WRITTEN TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-THIRD LEGISLATURE, 2026

ON THE FOLLOWING MEASURE:
S.B. NO. 3077, S.D. 1, RELATING TO HEALTH CARE.

BEFORE THE:
SENATE COMMITTEE ON JUDICIARY

DATE: Thursday, March 5, 2026 **TIME:** 10:01 a.m.

LOCATION: State Capitol, Room 016

TESTIFIER(S): **WRITTEN TESTIMONY ONLY.**
(For more information, contact Erin L. Lau,
Deputy Attorney General, at (808) 587-3050)

Chair Rhoads and Members of the Committee:

The Department of the Attorney General (Department) supports this bill; however, we respectfully recommend the deletion of section 17 of the bill, as discussed below.

Currently, two separate chapters of the Hawaii Revised Statutes (HRS), chapters 327E and 327G, HRS, provide a legal framework for advance health-care directives. The purpose of this bill is to update and consolidate our current laws by repealing those outdated chapters and replacing them with a new chapter, which is a modified version of the Uniform Health-Care Decisions Act (2023), as promulgated by the Uniform Laws Commission. The proposed changes reflect a modern understanding of capacity and reduce barriers to creating advance directives for both general health care and mental health.

The bill includes several key updates:

1. **Simplifying the requirements to execute a power of attorney for health care:** The bill reduces the number of witnesses required to create a power of attorney instruction from two witnesses or a notarization to one witness.
2. **Clarifying and safeguarding an individual's right to receive treatment during a psychiatric or psychological event:** The bill explicitly permits an individual to include an enforceable instruction in their advance mental health-care directive. While current law allows an individual to create an advance mental health-care directive, it does not clearly address the enforceability of

treatment instructions contained in the advance mental health-care directive during psychiatric or psychological events, nor does it provide any safeguards to ensure that the individual instructed such treatment. This bill provides those safeguards missing in the current law to ensure the instruction was consented to by the individual by requiring the signatures of two in-person witnesses in the advance mental-health care directive. Those safeguards make the treatment instructions enforceable during psychiatric or psychological events, even if the individual refuses treatment due to the individual's medical condition.

3. **Expanding the pool of qualified providers who may determine capacity:** The bill allows an advance practice registered nurse (APRN) with advanced education and specialized clinical training to determine whether an individual has capacity. Under current law, only a physician or a licensed psychologist can make that determination. The addition of APRNs will enhance accessibility to timely capacity assessments while maintaining high professional standards.
4. **Making it easier for sample forms to be updated:** The bill shifts the responsibility of creating and updating sample forms for advance health-care directives from statutory inclusion to the Department of Health (in consultation with the Department). This change ensures that the sample forms can be updated promptly to address evolving community needs. The current statutory forms, based on the previous Uniform Health-Care Decisions Act (1993), do not reflect a modern understanding of capacity, treatment options, or accessibility, creating unnecessary barriers for individuals seeking to create an advance health-care directive.

<u>This bill maintains two key aspects of Hawaii's current law that are not found in the Uniform Health-Care Decisions Act (2023):</u>

1. **Default surrogate as an authorized Medicaid representative:** In 2018, chapter 327E, HRS, was amended to allow a default surrogate to act as an authorized representative for Medicaid purposes. The bill preserves this authority to ensure continuity in health-care decision making for individuals relying on Medicaid.

2. **Default surrogate selection process:** When Hawaii adopted the Uniform Health-Care Decisions Act (1993), it created a process for choosing a default surrogate by requiring a physician, or the physician's designee, to locate interested persons and have those persons choose a default surrogate from among themselves. This process has been effective, as reported by medical providers, and reflects Hawaii's unique cultural context, including the recognition of "hanai" relationships.

We believe this bill provides significant and meaningful updates to the laws that will clarify and simplify the process to execute advance health-care directives and advance mental health-care directives. These changes will make it easier for individuals and their families to use advance directives to ensure autonomous decision-making and obtain appropriate care.

Recommended amendment—delete section 17 (working group). We recommend deleting section 17 (page 66, line 6, through page 68, line 3), which would create a formal working group convened and facilitated by the Department. We believe that a working group is unnecessary and would make discussions regarding implementation more difficult. The Department has engaged with stakeholders or invited stakeholders for discussions, including but not limited to HAH, Kokua Mau, Hawaii Health Systems Corporation, The Queen’s Health Systems, Kaiser Permanente, Hawaii Pacific Health, Hawaii Care Choices, Hospice Maui, and Kauai Hospice. Concerns raised in those discussions are addressed by the amendments suggested by HAH and incorporated into Senate Draft 1 of this bill.

During the transition period prior to the effective date of the bill, the Department will continue to collaborate with stakeholders and welcome input, particularly in updating the model forms, without creating an unnecessary formal working group. We, therefore, recommend the deletion of section 17.

Thank you for the opportunity to provide testimony.

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, M.D., M.G.A., M.P.H.
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
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Testimony in SUPPORT of SB3077 SD1
RELATING TO HEALTH CARE

SENATOR KARL RHOADS, CHAIR
SENATOR MIKE GABBARD, VICE CHAIR
SENATE COMMITTEE ON JUDICIARY

Hearing Date: Thursday, March 5, 2026 10:01 a.m. Room Number: 016 & Video

Fiscal Implications: Undetermined.

Department Position: The Department of Health ("Department") supports this measure.

Department Testimony: The Adult Mental Health Division offers the following testimony on behalf of the Department.

The Department supports SB 3077, SD1, which seeks to adopt the Uniform Health-Care Decisions Act (2023) with amendments to replace HRS chapters 327E and 327G; convene a working group to review, discuss, and provide recommendations regarding the implementation of the Uniform Health-Care Decisions Act; and require a report to the Legislature. The State of Hawaii previously adopted the 1993 version of the Uniform Health-Care Decisions Act as HRS chapter 327E. The 2023 revision of the Uniform Health-Care Decisions Act and accompanying modifications designed for our State intend to improve flexibility, ease-of-implementation, and individual preferences for decisions involving guardianship, surrogacy, and advance health care or mental health care directives.

The Department appreciates its inclusion in the added working group and the ongoing collaborative effort to improve the system of mental health care on our islands.

Thank you for the opportunity to testify on this measure.

STATE OF HAWAIʻI
KA MOKUʻĀINA O HAWAIʻI
STATE COUNCIL ON DEVELOPMENTAL DISABILITIES
'A'UNIKE MOKU'ĀPUNI NO KA NĀ KĀWAI KULA
PRINCESS VICTORIA KAMĀMALU BUILDING
1010 RICHARDS STREET, Room 122
HONOLULU, HAWAIʻI 96813
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March 5, 2026

The Honorable Senator Karl Rhoads, Chair
Senate Committee on Judiciary
The Thirty-Third Legislature
State Capitol
State of Hawaiʻi
Honolulu, Hawaiʻi 96813

Dear Chair Rhoads and Committee Members:

SUBJECT: SB3077 SD1, Relating to Health Care

The Hawaiʻi State Council on Developmental Disabilities provides **comments** on SB3077 SD1. While the Council does not take a position on the bill as a whole, we strongly support the definition and inclusion of Supported Decision-Making (SDM) within the measure. This measure adopts the Uniform Health Care Decisions Act (2023), as modified, to replace existing chapters related to advance health care directives and advance mental health care directives.

On page 2, lines 4–7, the bill appropriately strengthens recognition of Supported Decision-Making and modernizes Hawaiʻi's advance directive laws to better protect the rights, autonomy, and dignity of people with disabilities.

The Council is pleased to see the bill affirm that individuals may have the capacity to make health care decisions with the assistance of supports, technology, and reasonable accommodations. This principle is central to disability civil rights, person-centered planning, and the Supported Decision-Making framework enacted by the Legislature last year.

Thank you for this opportunity to provide testimony supporting the advancement of Supported Decision-Making within SB3077 SD1.

