier, more affluent patients and earn more by moving to a city or moving to the mainland where the cost of living is lower.

I am originally from Hawaii County and I was so disappointed to learn that the residents of Hawaii County have a greater difficulty using the Our Care, Our Choice Act (OCOCA) law.

I found the following information below from the Kona Community Hospital website which links a news story from the Hawaii Tribune Herald from Feb. 14, 2021. See below: https://kch.hhsc.org/news/hospitals-resist-our-care-our-choice-act/

The East Hawaii Region of the Hawaii Health Systems Corp., which includes Hilo Medical Center, does not participate in OCOCA-related services on its premises, according to a policy implemented in Feb. 2021. Those services include the duties required by providers under the law, prescribing or delivering aid-in-dying drugs; and prohibiting patients from self-administering the drug while a patient is in an East Hawaii Region facility. The Hilo Medical Center supports the OCOCA law, but lacks the resources to needed to fulfill all of the requirements of the OCOCA law.

In addition, other hospitals including the Queen’s North Hawaii Community Hospital in Waimea (which is on the other side of the island from the district of Hilo) does not participate in the OCOCA-related services. Kona Community hospital does not participate in OCOCA by way of allowing the administration of end-of-life medications on the KCH campus.

Instead these hospitals refer patients to physicians who are willing to provide medical aid in dying treatment away from the hospital campus. Unfortunately, there are not enough primary care doctors especially in Hilo. While living in Hilo, I had so much difficulty finding a primary care physician willing to take a new patient. Most of the physician offices that I contacted in Hilo shared that I probably needed to wait over a year for a slot to open up. If you're lucky enough to even have a primary care doctor in Hilo, you need to cross your fingers that your physician is willing to provide medical aid in dying.

The University of Hawaii John A. Burns School of Medicine website (https://jabsom.hawaii.edu/report-finds-hawai%CA%BBi-physician-shortage-exacerbated-by-the-pandemic/) shows that the COVID-19 pandemic has increased the physician shortage on all of our counties. The update on January 2, 2021 reports that older physicians are opting for early retirement and COVID-19 has disrupted and shortened clinical operations. The statewide physician shortage remains between a range of 710 and 1,008.

Please exercise greater compassion for all who wish to use the medical aid in dying law. All of us will not escape death and we will end our lives from old age, sickness and/or death. Empowering terminally ill individuals with more control over their death does not diminish the right of others to live. I believe that HB1823 HD2 will provide greater mental ease and comfort to terminally ill individuals and their families. Please support HB 1823 HD2 SD1.

Mahalo,

Caroline Kunitake

HB-1823-SD-1
Submitted on: 3/29/2022 7:36:16 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Ellen Godbey Carson	Individual	Support	Written Testimony Only

Comments:

Please pass this bill.These are reasonable measures to assist in comfort for those who are dying, and provide reasonable safeguards as well. We all deserve to have choices in how to face our own death, and to maximize alleviation of pain.

Thank you

OPPOSITION TO HB 1823 SD2 POINTS OF CONCERN

My name is Dr Craig Nakatsuka. I am testifying in opposition to HB 1823 SD2.

I applaud the revisions made to the bill since the last hearing and urge you to keep them in place. However, I have two concerns remaining:

One is regarding the expansion for providers to include APRNs and PAs for counseling and assessment of prognosis. While there clearly is a need to address the issues of access to medical care in rural and neighbor island communities, it has to be balanced against the assurance of competency of these said providers. The wording in the bill of being limited to their "scope of practice" is too vague and subject to too broad an interpretation. I strongly recommend more specific wording as recommended by an authoritative group of medica professionals.

Secondly, regarding the Department of Health's amendment regarding the information collected

"**shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative or other proceeding**" is of concern. While the DOH appropriately would like to avoid fishing trips by attorneys, on the other hand, to raise such a thick wall may significantly hinder the ability to obtain data for quality improvement of the Medical Aid in Dying process. Indeed, a medical authority who may desire more robust data to have a better perspective on this bill would seem to be prevented with the current wording.

HB-1823-SD-1
Submitted on: 3/29/2022 8:18:01 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
stephanie marshall	Individual	Support	Written Testimony Only

Comments:

As a retired oncology nurse and retired nursing faculty, I strongly support this bill that allows APRNS to act as attending or consulting providers for those patients who choose medical aid in dying. This is within their scope of practice and they have the skills and competency to perform these duties.

I also support reducing the wait time between requests and giving the provider options to waive that timeframe if it appears the patient may not make it to the second request

These patients are terminal and many in insufferable pain. I strongly urge you to pass this bill that will provide these patients greater access and timeliness in their request for a peaceful death.

Stephanie Marshall RN,FAAN

HB-1823-SD-1
Submitted on: 3/29/2022 8:53:46 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Jane E Arnold	Individual	Support	Written Testimony Only

Comments:

Please pass HB1823. Thank you.

Medical Aide in Dyng legislation

Who and I and Why do I care?

I am a retired ICU/ED RN and former hospital administrator of some 50 years. I have seen more pain and suffering than i ever expected to see during my tenure. The sad part was that I knew all along that we could do better. I knew we had the capacity and the skills to end suffering for those who were diagnosed as terminal or already in the dying process. On a personal note, My stepmother died of metastisized renal cancer. We tried every pain medication available to us to no avail. Her life was one day of suffering after another. Even when she was knocked out on narcotics, she groaned and rubbed her fractured femur that the cancer had eaten its way thru. She asked me many times to end her suffering. I lay there after medicating her thinking how easy it would be to give her a dose that might stop her breathing, knowing i could not do that. It was a terible time for our whole family. Since that time, I have dedicated my life to educating people about options at end of life so that they can maintain some semblance of control. I see a lack of this communication between patient and medical professionals as exhibited by those who consult with me.

