

PA13-55

SB0991

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H – 1162

**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2013**

**VOL.56
PART 13
4177 – 4511**

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Thank you, Representative Kiner. The House will return to the Call of the Calendar. Will the Clerk please call Number 557.

THE CLERK:

Calendar 557 on Page 32, Favorable Report of the Joint Standing Committee on Public Health, Substitute Senate Bill 991 AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Good afternoon, Mr. Speaker. I move the Joint Committee's Favorable Report and passage of the bill in concurrence with the Senate Amendment.

DEPUTY SPEAKER BERGER:

Motion before the Chamber is passage of the bill in concurrence with the Senate. Would you remark further, Representative?

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This bill is a bill that will help create a task force that will be an advisory council on palliative care.

Over the years we've discovered that palliative care has been a great help to many, many people who

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are suffering with chronic illness and disease. The discovery was first found when people would go into hospice care for end of life care and they would receive palliative treatment, feel much better, and live longer.

This type of treatment has been extended to people with serious chronic illnesses and now we're finding good results in terms of the reduced costs in health care and also more higher and better quality of life for people who suffer with things like multiple sclerosis and Parkinson's disease, diseases that cause a great deal of pain, heart failure and those kinds of illnesses.

So, palliative care is a great opportunity for us to continue to provide care that will reduce our costs and help people live fuller and happier lives. I move adoption.

DEPUTY SPEAKER BERGER:

Motion before the Chamber is adoption of the bill. Motion before the Chamber is adoption of the bill. Will you remark further on the bill before us? Will you remark further on the bill before us? Representative Johnson.

REP. JOHNSON (49th):

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Thank you, Mr. Speaker. Yes. So this bill will create a task force that will have to be appointed. The appointments will be finished by January, December 31, 2013 and the recommendations of the bill will be made by January 1, 2015. I call Senate "A" and move adoption.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 6176. It will be designated as Senate Amendment "A".

THE CLERK:

Senate Amendment "A", LCO 6176, Amendment offered by Senator Gerratana and Representative Johnson.

DEPUTY SPEAKER BERGER:

The Representative seeks leave of the Chamber to summarize the Amendment. Is there objection to summarization? Is there objection to summarization? Seeing none, please proceed, Representative.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This Amendment is a technical Amendment that provides one small change in terms of the appointment and also changes some of the language that's purely technical in nature and I move adoption.

DEPUTY SPEAKER BERGER:

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The question before the Chamber is adoption of the Amendment, Senate Amendment "A". Will you remark further on the Amendment? Will you remark further on the Amendment?

If not, I will try your minds. All those in favor of the Amendment signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER BERGER:

Opposed? The Ayes have it. Will you comment further on the bill as amended? Will you comment further on the bill as amended? Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This bill will provide great opportunities for many, many people who are suffering with a lot of pain and difficulty. Through the recommendations of the task force, palliative care will become well known to people all throughout Connecticut and it's been found that most people who have these chronic conditions are unaware of the option of trying to access palliative care and once they find out about that, the opportunities that palliative care offers, in those circumstances they're

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much, much better able to manage their illnesses, so I
move adoption. Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

The motion before the Chamber is adoption of the
bill as amended by Senate Amendment "A". Will you
comment further? Will you comment further?
Representative Srinivasan of the 31st, sir.

REP. SRINIVASAN (31st):

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Good afternoon, sir.

REP. SRINIVASAN (31st):

As we know, our population is aging, and with
aging population comes its challenges, and for us to
look into this advisory council, to look at palliative
care, to look at alternate forms of giving treatment
to patients when it is needed, is something, which I
think will go significantly a long way in rendering
appropriate health, appropriate health care to those
people who need it in this stage of their lives.

Through you, Mr. Speaker, just one question to
the proponent of the bill as amended.

DEPUTY SPEAKER BERGER:

Please proceed.

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REP. SRINIVASAN (31st):

Through you, Mr. Speaker, in Line 14 where we have replaced six with seven people who are going to be appointed by the Department of Public Health, through you, Mr. Speaker, do we know who the seventh person is going to be? Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. The appointments haven't been made and there is no information on who the appointments will be until, and they don't have to be made until December 31, 2013. Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, Representative. Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, maybe I was not clear in my question. I just want to make sure the six appointed by the Commissioner of Public Health lists who they will be. I did not mean as to who they are in terms of the person's name or background. I did

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not mean that at all. Of course, we will not know that.