Sincerely,

Daintry Bartoldus
Executive Administrator

SB-3077-SD-1
Submitted on: 2/25/2026 6:31:39 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Louis Erteschik	Testifying for Hawaii Disability Rights Center	Oppose	Written Testimony Only

Comments:

We oppose the so called Ulysses clause just as we did last year when a similar measure was heard. It is nothing more than an attempt to get people to waive their legal and constitutional rights. Aside from being bad policy, we question its validity and legality. If the individual changes their mind at the moment it would otherwise occur, we believe it may be unenforceable and would still require a Court order. We also question if the person who would administer the medication is really going to want to follow through without legal intervention. We remain concerned that this will be utilized as a way to make it easier to involuntarily medicate people under the guise of individual choice.

Beyond that, it is not really clear what purpose this bill serves. The current law is not particularly ”broken”. While this is supposedly modeled on the Uniform Law, our understanding is only two other states have adopted this. This is a lengthy bill with a lot of different parts to it, that was developed mostly by the Administration without a lot of stakeholder engagement. We would prefer to see the Legislature designate a work group to meet in the Interim if it feels that this issue is significant enough to warrant further discussion.

HAWAIʻI STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Testimony Presented Before the Senate
Committee on Judiciary
Thursday, March 5, 2026 at 10:01 AM
Conference Room 016 and Videoconference
By
Laura Reichhardt, APRN, AGPCNP-BC
Director, Hawaiʻi State Center for Nursing
University of Hawaiʻi at Mānoa

Comments on SB 3077, SD1

Chair Rhoads, Vice Chair Gabbard, and members of the Committee:

The Hawaiʻi State Center for Nursing (HSCN) recognizes the significance of SB3077, SD1, which proposes to adopt the Uniform Health Care Decisions Act (2023), as modified, to replace existing statutes related to advance health care directives and advance mental health care directives. The Center for Nursing provides comments only as it relates to the definition of Advanced Practice Registered Nurse (APRN).

While the majority of the contents of this bill addresses advanced mental health care directives, it is pertinent to note that the chapter this bill will create, and sections including determining capacity are germane to more specialties than psychiatric advanced practice registered nurses alone. Family Nurse Practitioners, Oncology Clinical Nurse Specialists, Adult-Geriatric Primary Care Nurse Practitioners, and Adult-Geriatric Acute Care Nurse Practitioners all are currently capable to engage in advanced health care directive support with patients. Many engage in this practice today.

The current definition of APRN will significantly reduce the available workforce that may engage in advanced health care decision making, even though they often serve as the primary point of contact for patients navigating these decisions. To remedy this, HSCN recommends the following amendment:

Part I, Section I, Page 3, lines 12-13

"Advanced practice registered nurse" means a person licensed pursuant to section 457-8.[~~5 and who holds an accredited national certification in an advanced practice registered nurse psychiatric specialization~~].

The mission of the Hawaiʻi State Center for Nursing is to collaborate on fostering workplace conditions that support nurses to remain in a fulfilling profession.

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www.AlohaILHawaii.org

Mar 1, 2026

The Honorable Senator Karl Rhoads, Chair
Senate Committee on Judiciary
The Thirty-Third Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

SUBJECT: SB 3077 SD1, Relating to Health Care

Chair and Members of the Committee:

Aloha Independent Living Hawaii (AILH) respectfully submits testimony in **support of SB3077 SD1 with recommendations**.

SB3077 SD1 amends section 368-11, Hawaii Revised Statutes, to require that if the Hawaii Civil Rights Commission has not completed its investigation within 180 days of the filing of a complaint, the Commission shall provide written notice to the complainant explaining that the complainant may request a notice of right to sue. The bill also clarifies that complainants may request such notice at that time.

For individuals with disabilities, Chapter 368 provides critical protections against discrimination in employment, housing, public accommodations, and other essential areas of daily life. When complaints are delayed without clear communication regarding procedural options, individuals may experience prolonged uncertainty and barriers to timely resolution.

SB3077 SD1 strengthens procedural transparency and reinforces the right of complainants to make informed decisions regarding administrative versus judicial remedies. Clear notification at the 180-day mark supports due process and aligns with principles of fairness and accountability.

AILH respectfully offers the following recommendations:

First, notices provided pursuant to this section should be issued in accessible formats and plain language. Individuals filing discrimination complaints may

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require alternative formats, auxiliary aids, or simplified explanations to fully understand their rights and options.

Second, implementation guidance should clarify that the 180-day notice does not discourage continued administrative resolution where appropriate, but rather ensures that complainants are aware of their available remedies.

Third, in addition to providing notice at the 180-day mark, the Legislature may wish to encourage periodic reporting on investigation timelines. Such reporting could include aggregate data regarding average case duration, common causes of delay, steps taken to address delays, and communication practices used to keep complainants informed during the investigative process. Transparency regarding these factors would support public confidence and help identify whether additional resources or procedural adjustments are needed.

Fourth, guidance accompanying the 180-day notice should clarify what complainants may do while an investigation remains pending, including the availability of continued participation in administrative resolution, access to mediation where appropriate, and the option to consult legal counsel. Clear communication about interim options can reduce uncertainty and empower informed decision-making.

SB3077 SD1 enhances clarity in the civil rights enforcement process and supports meaningful access to justice for individuals with disabilities and other protected classes.

AILH respectfully urges passage with the above recommendations.

Thank you for the opportunity to testify.

Aloha,

Roxanne U. Bolden

Roxanne Bolden

Executive Director

Hawai'i Association of Professional Nurses (HAPN)

To: The Honorable Senator Karl Rhoads, Chair, and Members of the Senate Committee on Judiciary (JDC)

From: Hawai‘i Association of Professional Nurses (HAPN)

RE: SB3077 SD1 — Relating to Health Care

Position: Support with Amendments

Decision Making: Thursday, March 5, 2026, at 10:01 a.m.

Aloha Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

On behalf of the Hawai‘i Association of Professional Nurses (HAPN), we submit this testimony in support of SB3077 SD1 with amendments. This measure adopts a modified Uniform Health Care Decisions Act framework to replace existing chapters related to advance health care directives and advance mental health care directives. HAPN supports the bill’s overall goal of modernizing Hawai‘i’s decision-making laws and creating a clearer, more workable statutory structure for patients, families, and providers.

HAPN appreciates that the bill recognizes APRNs within the broader framework for health care decision-making. Prior supportive testimony on this measure has described that inclusion as a way to expand the pool of qualified providers who may participate in capacity-related determinations and improve access to timely care planning. HAPN agrees with that general objective. However, as currently drafted, the bill defines physicians broadly while defining APRNs far more narrowly, and that discrepancy should be corrected before enactment.

The bill defines physicians broadly but limits APRNs to psychiatric specialization only.

Under the bill’s definitions section, a “physician” is defined broadly as an individual licensed to practice medicine or osteopathic medicine under chapter 453, without limitation by specialty. By contrast, an “advanced practice registered nurse” is defined only as a person licensed under section 457 who holds accredited national certification in an advanced practice registered nurse psychiatric specialization. This is an unjustified imbalance in the statute. If physicians are not limited by specialty in the definition, APRNs should not be limited in that way either.

The APRN definition is too narrow and excludes qualified clinicians who routinely care for patients facing these issues.

Advance health care decision-making does not arise only in psychiatric settings. Geriatric home care APRNs, neuro-specialized APRNs, hospice and palliative care APRNs, and other APRNs routinely care for patients with dementia, neurocognitive disorders, serious neurologic illness, progressive medical decline, and end-of-life needs. These are exactly the types of clinical circumstances in which questions about capacity, directives, surrogate decision-making, and patient preferences often arise. Limiting APRNs in this statute to psychiatric certification only excludes qualified clinicians who are already practicing within their lawful scope and who are deeply involved in these decisions every day.

The current language restricts APRNs more than the bill restricts physicians.

From HAPN's perspective, this is the core drafting flaw. The statute gives physicians a broad, profession-level definition, but it gives APRNs a specialty-restricted definition tied only to psychiatric certification. That approach is not neutral. It narrows APRN participation by definition and does so in a way that does not apply to physicians. Hawai'i should not modernize one part of its health care decision-making law while embedding a narrower, unequal recognition of APRNs into the new framework.