The current Medical Aide in dying law although a step in the right direction making me proud of our legislatures, needs to be altered to make the law easy to access. If you know anything about Hospice, youknow that way too many folks wait untill the last minute before accessing this valuable service. This must not be the case with the Medical Aide in Dying law. Once a person has made this difficult decision and has met criteria, we need to make it easy for them. We need to streamline the proces so that they can access the medication and then take a deep breath, knowing that they have regained control. Psychology has a huge affect on the body and its response. For many once they are back in the seat of control, the pain is lesssened and they actually don't need to take the medication. This is proven time and again.

Please consider making the law the best in the United States. Show the rest of the country what true Aloha stands for.

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Please if you have ever known or witnessed anyone who has died after suffering insurmountable pain and suffering consider making this process as easy as possible.   I know I am counting on it being available to me when the time comes.

,

HB-1823-SD-1
Submitted on: 3/29/2022 12:17:43 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Norman Goody, MD	Individual	Comments	Written Testimony Only

Comments:

I am a Big Island physician. In addition to working full-time in the ER in one of our rural, critical-access hospitals, I have a small, private practice that includes providing patients assistance with Medical Aid in Dying. I was recently made aware of an amendment that was added to this bill "requiring" an in-person visit with any patient requesting MAID. I am baffled, flabbergasted, upset and downright angry about this proposal. I already feel that there are far too many hurdles for both providers and patients to jump through in order to gain access to this much-needed service. I have had more patients DIE while waiting to clear these barriers than have actually been able to take advantage of MAID. One completely worthless and unnecessary barrier is the "requirement" for a mental health evaluation. Not only is it disrespectful, as I feel that physicians providing this service are generally quite competent at assessing the mental and emotional state of a patient, but it is an undue hardship for most patients and does little but contribute to delaying their care. I have never spoken with a colleague where this "required assessment" made one bit of difference in the treatment plan or the outcome. Furthermore, there is absolutely nothing "preventing" the attending physician from requesting an evaluation "if" they have any questions or concerns. It is a completely unnecessary and wasteful step- especially when we are in such short supply of therapists to start with.

I have now assisted 14 different patients with MAID, although only 4 of them went all the way through with ingesting their medications to end their lives. Two are still "waiting", 2 decided not to pursue it, 1 got his meds but died naturally without taking them, and the other 5 died during the "mandatory waiting period".

I met about 1/2 of these patients "in-person" at some stage of the process but a number of them live on the other side of the island, which is a 2 1/2 hour drive EACH WAY. Most of those patients were homebound (e.g., with ALS) but I would have not asked them to spend 5 hours driving just to see me in person. I am already working 80-100+ hours/week and it would simply be impossible for me to spend an entire day just to go visit a single patient in-person (often for NO pay, by the way, since many insurances do not cover this service and many patients cannot afford to pay out of pocket for it. I consider those pro bono cases [about 1/3 of them] a "community service").

While I have absolutely enjoyed meeting some of these patients in person (I was previously a hospice medical director for 5 years, so visiting terminal patients in their homes is something I am quite familiar and comfortable with), I can quite honestly say it has added NOTHING to the care I was able to give them. I know they appreciated it, but it did not materially change a single thing. For the patients that I treated strictly via telemedicine, we were able to have visits that were equally helpful, as this process is really more "administrative" than "medical". They already have the diagnosis before they are referred to me. There are no physical exams or diagnostics needed by the time they are seeking MAID. The ONLY function of the attending physician is to determine, confirm and document their diagnosis (from the patient's history and corroborated with their medical records obtained from their PCP, oncologist, etc.), coordinate a consulting physician and mental health provider, complete all the required paperwork and ensure the law is being followed correctly and then to prescribe the medications. I have had only one patient who requested that I be "present" when he takes his meds.... and that is mostly because he had previously been my patient for 15+ years (for an unrelated issue) so I have a long-term relationship with him and he asked if I could be there for him. All other patients have chosen to keep the process a private and personal one with only their immediate family present. In a few other cases, those patients were under the care of hospice and they had their hospice nurse either present or immediately available.

I see absolutely NO benefit of imposing yet another restriction on a process that is already overly restrictive. Furthermore, this will have a CLEAR negative impact for most neighbor island patients, especially on the Big Island, where distances and travel times can be very great and the availability of providers is extremely limited (e.g., there has been NO provider anywhere in East Hawaii, meaning a minimum 4 hours driving just to make an in-person visit). Furthermore, as I have had more patients die during the "mandatory waiting period" than complete the process, anything that delays the process further will have negative consequences. It would also have a significant negative impact on the only two Big Island physicians currently providing MAID services for the entire island, as we are already over-worked due to the physician shortage, here.

I don't know why the HI Psychiatric Medical Association is even involved in this- especially given my earlier comments about the inappropriate and unnecessary "mandatory mental health evaluation" (given that Hawaii is one of the only States that "requires" it) but I implore that you listen to the doctors that are ACTUALLY PROVIDING this service and remove this amendment.

Regards,

Dr. Norm Goody
Pono Medicine
Kona, HI
808-987-6465
DrNorm@Pono-Medicine.com

HB-1823-SD-1
Submitted on: 3/29/2022 12:53:15 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Bob Grossmann, PhD	Individual	Support	Written Testimony Only

Comments:

The admentment that requires an "in-person" visit for an oral request may inadvertently result in reduced access and add to further delays (especially for those living in rural areas). This language should be reconsidered from Hawaii's and other states' data. Is such language effective?

Otherwise, the other amendments will improve access and timeliness of care.

HB-1823-SD-1
Submitted on: 3/29/2022 1:13:29 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
I. Robert Nehmad	Individual	Support	Written Testimony Only

Comments:

My name is I Robert Nehmad and I reside in Honolulu.

I support this bill because we need to be cognizant of the pain and suffering individuals must bear at times, and we should allow the option to terminate the suffering when there are no available means to diminish the pain/suffering.

HB-1823-SD-1
Submitted on: 3/29/2022 1:21:08 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Paula Rubin	Individual	Support	Written Testimony Only

Comments:

I absolutely approve of the HB1823 SD1 bill.
I saw my mother die in hospice at my home. Two long weeks of starving and watching her slowly die. She didn't want that. Nobody does.