But if you look at Line 17, it's an in-patient palliative care going on and on and on, you know basic seven, all the way to palliative care for adults and elderly persons. So that becomes the six people that the Department of Public Health is responsible for appointing into this council.

Now, as the bill is amended, we have seven, and I just want to know, not the name of the person, but who, in what capacity will be of the person who is going to be serving the council. Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson on the redirect.

REP. JOHNSON (49th):

Yes, thank you, Mr. Speaker. The seventh person will be an in-patient person in a psychiatric facility, in-patient palliative care in a psychiatric facility, so someone who specializes in providing assistance with palliative care in a psychiatric facility.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So, through you, Mr. Speaker, so this seventh person will be somebody who has an expertise in in-patient psychiatric care? I just want to be clear on that.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's correct. There has been a recognition that not only are there difficulties with serious chronic illnesses like heart disease or multiple sclerosis, Parkinson's disease, but also people who suffer from serious depression, other types of psychiatric disabilities also can benefit from palliative care. Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you for that answer. And through you, Mr. Speaker, we had heard a request that people who are in

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hospital associations, they need a member to be in this palliative council, advisory council as well.

Is that seventh position that is now being added on, is it confirmed that it has to be somebody in a psychiatric in-patient setting or do we have any wiggle room there?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker, and I thank the good Representative for the question for clarification.

In-patient palliative care, so yes, it would be from an institution, a hospital institution that provides in-patient psychiatric care. Thank you, and through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

And through you, Mr. Speaker, my final question, is there a fiscal impact? Is there a fiscal note that is attached to this advisory council?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

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Representative Johnson.

REP. JOHNSON (49th):

There's a \$1,000 impact on, the standard impact for any type of task force or advisory council on making recommendations to the Department of Public Health.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker, and thank the good Chair of the Public Health for her answers.

And I think this is definitely a direction we need to go. We know that need is there and from the task force to take it to the next step of the advisory council, so that we have a good option for our patients in our state requiring, needing palliative care, and I urge adoption both sides of the aisle.

Through you, thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, Representative. Will you comment further on the bill as amended before us? Will you comment further on the bill as amended that is before us? Representative Carter of the 2nd.

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REP. CARTER (2nd):

Thank you very much, Mr. Speaker, good morning.'

DEPUTY SPEAKER BERGER:

Good afternoon.

REP. CARTER (2nd):

Afternoon. It's been a long night. Ladies and gentlemen of the Chamber, I would say on face value this is a very good bill. There's no question that we have folks in our society who needlessly suffer from pain associated with many different chronic diseases.

There's one part of this bill that I do want to, one idea about this bill that I do want to think about in public, I guess is, that we should be thinking more about chronic disease as a whole, not just palliative care.

I think while this is a good idea moving forward, I will definitely support it. I think we should think about next year expanding this advisory council to look at chronic disease as a whole and look more of the preventative side in addition to be treating the system side, or excuse me, be treating the symptom side.

So with that, I will support the bill, but just to understand in this Chamber, I think this is only

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scratching the surface of where we need to go with respect to chronic disease. Thank you.

DEPUTY SPEAKER BERGER:

Thank you, Representative. Will you comment further on the bill as amended that is before us? Will you comment further on the bill as amended that is before us?

If not, will staff and guests please come to the Well of the House. Will Members please take their seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll.

The House of Representatives is voting by Roll.

Will Members please return to the Chamber immediately.

DEPUTY SPEAKER BERGER:

If all the Members have voted, have all the Members voted? If all the Members have voted, the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

THE CLERK:

S.B. 991 in concurrence with the Senate and amended

by Senate "A".

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Total Number Voting	133
Necessary for Passage	67
Those voting Yea	133
Those voting Nay	0
Those absent and not voting	17

DEPUTY SPEAKER BERGER:

The bill passes as amended in concurrence with
the Senate.