The bill should not limit APRNs in a way that interferes with full-scope practice.

APRNs in Hawai'i practice across multiple specialties and settings, including geriatrics, neurology-related care, home-based care, hospice, and serious illness management. Those clinicians often have longstanding therapeutic relationships with patients and are well positioned to participate in advance care planning and decision-making discussions. A statutory definition that excludes them does not improve quality or safety. Instead, it creates an artificial scope restriction that is inconsistent with how care is actually delivered and inconsistent with the bill's broader goal of improving clarity and access.

A narrower definition may also undermine the bill's own implementation goals.

Supporters of SB3077 have emphasized modernization, usability, and broader access to qualified providers. HAPN agrees those are worthy aims. But if the bill includes APRNs only in a psychiatric-specific way, it unnecessarily limits the number of appropriate APRNs who may participate in directive-related and capacity-related functions. That weakens the access rationale used to support the bill and may create avoidable barriers in settings where non-psychiatric APRNs are the clinicians most involved in the patient's ongoing care.

HAPN respectfully requests an amendment to broaden the APRN definition.

At a minimum, HAPN urges the Committee to amend the bill so that "advanced practice registered nurse" is defined in a manner parallel to the physician definition, such as: "Advanced practice registered nurse" means a person licensed pursuant to section 457. If the Legislature believes that certain provisions related specifically to advance mental health care directives require specialty-specific language, that limitation should be addressed only in those specific operative sections rather than imposed as a chapter-wide definition. That would be a cleaner and more equitable drafting approach.

"Advanced practice registered nurse" means a person licensed pursuant to section 457~~-8.5 and who holds an accredited national certification in an advanced practice registered nurse psychiatric specialization~~.

Conclusion

HAPN supports the overall purpose of SB3077 SD1 and appreciates the effort to modernize Hawai'i's laws governing advance health care decisions. However, the bill should be amended so that APRNs are not defined more narrowly than physicians and so that qualified APRNs practicing in geriatrics, neurology-related care, home care, hospice, and other relevant specialties are not excluded from participation. For these reasons, HAPN respectfully urges the Committee to PASS SB3077 SD1 WITH AMENDMENTS.

Mahalo for the opportunity to provide testimony.

Respectfully submitted,
Hawai‘i Association of Professional Nurses (HAPN)

TO:
Chair Karl Rhoads
Vice Chair Mike Gabbard
Senate Committee on Judiciary

FROM:
Tricia Yamashita MPH, MSPC
Executive Director
Kaua‘i Hospice

RE:SB 3077 SD1 – Relating to Health Care
Position: Comments; Request to Retain Statutory Working Group and Delay Implementation

Aloha Chair Rhoads, Vice Chair Gabbard, and Members of the Committee,

Mahalo for the opportunity to provide testimony on SB 3077 SD1.

Kaua‘i Hospice has served our island community for more than four decades, providing hospice and palliative care to patients and families navigating serious illness, incapacity, and end-of-life decision-making. Advance health care directives (AHCDs) are not abstract legal tools in our work—they guide deeply personal decisions during some of the most vulnerable moments in a person’s life.

We appreciate the intent of this measure to modernize and consolidate Hawai‘i’s laws concerning advance health care directives and advance mental health care directives. However, we have significant concerns regarding both the breadth of the statutory overhaul and the proposed removal of the statutory working group in Section 17.

SB 3077 SD1 repeals Chapters 327E and 327G and replaces them with an entirely new statutory framework based on the Uniform Health-Care Decisions Act (2023), as modified. This is not a technical update, it is a structural rewrite affecting capacity determinations, default surrogate selection, mental health directives, institutional duties, immunity protections, and court processes. For providers who operationalize these laws daily, this represents a substantial shift that will require careful implementation, education, and systems alignment.

For that reason, **retention of the statutory working group in Section 17 is essential.** A formal, multi-stakeholder working group ensures transparency, balanced representation, legislative oversight, and a structured opportunity to identify ambiguities or unintended consequences before full implementation. Advance health care directives implicate fundamental issues of autonomy and bodily integrity. Public trust in this framework depends on transparent and accountable implementation.

We also **strongly support a delayed effective dat**e. In hospice and palliative care settings, we routinely navigate complex family dynamics, questions regarding surrogate authority, and situations involving both physical and mental health conditions. Even well-intended statutory revisions can create confusion in real-time clinical decision-making if guidance is not clear and coordinated. A formal working group provides the appropriate mechanism to develop education for providers and the public and to ensure the law functions effectively across hospitals, long-term care facilities, outpatient settings, and rural communities.

On neighbor islands like Kaua‘i, where specialty resources are limited and teams are small, statutory clarity is particularly critical. Implementation must be thoughtful and inclusive to preserve the decade of progress Hawai‘i has made in advance care planning and end-of-life decision-making.

Kauaʻi Hospice respectfully requests that the Committee retain the statutory working group in Section 17 and ensure a deliberate, transparent implementation process. This measure represents a foundational shift in how advance health care decisions will be governed in Hawaiʻi. The structure of implementation will determine whether this transition strengthens or destabilizes a system that patients and families rely upon during life's most vulnerable moments.

Mahalo for your thoughtful consideration.

With respect,

Tricia L. K. Yamashita, MPH, MSPC
Executive Director
Kauaʻi Hospice
tyamashita@kauaihospice.org

Kōkua Mau
Continuous Care
A Movement to Improve Care

March 2, 2026

Dear Chair Rhoads, Vice-chair Gabbard and members of the committee,

I am writing today to express my concern about **SB3077 SD1** that would make changes to the Uniform Healthcare Decisions Act. This bill makes substantive changes to how medical decisions are made for some of the most vulnerable in our society, those who are too sick to speak for themselves. We recognize that work has been done to update existing law through this bill and we are ready to work with the administration and other key stakeholders on changes to improve existing statutes.

Kōkua Mau is a 26-year-old non-profit, and I have served as the Executive Director for the past 16 years. We are one of the lead agencies statewide for educating professionals and the public about Advance Directives. Over the past 26 years, we have educated thousands of professionals and members of the public. Our website is the "go-to" site for background information, a downloadable advance directives form (including versions in 13 languages), and other tools and resources to help people understand these decisions.

Our System for Advance Care Planning is working well. SB3077 makes substantive changes which would impact hundreds of providers - doctors, nurses, social workers, case managers as well as elder law attorneys. Tens of thousands of people complete Advance Directives yearly and are used in many settings including hospitals, long term care facilities, hospices and home-based care. Healthcare is under a lot of stress right now, as we know. We question the need to change what isn't broken.

Suggestions for improving the bill

1. **Create a working group before the bill is passed.** SB3077 makes **substantive changes to the existing statutes, directly affecting care delivery in Hawaii.** It impacts decision making, surrogacy, capacity and other crucial issues for both advance directives and mental health directives. We should take time to study the issues, create solutions and address unforeseen consequences collaboratively *before* legislation is introduced, not after.
2. **Edits from the Healthcare Association improve the bill but raise new questions.** At the first Senate hearing, the committee accepted all seven pages of edits from HAH without discussion. While we agree with most of the edits, we now have a 64-page complex bill AND edits without an opportunity for explanation or discussion and questions remain.
   Content issues with the bill:
   a. **Confusion about health care instructions revoking Advance Directives.** HAH included an amendment (Page 15, lines 18-21, Page 16 line 1-3) which strives to preserve the integrity of advance care planning, but it is not clear what these changes mean. Are we removing the patient's ability to orally change a directive? Are we removing the ability to change wishes written in an Advance Directive? Further

discussion and clarification is needed. Patients need to preserve the right to change their directives if they have capacity.

b. **Reducing the need to have only one witness who can be a healthcare provider raises important consumer protection concerns**. Other solutions can be found to make Advance Directives simpler to complete or allow only one witness but not have them be a healthcare provider.
c. **Confusion with decision makers in Advance Directive and Mental Health Directive remain.** Further work is needed to determine the line between physical condition and mental or behavioral health conditions when determining the authority of the agent. What if a physical condition causes behavioral issues such as delusions, paranoia, delirium and the like? No guidelines are included to determine which type of Directive controls. Are other solutions needed to help with mental health decision making?
d. **Discussion of POLST –** Provider Orders for Life Sustaining Treatments. Why is this included? POLST has its own statute and is **not** an Advance Directive.
e. **§321-23.6 Rapid identification documents for Comfort Care.** Is this an effort to start Comfort Care Only bracelets again? Hawaii stopped using them years ago and uses POLST to document out-of-hospital comfort measures. Recommend to eliminate this provision.