HB-1823-SD-1
Submitted on: 3/29/2022 1:30:38 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Scott Smart	Individual	Oppose	Written Testimony Only

Comments:

I OPPOSE HB1823 HD2 SD1.

This is part of an organized "slippery slope" technique to expand assisted suicide. It was wrong when first authorized and remains wrong today. The legislature should take an interest in preserving life, not looking for more ways to destroy it.

Aside from assisted suicide, there is s troubling trend of dealing with the shortage of licensed physicians in this state by "dumbing down" the requirements to practice medicine. We are getting to the point that our medical "service" is nothing more than pill and test dispensing.

HB-1823-SD-1
Submitted on: 3/29/2022 1:46:12 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Carla Hess	Individual	Support	Written Testimony Only

Comments:

As a former Hospice Maui nurse, I am strongly in favor of this bill. It will enable more terminally ill people who are suffering to be in control of the manner in which they pass. Thank you for your compassion.

Mary M. Uyeda, retired APRN

To our Senate committee hearing (Judiciary and Consumer Protection) Mar. 29, 2022

I support HB 1823 SD1 for its removal of access and timing barriers to our terminal residents on the neighbor islands - especially the Big Island, with one exception: I would delete PAs who do not have the extensive training of APRNs.

Currently, the Big Island has one physician willing to give terminal patients their choice at end of life. It is known that the specific paperwork is cumbersome, let alone the timing issues of using this alternative but our patients are deeply grateful for having this law in Hawaii! However, we are still far behind the Oregon law which has addressed their barriers over the last 20+ years.

Let us join together and improve our law by removing the access barrier on the outer islands by including APRNs who will put in the time since most terminal patients would rather die at home - surrounded by the people who cared for them. In addition, please shorten the waiting period that a terminal patient has to endure in order to have their choice at end of life.

Help us improve the Our Care, Our Choice Act and pass HB 1823 SD1.

HB-1823-SD-1
Submitted on: 3/29/2022 2:56:27 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
AUBREY HAWK	Individual	Support	Written Testimony Only

Comments:

I am a resident of rural Hawaii Island and I strongly support HB1823. In my role as a volunteer patient navigator I try to help terminally ill patients seeking to use the Our Care, Our Choice Act. Too many of them--mostly poor, rural residents not affiliated with a major healthcare system, have been denied this legal end-of-life option. This is either because they cannot find a doctor willing to assist them, or because they cannot survive Hawaii's needlessly long mandatory minimum waiting period—the longest in the nation. Allowing qualified APRNs to serve their patients seeking to use OCOCA, and shortening the waiting period, would do much to mitigate this dire inequity in health care access.

I am, however, deeply concerned about the recent amendment made in the Senate Committee on Health, which would add 'in person' to the first oral request. This would add a new barrier to the law and would require the bill to return to the House, which has already approved the other core amendments. This amendment would be a tragedy for patients seeking to use the OCOCA, greatly reducing the number of providers willing to support their patients with the law. I hope you will remove it.

HB-1823-SD-1
Submitted on: 3/29/2022 3:51:33 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Dara Carlin, M.A.	Individual	Oppose	Written Testimony Only

Comments:

Standing in STRONG OPPOSITION to HB1823 HD2 SD1.

Please consider the following messages from Heaven before casting a vote in support for such misguided legislation that only leads to condemnation:

December 4, 2015:

Mary, Refuge of Holy Love says: “Praise be to Jesus. You must not think that peace and security will come to you by accommodating evil. Hearts must change for actions to change. You must pray, dear children, for the victory of Truth in all hearts. I speak once again of the Truth between good and evil. **The taking of human life is always evil**. Do not compare the murder of innocent people to being politically correct. *God is on the side of Truth - not compromise*. Courageously stand up for the Truth."

March 22, 2016:

Mary, Refuge of Holy Love says: "Praise be to Jesus. **God does not condone the taking of life** - *not in abortion,* ***euthanasia*** *or any form of terrorism. Those who believe they act in the Name of God by taking life have been misled by Satan*. Demons are all around you encouraging small acts of evil, often under the guise of good and hoping to lead souls into greater evil."

June 28, 2021:

Once again, I (Maureen) see a Great Flame that I have come to know as the Heart of God the Father. He says: "The Fifth Commandment is **'Thou shalt not kill'**. These days, this Commandment is flagrantly violated. *Any taking of life is profaning the Fifth Commandment*. A whole industry - abortion - has been built around violation of this Commandment. This also includes the harvesting and use of stem cells. Beyond that, there is the acceptance of ***euthanasia*** and suicide. I am the Lord and Giver of Life. Only I must be the One Who calls life unto Myself."

July 27, 2021

Once again, I (Maureen) see a Great Flame that I have come to know as the Heart of God the Father. He says: "*It is necessary that the hearts of leaders be convicted in the Truth in order for* *the conscience of the world to be converted to the Truth. Leadership which does not embrace My Commandments is errant leadership*. **Those in the role of leadership will be judged according to how many souls they led to salvation and how many they lost.** I did not impart My Commandments to the world just for some, but for all."

HB-1823-SD-1

Submitted on: 3/29/2022 4:29:13 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Rick Tabor	Individual	Support	Written Testimony Only

Comments:

RE: HB1823 our Care, Our Choice Amendment

TO; HTH, CPN/JDC Representative: HASHIMOTO, BELATTI, BRANCO, GANADEN, HASHEM, HOLT, ICHIYAMA, ILAGAN, KAPELA, LOWEN, MARTEN, MORIKAWA, NAKAMURA, NAKASHIMA, NISHIMOTO, OHNO, ONISHI, PERRUSO, TAKAYAMA, TARNAS, TODD, WILDBERGER, YAMASHITA, Matayoshi, Tam

Thank you for your time, hearing HB 1823 HD2 SD1

Authorizes advanced practice registered nurses and physician assistants to practice medical aid in dying or provide counseling to a qualified patient. Requires a prescribing provider to conduct an initial visit in-person. Amends the mandatory waiting period between oral requests and the provision of a prescription. Prohibits the disclosure, discovery, or compelled production of information collected or retained pursuant to incidental or routine communication between DOH and qualified patients or providers. Effective 7/1/2060.