Will the Clerk please call Calendar Number 115.

THE CLERK:

Calendar 115 on Page 3 of today's Calendar,
Favorable Report of the Joint Standing Committee on
Labor and Public Employees, Substitute House Bill 6451
AN ACT IMPROVING THE TIMELINESS AND EFFICIENCY OF THE
DEPARTMENT OF LABOR'S UNEMPLOYMENT INSURANCE TAX
OPERATIONS.

DEPUTY SPEAKER BERGER:

Representative Tercyak.

REP. TERCYAK (26th):

Thank you very much, Mr. Speaker. I move for
acceptance of the Joint Committee's Favorable Report
and passage of the bill.

DEPUTY SPEAKER BERGER:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 9
2727-3065**

2013

Then there's Brian Prairie.

Oh, I'm sorry, Kevin Bauers. I thought that's what she said. Okay.

Dr. Andrew Salner?

DR. ANDREW SALNER: Good morning, members of the Public Health Committee. I'm Dr. Andy Salner, I'm director of the Helen and Harry Grey Cancer Center in Hartford Hospital, and I'm representing the American Cancer Society Cancer Action Network in strong support of SB 991, AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE.

Palliative care is about improving quality of life and providing an extra layer of support to relieve pain, symptoms and stress of serious illness. It's about treating the person beyond the disease, and it's appropriate at any age and any stage. Palliative care improves quality of life and survival and also creates care efficiencies that curb costs.

And earlier 2008 study of eight diverse nationwide showed that palliative care resulted in adjusted net savings of about \$1700 in direct cost for admission, including significant reductions in laboratory and intensive care unit costs.

Hospitals are increasingly recognizing the importance of palliative care. In fact, a number of palliative care programs in hospital settings has increased about 140 percent nationally from more than 600 in 2000 to more than 1900 today. But there's a difference between simply having palliative care teams available and actually using them effectively in daily practice through integrated service to deliver the palliative care benefits that have been shown.

Lack of understanding about palliative care, both what it is and when it should be provided, remains one of the chief barriers preventing access to it. Despite the rising body of evidence showing its benefits, many professionals mistakenly equate palliative care with life in hospice. At the same time the general public is not at all knowledgeable about palliative care. Recent public opinions research shows that 70 percent of Americans are not at all knowledgeable about palliative care. Yet once consumers understand what it is, with an emphasis on relief of symptoms, pain and stress, 92 percent would likely consider it for themselves or their families.

SB 991 would establish an interdisciplinary council of experts to look at where we are with palliative care in Connecticut and what needs to be done to get us to where we need to be. The council will analyze existing policies and practices and work with the Department of Public Health on palliative care issues moving forward. It provides an opportunity for the best minds in the state to get together and dedicate time and energy to concentrate on the big picture, to formulate a common agenda and develop better communication in coordination on palliative care and quality of life issue.

We would respectfully request that the bill be amended to better reflect the intent that palliative care is appropriate for any stage of a serious or chronic illness, not just end of life by removing the phrase "terminal illness" and replacing it with "serious or chronic illness" throughout the bill including the physician qualifications, and we urge a favorable report from your committee.

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March 15, 2013

pat/cd/gbr PUBLIC HEALTH COMMITTEE

10:30 a.m.

Thank you and I'm happy to answer any questions you might have. Thank you and I may answer any questions that you may have.

SENATOR GERRATANA: Thank you, Doctor. Did you submit your testimony?

DR. ANDREW SALNER: Yes, I did.

SENATOR GERRATANA: You did. Okay, I just don't see it online but that's quite all right. I don't think there are any questions but thank you for giving your testimony this morning.

DR. ANDREW SALNER: Thank you. I appreciate it.

SENATOR GERRATANA: We appreciate it.

Next is Susan Richter. Susan's not here.

Next is Nicole Garrah. Is Nicole Here? No.

John Johnson.

Stacey Violante Cote?

Gene Rexford? I don't see Gene.

Kathleen Napstry?

Brian Jordon?

M.C. Culbertson?

David John?

They had to go to work?

Greg Shangold? I guess he went to work.

And Mark McThompson, maybe, Mark or Mac? No.

