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 SB2680 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: Maarch 1, 2022 Room Number: Videoconference

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, often with tremendous suffering.

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 Board of Nursing

Before the
Senate Committee on Commerce and Consumer Protection
and
Senate Committee on Judiciary
Tuesday, March 1, 2022
10:00 a.m.
Via Videoconference

On the following measure:
S.B. 2680, 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 APRNs, in addition to physicians, to practice medical-aid-in-dying in accordance with their scope of practice and prescribing authority; (2) authorize licensed psychiatric mental health nurse practitioners, clinical nurse specialists, and marriage and family therapists, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient; (3) strengthen nondisclosure protections; (4) reduce the mandatory waiting period between oral requests from twenty days to fifteen days; and (5) waive the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

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.

ALOHACARE

To: The Honorable Rosalyn H. Baker, Chair
Senate Committee on Consumer Protection
The Honorable Karl Rhoads, Chair
Senate Committee on Judiciary

From: Peggy Mierzwa, Community and Government Relations

Hearing: Tuesday, March 1, 2022

RE: **SB2680 SD1 Relating to Health - Support**

AlohaCare appreciates the opportunity to provide testimony in **support** of **SB2680 SD1.** This measure will authorize Advanced Practice Registered Nurses (APRN), in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority as well as authorize psychiatric mental health nurse practitioners and clinical nurse specialists, in addition to psychiatrists, psychologists, licensed marriage and family therapists, and clinical social workers, to provide counseling to a qualified patient. In addition to the changes for APRNs, 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 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. 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 will continue to support allowing APRNs and other 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 SB2680 SD1**.

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

Tuesday, March 01, 2022 at 10:00 AM
by
Laura Reichhardt, APRN, AGPCNP-BC
Director, Hawaiʻi State Center for Nursing
University of Hawaiʻi at Mānoa

Comments on SB 2680, 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 SB 2680, 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 the percent of APRNs working in HSRA designated primary care shortage areas and medically underserved areas (Hawaiʻi State Center for Nursing, 2021).

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 the APRN's scope of practice. APRNs include Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. APRNs are educated from accredited schools of nursing in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psych/mental health. An APRN may apply for licensure only upon achieving national certification in their educated role and population foci. Hawaiʻi law (§457-2.7) defines APRN scope of practice to include advanced assessment and the diagnosis, prescription, selection, and administration of therapeutic measures including over the counter drugs, legend drugs, and controlled substances within the APRN's role and specialty-appropriate education and certification. Hawaiʻi's laws for APRNs ensure public safety during patient care through authorized 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.

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.
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SB-2680-SD-1
Submitted on: 2/27/2022 3:24:28 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Jonathan M Gillentine	Testifying for Retirement Issues Committee of HSTA-Retired	Support	No

Comments:

Good morning Chairs Baker and Rhoads, Vice-Chairs Chang and Keohokalole, and members of the committees:

I am writing in support of SB 2680. Our organization believes this bill will provide better access to medical-aid-in-dying for those citizens of Hawai`i who desire it. Thank you for the opportunity to offer testimony.

Aloha, Jonathan Gillentine, PhD, NBCT

TESTIMONY ON BEHALF OF HAWAIʻI PSYCHIATRIC MEDICAL ASSOCIATION

To: Chairs Rosalyn Baker and Karl Rhoads
Vice Chairs Stanley Chang and Jarrett Keohokalole
Members of the Committees on Commerce & Consumer Protection and Judiciary
From: Dr. Denis Mee-Lee, Legislative Committee Co-Chair
Hawai'i Psychiatric Medical Association
Time: 10:00 a.m., March 1, 2022
Re: SD 2680, SD1
Position: **OPPOSE**

Dear Chairs Baker and Rhoads, Vice Chairs Chang and Keohokalole, and Committee Members:

Hawai'i Psychiatric Medical Association (HPMA) is a state medical organization whose physician members specialize in diagnosing, treating, and preventing mental illnesses. We advocate for safe, quality care by those appropriately trained. HPMA represents more than 130 psychiatrists in Hawai'i.

HPMA opposes SB 2680, SD1.

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Key data is missing. During the first year of the law in Colorado, nine of 69 cases were not reported by physicians, twenty-two cases had no written request, forty-two cases were missing the consultant's evaluation, and. only one patient received a mental health evaluation. Despite this clear failure to submit mandatory reports, all prescribers attested that they followed the law.

A non-psychiatrist in Colorado has prescribed lethal medication through Telehealth for three patients for whom the sole diagnosis was anorexia nervosa.

Given these concerns, a bill, which expands the number of participating providers while loosening safeguards is both premature and a danger to public health. HPMA notes that the Committees on Consumer Protection and Judiciary have the power to protect Hawaii's consumers, our patients, by strengthening the existing law.

We respectfully recommend the following amendments to Hawai'i Revised Statutes (HRS) §327L-1, the Our Care, Our Choice Act.

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 requires the prescribing provider to conduct an initial visit in-person. This is already a requirement for anyone prescribing opiates under the Hawai'i Prescription Drug Monitoring law. However, medications other than opiates are now also being used for aid-in-dying.

HRS§327L-4(a) - Attending provider; duties (1) Make the initial **[in-person]** determination of whether a patient has a terminal disease, is capable of medical decision-making, and has made the request for the prescription voluntarily.

3) 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].

4) 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.

5) 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).

6) 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 noncompliant 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.

7) 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 SD 2680, SD1 and urges the Committees to amend to strengthen HRS §327L-1, the Our Care, Our Choice Act, to protect our Kūpuna and other vulnerable patients in Hawai'i.