I could represent any of the number of nonprofits I'm involved in, as they all support this very important bill. As you know, those nonprofits & roles include; President of HPGS (Hawai'i Pacific Gerontological Society). Vice President of the Kokua Council & Hawai'i Meals on Wheels, Board of Directors Rotary Club of Honolulu, Alzheimer's Association Hawai'i Ambassador/Champion volunteer, Hawai'i Team Leader Compassion and Choices Hawai'i, just to name a few.

I'm writhing my strong support for the HB1823 bill, Our Care, Our Choice Amendment. But seriously disagree with the new additional hurdle of 'Requires a prescribing provider to conduct an initial visit in-person.' This late bill add-on is unnecessary and will be a deal breaker for some of our Island's terminally ill individuals. It seems cruel and in-humane to expect a dying person who many times will be bed-ridden to get up, get clothed, make it to a ride and be transported ion to a doctor's office for an appointment regarding their desire to obtain medical-aid-in-dying. We've done well with telehealth during the pandemic and hope to expand that modality. In-home doctor visits is also a hoped reality in the future. Why add an additional unsurmountable burden to some of our terminally ill patient's list of steps to fulfill their peace-of-mind wishes. Please return to HB 1823 without that requirement.

As a survivor of my first round of cancer who has recently lost two same aged cousins and an uncle to cancer, and retired from a 46-year mental health counselor career. I feel I have a few perspectives of the importance of this aging with dignity and peace of mind amendment.

I'm not going to repeat the data others have shared. I'll just say, this issue is a well-documented one. And the solutions are very clear. What clouds the issues is when someone personalizes the issue instead of viewing it form the view of the person who chooses medical aid in dying. To that, I'll just say, that is not what the HB1823amendment is about. The Our Choice, Our Care option passed a few ears ago. Today we're asking to make it more humane.

It's not for everyone, medical aid in dying will primarily be a choice reserved for the unfortunate who are suffering, battling, enduring a chronic terminal illness and are faced with an end-of-life option that we all hope we never have to face. Once there, our families and loved ones are usually emotionally & physically exhausted and trying their best to hang on. You may have experienced this roller-coaster ride.

Add to it, a bill, let's call it Our Care, Our Choice passes, giving the terminally ill the option to medical aid in dying. And they set out to accomplish the peace of mind option. All they need to do is 17 steps to approval. And let's say this person lives on a Hawaiian Island. Well as great as that all is, this person will probably fail to complete the steps needed unless we amend the current bill. And that brings us to this hearing.

As we all know, Hawai'i's faced with a medical provider shortage. There's not enough Medical Doctors to care for those needing medical care. Answer, allow APRNs to assist with the assessments. And the 20 day wait period is the longest of any state. Solution, wave the 20 day wait period.

I'm confident we can easily resolve the issues and hope you agree. Thank you for your time and consideration on this very important amendment.

Take Care,

Rick Tabor

HB-1823-SD-1
Submitted on: 3/29/2022 6:51:40 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
David Gili	Individual	Support	Written Testimony Only

Comments:

Let's get this done. Please vote in support of SB1823.

March 29, 2022

Honorable Chair Baker, Vice Chair Chang, and Esteemed Senate Committee on Commerce and Consumer Protection members

Honorable Chair Rhoads, Vice Chair Keohokalole, and Esteemed Committee on Judiciary Members

I have practiced and taught full-time palliative medicine in Hawaii for over 17 years, and I am writing, as an individual, in **strong opposition to HB 1823.**

With barely three years' experience with the Our Care, Our Choice Act (OCOCA), this bill would take Hawaii from what was touted as the safest physician-assisted suicide legislation in the nation to the one most willing to sacrifice safety in the interests of streamlining the process.

- **Certification of a terminal prognosis is not within the scope of practice for Advanced Practice Registered Nurses (APRN's) or Physician Assistants (PA's).** APRN's are an essential component of any high-quality palliative care team. Personally, I am fortunate to work on a daily basis with the most skilled palliative care APRN's in the state. However, <u>Medicare specifically prohibits APRN's and PA's from certifying 6-month prognosis for hospice</u> (although they may serve as attending). This certification of six-month prognosis is an <u>essential</u> role of the attending and consulting physicians under the OCOCA. In addition, the Our Care, Our Choice Act, like all other legally accelerated death laws in the US, defines the attending provider as having "responsibility for the care of the patient and treatment of the patient's terminal disease." APRN's and PA's do not meet this definition in that they do not have responsibility for the treatment of cancer or the neurodegenerative, pulmonary or cardiac diseases that are the most common terminal illnesses affecting people that pursue legally accelerated death. Why would Hawaii consider it scope of practice for APRNs to certify terminal prognosis when the federal government does not? On what evidence is this based as being safe or appropriate care?

- **Waiving the waiting period for those not expected to survive the waiting period is clinically illogical and an invitation to fraud and abuse.** A physician can only reliably predict that a patient will only survive days and not weeks once the patient has entered the actively dying phase. <u>Patients at this stage nearly always lack the ability to perform the cognitive and physical functions required to self-determine their care under the OCOCA</u>. Passing this provision would open the door to abuse by authorizing patients that are unable to self-determine and self-administer the lethal drugs or abuse by physicians succumbing to pressure to expedite the process. While legally accelerated death is nearly always about controlling life's end, the idea of waiving waiting periods to hasten dying for people who are believed at high risk of dying <u>too soon</u> hardly seems worth any reduction in safety that may come from expediting the process.