3. **Funding is needed for the Education Materials and campaigns that would need to be created** to reach statewide all facilities and providers impacted by these changes. This includes hospitals, health systems, clinics, hospices, home health agencies, community-based organizations, health plans, long-term care and anyone else who cares for those with serious illness. Policies and procedures will need to be re-written. New forms will need be created for the current Advance Directive as well as all existing translations to meet state and federal guidelines. (All of this currently exists on the Kōkua Mau website.) Additionally, Mental Health Directives would need to be modified. No financial provision is made in the bill for this. Who is paying for the Herculean effort?

This law is not seen as best practice nationally and only two states, Nevada and Delaware, have adopted it. Other states that are at the forefront of serious illness care have not moved to adopt it.

We hope that more time can be taken, with input from all stakeholders in Hawai‘i, if changes are needed to this important legislation and are ready to work with our colleagues to make that happen.

Thank you for your consideration.

Jeannette Koijane, Executive Director, Kōkua Mau

Website: kokuamau.org , Phone 808 585-9977

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB BENIOFF WILCOX

Thursday, March 5, 2026; 10:01 a.m.
Conference Room 016 & Video Conference

Senate Committee on Judiciary

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: SB 3077, SD1 – Comments Relating To Health Care

My name is Michael Robinson, Vice President of Government Relations & Community Affairs at Hawaiʻi Pacific Health (HPH). HPH is a not-for-profit health care system comprised of its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox and over seventy locations statewide with a mission of creating a healthier Hawaiʻi.

I write to provide COMMENTS on SB 3077, SD1 which adopts the Uniform Health Care Decisions Act (2023), as modified, to replace existing chapters related to advance health care directives and advance mental health care directives. The measure further requires that the Attorney General convene a working group to provide recommendations as to implementation.

We support the amendments suggested by the Healthcare Association of Hawaiʻi (HAH) and concur with the establishment of a working group which would fully research the many issues surrounding advance health care directives and advance mental health care directives before implementation.

SB 3077, SD1 introduces significant changes to the laws on advanced health care directives, affecting critical decisions for seriously ill or incapacitated individuals. Such reforms must integrate smoothly across care settings and stakeholders, as even well-meaning statutory updates can have widespread effects if not carefully coordinated with actual care practices.

HPH's providers and staff are committed to honoring patients' wishes and following the Uniform Health Care Decisions Act. However, merging the Advance Health Care Directive with the Advance Mental Health Care Directive may complicate how patient preferences for end-of-life and mental health care are interpreted and supported.

HPH would welcome the opportunity to participate in the working group so that patients as well as providers will not be adversely affected by the changes to the law contemplated by SB 3077, SD1.

Thank you for the opportunity to provide testimony on this measure.

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Government Relations

LATE

Testimony of
Jonathan Ching
Head of Government Relations

Before:
Senate Committee on Judiciary
The Honorable Karl Rhoads, Chair
The Honorable Mike Gabbard, Vice Chair

March 5, 2026
10:01 a.m.
Conference Room 016
Via Videoconference

Re: SB 3077, SD1, Relating to Healthcare.

Chair Rhoads, Vice Chair Gabbard, and committee members, thank you for this opportunity to provide testimony on SB 3077, which amends the Uniform Health-Care Decisions Act.

Kaiser Permanente Hawai‘i submits COMMENTS to SB 3077, SD1 .

Kaiser Permanente Hawai‘i supports the amendments submitted by the Healthcare Association of Hawaii (HAH). These amendments are offered after thoughtful consultation with providers, including our providers, who work with patients with diminished capacity and their families everyday, and further refine amendments accepted by the Senate Health and Human Services.

Kaiser Permanente is one of the nation’s largest not-for-profit health plans, serving 12.6 million members nationwide and more than 271,000 members in Hawai‘i. In Hawai‘i, more than 4,600 dedicated employees and more than 650 Hawai‘i Permanente Medical Group physicians and advance practice providers work in our integrated health system to provide our members coordinated care and coverage. Our providers include those specializing in continuing care, often managing patients with long-term conditions, diminished capacity, or being treated for end-of-life and palliative care.

As this measure is being considered, it is important to stress that the situations impacted by this measure are complex. Challenges faced by affected individuals, their families, and providers include fluctuating capacity (especially in situations such as delirium), disagreements among decision-makers, and/or time-sensitive, critical care decisions.

Our providers aim to *keep patients at the center of our care*. In cases where capacity is in question, our providers seek to preserve as much patient autonomy as possible, to the extent

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patients are capable of understanding and making decisions. These situations can be fluid, and it is critical for such complexities to be accounted for by the law.

Kaiser Permanente Hawai‘i respectfully requests the committee accept HAH’s proposed amendments. Furthermore, we strongly support a delayed implementation date and the formation of a working group, both of which are critical to ensure providers are adequately prepared to implement the changes proposed by SB 3077, SD1.

Mahalo for the opportunity to testify on this important measure.

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Submitted Online: March 4, 2026

TO: Senate Committee on Judiciary
Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair

FROM: Eva Andrade, President

RE: Opposition to SB3077 SD1 Relating to Healthcare

Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawai‘i. We respectfully oppose SB 3077 SD1.

We appreciate that amendments were made after concerns were raised. The removal of certain provisions shows that stakeholder voices were heard. However, the central issue remains: this bill still replaces Hawai‘i’s long-standing advance directive laws with an entirely new framework.

Advance health care directives are not abstract policy tools. They come into play at some of the most sacred and painful moments in a family’s life — when a loved one cannot speak for themselves. These laws affect how decisions are made about treatment, mental health care, and end-of-life choices. For people of faith, these moments are deeply connected to human dignity, conscience, and family responsibility.

Our question is simple: Why change what isn’t broken?

Hawai‘i’s current system has been in place for decades. Families understand it. Providers are trained under it. Forms are translated and widely distributed. There has been no demonstrated crisis requiring a full repeal and replacement of the law. If improvements are needed, they can be made carefully within the existing structure.

The bill still expands the “default surrogate” process, which could broaden the group of people involved in making decisions when someone loses capacity. In times of medical crisis, families need clarity — one clear decision-maker — not additional layers of uncertainty that could create tension or delay.

The bill also continues to allow advance mental health directives that may prevent a person from changing their mind during a future psychiatric episode. Questions about when someone can revoke their own directive during a mental health crisis are not minor technical details. They touch autonomy, vulnerability, and dignity. These issues deserve careful community conversation before becoming law.

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We are also concerned that parts of the bill could create confusion for health care providers who must comply with federal privacy rules. When state and federal expectations do not clearly align, patients and families may ultimately feel the consequences.

Finally, while the addition of a working group may be well-intentioned, forming a group after passage suggests that significant questions remain. Laws affecting life, mental health, and end-of-life decisions should be studied and agreed upon before they are enacted — not sorted out afterward.

When legislation touches life, dignity, and the protection of vulnerable persons, moving carefully is not obstruction — it is wisdom.

For these reasons, Hawaii Family Forum respectfully urges the Committee to defer SB 3077 SD1 and allow for broader public and professional discussion **before making permanent changes to this important area of law.**

Thank you for the opportunity to testify in opposition.

HAWAII CATHOLIC CONFERENCE

The Public Policy Voice of the Roman Catholic Church in the State of Hawaii

DATE: **March 3, 2026**

TO: **Senate Committee on Judiciary**

FROM: **Eva Andrade, Executive Director**

RE: **OPPOSITION to SB3077 SD1 – Relating to Health Care**

Chair and Members of the Committee,

My name is Eva Andrade, and I serve as the Director of the Hawai'i Catholic Conference, the public policy voice of the Catholic Church in our state. The Conference respectfully opposes SB3077 SD1.