HAWAI‘I PACIFIC HEALTH | KAPI‘OLANI PALI MOMI STRAUB WILCOX

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

From: Michelle Cantillo, RN, Advance Care Planning Coordinator, Hawai‘i Pacific Heath

RE: SB 2680, SD1 (Companion HB1823) relating to Our Care, Our Choice Act (OCOCA), Advanced Practice Registered Nurse; Mandatory Waiting Period

I, Michelle Cantillo, RN, Advance Care Planning (ACP) Coordinator representing Hawaii Pacific Health (HPH) am writing to express HPH support of SB 2680, SD1. This bill allows more providers to voluntarily participate in OCOCA to help support their terminally ill patients. SB 2680, SD1 will help patients to grant their dying wishes as their time is limited.

Over the past 3 years since the OCOCA bill there have only been a limited amount of physicians who are willing to be an attending physician for this law. At HPH, there are only less than 15 physicians who are willing to participate in writing the aid-in-dying prescription. Currently that is only 1% participating attending physicians at our 4 hospitals (1505 physicians on medical staff).

In my role as an ACP coordinator, I help patients or non-participating providers find a participating physician. With only one percent of our physicians willing, it can be very challenging to find a physician quickly for these terminally ill patients. We have seen in Hawai‘i that there is a shortage of physicians in primary care and specialty areas especially outer islands. One of Straub's participating oncologist recently retired and replacement for his specialty is here on island for a couple of months! The current oncologists are stretched very thin trying to schedule new consults and continuing patients. For the few oncologists who try to help patients requesting OCOCA, they have to fit them in their already busy schedules and have voiced concerns why other physicians do not participate more! Eight-three percent of HPH patients who have started the OCOCA process in the past three years (2019-2021) have cancer with metastases.

We have no physicians willing to write the aid-in-dying prescription on Kaua‘i. HPH supports the other islands too and it is our Oahu participating physicians that will see these patients! I am thankful for these few physicians who go above and beyond and willingly volunteers to see patients whose own physicians will not participate in the law. Many of the Advanced Practice Registered Nurses (APRN) at HPH have expressed their support to this bill. With training, our APRNs or PAs will continue to work closely with physicians and collaborate on how best to help their patients requesting OCOCA.

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 have a rapid decline and expire during this time period. HPH is in favor of waiving the mandatory waiting period and reduce the 20 day waiting period to 15 days. The providers are very skilled at assessing their patients and supports to waive the waiting period for terminally ill patients not expected to survive the mandatory waiting period.

Let’s create a law that works for the terminally ill people of Hawai‘i who do not want to die however wishes to have this end-of-life option. Now that we have the law, let’s make it work!

HPH urges you to support SB2680, SD1! Thank you for the consideration of our testimony.

Mahalo,

Michelle Cantillo, RN, ACP Coordinator, HPH
michelle.cantillo@hawaiipacifichealth.org

Written Testimony Presented Before the
Senate Committee on Commerce and Consumer Protection
and
Committee on Judiciary
Hearing: March 1, 2022 @ 10AM
State Capitol, Via Videoconference

By Hawai‘i – American Nurses Association (Hawai‘i-ANA)

SB2680 RELATING TO HEALTH

Chair Rosalyn H. Baker, Vice Chair Stanley Chang, members of the Senate Committee on Commerce and Consumer Protection, and Chair Karl Rhoads, Vice Chair Jarrett Keohokalole, members of the Senate committee on Judiciary, thank you for this opportunity to provide testimony **in strong support of SB2680, SD1,** Relating to Health. This bill seeks to explicitly authorize advanced practice registered nurses (APRNs) as attending providers and consulting providers capable of performing all necessary duties under the Our Care, Our Choice Act in accordance with their scope of practice and prescribing authority. This bill also seeks to reduce the mandatory waiting period between oral requests made by a terminally ill individual from twenty to fifteen days, and to allow an attending provider to waive the waiting period for terminally ill individuals not expected to survive the mandatory waiting period.

We are members of the American Nurses Association in Hawai‘i (Hawai’i-ANA) who speak for over 15,000 Registered Nurses in Hawai‘i caring for patients every day, throughout their lifespan, from birth through dying and death. We have supported the passing of the bill to enact this measure in the past, in our interest to provide choices and options to patients addressing end-of-life issues. We continue to support the Act as an option for both patients and providers, to consider in meeting the personal needs of the individual patient.

We believe the information provided by the State of Hawaii Department of Health regarding the use of this Act highlights the very real difficulties individuals in Hawaii are experiencing in meeting the established criteria and safeguards to ensure a secure, compassionate, and patient-centered end-of-life process. In particular patients on neighbor islands have great difficulty accessing a provider to participate in the prescribed process. Authorizing APRNs to practice medical aid in dying, in accordance with existing scope of practice and prescribing authority, will expand access for neighbor island patients who choose to avoid needless suffering in their final days of life.

In addition, the waiting period of 20 days is the longest in any state that has enacted such a law to regulate dying with dignity by individual choice. Patients have met all the requirements of the law to bring them to the point of ingesting the prescribed medication when they are required to wait another 20 days. Surely the provider of care along with the patient and the family can determine that the patient is not likely to survive that long, and therefore the waiting period should be waived, again to provide greater mental ease and comfort to terminally ill individuals and their families.

We respectfully request that SB 2680, SD1 pass out of this committee. Thank you for your continued support for measures that address the healthcare needs of our community.