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 10
3066-3376**

2013



**TESTIMONY RE: Raised Bill No. 991 AN ACT CONCERNING AN ADVISORY COUNCIL ON
PALLIATIVE CARE**

PUBLIC HEALTH COMMITTEE

March 15, 2013

Good afternoon Senator Gerratana, Representative Johnson and esteemed members of the Public Health Committee.

Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA) related to Raised Bill No. 991 AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE. I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University.

I speak in support of Raised Bill No. 991 AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE

Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along

with curative treatment.

Palliative care treats people suffering from serious and chronic illnesses such as cancer, cardiac disease such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's, Parkinson's, Amyotrophic Lateral Sclerosis (ALS) and many more.

Palliative care focuses on symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression. It also helps you gain the strength to carry on with daily life. It improves your ability to tolerate medical treatments. And it helps you have more control over your care by improving

The core team includes doctors, Advanced Practice Registered Nurses, nurses and social workers that are palliative care specialists. Massage therapists, pharmacists, nutritionists, chaplains and others may also be part of the team. The goal of the team is to provide care and spend time with the patient, family and doctors. The goal is to support the patient, family in controlling symptoms and fostering understanding of treatment options (2012, Center to Advance Palliative Care).

Palliative care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling.
- Will enhance quality of life, and may also positively influence the course of illness (World Health Organization)

Many of our Hospitals now have Palliative Care Teams, however, the industry

needs to expand the use of Palliative Care teams to Community providers and skilled facilities. It is essential that high quality, properly staffed Palliative Care Programs be developed and implemented within all care provider systems. In order to accomplish the goal we must first ascertain what is already available, the quality of the programs, the outcomes of care and the impact of the Teams on patients, families and provider systems. We must assess models currently available and find cost effective ways to expand quality programs within systems.

We have experts in our State and we have programs in some facilities, we now need to assess and expand our efforts. The first step is assessment of the current state of the current Palliative Care System. Palliative Care improves the quality of life for individuals who are terminally ill it also provides the families and care givers with the tools they need to care for their loved ones in the communities in which they live. We have an aging population and we must provide them with programs that maintain their dignity and quality of life.

Thank you

Mary Jane M. Williams PhD., RN

† AMERICAN LUNG ASSOCIATION.

Fighting for Air

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March 15, 2013

Public Health Committee
Room 3000, Legislative Office Building
Hartford, CT 06106

Testimony of the American Lung Association in Connecticut in Support of Raised Senate Bill 991 An Act Concerning an Advisory Council on Palliative Care

Senator Gerratana, Representative Johnson and Members of the Public Health Committee:

The American Lung Association in Connecticut writes in support of Senate Bill 991, which would establish the Connecticut Palliative Care Advisory Council within the Department of Public Health.

Palliative care focuses on relieving those with a serious illness from symptoms, pain, and stress, with the goal of improved quality of life for both the patient and their family. Palliative care gives patients control and choice over their own care. The strong partnership between patients, families, and the palliative care team assures that treatment goals are established and coordinated throughout the course of a serious illness.

This legislation will focus on improving the quality and delivery of patient-centered and family-focused care to Connecticut residents facing a serious illness by establishing a State Advisory Council on Palliative Care. The Advisory Council will analyze the current state of palliative care in Connecticut and advise the department on matters relating to the improvement of palliative care and the quality of life for persons with terminal illnesses.

Lung cancer is the leading cancer killer in both men and women in the United States. Approximately 375,000 Americans are living with lung cancer today and an estimated 160,000 will die from the disease this year. According to the National Cancer Institute, in 2009 there were approximately 2,600 individuals in Connecticut with lung cancer. A 2010 clinical study of 151 lung cancer patients showed that early palliative care provided alongside cancer treatment delivered better patient quality of life and longer patient survival time¹.

Chronic Obstructive Pulmonary Disease (COPD) refers to both chronic bronchitis and emphysema; both are characterized by obstruction of airflow that interferes with normal breathing. COPD is the third leading cause of death in the United States. In 2011, there were 166,000 adults in Connecticut with COPD according to the Behavioral Risk Factor Surveillance System (BRFSS). Many individuals with COPD benefit from

palliative care due to the severity of the illness. Palliative care is used to manage the symptoms of COPD and the stress and anxiety caused by having the disease.