At the outset, we are concerned that this measure merges two fundamentally different areas of law into a single statutory framework. Advance health care directives traditionally address end-of-life and serious medical decision-making for the entire population, while advance mental health directives apply to a narrower set of circumstances and individuals. Combining these distinct issues into one comprehensive restructuring risks confusion, unintended consequences, and insufficient scrutiny of the unique ethical considerations involved in each area.

Decisions about health care, especially those involving end-of-life care or periods of mental vulnerability, are deeply personal and moral in nature. Laws governing these decisions must prioritize clarity, relational accountability, and the protection of human dignity. Sweeping statutory restructuring without broad community understanding and careful implementation risks creating uncertainty in some of the most sensitive moments of life.

While we appreciate the intent to modernize and consolidate existing statutes, the bill introduces significant structural and ethical concerns. It adopts a modified version of the Uniform Health Care Decisions Act (2023), substantially expanding the legal framework governing advance directives, surrogate decision-making, and mental health care planning.

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One major concern is the authorization of so-called "Ulysses clauses," which allow individuals to create advance mental health directives that cannot be revoked during a specified psychiatric episode. While intended to support continuity of care, this provision raises serious ethical questions about autonomy and the dignity of persons experiencing mental health crises. Individuals may later find themselves bound by decisions made under very different life circumstances.

The measure also expands the authority of default surrogates and non-family decision-makers, allowing individuals outside traditional family structures to make critical health care decisions when capacity is questioned. This raises concerns about safeguarding vulnerable persons, particularly the elderly, disabled, and socially isolated.

Additionally, the bill substantially alters how capacity is determined and documented, introducing complex procedural pathways that may be difficult for families to navigate during already stressful and emotional medical situations.

We are also concerned about the sequencing of policymaking. The committee report acknowledges that further implementation discussions are anticipated through a future working group. Major structural reforms to advance directive law should be guided by broad consensus and careful deliberation prior to enactment, not developed after passage.

Given the complexity and far-reaching implications of this proposal, we respectfully urge the Legislature to proceed cautiously. A more prudent approach would involve separating these issues, engaging a broader range of stakeholders, and ensuring stronger safeguards before undertaking such sweeping reforms.

For these reasons, the Hawai'i Catholic Conference respectfully urges you to defer SB3077 SD1.

Thank you for the opportunity to testify.

LATE

Hawaii Medical Association
1360 South Beretania Street, Suite 200 • Honolulu, Hawaii 96814
Phone: 808.536.7702 • Fax: 808.528.2376 • hawaiimedicalassociation.org

SENATE COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair

Date: March 5, 2026
From: Hawaii Medical Association (HMA)
Elizabeth Ann Ignacio MD - Chair, HMA Public Policy Committee
Christina Marzo MD and Robert Carlisle MD, Vice Chairs, HMA Public Policy Committee

Re: SB 3077 SD1 RELATING TO HEALTH CARE.
AG; Uniform Health Care Decisions Act (Modified); Advance Health Care Directives; Advance Mental Health Care Directives; Working Group; Report
Position: Comments

This measure would adopt the Uniform Health Care Decisions Act (2023), as modified, to replace existing chapters related to advance health care directives and advance mental health care directives. Requires the Attorney General to convene a working group. Requires a report to the Legislature. Effective 1/30/2050. Implementation effective 7/1/20209. (SD1)

Hawaii's current laws on health care decision-making are spread across separate statutes (including a separate framework for advance mental health preferences), which can make it harder for patients, families, and clinicians to know who can speak for a patient, when a surrogate can step in, and how to honor documented wishes in real-world emergencies.

HMA supports this measure as amended, that may unify advance health care and advance mental health care directive statutes into a coherent act replacing the old chapters. From a patient-care perspective, this measure promotes autonomy and continuity by encouraging earlier, values-based planning, reducing confusion during crises, and supporting care that reflects what matters most to the patient, including during serious illness and at end of life. It also strengthens the ability to honor patient preferences when decision-making capacity is impaired, which is especially important in behavioral health and emergency settings.

There are likely transition and education challenges to move from familiar, legacy forms to a new consolidated framework. The amendment to require the Attorney General, in consultation with the Department of Health, to convene and facilitate a working group, will allow for careful review and guidance regarding the implementation. The long-term benefits of clarity, patient autonomy, and continuity of care ultimately strengthen patient-centered decision-making across care settings in Hawaii.

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

REFERENCES AND QUICK LINKS

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"Senate Bill No. 309: An Act to Amend Title 12 and Title 16 of the Delaware Code Relating to Health-Care Decisions." (Text of enacted/adopted UHCDA 2023 framework), https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocument?docTypeId=2&legislationId=141421&legislationName=SB309&legislationTypeId=1

Rosa, William E., et al. "Advance Care Planning in Serious Illness: A Narrative Review." *Journal of Pain and Symptom Management*, vol. 65, no. 1, Jan. 2023, pp. e63–e78. *PubMed*, doi:10.1016/j.jpainsymman.2022.08.012.

Morrison, R. Sean. "Advance Directives/Care Planning: Clear, Simple, and Wrong." *Journal of Palliative Medicine*, vol. 23, no. 7, July 2020, pp. 878–879. *PubMed*, doi:10.1089/jpm.2020.0272.

Healthcare Association of Hawaii

LATE

March 5, 2026 at 10:01 am
Conference Room 016

Senate Committee on Judiciary

To: Chair Karl Rhoads
Vice Chair Mike Gabbard

From: Paige Heckathorn Choy
VP, Government Affairs
Healthcare Association of Hawaii

Re: Submitting Comments
SB 3077 SD 1, Relating to Health Care

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide.

Thank you for the opportunity to provide **comments** on this measure, which seeks to update Hawaii state law regarding advanced healthcare directives and other legal frameworks around decision-making for individuals who have lost capacity. The current draft includes several critical amendments for the provider community that will help to ensure a more seamless application of the changes envisaged by this measure.

Because these changes affect some of the most sensitive and complex moments in health care — including situations involving serious illness, incapacity, and end-of-life decision-making — it is essential that the statutory framework operate seamlessly across hospitals, long-term care facilities, outpatient settings, and emergency services. Even well-intended revisions can create operational and clinical challenges if they are not fully aligned with how care is delivered in real-world settings.

As a result, while we appreciate the work that has gone into the latest version of the bill and recognize the importance of modernizing this framework, we continue to believe that a delayed implementation date is necessary. This will give time for stakeholders to identify any provisions that require clarification prior to the law going into effect. Further, we understand there is interest in removing the working group from this bill and, instead, inserting it into a resolution that can be supported by the agencies involved in this effort. Our members feel strongly that

there needs to be a formal group created to discuss the issues around implementation of this measure and that all parties must be present to ensure that patients and providers are provided the clarity they need to make these important decisions.

We also want to note that, based on feedback from the Attorney General, there are additional targeted amendments that our members agree with and support. Those suggested changes are included below.

Below, please find the suggested amendments:

1. Remove subsection (d) on page 15 line 18 to page 16 line 3 and amend subsection (c) on page 15 to read:

> (c) A health care instruction made by an individual that conflicts with an earlier health care instruction made by the individual, including an instruction documented in a medical order, shall revoke the earlier instruction to the extent of the conflict. A health care instruction, whether oral or written, shall not revoke, suspend, or otherwise invalidate an advance health care directive unless the individual expressly states an intent to revoke or modify, in whole or in part, the advance health care directive and is determined to have capacity to make health care decisions as described in this section at the time the revocation or modification is made.

This change is requested mainly to group similar ideas together, to make it more clear for clinicians what directives or instructions they should follow.