Contact information for Hawaii – American Nurses Association

President: Katie Kemp, BAN, RN-BC president@hawaii-ana.org
Executive Director: Dr. Linda Beechinor, APRN-Rx, FNP-BC
executivedirector@hawaii-ana.org
phone (808) 779-3001
500 Lunalilo Home Road, #27-E
Honolulu Hawaii USA 96825

hawaii family forum

Submitted Online: February 28, 2022

HEARING: Tuesday, March 1, 2022

TO:	Senate Committee on Commerce & CP 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 SB 2680 SD 1 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.

If this bill is passed, it will allow (1) authorize advanced practice registered nurses, in addition to physicians, to practice medical-aid-in-dying in accordance with their scope of practice and prescribing authority, (2) authorize licensed psychiatric mental health nurse practitioners, clinical nurse specialists, and marriage and family therapists, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient, (3) strengthen nondisclosure protections, (4) reduce the mandatory waiting period between oral requests from twenty days to fifteen days and (5) waive the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period..

The most problematic part of this bill are two things: (1), waiving the mandatory waiting period for qualified patients not expected to survive the mandatory waiting period. Doctors can only give their best professional "guess" on patient survival. What if they are wrong? If that isn't alarming enough, this version (2) prohibits the disclosure of information "or retained as the result of incidental or routine communication with providers and patients." 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[i]." 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 education on available access to palliative care and hospice

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

Testimony of Sam Trad, Hawai'i State Director, Compassion & Choices
Supportive Testimony Regarding SB2680 SD 1
Senate Committees on Judiciary and on Commerce and Consumer Protection

Good morning Chairs Baker and Rhoads, Vice Chairs Chang and 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 SB2680 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. Just one year into implementation of the Hawai'i Our Care, Our Choice Act, 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 wanted the option

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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/

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) to support patients in the option of medical aid in dying by acting as the attending provider, consulting provider and/or mental health counselor.
- Allow LMFTs to provide Counseling to a Qualified Patient

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

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

Hawai'i 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. Hawai'i physicians have said that their eligible terminally ill patients are suffering terribly at the end of 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 amount 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

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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.

[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/

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 Hawaiʻi 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 when receiving and filling the prescription.[11]

<u>Expanding the Definition of Provider to include Advanced Practice Registered Nurses with Prescriptive Authority (APRN Rx)</u>

Hawaiʻi 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 training, including prescribing all forms of medication, including controlled substances.[12] However, by not including APRNs within the definition of "provider," the Our Care, Our Choice Act unnecessarily prohibits APRNs 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 to participate as providers under the Our Care, Our Choice Act is consistent with their scope of practice and would help address the disparity in access to participating providers, particularly in rural areas and neighboring 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

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[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, Hawaiʻi 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

[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

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 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 to serve as either the attending or consulting provider.[13]

Authorizing Licensed Marriage and Family Therapists (LMFTs) to provide Counseling to a qualified patient

In Hawai'i, the scope of practice for Licensed Marriage and Family Therapists (LMFTs) includes assessing, diagnosing, and treating mental health issues.[14] LMFTs are trained to assess mental functioning and diagnose mental health disorders that may impair mental capacity. Authorizing LMFTs to provide counseling to qualified patients under the Our Care Our Choice Act is consistent with their scope of practice, and would help to improve access to this compassionate option. Furthermore, Hawai'i is the only authorized jurisdiction that requires a mental health consultation. This requirement creates yet another roadblock for patients, as they must find three healthcare professionals to qualify them under the Act. Authorizing LMFTs to provide counseling under the Act would expand patient options for meeting the mental health consultation requirement.

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 neighboring 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

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[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] Hawaii Revised Statutes, HRS § 451J-1, Definitions

SB-2680-SD-1
Submitted on: 2/28/2022 10:00:43 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

LATE

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Charles Miller	Testifying for Hawaii Society of Clinical Oncology	Support	No

Comments:

Dear Chairs Baker and Rhoads and Vice Chairs Chang and Keohokalole

I'm a medical oncologist representing the Hawaii Society of Clinical Oncology, the largest organization of cancer specialists in the state and I also serve as Director of Kaiser Hawaii's Medical Aid in Dying (MAID) program. I have the most experience of any physician in the state with patients requesting MAID, and I'm writing to you today to urge you to support SB2680 which makes very necessary improvements to the Our Care, Our Choice Act. In my three years of seeing MAID patients, I have consulted on over 125 patients. For some patients the law works well, but for many eligible terminally ill patients the requirements of the law presents barriers that prevent them accessing the law even though they meet all of the requirements. This causes them needless and very much unwanted suffering. We have data from the State Department of Health, Kaiser Hawaii and Hawai'i Pacific Health, that over 30% of patients who requested MAID died of their underlying medical conditions before the required 20 day waiting period. I strongly believe that providers should be allowed to waive the waiting period for their patients if the patient meets all other requirements but is unlikely to survive 20 days. This is inexcusable and one of the problems that these amendments will address. Twenty days is the longest waiting period of any jurisdiction which support MAID and it should be shortened to at least no more than 15 days.

The other major obstacle to access to aid in dying is the growing shortage of physicians. This makes it very difficult to find the two doctors required to qualify for medical aid in dying, especially on neighbor islands. This bill has a solution to this problem: Advanced Practice Registered Nurses (APRNs), also known as Nurse Practitioners (NPs), are highly trained professionals helping to fill this gap in virtually all other areas of health care. In fact, Hawai'i is one of 22 states that gives APRNs authority to independently carry out all medical acts consistent with their education and training, including prescribing all forms of medication. Yet as the law is written, APRNs are prohibited from helping in this most crucial area. The Our Care, Our Choice Act currently limits their scope of practice, preventing them from supporting their patients who want the option of medical aid in dying.