I have no objections to two of the other provisions of HB 1823: shortening the waiting period to 15 days, consistent with the practice in other states, and the inclusion of <u>psychiatric</u> APRN's among the behavioral health consultants to confirm capacity. However, PA's and other APRN's, just like physicians that are not psychiatrically trained, lack the additional behavioral health training and expertise of psychiatric APRN's to fulfill the counseling function of the OCOCA.

Thank you for your thoughtful consideration as you weigh this serious matter, attempting to find the best balance between minimizing suffering for the less than 0.5% of people that typically access physician-assisted suicide while promoting safe and compassionate care for the 100% of us that will face the end of life.

Respectfully,

Daniel Fischberg, MD, PhD, FAAHPM
Board-certified in Hospice & Palliative Medicine, Pain Medicine, Addiction Medicine, Internal Medicine
Kailua, HI

HB-1823-SD-1
Submitted on: 3/29/2022 10:15:16 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
LUCIEN WONG	Individual	Support	Written Testimony Only

Comments:

How many more people must painfully suffer dying without hope of recovering because the MAID law places unnecessary restrictions on what can be done to avail them of a humane way to pass. HB1823 will help simplify the process.

To: Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair

Senate Committee on Judiciary
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

From: Jolina Baruela

Date: Tuesday, March 29, 2022

Re: Support for HB1823 HD2 SD1, RELATING TO HEALTH

My name is Jolina Baruela, a student of Myron B. Thompson School of Social Work at University of Hawai'i at Manoa. I am testifying in **support** of HB1823 HD2 SD1. Lines 2-4 stated, "...Our Care, Our Choice Act to ensure that all terminally ill individuals have access to the full-range of end-of-life care options." and lines 10-13 stated, "...the State's shortage of physicians create barriers to access for qualified terminally ill individuals. Finding a physician may be burdensome, especially for individuals on the neighbor islands." I strongly believe that Advanced Practice Registered Nurses and Physician Assistants should be authorized to practice medical aid in dying to fulfill the Our Care, Our Choice Act, and lessen the burden/barriers towards qualified terminally ill individuals (especially individuals on the neighboring islands). No terminally ill individual should experience waiting, bearing the pain, and not being able to obtain his/her last wish relating to end-of-care due to shortage of available medical professionals to practice medical aid in dying.

I **strongly support** HB1823 HD2 SD1, Relating to Health.

Thank you for the opportunity to testify.

HB-1823-SD-1
Submitted on: 3/30/2022 10:13:40 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Lawren Love	Individual	Support	Written Testimony Only

Comments:

To Whom It May Concern:

I am a hospice physician in Hawaii with experience in medical aid in dying. Requiring that visits for this process be made in person could make it impossible for some patients to use this option. It is difficult enough to find physicians for these patients and now we would need them to make house calls as many of these patients are not in the physical condition to go to a doctors office. I had hoped we were making this option more accessible to our sickest patients rather then less.

Sincerely,
Lawren Love,MD

HB-1823-SD-1
Submitted on: 3/30/2022 11:00:38 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Diane Ware	Individual	Support	Written Testimony Only

Comments:

Dear Committee members,

I strongly support this measure.

99-7815 Kapoha Pl, Volcano Hi 96785

HB-1823-SD-1

Submitted on: 3/30/2022 11:24:32 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Brian Goodyear	Individual	Support	Written Testimony Only

Comments:

Aloha Senators,

I am writing to express my strong support for HB1823 and to urge you to support passage of this bill without the amendment that would require in-person visits. I am a clinical psychologist who conducts mental health consultations for terminally ill patients who have requested medical aid in dying. Since the Our Care, Our Choice Act went into effect I have had the privilege of doing well over 80 of these consultations, mostly for Kaiser patients. Based on my experience thus far, I believe that the Act is working as intended for the most part. All of the patients that I have seen have been grateful and relieved to have this option available in case their suffering becomes unbearable at some point. I have also been impressed by how acceptant these patients have been of the fact that they have only a very limited amount of time remaining in their lives.

There are, however, some changes that should be made to the legislation to address certain problems that have arisen for some patients who have requested medical aid in dying and have not been able to take full advantage of the current law. HB1823 directly addresses these problems.

One problem, particularly for patients on the neighbor islands and in rural areas of Oahu, is the shortage of physicians who are able to act as the attending or consulting provider. This mirrors the more general shortage of medical providers in these areas of the state. Allowing APRNs, who are well qualified to do so, to take on these roles would greatly help to alleviate this shortage.

The second problem is that some critically ill patients have been too ill to survive the 20 day waiting period. Two changes are in order to address this problem. The waiting period could safely be reduced to 15 days to bring the law in line with similar pieces of legislation in other jurisdictions. In addition, the attending provider should be allowed to waive the waiting period completely for patients who are not expected to survive the waiting period. Similar changes have already been enacted in Oregon and California, and are also being considered in other jurisdictions.

The proposed amendment to HB1823 that would require the first oral request to be made in-person is unnecessary. One of the main reasons for the introduction of HB1823 is to reduce barriers to access to the provisions of the Our Care, Our Choice Act, particularly for terminally ill patients on the neighbor islands and in rural Oahu. Such patients often have difficulty finding providers who are close to home and who can schedule in-person visits in a timely manner. Moreover, some patients are too ill to attend in-person visits without great difficulty. Rather than reducing barriers, this proposed amendment merely adds an unnecessary barrier to the process. As the Department of Health and my colleagues can confirm, telehealth visits have proven to be an effective and appropriate way of providing care to patients who would otherwise have difficulty accessing the care that they need.

I would add that, whenever possible, my colleagues and I do perform our consultations in person, usually at patients' homes, but inevitably there are times when it is just not feasible to do so. There is simply no good reason to add an unnecessary requirement for in-person visits for these patients.

In summary, I would respectfully urge you to support passage of HB1823 without the proposed amendment that would require in-person visits.

Mahalo for your consideration of HB1823.

Brian Goodyear, Ph.D.