2. Amend a few areas of Section 10, which outlines how providers should manage conflicts in an advanced health care directive and an advance mental health care directive, to more properly consolidate directions into the same subsections and provide clarifying language:

> **§ -10 Relationship of advance mental health care directive and other advance health care directive.** (a) If a direction in an advance mental health care directive of an individual conflicts with a direction in another advance health care directive of the individual, the later direction shall control and revoke the earlier direction to the extent of the conflict; provided that the existence of a conflict shall be determined based on the specific health care decision at issue, rather than on whether the individual's condition is characterized as mental or physical. When a proposed course of treatment addresses both mental and physical health aspects, the agents shall, to the extent practicable, consult with one another. If the

agents disagree, authority shall be determined by the primary purpose of the specific decision at issue, as determined by the attending health care provider acting in good faith.

(b) An agent appointed to make health care decisions other than mental health care decisions has authority over all other health care decisions, [~~including~~] such as decisions relating to medical or surgical treatment, palliative care, life-sustaining treatment, and care for physical conditions, even when the conditions are comorbid with a mental [~~or behavioral~~] health condition.

(c) An agent appointed to make decisions only for mental health care has authority over decisions primarily relating to the diagnosis, treatment, or management of a mental or behavioral health condition, including decisions regarding psychiatric treatment and admission to or discharge from a mental health facility, to the extent authorized by the advance mental health care directive.

[~~(d) When a proposed course of treatment addresses both mental and physical health aspects, the agents shall, to the extent practicable, consult with one another. If the agents disagree, authority shall be determined by the primary purpose of the specific decision at issue, as determined by the attending health care provider acting in good faith.~~]

[~~(c)~~] (d) A health care provider who relies in good faith on a determination under subsection (b) or (c) shall not be subject to civil or criminal liability or discipline for unprofessional conduct for acting in accordance with that determination.

3. Amend subsection (c) on page 24 to reference the appropriate sections of this measure that are related to determinign capacity:

(c) If the individual has not appointed an agent, lacks capacity to identify a default surrogate under section 3(a)(1) and (2)(C), and there are no instructions on identifying a default surrogate, the responsible health care professional or the responsible health care professional's designee shall make reasonable efforts to locate as many interested persons as practicable, and the responsible health care professional or the responsible health care professional's designee may rely on the

interested persons to notify other family members or interested persons. Upon locating interested persons, the responsible health care professional or the responsible health care professional's designee shall inform the interested persons of the individual's lack of capacity and that a default surrogate should be selected for the individual.

4. Amend subsection (g) on pages 40 and 41 to make the criteria around potential transfer more clear, and to account for a situation when a transfer may not be feasible:

(g) A health care professional or health care institution that refuses to provide care under subsection (f) shall:

(1) As soon as reasonably feasible, inform the individual, if possible, and the individual's surrogate of the refusal;

(2) Immediately make a reasonable effort to transfer the individual to another health care professional or health care institution that is willing to comply with the instruction or decision and provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible; and

(3) If a transfer is not feasible, provide continuing care to the patient while the patient remains under the refusing provider or institution's care.

5. Amend subsection (d)(1) on pages 45-46 to read:

(1) The violation occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care is appropriate to avoid imminent loss of life or serious harm to the individual or providing care; provided that the emergency medical services personnel or first responder personnel were not aware in advance of the existence of a valid provider order for life-saving treatment;

HAWAI'I CARECHOICES
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COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair

RE: Testimony in Opposition to SB 3077 SD1 – Uniform Health Care Decisions Act (Modified); Advance Health Care Directives, Advance Mental Health Care Directives; Working Group; Report

Hearing: Thursday, March 5, 2026, at 10:01 a.m.

Dear Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

Thank you for the opportunity to submit testimony regarding SB 3077 SD1, which proposes to unify the Advance Mental Health Care Directive (AMHCD) within the existing Advance Health Care Directive (AHCD) under a single statutory framework. I respectfully oppose this measure.

While both directives are grounded in the fundamental principle of patient self-determination and informed consent, they address materially different legal, ethical, and clinical contexts.

The AHCD is primarily designed to guide end-of-life decision-making, preferences for life-sustaining treatment, and care planning for serious or terminal medical conditions. Its framework reflects long-standing statutory and clinical practices regarding capacity, surrogate decision-making, and the withdrawal or withholding of life-sustaining interventions.

By contrast, the AMHCD governs treatment preferences during periods of temporary incapacity resulting from acute mental health crises. These circumstances are distinct in several critical ways. Consolidating the AMHCD into the AHCD risks unintended consequences.

First, merging two complex areas of health law into a single instrument may create confusion for patients, families, and providers. A unified document could become lengthy, technical, and overwhelming – discouraging completion altogether. Advance directives are effective only when individuals are willing and able to complete them.

Second, Hawaii's current AHCD framework is widely utilized and operationalized. It provides a clear and functional structure for end-of-life planning. Thousands of individuals complete advance directives annually, and hundreds of physicians, nurses, social workers, case managers, and elder law attorneys rely upon the existing statutes. Substantial statutory restructuring should be approached cautiously to avoid destabilizing established care processes.

Both AHCD and AMHCD advance patient autonomy. However, autonomy is best protected when legal tools are precise, understandable, and context-specific. Separate statutory frameworks provide clearer guidance for end-of-life and mental health decision-making; combining them introduces complexity and potential risk without demonstrated benefit.

I urge the Committee to reconsider the proposed consolidation and maintain distinct statutory treatment for the Advance Mental Health Care Directive. Furthermore, I support the amendments suggested by the Healthcare Association of Hawaii (HAH) and Kokua Mau.

Respectfully,

Brenda S. Ho, MS, RN
Chief Executive Officer

WRITTEN TESTIMONY
In Opposition to SB3077 (Request to Defer)
Relating to Advance Health Care Directives

Chair and Members of the Committee,

My name is Tanya Barbero. I submit this testimony in opposition to SB3077 as currently drafted and respectfully request that this measure be deferred so that advance medical directives and advance mental health directives may be considered separately.

I serve both as a Catholic Family Life minister and as a hospice outreach worker. In hospice outreach, I regularly accompany patients and families navigating end-of-life decisions. I strongly support ethical and thoughtful advance care planning. Advance medical directives are essential tools that protect patient dignity, reduce family conflict, and help ensure that a person's wishes are honored when medical decline is progressive and often irreversible.

In my professional experience in hospice outreach, Hawaii's existing advance medical directive framework has provided clarity and protection for patients and families. I have not encountered systemic confusion or breakdown that would justify merging fundamentally different statutory areas.

However, advance medical directives and advance mental health directives arise from fundamentally different clinical, ethical, and pastoral realities. End-of-life medical decision-making typically involves progressive physical illness with more stable capacity determinations. Mental health crises frequently involve fluctuating capacity and episodic impairment, requiring distinct safeguards and careful discernment.

Combining these directives into a single statutory framework risks blurring necessary distinctions and may unintentionally weaken protections for vulnerable individuals. Provisions that prioritize prior written consent during psychiatric crisis, even when contemporaneous objection is expressed, raise serious ethical concerns. Additionally, families already struggle to understand advance directives during end-of-life care; merging psychiatric and medical directives may increase confusion in already fragile situations.

From a Catholic moral perspective, human dignity requires careful protection of those whose capacity is diminished. Safeguards must be tailored to the specific type of vulnerability present. Administrative streamlining should not supersede moral clarity and vulnerability protections.

For these reasons, I respectfully urge the committee to defer SB3077 and allow these matters to be addressed in separate legislation with continued dialogue with the

organizations and institutions that are stakeholders in this process.

Thank you for your time and consideration.

Respectfully submitted,

Tanya Barbero

Lee.tanyabarbero@gmail.com

SB-3077-SD-1
Submitted on: 2/27/2026 1:04:52 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
rachel porter	Individual	Oppose	Written Testimony Only

Comments:

I would like to strongly voice my opposition to the passage of SB3077.

As a hospice volunteer in Hawaii for the last 40 years, I am very familiar with Advance Care Directives and frequently find myself explaining their importance to friends and community members.

When my husband was being treated for cancer, I never entered the hospital without a copy of his ACD, which included documentation that I had his medical power of attorney-- and had to produce it and read it to medical staff on 2 occasions when they were not complying with his wishes.

In the simplest terms, my opposition to this bill is twofold:

1. The law as it is currently written is effective and has been working well for many years. It is NOT broken and does not need to be fixed.