If even one qualified patient is forced to spend their final weeks in fear and pain, unable to access the law, then that is one patient too many. Please provide the needed relief to terminally ill Hawai'i residents and ensure everyone in the Aloha State is empowered to choose end-of-life care that reflects their values, priorities, and beliefs.

Sincerely,

Charles F. Miller, MD, FACP, FASCO

Hawaii Society of Clinical Oncology

Director, Kaiser Hawaii Aid In Dying Program

SB-2680-SD-1
Submitted on: 2/25/2022 2:11:35 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Brian Goodyear	Individual	Support	No

Comments:

Aloha Senators,

I am writing to express my strong support for SB 2680 and to urge you to support passage of this bill. 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 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. SB2680 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.

Mahalo for your support of these proposed changes.

Brian Goodyear, Ph.D.

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Honolulu, HI 96816

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bsgoodyear@aol.com

SB-2680-SD-1
Submitted on: 2/25/2022 1:11:33 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Bob Gahol	Individual	Support	No

Comments:

I am submitting my written testimony in strong support of SB 2680 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.

SB-2680-SD-1
Submitted on: 2/25/2022 4:05:53 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Eri Shimizu	Individual	Support	No

Comments:

Dear Members of the Commerce & Consumer Protection Committee and the Judiciary Committee Committee,

First and foremost, thank you for all the hardwork that you do. I appreciate your tireless efforts in making our state a safe and beautiful place to call home.

I am a Hospitalist Physician on Maui and I have been with many patients at the end of life. Thus, I felt prepared to care for my father on Hospice during his last weeks of life. I have always confidently assured my patients that Hospice care could prevent suffering at the end. I was wrong.

On August 15, 2021, my 82-year-old old father, Stanley Shimizu, was diagnosed with metastatic pancreatic cancer. At the time of his diagnosis, the cancer had already spread to his liver and invaded the small intestine. The biopsy revealed a very aggressive pancreatic cancer, meaning a terminal prognosis with an expected life expectancy of weeks to months. In a matter of three weeks, he went from a strong, stoic man -- who just a few weeks prior had cut down a palm tree -- to one too weak to sit up or drink more than a few sips. Despite the resources of home hospice, a PCA pump (a machine that delivers opioids on demand), and anti-nausea medications, my father suffered terribly. At the very end, he couldn’t even sleep because he was so uncomfortable. On September 10, 2021, he passed away after choking on large amounts of bloody vomit. I suspect his tumor completely eroded into his intestine, causing a complete obstruction. He died scared and fearful.

I watched my father, a man with a samurai’s soul, suffer and die with fear in his eyes - a mental image that haunts me and an experience I would never want for anyone else. This was preventable. My father could have passed away as he wanted, on his terms, without the suffering and fear. He wanted to die with dignity. In Hawaii, we are fortunate that death with dignity is available. And yet, is it really?

Upon his diagnosis, my father informed his wife and children that he wanted the death with dignity program. He had supported this program even before his illness. We worked with his oncologist and primary care physician to gain approval; he had the required consultation with a psychiatrist. By the time of his passing, he still had not been approved.

The current requirements of Our Care, Our Choice program hinder too many patients, including my father, from actually receiving the help this program should provide. Legalizing the death with dignity program was a momentous step, but it is not enough. I beg you now to remove the barriers that would make this program accessible to those who genuinely need it.

Mahalo,

Eri Shimizu, MD.

SB-2680-SD-1
Submitted on: 2/25/2022 4:57:46 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kathleen M. Johnson	Individual	Support	No

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.

SB-2680-SD-1
Submitted on: 2/25/2022 5:22:06 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Caroline Kunitake	Individual	Support	No

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 SB2680 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 SB2680 SD1 will provide greater mental ease and comfort to terminally ill individuals and their families. Please support SB2680 SD1.

Mahalo,

Caroline Kunitake

SB-2680-SD-1
Submitted on: 2/25/2022 6:03:15 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Mary H Shimizu	Individual	Support	No

Comments:

My husband, Stanley always supported death with dignity legislation. Late last year he was diagnosed with stage four pancreatic cancer, terminal. We applied for death with dignity assistance. By the time he spoke with the psychiatrist, about 2 weeks after his diagnosis, he was so weak, the doctor prescribed antidepressants so he would eat more. By that time he was barely taking sips of water. We were to meet with the doctor in a week. My husband passed by then.

We were able to keep him mostly comfortable at home with hospice help, but the end was not pretty. He was in a lot of pain and scared. He literally drowned on his own bloody vomit. I still think about it, a lot. It hurts and haunts me. And, worse, this fear and pain could have been prevented..

Stanley was diagnosed on August 15 and passed on September 10. We might have saved him if there were clear symptoms so tests could have been done sooner. But, there are no early warning symptoms and by the time the cancer was detected, it was too late. I am told this is the case with pancreatic cancer. I urge you to pass this bill so patients diagnosed with these terminal illnesses do not have to suffer through the lengthy approval process.

Mahalo

SB-2680-SD-1
Submitted on: 2/25/2022 7:20:34 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Carolann Biederman	Individual	Support	No

Comments:

Aloha,

I strongly support this bill. The Our Care, Our Choice Act has been in effect for more than three years, yet many eligible terminally ill patients are having trouble accessing the law, causing needless suffering.