2924 Alphonse Place

Honolulu, HI 96816

(808) 285-9393

bsgoodyear@aol.com

HB-1823-SD-1
Submitted on: 3/30/2022 12:17:26 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Kathleen M. Johnson	Individual	Support	Written Testimony Only

Comments:

My husband was the second resident of Hawaii to use MAID. Stephen T. Johnson. He was diagnosed with terminal prostate cancer in November 2018, told he would not live to see the summer, and all that he should expect as cancer killed him. He told the oncologist he would not live it out, he'd find a way to end his life. That Kaiser doctor advised the law was passed and effective January 1st. So the quest began January 2nd. The process needs to be smoother, easier access, less confusing and arbitrary delays. His life was already in limbo, on hold, full of stress and increased until he finally had the prescription in hand - having gone through all the hoops, delays and obstacles. I know some people are not as capable nor have the means and support that he did, it needs to be easier and quicker. The relief, almost joy, he had after flying from Kona to pick up the medication from a compound pharmacy in Kailua made him giddy, teasing and laughing with the taxi driver who did not see any reason for joy. But my hustand told that happy story many times. He lived 2 final months without stress or concern. But he lost those months between November and March to extreme stress and anxiety. We didn't understand then and I do not understand now who is being protected by delay protocols designed by the law. What does that achieve? Anything that smooths out the process, makes it more accessible, will only improve the quality of life and well being of a dying person, their family and friends. He drank the medication and died on May 5, 2019. Considering the whole story and all he and the family went through, he had a peaceful death with dignity, in control of his destiny. I certainly hope the prescription can be filled on all islands.

I would like to provide for you some insights into not mandating that the first visit be in person:

I am a cardiologist in private practice at the Queen's Medical Center, who actively provides medical care via Telehealth and have had the opportunity to participate in the OCOCA in helping one of my patients with medical aid in dying.

Telehealth as a way of accessing healthcare has been around for years, but it came to be a necessity during the COVID pandemic and crisis. Many patients and practitioners were initially hesitant and wary of using technology. With the support of the major insurance carriers, both federal, state and private, Telehealth has become a powerful tool and has provided ready access to timely medical care. Now Telehealth is widely accepted by both practitioners and patients, even as the pandemic has waned, and it remains a preferred option for many patients and practitioners. Who would know that the smart phone, computers and the internet, that practically everyone has access to has allowed such an opportunity to provide quality health care.

Many patients and practitioners regularly use Telehealth for initial consultation and even arrange for pre operative visits to plan surgeries. In my own practice of cardiology, I am doing telehealth sessions at least once a week, and in fact as soon as I complete this letter, I have patients waiting. This week I was able to care for a patient of mine who was on vacation in Utah who ran into a medical issue, saving her the hassle of trying to go to an Emergency Room in an unknown environment. I have a practice in Honolulu, but have a practice on the island of Molokai as well ---- without Telehealth, I would not have had the opportunity to serve my patients, as travel was significantly curtailed. Many of my patients are elderly, with mobility issues, and they have been substantially limited by access to necessary specialty care via conventional travel even after travel became more possible because of the airline issues that have fundamentally prevented many wheelchair bound passengers from travelling on Mokulele airlines.

In my own experience with a patient who requested participation in the OCOCA program a Telehealth option would certainly have facilitated his access to care in his terminal state. He was extremely frail and developed chest pain with minimal exertion. Although he had access to a motorized wheelchair and Handivan services, having to attend to multiple 30-60 minute appointments to get thru the process of visiting consultants was tedious. Although his home was only 3 miles away from my office and the hospital complex, it would require 6-8 hours on the day of his appointment to travel to the appointment, and return home. For a patient on the outer islands to travel for consultations it would of course require much more time and a major financial burden, and might require multiple appointments.

It is abundantly clear that access to care is a major hurdle for patient seeking medical aid in dying. Allowing the initial visit (and even subsequent visits) to be performed via Telehealth increases access in a timely fashion, eliminating the need for costly travel and the associated delays; maintains safety and well being for those in frail health and/or are at higher risk of COVID; and allows for statewide access to the practitioners with the expertise needed, who are mostly practicing on Oahu. In addition, Telehealth platforms offer the opportunity to involve the patient and others including family members who may even be geographically distanced, all at the same time. Finally, being able to make a “Virtual Home Visit” helps in the assessment of the patient’s environment in a way that has never been possible with in office visits.

Of note, during pandemic, I am aware that the State of Hawaii had waived in person visits for those that wanted to apply or re-certify for the medical cannabis program, so there is precedent.

I hope my insight and experience with Telehealth will help you decide to eliminate the need for the initial visit to be mandated to be in person. I will be happy to be available to you for further discussion via email or by telephone, please contact me via personal cell phone (808) 927-3883 or thru the Physician’s Exchange (808) 524-2575.

Respectfully submitted,

Joana H Magno, MD, FACC
Cardiology

550 S. Beretania St suite #201
Honolulu, HI 96813

HB-1823-SD-1
Submitted on: 3/30/2022 1:54:33 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Mary Smart	Individual	Oppose	Written Testimony Only

Comments:

I strongly oppose this bill. We don't need any more bills to make it easier to kill Hawaii residents. This bill is offensive to humanity. Do not make more individuals complicit in the murder (so called assisted suicide) of patients. Do not pass HB1823 SD1.

HB-1823-SD-1
Submitted on: 3/30/2022 3:24:49 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Christa Braun-Inglis	Individual	Support	Written Testimony Only

Comments:

To Whom It May Concern: Advanced Practice Providers who include Nurse Practitioners (NPs) and Physician Assistants (PAs) are highly qualified health care providers who not only provide quality health but also increase access to health care. Many end of life patients have NPs or PAs as there primary care providers who could assist in a patient's Medical Aid in Dying (MAID) process if the current OCOCA was amended. By limiting MAID providers in the state of Hawaii to physicians only serves as a barrier to patients who most need access to care. Please consider passing this bill to increase compassionate care to the people of Hawaii.