1. The changes proposed in this new bill simultaneously weaken the current law and make it vastly more complicated and unclear. The proposed creation of “co-agents” for example-- each of whom can exercise independent authority-- is certainly a recipe for disaster. Ditto the clause that states that a health care professional is not required to comply with the patient’s directive if it conflicts with their own personal religious beliefs.

I have identified 8 other major concerns with this bill, but in the interest of brevity, I would like to go on the record as strongly opposing this bill. It does not “fix” anything and it only creates unnecessary confusion and impedes the intent of the original law as it is currently written.

Mahalo for including my testimony,

Rachel Porter

I would like to strongly voice my opposition to the passage of SB3077.

As a hospice volunteer in Hawai‘i for the last 40 years, I am very familiar with Advance Care Directives and frequently find myself explaining their importance to friends and community members.

When my husband was being treated for cancer, I never entered the hospital without a copy of his ACD, which included documentation that I had his medical power of attorney-- and had to produce it and read it to medical staff on 2 occasions when they were not complying with his wishes.

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I have identified 8 other major concerns with this bill, but in the interest of brevity, I would like to go on the record as strongly opposing this bill. It does not “fix” anything and it only creates unnecessary confusion and impedes the intent of the original law as it is currently written.

Mahalo for including my testimony,

Rachel Porter

SB-3077-SD-1
Submitted on: 3/1/2026 3:36:00 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Kathryn Braun	Individual	Oppose	Written Testimony Only

Comments:

Aloha,

I am a longtime educator in the Hawai‘i State system and a caregiver for my disabled husband. I also was one of the founders of Kokua Mau in the early 2000s and have supported our current advance care planning system.

I am testifying as an individual in opposition to the current version of SB3077 SD1. I have several concerns.

First, the current system for advance care planning is working well. SB3077 makes substantive changes that would impact and potential confuse hundreds of providers - doctors, nurses, social workers, case managers, and elder law attorneys. Policies and procedures would need to be re-written and new forms created. The bill does not allocate funds to make all these changes, and this may extend the period of time at people who are seriously ill are in limbo.

Second, edits from the Healthcare Association have improved the bill but raise new questions. At the first Senate hearing, the committee accepted all seven pages of suggestions and edits from HAH without discussion or explanation. While I agree with manyof the edits, we now have a 64-page complex bill AND edits without an opportunity for explanation or discussion.

For example, there is confusion about health care instructions revoking Advance Directives. HAH included an amendment (Page 15, lines 18-21, Page 16 line 1-3) which strives to preserve the integrity of advance care planning, but it is not clear what these changes mean. Are we removing the ability to orally change a directive? Are we removing the ability to change wishes written in an Advance Directive?

Also, reducing the witness to only one person who can be a healthcare provider raises important consumer protection concerns. Perhaps other solutions can be found to make Advance Directives simpler to complete or allow only one witness but not have them be a healthcare provider.

Also, it is unclear why information is included about the POLST – Provider Orders for Life Sustaining Treatments, when POLST has its own statute and is not an Advance Directive.

I support the call by advocacy groups to create a working group before the bill is passed. SB3077 proposes to shake up the whole system, and we should take time to study the issues, create solutions, and address unforeseen consequences collaboratively before legislation is introduced.

Stakeholder buy-in is crucial when important, substantive, complex changes are proposed. To date, little outreach or education by the bill's authors has been provided. As written, the proposed bill will create confusion, frustration, and anger across provider and consumer groups and among patients and caregivers.

SB-3077-SD-1
Submitted on: 3/1/2026 8:48:01 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Shanda Brack	Individual	Support	Written Testimony Only

Comments:

To: The Honorable Senator Karl Rhoads, Chair, and Members of the Senate Committee on Judiciary (JDC)
RE: SB3077 SD1 — Relating to Health Care
Position: Support with Amendments
Hearing: March 5, 2026

Aloha Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Shanda Brack, a nurse practitioner, and I submit this testimony in support of SB3077 SD1 with amendments.

I support the bill's goal of modernizing Hawai‘i's laws governing advance health care and advance mental health care directives. A clearer statutory framework will benefit patients, families, and the clinicians who guide them through complex decision-making.

I appreciate that the bill includes APRNs within the health care decision-making structure. Expanding the pool of qualified clinicians who may participate in capacity determinations and advance care planning is both practical and necessary.

However, I am concerned that the bill defines physicians broadly while defining advanced practice registered nurses narrowly, limiting APRNs to those with psychiatric certification. Physicians are not restricted by specialty in the definitions section. APRNs should not be either.

Advance care decision-making does not occur only in psychiatric settings. APRNs practicing in geriatrics, hospice, palliative care, neurology-related care, and home-based care routinely care for patients with dementia, neurocognitive disorders, serious illness, and end-of-life needs. These are precisely the situations in which capacity questions and directive-related discussions arise. Excluding those clinicians from the statutory definition is inconsistent with how care is actually delivered.

As drafted, the bill restricts APRNs more than physicians. That imbalance should be corrected before enactment. If the Legislature intends to modernize decision-making laws and improve access, the statute should not narrow the participation of qualified APRNs who are already practicing within their lawful scope.

I respectfully request that the APRN definition be amended to parallel the physician definition. At minimum:

“Advanced practice registered nurse” means a person licensed pursuant to section 457.

If specialty-specific language is necessary for provisions addressing advance mental health care directives, that limitation should appear only in those specific sections rather than in the chapter-wide definition.

I support the purpose of SB3077 SD1 and respectfully urge the Committee to PASS THE BILL WITH AMENDMENTS to ensure equitable recognition of APRNs.

Mahalo for the opportunity to provide testimony.

Respectfully,
Shanda Brack

SB-3077-SD-1
Submitted on: 3/2/2026 7:44:09 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Marilyn Seely	Individual	Oppose	Written Testimony Only

Comments:

My experience has been with the UHCDA rather than with mental health since its inception and enactment. I must admit I am perplexed by this bill. It is cumbersome, extremely long and is largely a bill for mental health. Yet, I have found little support or knowledge of the bill in the mental health community. Even though numerous amendments regarding our concerns were inserted in SD 1 how these issues will be implemented into a mental health bill are still unclear not only to me but to practitioners who daily use the UHCDA quite sucessfully as I understand. The provisions in this new bill will require considerable outreach and education to a wide variety of professionals who must use it. Who will be responsible for this? Given the expectation that there will be many issues that arise after the bill is enacted, are we to start over next year with more corrections in the language?

In conclusion in my opinion here has been far too little discussion about the intent of the bill, too few mental health providers weighing in, too many legitimate concerns and questions from those who use the current law, unclear and confusing language in the bill and a lack of convincing evidence of the benefits of combining the two laws.

Respectfully submitted, Marilyn Seely, MPH

SB-3077-SD-1
Submitted on: 3/2/2026 6:24:42 AM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Leilani Kailiawa	Individual	Support	Written Testimony Only

Comments:

Aloha Chair, Vice Chair and Committee Members,

I am a parent and community leader. I am in strong SUPPORT for this bill

I urge you to please pass this bill.

Mahalo nui loa for allowing me to share in this support of this bill

With gratitude

Leilani Kailiawa

SB-3077-SD-1
Submitted on: 3/2/2026 4:38:52 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Georgia Bopp	Individual	Oppose	Written Testimony Only

Comments:

I'm very concerned about SB 3077. Please do not pass this now - it's complicated and confusing. Is it really appropriate to merge the two statutes? Time is needed for study by a qualified working group to resolve the concerns before the bill passes. I agree with the prior/testimony from Kaiser, Kokuamau, and others detailing the many issues. Thank you.

March 3, 2026

RE: Comments on SB3077_SD1

Dear Chair Rhoads, Vice-chair Gabbard and members of the committee,

My name is Hope Young; I am the Advance Care Planning Coordinator for Kōkua Mau and am submitting testimony as a **private citizen** and not on behalf of Kōkua Mau. In my work as the Advance Care Planning Coordinator, I educate community members on the importance of Advance Health Care Directives (AHCD). In my 9 years working for Kōkua Mau, I have educated thousands of community members on the importance of an AHCD and have also notarized hundreds of AHCD. I have done presentations at churches, temples, senior groups, senior centers, assisted living facilities, on-line and in-person Lunch and Learn sessions for caregivers across the state. I also provide Professional Development training for professionals with regards to the AHCD and the importance of conversations about what matters most and facilitating these conversations with consumers/patients and families.