The physician shortage makes it very difficult for eligible patients to find the two doctors required to assist them, especially on neighbor islands. One solution is allowing Advanced Practice Registered Nurses (APRNs) to fill this gap, as they do in virtually all other areas of care. Yet as the law is written, the Our Care, Our Choice Act currently limits their scope of practice, preventing them from supporting their patients who want the option of medical aid in dying.

Health inequities in our state impact people in all communities. For patients seeking medical aid in dying, the inability to find a supportive provider means they simply don’t get to access this compassionate option, despite it being their legal right.

Please insure that qualified patients are able to spend their final without fear and pain, and ensure everyone is empowered to choose end-of-life care that reflects their values, priorities, and beliefs. With thanks and aloha, Carolann Biederman, 44-391 Nilu Street #4, Kaneohe, HI

SB-2680-SD-1
Submitted on: 2/25/2022 7:55:52 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Bob Grossmann, PhD	Individual	Support	No

Comments:

Please support this measure to improve access to providers and timeliness of the provisions to improve functionality.

SB-2680-SD-1
Submitted on: 2/26/2022 7:31:42 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
LUCIEN WONG	Individual	Support	No

Comments:

The laws in Hawaii should allow those that are dying to do so, if they choose, in a way that will end the suffering and pain for them, their family and good friends in the most humane and dignified way. SB2680 will help allow this! Mahalo!

SB-2680-SD-1
Submitted on: 2/26/2022 9:49:55 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Mary Uyeda	Individual	Support	No

Comments:

Mary M. Uyeda, retired APRN

To our Senate Committees on Consumer Protection & Commerce (CPC) and Judiciary (JDC), Feb. 26, 2022

I support SB 2680 for its removal of access and timing barriers to our terminal residents on the neighbor islands, especially the Big Island.

For example, 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 including the APRN. In addition, 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 SB 2680.

SB-2680-SD-1
Submitted on: 2/26/2022 8:06:32 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
James Long	Individual	Support	No

Comments:

I positively support SB2680 which would expand and improve the Our Care, Our Choice Act which would effectively improve and expand compassionate care and ask that you pass SB2680.

Thank you

SB-2680-SD-1
Submitted on: 2/26/2022 11:45:09 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Jane E Arnold	Individual	Support	No

Comments:

Please support SB 2680. Thank you.

SB-2680-SD-1
Submitted on: 2/26/2022 12:37:59 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kristen Thompson	Individual	Support	No

Comments:

My name is Kristen Thompson, and I am a social work graduate student with a Gerontology focus. I am currently employed as a palliative care social services coordinator with a palliative, hospice, and bereavement program located on Hawai'i Island. As a social services worker and graduate student, I strongly support the passage of SB 2680, which would make improvements in accessing the benefits provided through the Our Care Our Choice Act (OCOCA). I strongly support the recommendations made by the Hawai'i Department of Health on ways to improve this law.

As a social services coordinator in a hospice and palliative program, I have witnessed first-hand the importance of "time." Hawai'i has some of the strictest policy laws in accessing these prescriptions with long mandatory waiting periods. While many people may have that time to wait, hospice patients often do not have a month or longer. Without access to the right to end their suffering on their own timeline, there is a danger that they will die before the mandatory waiting times have concluded, resulting in unnecessary pain and suffering. The amendments to SB 2680 would allow participating medical professionals to waive the current mandatory waiting times if a patient's prognosis is short or if a patient may lose their ability to self-administer medication, such as the case with Parkinson's Disease or Multiple Sclerosis. Updating this provision is a humane and respectful way to support this vulnerable population.

We know that there is a disparity in accessing OCOCA participating providers on Hawai'i Island and the neighboring islands. Advanced Practice Nurses are vital in bringing medical care to our island residents. APRNs in Hawai'i have the right to prescribe all medications, including opioids and other controlled substances. To ensure our residents have equal access to the rights provided under this law, we must update the law to allow our APRNs to prescribe the medications used in Death with Dignity programs. SB 2680 supports APRNs being considered appropriate entities to prescribe these medications.

I believe an adult of sound mind with a terminal diagnosis should have the right to choose how they wish to die and how much suffering they should have to endure. The Our Care Our Choice Act affords our community members that right, and the proposed changes in SB 2680 continue that support and respect. The Code of Ethics for the National Association of Social Workers supports the principle values of social justice and upholding the dignity and worth of our community members.

Thank you for this opportunity to testify my support for SB 2680.

Hawaii is one of 11 US jurisdictions whose residents have the full range of options for care at the end of life, including medical aid in dying. At the same time, we have one of the most daunting and over regulated processes in the US. The Our Care Our Choices Act was designed to guarantee access to medical aid in dying to terminally ill individuals while ensuring protection for patients and families and prevent abuses.

The unintended consequence of the desire to protect our residents is that many who wish to exercise their option are unable to do so. The data driven Department of Health 2019 and 2020 Reports to the Legislature on the implementation of the OCOCA show that access to care and the burdensome patient request process are limiting many residents from exercising their right to a death with dignity.

I concur with the DOH 2020 recommended changes to the OCOCA including 1) waiver of any waiting periods if the attending provider and consulting provider agree that patient death is likely prior to the end of the waiting periods; and authorizing advance practice registered nurses to serve as attending providers for patients seeking medical aid in dying.