My name is Dr. Charlotte Charfen, and I am a board-certified emergency physician that practices emergency medicine on the Big Island in North Kohala and Kona. I am providing written testimony in **support** of HB 1823 which makes very necessary improvements to the Our Care, Our Choice Act.

Because of my ER work over 20 years across our nation, I have come to realize the severe lack of communication and discussion when it comes to end-of-life issues. I see how that often translates into fear and suffering for the patient, families and medical providers. This led me to create a nonprofit called Life & Death Wellness to educate and support about all life matters, especially the end-of-life.

In doing this work, I have now helped several patients that have attempted to access the Our Care Our Choice Act. Some were successful. Many were not. I have seen first-hand the many flaws in this law although I am still very grateful for its existence. I am in full support of amending the law so that more of our residents, especially on outer islands, can have access.

Currently I have now helped thirteen patients get access. All of them found me because their own physicians would not or were not allowed to help them due to the hospital system they belonged. Some have gone so far as to be blatantly condescending and cruel when they were approached by the patients that trusted them. One was even told by a physician to take a bottle of Benadryl instead to end their life. This disturbing and reckless statement would have resulted in a terrible outcome and suffering for my patient, that would not have included death. This is the type of ignorant, misinformation that exists in our medical community that I personally do my best to curb but it’s not enough. We need compassionate, informed legislative change.

After developing cancer last year, I had to step back from helping patients. I saw even more just how fragile access on the outer islands really is. I was one of three physicians willing to help dying patients with this option. Without me in the workforce, the entire island only had two physicians willing to participate that were completely overwhelmed with requests and their own private patient loads. That is a sad testament to how this law needs change. Advance nurse practitioners are willing to help make this choice more accessible if not enough physicians are prepared. And right now, that appears to be the case, at least on my island.

I believe determining a patient’s mental competence and terminal prognosis is well within a trained advance nurse practioner’s scope of practice. I personally use APRNs for my primary and specialty care, even my oncology care. I have also worked alongside them in emergency care for over 20 years. Even if only a few APRNs participated in the law, it would bridge a much-needed gap. We only need approximately 3 to help support our island’s population. And I have already identified three that are willing and more than eager to help terminal patients die with their dignity and autonomy.

And as a physician I believe it would be helpful and humane to limit the waiting period from 20 to 15 days and allow providers the flexibility of waiving the waiting period if our sound judgment determines the patient will most likely not survive but would qualify. One of my patients died the very day I was legally able to write his prescription. My clinical judgement would have waived his case had I been given that chance under the law and saved his wife the pain and suffering she endured knowing his wishes were not met because of the current barriers our law affords.

I have heard some report that we have the safest MAID law in the country. I beg to differ. We have the most prohibitive. Barriers do not ensure safety, but they do ensure more pain and suffering in patients and their families that are already struggling with the complexities that come with ones ending.

Thank you for accepting my testimony. I am always willing to speak to this matter if I can help in any way.

Addition:

(This was a letter I wrote to Senator Keohokalole after I was informed of the addition to the amendment. I am attaching it in hopes it helps this committee make an informed decision)

It just came to my attention your proposed amendment to HB1823, requiring the first OCOCA visit be in-person with the prescribing provider. As the first physician on a neighboring island (Hawai'i Island) willing to participate in the OCOCA for Hawai'i residents who has been involved since the law took effect, I must tell you that you are creating one of the worst discriminatory barriers imaginable for our rural and neighboring island terminal patients. This addition would defeat the entire purpose of the initially proposed amendment and only lengthen waiting periods, not decrease them. I am hopeful that you have just been misguided and have no idea of the deleterious effects such action would create. I humbly ask that you read my words as a physician that cares deeply about the rights and life of our dying. I have dedicated myself to their service and know first-hand just how terrible this action would be for them.

Neighboring islands and rural patients already face far worse barriers than those located in the metro area of Honolulu due to lack of access to participating providers. On our vast island of Hawai’i there are now only two actively participating physicians that must cover the entire geographical region. This would be impossible without the use of telemedicine. Have you considered our other islands that have NO actively participating doctors? You seriously want a terminal patient to make a 3-hour drive to visit my office or get on a plane to have an in-person meeting so that they can die peacefully on their terms? This addition would certainly remove that possibility and only create more suffering.

If this pandemic taught the medical and lay professions anything, it was that telemedicine can be one of the safest and most cost-effective ways to get medical care to those in need. For patients that are immunocompromised by the disease that will ultimately kill them, staying out of a doctor's office not only ensures their safety from infectious disease and gives them more time with their loved ones but it also prevents the physical challenges that occur when just trying to get prepared to go to an in-person visit. Many of my patients cannot walk or barely have the energy to sit or talk for very long. Why would you want to make this that much harder for them and their loved ones? Telemedicine has been a godsend to them, and you would now like to take that away?

I’ve now helped thirteen patients gain access since the law went into effect. Out of those patient’s there was only one that I knew I had to see in-person because he was so disabled by his disease that only an in-person exam would suffice for me to determine mental competence. I made an actual house-call because there was no way that he could physically leave his home. Not many patients have the financial resources or a physician willing to even do this. But that is my call and assessment as the physician that falls only under my scope of practice. It is not something that should be legislated. Although I have seen many other patients in-person, none of them actually needed my physical presence to determine their criteria under our law. I’m baffled and confused by such an egregious recommendation. I am sure you are not purposely trying to discriminate against the terminally ill but that is exactly what this addition will do.

I read the requests of the Hawai’i Psychiatric Medical Association that I presume has influenced this addition to the amendment. Their interpretation is not only flawed but I have serious concern that they are twisting statistics and misinformation from other states to meet an agenda they clearly have against the law in general. They are erroneous in equating the compounded medication (currently a mixture of five different medications) used to hasten a peaceful death to fall under the guidelines set out by the Hawai’i Prescription Drug Monitoring Law. That law was designed in the acute or long-term use of opiates to decrease the abuse, addiction, or serious interactions that narcotics can cause when they are used daily in the outpatient setting. Aid in Dying medication is a one-time, final act of a combination of compounded medications. They are not separate and cannot be abused. It does not fall in any way under the monitoring law. It’s concerning that an actual medical society would suggest such unsound reasoning. It begs the question if they even understand the medications and the process itself. If this is the reason you were influenced to add this into the amendments, I strongly urge you to reconsider as it is not based in fact or good, solid medicine.