Being aware of and having access to palliative care is vital to improving the quality of life for people in Rhode Island diagnosed with lung cancer. Thank you for your consideration of SB991. We urge your favorable vote on this bill.

Thank you,

Michelle Marichal

Michelle Marichal
CT Acting Director, Health Education and Public Policy
American Lung Association in Connecticut

Second Thoughts Connecticut

Advocates against the legalization of assisted suicide

Testimony concerning SB 991 An Act Concerning an Advisory Council on Palliative Care

Senator Gerratana, Rep Johnson, and members of the Public Health Committee

Second Thoughts Connecticut has questions and concerns about HB 991, An Act Concerning an Advisory Council on Palliative Care. Let us start off by expressing our support for the goal of improved palliative care. This is an important and much needed medical specialty, and contrary to the misconceptions of a small fringe, palliative care is not at all synonymous with euthanasia. That having been said, there are different individuals and organizations in the field which have widely divergent attitudes on controversial issues, including the legalization of assisted suicide (a.k.a. aid-in-dying) and the withholding of nutrition and hydration. If this advisory council is to be beneficial and not harmful, we need to first know what the values of those who might serve on this council are—and by extension, the values of those appointing them.

In particular, we need to know where this is heading in terms of attitudes toward disability, "suffering," people diagnosed with terminal illness viewing themselves, and others viewing them, as a "burden," and the steering of people away from life-prolonging treatment, often due to ulterior motives such as fear of disability or cost containment. Palliative care issues are disability issues, and the perspective of the disability community needs to be fully included (i.e., not just one token representative).

As for what we already know in the field of palliative care, and suggestions for improvement, we would like to call your attention to testimony Dr. Ira M. Byock, MD recently gave to the Vermont Senate Committee on Health and Welfare on End of Life Choices, posted on the website of Not Dead Yet at <http://www.notdeadyet.org/2013/01/vermont-testimony-of-ira-byock-md-to-vermont-senate-committee-on-health-and-welfare-hearing-on-end-of-life-choices.html>. Dr. Byock directs the palliative care program at Dartmouth-Hitchcock Medical Center in Lebanon, NH, and is a nationally recognized authority in the field. He notes in his testimony that he is a staunch political progressive, yet opposes the legalization of assisted suicide as, in his words, "regressive social policy." He makes a number of important recommendations for improving palliative care in Vermont, most of which are equally applicable in Connecticut. We would urge all to read his entire testimony; here is what he had to say regarding improving care and quality of life.

"An authentically progressive agenda for improving the way we die would include the state of Vermont making use of the Medicare waiver mechanism within the state's health plan to dissolve the arbitrary requirement that incurably ill people give up treatment for their disease to receive hospice care for their comfort and quality of life and support for their families

The Vermont legislature could preserve the dignity of frail elders and physically ill and dependent people by ensuring that there sufficient staff in long-term care facilities to answer the bell when Vermont's mothers or fathers, grandmothers or grandfathers, need help in getting to the bathroom. Nothing assaults an ill or demented person's dignity more than being unable to get help when needed.

It is past time for every state legislature to insist that every medical student receives adequate training and passes competency tests in basic palliative care knowledge and in the skills required for effective symptom management, communication, shared decision-making, and counseling related to serious illness and dying – skills that too many physicians lack today.”

It is important to note that Dr. Byock does **not** view the need for assistance in toileting, eating, or other activities as impinging on human dignity. Earlier in his testimony, he points out that we all have inherent dignity, citing the 1948 United Nations Universal Declaration of Human Rights. Rather, human dignity is violated when someone in need of assistance is unable to get that help, particularly because of insufficient resources for self-directed attendant care in the community, which keeps people trapped in institutions they would prefer not to be in. This is an important consideration when we see what percentage of people in Oregon are requesting “aid-in-dying” because of alleged “loss of dignity” (84.1% from 1998-2010, as opposed to only 21.3% who cited inadequate pain control or were concerned about it; see Oregon’s own statistics at <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityct/documents/year13.pdf>).