As the Dean Emerita of the Nancy Atmospera - Walch School of Nursing at UH, I assure you that participation in the act is within the scope of APRN practice and that APRNs have the required skills and compassion to aid patients though the dying process.

I strongly support this thoughtful and well considered effort to update the OCOCA.

Mary G. Boland, DrPH, RN, FAAN
Dean Emerita
Nancy Atmospera-Walch School of Nursing
University of Hawaii at Mānoa

SB-2680-SD-1
Submitted on: 2/26/2022 2:20:07 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Diane Ware	Individual	Support	No

Comments:

Dear Legislators,

I have long supported and testified on the difficulty of end of life choices for many of us rural older persons with a terminal diagnosis. I live in Volcano and it is hard to find an MD as primary care not to mention an end of life RX. This bill will reduce anxiety and unnecessary suffering.

Respectfully,

Diane Ware, 99-7815 Kapoha Pl, Volcano Hi 96785

SB-2680-SD-1
Submitted on: 2/26/2022 2:25:19 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Dave Willweber	Individual	Oppose	No

Comments:

Aloha Ke Akua,

This bill raise profound questions. If we as humans terminate our kupuna at the end of life and we terminate preborns at the beginning, all in the name of humanness, peace, and dignity, how will we begin to treat everyone in between? What does this legislative mana'o & worldview suggest is dignified about humans? Where does that dignity come from?

If the legislature is coming from the viewpoint that all humans came from slime millions of year’s ago, this worldview justifies terminating humans bc there is no inherent dignity or worth in evolved slime. If this is true, let’s be consistent and delete the words in the bill that speak of peace, humaneness, & dignity since slime cannot produce these values.

The other alternative is that humanity did not come from slime, but from Ke Akua Maoli, the One True Creator God. Because Ke Akua Maoli is the God of Aloha; true peace, dignity, & humaneness flow from His very being on to a dignified humanity that He thought of and created. If this worldview is correct, and I believe there is plenny evidence to support it….just go examine a flower, watch a sunset, parent a child, look at the stars at night….then legislators should think long and hard about any legislation that takes any life.

Because I know Ke Akua Maoli and His Aloha, I value people and life. He has influenced me to treat all kupuna with respect and worth, to aloha all keiki, to hanai a special needs keiki who cannot walk and talk, to welcome my parents back into our hale where they can die a truly humane, dignified, and peaceful life til there last breath in Ke Akua’s perfect timing.

Mahalo for your reflection on this mana’o,

Ke Akua pu,

Dave Willweber

TESTIMONY OF ANNETTE HANSON, MD

443-882-0964
hanson1072@gmail.com

To: *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

From: Annette Hanson, MD
Time: 10:00 a.m., March 1, 2022
Re: SD 2680, SD1
Position: **OPPOSE**

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

I am a forensic psychiatrist practicing in the state of Maryland and have been studying the issue of assisted suicide or aid-in-dying for several years since a bill was first introduced in my state in 2015. I provide education and training with regard to the assessment of decision-making capacity, and I also provide clinical care in my state's correctional facilities. As a result of this experience I have realized the risk and inadequacy of certain aspects of these laws.

Based upon existing data from the states of Washington, Oregon, and Colorado, I have calculated that statutory safeguards must be approximately 90% accurate in order to prevent the unlawful deaths of unqualified patients. One proxy measure of safeguard accuracy is adherence with required reporting procedures. An investigative report of ten years of data in Washington and Oregon, done by the Des Moines Register in 2016, found that in 40% of reported cases the reports were missing key data, giving an accuracy rate of only 60%. (1) Similarly, during the first year of the law in Colorado, nine of 69 cases were not reported by physicians, for an accuracy rate of 87%. Twenty-two cases had no written request, for an accuracy rate of 68%. Forty-two cases were missing the consultant's evaluation, for an accuracy rate of 39%. Only one patient received a mental health evaluation. ***In spite of this clear failure to submit mandatory reports, all prescribing physicians attested that they followed the law.*** (2)

Of more concern is the fact that at least one non-psychiatrist in Colorado has prescribed lethal medication through telehealth for three patients for whom the sole diagnosis was anorexia nervosa.(3) This internist is licensed in 21 states, to include 16 states in which the practice is a crime. There is presently no mechanism to detect the illegal prescription of lethal medication across state lines. Furthermore, even among mental health professionals, few clinicians are qualified to manage and treat anorexia nervosa.

Given these concerns, a bill which expands the number of participating providers while loosening safeguards is both premature and a danger to public health.

I respectfully recommend the following amendments to Hawaii Revised Statutes §327L-1 et. Seq., the Our Life, Our Choice Act.

TESTIMONY OF ANNETTE HANSON, MD
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The following amendment requires 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 undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter.

The following amendment requires the prescribing provider to conduct an initial visit in-person. This is already a requirement for anyone prescribing opiates under the Hawaii Prescription Drug Monitoring law. However, medications other than opiates are now also being used for aid-in-dying.

§327L-4(a) - Attending provider; duties
(1) Make the initial **[in-person]** determination of whether a patient has a terminal disease, is capable of medical decision-making, and has made the request for the prescription voluntarily;

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.

§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]

The following 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.

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
  (E) social dependency

(2) The nature of the patient's relationship with a primary caregiver, household members, or other influential individuals, including
  (A) controlling access to the patient's daily needs and medication
  (B) controlling access to interactions with others
  (C) controlling access to needed information or services
  (D) the use of affection, excessive persuasion, or intimidation to initiate changes in personal or property rights
  (E) other factors relevant to the detection of elder exploitation or abuse

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 noncompliant health care providers. This would also allow the department to refer noncompliant providers 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.