In my long career as a physician, I have always been drawn to help those at the end of their life. It has been an honor to play a small role in helping someone find peace, comfort and support when facing their mortality. I witness first-hand the struggles, the fear, and the suffering that comes with a terminal diagnosis. I implore you to not add to the burdens of a dying patient and their loved ones. Allowing this addition to stay in the bill would do just that. Please remove it and let this bill lessen the barriers for our dying, not create more.

Respectfully,

Dr. Charlotte Charfen

HB-1823-SD-1
Submitted on: 3/30/2022 4:11:41 PM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
byron eliashof	Individual	Support	Written Testimony Only

Comments:

This testimony is to support the passage of the current bill regarding death and dying.

I have had personal experiences over the years which made it very clear to me, that in order to ensure death when the quality of life is no longer acceptable, provisions must be made in advance.

One event occured when an aunt was badly injured in an auto accident. After this, she was completely dememted and could only say "that's right" by way of cenversation. She remained in this state for 7 years until she passed away from pneumonia.

Another situation involved a clode friend who developed advanced dementia. She required 24 hour care for several years and did not recognize her own children until she passed away from pneumonia.
It is my strongly held opinion that individuals be allowed and/or assisted in dying under these circumstances.

Sincerely,

Byron A. Eliashof MD

HB-1823-SD-1
Submitted on: 3/31/2022 7:02:23 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Caryn Ireland	Individual	Support	Written Testimony Only

Comments:

Please vote YAY in support of these important updates to the Our Care, Our Choice Act. As someone who focuses on increasing awareness, education and support for Medical Aid in Dying, I have had the opportunity to work with such caring physicians, mental health professionals and pharmacists who have helped patients. However, with the physician shortages across the State of Hawaii, there are times when it has been very difficult for a patient to find a physician to help them with this end-of-life option. It is critical to add APRNs as an additional provider for this work.

In addition, there have been too many end-of-life patients who have not been able to make it through the required waiting period, which is so difficult for the patient and their family & friends. Please support the suggested improvements to lessen the waiting period.

Thank you for helping our residents of Hawaii with having the choice of this End-of-Life option.

April 1, 2022

Senator Rosalyn H. Baker, Chair
Senator Stanley Chang, Vice Chair
Senate Committee on Consumer Protection
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair
Senate Committee on Judiciary
Hawaii State Capitol
415 South Beretania
Honolulu, HI 96813

Thank you for considering HB 1823, HD2, SD1 which I strongly support.

This proposed legislation offers important amendments to the Our Care Our Choice Act (passed in 2018). These amendments are designed to improve access for all residents as well as improve the quality of life for many terminally ill patients who choose to access medical aid in dying.

There are two amendments to this legislation that I do not support, and feel are worth mentioning:

Section 4 of the legislation discusses attending provider duties. It calls for an initial <u>in-person</u> determination of whether a patient has a terminal disease, is capable of medical decision making and has made the request voluntarily. If HB 1823 HD2 SD1 were to pass it would be a greater barrier to sick people who feel vulnerable leaving their homes their homes but who could instead manage a telehealth visit. It also would require some patients to travel long distances to their in-person appointments to meet face-to-face with their attending provider. The effect of this clause is devastating to people who are too sick to travel, don’t have an attending physician on their island or the financial reserves or time to make it work.

Also, the effective date of this legislation was inserted to provide for further discussion. I believe it now should become effective as of the date the bill is signed into law.

I sincerely hope this committee will recommend passage of HB 1823, HD2, SD1, as amended, which will result in helping more people by providing peace of mind that if needed (and if they choose) they will be able to access the law more easily.

Mahalo,

Mary Steiner

LATE

HB-1823-SD-1
Submitted on: 3/31/2022 10:43:16 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Lynn B Wilson	Individual	Support	Written Testimony Only

Comments:

STRONG support for this bill, HB1823 HD2 SD1, to expand access to end-of-life care for those who are terminally ill. Mahalo!

LATE

HB-1823-SD-1
Submitted on: 3/31/2022 10:49:36 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Kim Coco Iwamoto	Individual	Comments	Written Testimony Only

Comments:

I strongly support the portion of HB1823 that removes barriers for patients seeking access to medical treatment in a timely manner. I strongly oppose the recent amendment inserted into the bill by Health Chair Keohokalole, taken from one self-serving testimony, which would have the potential impact of creating an even greater barrier for the patient seeking a specific medical treatment. I strongly urge this commitee remove the sections related to, "Requiring a provider prescribing medications for medical-aid-in-dying to conduct an initial visit with the patient in-person." The community has been working on getting compassionate choices codified into law for decades and it should not be rolled back on a whim.

LATE

HB-1823-SD-1
Submitted on: 3/31/2022 11:23:39 AM
Testimony for CPN on 4/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Carolann Biederman	Individual	Support	Written Testimony Only

Comments:

Aloha,

I strongly support this bill. Though the Our Care, Our Choice Act has been in effect for more than three years, many eligible terminally ill patients still experience time, geographic and provider-related barriers to accessing the law, causing needless suffering.

Health inequities in our state impact people in all communities. The addition of a required initial first “in-person” visit will present another barrier for patients. Please consider deleting that section from the bill.

Your YES vote will insure that qualified patients who want to access medical aid in dying are able to spend their final weeks without fear and pain. The intention of the original law is clear - that every eligible patient across the state should be able to chart their own end-of-life journey that reflects their values, priorities, and beliefs. Thank you for your hard work and your commitment to the people of Hawai‘i. With thanks and aloha, Carolann Biederman