The General Assembly can start acting on the above recommendations now, rather than wait for an advisory council to give theirs in 2015. We would suggest this committee raise legislation to this effect in next year’s session.

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**Public Health Committee
 March 15, 2013**

American Cancer Society Cancer Action Network Testimony

SB 991 (RAISED) - AN ACT CONCERNING AN ADVISORY COUNCIL ON PALLIATIVE CARE.

Achieving Patient Centered & Family Focused Care in Connecticut

It goes without question that our nation has made significant progress in the treatment of cancer. Today, we are saving 350 more lives per day than we were in 1990. However, as doctors focus on the treatment of a patient's cancer, the patients' comfort and concerns are frequently overlooked. People with cancer often suffer not only from the disease, but also from pain, nausea, shortness of breath, anxiety and other symptoms in their struggle to get well.

The American Cancer Society Cancer Action Network (ACSCAN) is pleased to support SB 991 (Raised) An Act Concerning an Advisory Council on Palliative Care and the importance of providing concurrent palliative care to promote quality of life and prevent suffering for every patient, in every care setting, and for every type of serious illness experienced by patients and their families in Connecticut.

This bill would establish an interdisciplinary council of experts to look at where we are and what needs to be done to get us to where we need to be. The council will analyze existing policies and practices and work with the Department of Health on palliative care issues moving forward. It provides an opportunity for the best minds in the state to get together and dedicate time and energy to concentrate on the big picture, to formulate a common agenda, and develop better communication and coordination on palliative care and quality of life issues.

What is palliative care? It's a growing field of specialized medical care that improves the quality of life of patients and their families by focusing on symptoms of treatment for a serious disease such as cancer or other chronic illness. Palliative care *is appropriate at any age and any stage of a serious or chronic illness* and can be provided with curative treatment. Palliative care is delivered by trained specialists who work together with doctors and nurses in a team-based approach that focuses on the patients' needs, explains treatment options and gives patients and their families a voice in determining their treatment and care.

Treating the whole patient—not only the disease but also the physical and psychological consequences of treatment—is the key to both extending life and enhancing the quality of the time gained. Evidence building over the past decade has consistently demonstrated the benefits of palliative care in improving quality of life and addressing the harmful effects of pain, symptoms and emotional distress as well as family caregiver burden, making a clear case for the importance and value of providing palliative care at

the same time patients are provided disease-directed treatments. More recent evidence also shows that palliative care may enhance survival and reduce costs driven by unnecessary use of hospitals, diagnostic and treatment interventions, and non-beneficial intensive care.

Palliative care is a big change in health care delivery, and it works in favor of the patient. But despite the benefits, thousands of patients who are suffering from the side effects of treatment for chronic disease have no idea that palliative care is available to them and can help relieve their symptoms and help them focus on getting well. Recent public opinion research shows that a majority (70%) of Americans are “not at all knowledgeable” about palliative care.¹ Yet the survey also revealed that once consumers understand palliative care as an increased emphasis on relief of symptoms, pain, and stress that is appropriate at any stage of serious illness, a large majority (92%) would be likely to consider it for themselves or their families and think it should be available in hospitals nationwide. The overwhelming majority (95%) of these consumers also agreed on the need for patients and families to be educated about palliative care, consistent with subsequent poll findings among physicians, of whom 96% confirmed the importance of educating consumers.²

The American Cancer Society and ACS CAN, together with national partners like the Center to Advance Palliative Care (CAPC) and National Palliative Care Research Center (NPCRC), are taking action to integrate palliative care earlier in the course of illness as an essential element of providing quality patient-centered and family-focused care. Connecticut ranks average nationally, achieving an “B” grade on access to hospital-based palliative care teams in the most recent evaluation from CAPC and NPCRC, with 100% of its larger hospitals (300+ beds) reporting a palliative care team and 72% of its more smaller hospitals (50< beds).³ Despite this growth, significant disparities continue to exist in access to and delivery of concurrent palliative care. Moreover, the remarkable increase in the number of palliative care teams in recent years has not been matched by growth in the number of trained clinicians to lead and staff these programs.