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.

§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.]

Thank you for your time and consideration of this testimony,

Annette Hanson MD

Annette Hanson, MD

References:
1. Munson K, Clayworth J. Suicide with a helping hand worries Iowans on both sides of the “right to die.” Des Moines Register. 2016. Available at: http://www.desmoinesregister.com/story/news/investigations/2016/11/25/too-weak-kill-herself-assistance-legal/92407392/. Accessed February 27, 2022

2. Colorado End-of-Life Options Act, Year One 2017 Data Summary. Available at: https://drive.google.com/file/d/1-kBXgAFzHl6kcfsvtLHfOQ94Unk9mDa-/view. Accessed February 27, 2022

3. Gaudiani J, Bogetz A, Yager J. Terminal anorexia nervosa: three cases and proposed clinical characteristics. Journal of Eating Disorders. 10(1):23, 2022

SB-2680-SD-1
Submitted on: 2/27/2022 8:47:12 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
AUBREY HAWK	Individual	Support	No

Comments:

I am a resident of rural Hawaii Island and I strongly support SB2680. 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, which is the longest in the nation. Allowing qualified APRNs (i.e., the ~700 APRNs who have Schedule II drug prescriptive authority) to serve OCOCA patients, and shortening the waiting period, would do much to mitigate this dire inequity in health care access.

February 27, 2022

Honorable Chairs Baker and Chang, Vice Chairs Rhoads and Keohokalole, and Esteemed Senate Committee on Commerce and Consumer Protection and 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 SB-2680.**

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.

- **The bill as written is factually incorrect. Certification of a terminal prognosis is not within the scope of practice for Advanced Practice Registered Nurses (APRN'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, Medicare specifically prohibits APRN's from certifying 6-month prognosis for hospice (although they may serve as attending). This certification of six-month prognosis is an essential 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 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. 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. 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 too soon hardly seems worth any reduction in safety that may come from expediting the process.

I have no objections to the other provisions of SB-2680: shortening the waiting period to 15 days, consistent with the practice in other states, and the inclusion of psychiatric APRN's among the behavioral health consultants to confirm capacity.

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

SB-2680-SD-1
Submitted on: 2/27/2022 9:56:47 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Caryn Ireland	Individual	Support	No

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 with this choice. 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 who choose the Our Care, Our Choice Act.

John B. Kelly
New England Regional Director, Not Dead Yet
66 Fenway APT 22
Boston, MA 02115

Testimony before the Senate CPN/JDC Committee on
"Our Care, Our Choice Act," HB 1823/SB 2680.

Thank you. I'm John B. Kelly, with the national disability rights group, Not Dead Yet. We oppose assisted suicide laws as a deadly form of discrimination. Expanding these laws only makes matters worse.

Assisted suicide is really all about disability because the people who get lethal prescriptions are disabled, and we learn from Oregon that the top five reported reasons relate to distress about the disabling features of their serious illness, such as physically depending on other people, feeling embarrassed about physical needs, and feeling like a burden on other people.

SB 2680:

(1) authorizes physician assistants and advance practice registered nurses to prescribe assisted suicide.
This is a problem because their training and required skills are less than those of doctors who already make lots of mistakes. 12 to 15% of people who enter hospice outlive six months.

(2) clarifies that counseling may be provided by PAs and advance practice nurses with specialized training; -
This is a problem because these sorts of providers are not generally trained or experienced in the emotional or practical aspects of coping with disability, or the resources to address our needs.

(3) reduces the waiting period between a qualified patient's initial oral request and the provision of a prescription –
This is a problem because it shortens the time for trying to address the person's concerns.

With the smallest amount of hindsight, it becomes evident that the so-called safeguards in the original assisted suicide law were the bait in a bait and switch. Now we're at the switch stage, rolling back the very same "safeguards" that persuaded some people that assisted suicide is safe. This reveals that the only real protections in these laws are the legal immunities granted to everyone involved in the assisted suicide – except the patient.

SB-2680-SD-1
Submitted on: 2/27/2022 3:58:51 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Marion Poirier	Individual	Support	No

Comments:

2/27/22

DEAR SENATE COMMITTEE CHAIRS AND MEMBERS:

My name is Marion Poirier, and I am an R.N. with a graduate degree in healthcare administration.I have studied this subject,as well as this proposal, and feel confident about lending mu wholehearted support to this proposed legislation. I am especially pleased that it boasts of choice.

Restrictions are lessened, and people can also choose to have specialized nurses provide end of life care. Please pass this bill.

March 1, 2022

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

RE: Testimony in Strong Support of SB 2680 SD1

This proposed legislation offers amendments important to terminally ill patients who are considering using medical aid in dying which was passed by this legislature in 2018. The amendments are designed to improve access and the quality of life for terminally ill patients who choose to end their dying days peacefully and on their own terms.

SB 2680 SD1improves the existing legislation by:

- Expanding access to the Our Care Our Choice Act by allowing Advanced Practice Registered Nurses (APRNs) to write prescriptions for medical aid in dying. This will help terminally ill individuals, particularly those who reside on neighbor islands and in rural locations, by eliminating barriers and providing better access to the law.
- Allowing consultations with psychiatric nurse practitioners and marriage and family therapists which is consistentwith their scope of practice.
- Waiving the mandatory waiting period if a patient is unlikely to survive the current wait called for in the statute. Statistics show that too many people die while counting the days to obtain their prescriptions.
- Reducing the barrier for individuals seeking medical aid in dying. Shortening the 20-day waiting period to 15 days between oral requests will alleviate a terminally ill persons' stress. Our current law is the longest waiting period of the ten authorized jurisdictions in the US.