I am also an informal caregiver and advocate for an individual who struggles with their mental health. I firmly believe that Advance Mental Health Directives (AMHCD) are important and AHCDs are also very important. However, the two documents are very different and would be used in very different settings and situations. The reality of the different uses of the two directives should not be convoluted into one bill. There are no flaws in the AHCD for end-of-life care. The AHCD is an important document to guide the type of care desired during a serious illness and at the end-of-life. It is also important to note that in an AHCD, nothing is set in stone, and the individual can change their mind regarding their care as long as they are able to speak for themselves. Adding a mental health component to a document intended to support wishes for care at the end of life creates an unnecessary mess for an already challenging document for individuals to complete. The two documents should not be combined when a single document for each situation would provide clear instructions and wishes included by the individual who created the document. While both instruments promote the patient's right to self-governance and to make informed decisions about their own medical care, they address fundamentally different legal, ethical, and clinical circumstances. Chapter 327E, Hawaii Revised Statutes and Chapter 327G, Hawaii Revised Statutes should continue to be separate and 327G should be adjusted to strengthen it up to be a much more robust statute to support the mental health community.

I'm concerned about the Ulysses Clause in the AMHCD. While it seems promising, has its practical application been considered? Has there been input from the mental health community or providers who might be responsible for enforcing it during crises? Are providers comfortable overriding a patient's autonomy in favor of an AMHCD, and what would that process look like—forced medication, restraint? This may work in institutional settings, but could be challenging in the community, especially if the individual cannot communicate their wishes. How is the AMHCD validated to confirm sound mind when completed, and what happens if the person later objects or changes their mind? This is a

subject that is serious in nature and should be discussed in further detail with Mental Health Providers, case workers, and advocates **before** becoming a law.

An additional concern is changing the rules of the witness. I would propose that it remain at two witnesses and one of the witnesses can be employed at the Health Care Facility where the individual is receiving care. Having only a facility-employed witness may speed up AHCD completion, but without discussing wishes for care with loved ones, the document could be challenged and even disregarded by loved ones. An AHCD is much more than just a document, while the law may govern who is eligible to witness the document, the wishes documented in the AHCD must be discussed with the loved ones to ensure that the wishes can be known and honored. For example, a patient is recently admitted to a hospital, and the daughter has the AHCD and is named in it as the Health Care Power of Attorney. The patient is confused and has forgotten that she has already completed one, so the provider encourages the patient to complete one (not knowing there is already one in place). Patient now completes a new AHCD, and names the son as the HCPOA, although the son is unaware of being named as the HCPOA. The provider witnesses the form, and now the patient has a document that conflicts with the prior AHCD, which all the family is familiar with. The daughter has been the primary caregiver for years, and now the provider has inadvertently created confusion for the family. Medical crises are already emotionally charged. The law should reduce uncertainty — not create additional layers of ambiguity, conflict or confusion.

Thank you for the opportunity to submit written testimony on the proposed inclusion of the Advance Mental Health Care Directive (AMHCD) within the existing Advance Health Care Directive (AHCD) under a single statutory framework, as outlined in SB 3077. While both instruments promote the patient's right to self-governance and to make informed decisions about their own medical care, they address fundamentally different legal, ethical, and clinical circumstances. These are complex ethical issues that deserve deliberate public discussion, and a work group should be created to include community voices and to hear concerns ***before*** the bill is passed into law.

Thank you,

Hope Young

hope@kokuamau.org

SB-3077-SD-1
Submitted on: 3/3/2026 5:17:05 PM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Lesley Milligan	Individual	Oppose	Written Testimony Only

Comments:

Letter Opposing SB3077 SD1

To Whom It May Concern,

As a member of Hawai‘i's healthcare community, I am writing to express significant concerns regarding SB3077 SD1, which proposes to replace Hawai‘i’s existing statutes on advance health-care directives and mental-health care directives with a single, unified framework modeled after the Uniform Health-Care Decisions Act (2023). While the goal of modernization is understandable, the bill raises several clinical, ethical, and operational issues that warrant careful reconsideration.

Clinical and Ethical Concerns

The consolidation of medical and mental-health directives into one statute risks weakening the specialized protections that individuals with psychiatric conditions require. Mental-health decision-making often involves fluctuating capacity, crisis-driven interventions, and unique consent considerations. These complexities are not adequately addressed within a generalized framework, potentially reducing patient autonomy and increasing the likelihood of inappropriate surrogate decision-making.

The bill’s revised definitions of *capacity* and *authority* may unintentionally broaden the circumstances under which a patient’s expressed wishes can be overridden. This is particularly concerning for vulnerable populations, including kūpuna, individuals with cognitive impairment, and patients with limited English proficiency. Maintaining clear, robust safeguards is essential to uphold ethical standards of informed consent and self-determination.

Operational and Implementation Challenges

Replacing entire chapters of long-standing law will require substantial retraining for clinicians, care coordinators, legal teams, and health-system administrators. Without a structured implementation plan, the transition may lead to inconsistent interpretations, delays in care, and increased administrative burden. These disruptions could negatively impact patient safety and continuity of care. In Hospice and Palliative medicine, urgency is paramount and adding confusion and inconsistencies will delay the process of the patient's ability to receive care.

Additionally, the bill's broad language introduces the possibility of legal Ohana involvement, and community-based approaches to care. A national model law may not fully reflect these local realities. Many community members and patient-advocacy groups have expressed that they were not adequately consulted during the drafting process. A policy shift of this magnitude should be grounded in broad, culturally informed engagement. I feel that there should, at the very least be reviewed by a workgroup to review and provide feedback to the proposed changes.

Request for Further Review

Given these concerns, I respectfully urge lawmakers to pause the advancement of SB3077 SD1 and engage in deeper consultation with medical professionals, behavioral-health specialists, patient advocates, and cultural leaders. A more deliberate, collaborative process will help ensure that any revisions to Hawai‘i's health-care decision laws strengthen—rather than compromise—patient rights, clinical clarity, and culturally responsive care.

Thank you for your consideration and for your commitment to the health and well-being of Hawai‘i's people.

Sincerely,

Lesley Milligan

Director of Business Development of an undisclosed Hospice Agency

LATE

SB-3077-SD-1
Submitted on: 3/4/2026 11:52:37 AM
Testimony for JDC on 3/5/2026 10:01:00 AM

Submitted By	Organization	Testifier Position	Testify
Raelyn Reyno Yeomans	Individual	Oppose	Written Testimony Only

Comments:

I am submitting strong testimony in opposition to SB3077.

First of all, this is NOT the adoption of the Uniform Health-Care Decisions Act if it has been "modified" by the State. In this case the proposed modifications have further weakened normal Due Process protections afforded to all individuals, especially those Disabled and/or Houseless individuals that have Mental Illness.

The state has previously removed a guarantee of legal counsel for individuals targeted by Assisted Community Treatment (ACT) orders so that we now have state-funded case management agencies in charge of individuals subject to ACT Orders that include forced treatment with long-acting injectables. Why is it that our state feels that Disabled Individuals have a lesser status and should not be afforded the same Due Process protections that anyone else would receive?

Please note that SB3077 includes "modifications" that will further erode the Due Process rights of these same Disabled individuals.

One of these modifications makes " (4) A public entity providing health care case management" an interested party under this bill. It's important to note that this bill provides for an Advanced Health Care Directive with a mental health Ulysses Clause that would override the stated wishes of an individual.

I am very concerned at how these actions in recent years by the state has chipped away at basic Due Process protections.

In addition, we are not getting a true picture of how this bill will negatively impact those under ACT Orders unless the State provides to the State Legislature all of the data mandated by the 2025 law resulting from the passage of SB1322.

Please defer this bill.