Patients and families facing serious illness need to be educated about palliative care so they can find their way to the best choices that minimize symptoms and suffering while fighting disease. Pain, worry and other symptoms and side effects of cancer and its treatment, for example, are not an inevitable consequence of cancer. They typically can be controlled. While enhancing palliative care information and awareness, we must also enact policies to cultivate and support development of more health care professionals who are trained to provide this multidisciplinary care to meet the growing community need.

ACS CAN is encouraged that the Public Health committee has made palliative care a focus for quality care delivery now and in the longer term. With greater access to palliative care, cancer patients will suffer less and be able to focus more on getting well.

SB 991 comes at a time when federal policy is both promising and yet still somewhat uncertain, and when state policy makers remain very active on issues affecting end-of-life care, establishing a

¹ Center to Advance Palliative Care 2011 Public Opinion Research on Palliative Care A Report Based on Research by Public Opinion Strategies
<http://www.capc.org/tools-forpalliative-care-programs/marketing/public-opinion-research/2011-public-opinionresearch-on-palliative-care.pdf>

² National Journal and The Regence Foundation Living Well at the End of Life Poll—Topline Results

<http://syndication.nationaljournal.com/communications/NationalJournalRegenceDoctorsToplines.pdf>

³ Meier DE, Morrison RS, America's Care of Serious Illness A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals (2011)
<http://www.capc.org/reportcard/>

framework for collaboration and consensus-building at the state level is all the more important. This is particularly important for the growing population of older adults living with chronic, serious illnesses such as cancer, heart disease, lung disease, and dementia. SB 991, will ultimately lead to patients and families having more control and choice about treatment options and will encourage more informed and shared decision making.

We would respectfully request that the bill be amended to better reflect the intent that palliative care is appropriate for any stage of a serious or chronic illness, not just end of life. To that end, we request that the phrase "terminal illness" be replaced with "serious or chronic illness" throughout the bill, including the position qualifications.

ACS CAN stands ready to support passage of this and future proposals to ensure that patients and families are made aware of these available services and that health professionals are equipped and able to address patients' quality of life concerns so that all Connecticut residents facing serious illness like cancer will have meaningful access to this more comprehensive model of patient centered and family focused concurrent care.

Thank you.

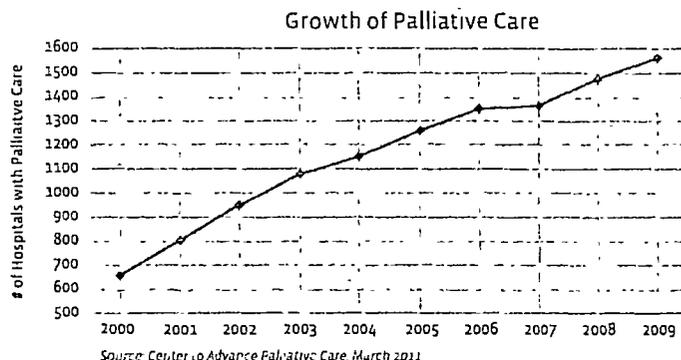
Palliative Care at a Glance

What is Palliative Care?

Palliative care, or palliative medicine, is specialized medical care for people facing serious and chronic illness. It focuses on relief from symptoms, pain, and stress – whatever the diagnosis. The goal is to improve quality of life for both patient and family. Palliative care is provided by a team that includes physicians, nurses, and other specialists who work together with a patient's own doctor to provide an extra layer of support. It is appropriate at any age and any stage in a serious illness and can be provided along with curative treatment.

Growing Trend in Health Care

Over the last ten years palliative care has been one of the fastest growing trends in health care. In fact, the number of palliative care programs within hospital settings has increased approximately 138%, from more than 600 in 2000 to more than 1500 today.



This growth has occurred primarily in response to the increasing number of Americans living with serious and chronic illnesses and to the caregiving realities faced by their families. But palliative care has also been embraced for the simple reason it gives patients and families control and choice over their own care. The strong partnership of patient, family and the palliative care team assures that treatment goals are established and coordinated and full communication is maintained in what is often a long, complex course of serious illness.