I sincerely hope this committee will recommend passage of SB 2680 SD1which will provide terminally ill people the peace of mind that if needed (and if they choose) the ability to access the law.

Mahalo,

Mary Steiner

SB-2680-SD-1
Submitted on: 2/27/2022 7:37:51 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Malachy Grange	Individual	Support	No

Comments:

When the Hawaii legislature passed and Governor Ige signed the OCOCA in 2018, it was a promise to Hawaii citizens that if they met all the criteria for Medical Aid in Dying they could obtain and use medications to end their life. Unfortunately due to the waiting time imposed by the OCOCA (20 days) and the dearth of medical providers in Hawaii, many people were not able to use Medical Aid in Dying. They passed away before they could obtain the medicines, either for the time limits or the lack of availability of medical providers.

Can you imagine the devastation endured by patients and their families when this happens? They had arranged a time and place to gather for final acts of love and forgiveness, for a celebration of life and a common acceptance of death. Instead, this was taken away from them, which means the compassionate promise of autonomy at the end of one's life was not fulfilled as the ACT intended.

This is a tragedy that can be prevented. The remedy is simple: reduce the waiting period from 20 to 15 days and allow the prescribing medical provider to shorten it more as needed if they deem the patient will not last the 15 days. The solution to the shortage of medical providers in Hawaii who will participate is to allow Advanced Practice Registered Nurses, APRNs, (known as Nurse Practitioners in other states) to prescribe Medical Aid in Dying. They are licensed, trained and experienced in providing services across the wide spectrum of medical care.

Do the right thing for us all, and pass these amendments.

Thank you

Malachy Grange

Retired RN

SB-2680-SD-1
Submitted on: 2/27/2022 9:05:41 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
janice palma-glennie	Individual	Support	No

Comments:

aloha,

i strongly support this bill and all efforts to allow ill individuals to decide when and how they will leave this earth, and they should be able to do it in a peaceful way.

why our state hasn't led the country in this effort is hard to understand. Dying with dignity and individual choice are hallmarks of a benevolent society which Hawai`i has formerly been shown to be.

mahalo for supporting SB2680 SD1.

sincerely,

janice palma-Glennie

kailua-kona

SB-2680-SD-1
Submitted on: 2/27/2022 9:25:19 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Nora E. Wolf	Individual	Support	No

Comments:

Thank you for your consideration of these important changes to Hawai'i's Our Care, Our Choice Act.

SB-2680-SD-1
Submitted on: 2/28/2022 9:18:11 AM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
stephanie marshall	Individual	Support	No

Comments:

As a registered nurse with a specialty in oncology for over 40 years, I fully support this bill. Also as retired nursing faculty from UH Manoa School of Nursing, I have total confidence that APRNs can fulfill the role of attending and consulting providers. We have a responsibility to provide greater access for those patients who choose this option for a peaceful death.
Please vote yes for this bill.

'Very respectfully,

Stephanie Marshall RN,FAAN

LATE

TESTIMONY OF EVAN OUE ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) IN OPPOSITION SB 2680 SD1

Date: Tuesday March 1, 2022

Time: 10:00 a.m.

My name is Evan Oue and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ) in **OPPOSITION and PROPOSING AMENDMENTS** to SB 2680 SD1, Relating to Health. HAJ is concerned with SB 2680 SD1as it broadly prohibits medical records collected or retained by the department from discovery in civil cases.

Specifically, the measure amends HRS Section 327L-14(c) to state "Information collected pursuant to this ~~[section]~~ chapter by the department or retained as the result of incidental or routine communication with providers and qualified patients shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding." HAJ opposes this provision because it could have the unintended consequence of preventing the discovery of relevant and important patient information in a civil case, merely because the information was sent to the department.

Essentially, this limitation on discovery will eliminate any form of recourse and accountability to exercise the proper standard of care and function as blanket immunity for health care providers that may or may not be related to end of life care There is no justification for such broad discovery limitations since there is sufficient safeguards already in place, which if followed, should not create any liability for physicians.

Further, while the amendment likely seeks to protect the privacy of patients and their family members, it instead acts to prohibit a patient's right to access their own medical information from any source. For example, if a patient's medical record was sent to the department, it could be argued based on the proposed amendment that the patient or the patient's representative cannot obtain their own medical record in discovery, even directly from a health care provider. 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:

> "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 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.

LATE

SB-2680-SD-1
Submitted on: 2/28/2022 8:17:00 PM
Testimony for CPN on 3/1/2022 10:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Barbara J. Service	Individual	Support	No

Comments:

Aloha Chair Baker, Vice Chair Chang and committee members

Aloha Chair Rhoads, Vice Chair Keohokalole and committee members

I am a resident of SB8 and HB19 and I am writing regarding supplements to the Our Care, Our Choice Act which passed in 2018 an went into effect in January 2019. Over time it has been observed patients have died during the waiting period between oral requests. This bill would shorten that waiting period from 20 days to 15 days. It would also allow certain professionals to provide the counseling required under the law. Ie would allow Advanced Practice Registered Nurses to practice medical aid-in-dying. Lastly. the bill would provide an expedited pathway for those terminally ill individuals not expected to survive the mandatory period.

Thank you for the opportunity to testify.

Barbara J. Service MSW (ret.)

Kupuna advocate