People Want Palliative Care

Palliative care is expected to increase as the public becomes more aware of its benefits. Recent public opinion research by the national polling firm Public Opinion Strategies reveals that even for those patients who are uninformed about palliative care, once they understand what it is, 92% report they would be highly likely to consider palliative care for themselves or their families if they had a serious illness. 92% also said they believe patients should have access to this type of care at hospitals nationwide.

Quality Care Leads to Cost Reduction

Today, approximately 90 million Americans are living with serious illness, and this number is expected to more than double over the next 25 years. About 20% of all Medicare beneficiaries have 5 or more chronic conditions, and two-thirds of Medicare spending goes to cover their care. This patient population is also the most likely to benefit from palliative care. Recent studies indicate that by closely matching treatments with a patient's goals, and improving their quality of life, palliative care can provide substantial cost reduction.

Policy Changes Would Help

Policy initiatives that address workforce needs, research and patient access could rapidly bring palliative care to scale in the United States. The implementation of such policies would help meet the needs of our sickest children and a growing population of older Americans with long-term chronic conditions.



To: The Public Health Committee, State of Connecticut

SB #991 – Advisory Council on Palliative Care

Friends:

As a long time oncology nurse and hospice advisor, I strongly support the concept of a pilot "MOLST" project. End of Life Care is a complex and challenging personal and public issue. The end of life care discussion should not be relegated to simply having an Advance Directive or a Do Not Resuscitate bracelet. These elements do not encompass the important and often delicate relationship between the medical provider and the family in times of extreme stress and urgency. We need to have a more comprehensive and inclusive process. This is the goal of having Medical Orders for Life-Sustaining Treatment. I strongly encourage the Public Health Committee to support this bill, which would launch a pilot project putting us in step with our nearby states.

MOLST is the standard of care for a number of states, including our neighbors in New York, and it has enabled a much more humane and ethical conversation by all involved parties coming to terms with often difficult decisions at the end of life. Medical Orders for Life-Sustaining Treatment (MOLST) also has guidelines to deal with different end of life scenarios such as health care proxies, adults with disabilities, children at the end of life etc.

We all die.. we all want our wishes to be adhered to by our medical providers and our families. MOLST will help all of us meet this goal.

In conjunction with this Bill, I would hope the Senate will attend to setting up an Advisory Council on Palliative Care. The multidisciplinary group of experts would explore a wide ranging approach to palliative care in an organized and systematic manner throughout Connecticut in all care settings (hospital, home, extended care facilities, prisons, VA units).

Thank you for your consideration.

**Janet M. Hooper, RN BSN OCN
Goshen, Connecticut**



March 15, 2013

Public Health Committee
John Bailey, Government Relations Director
Comments on SB No. 991: An Act Concerning an Advisory Council on Palliative Care

Good afternoon Senator Gerratana, Representative Johnson, members of the Public Health Committee.

The American Heart Association would like to voice its support for SB No. 991 "An Act Concerning an Advisory Council on Palliative Care".

When heart failure progresses to an advanced stage, difficult decisions must be made. For advanced heart failure patients and their doctors, making good decisions requires teamwork. Through shared decision making, doctors and patients consider both the options and the patient's preferences before charting a treatment course. To guide shared decision making, the American Heart Association recommends considering palliative care, offered alongside medical treatment, to help manage symptoms and assist patients and families with tough decisions.

The goal of palliative care is to help patients live better by relieving symptoms and improving quality of life. Members of the palliative care team may include a doctor, nurse, social worker, chaplain, physical therapist, occupational therapist, dietitian and psychologist. Palliative care can provide:

- Relief of pain and symptoms of heart failure;
- Emotional and spiritual support for the patient and the family;
- Help with making complex treatment decisions;
- Assistance with practical issues, such as advance directives or insurance; and,
- Support services for caregivers, such as respite care and grief counseling.

The American Heart Association stands ready to support passage of SB 991 to ensure that patients and families are made aware of these available services and health professionals are equipped and able to address patients' quality of life concerns. All Connecticut residents facing serious illnesses like heart failure should have meaningful access to this more comprehensive model of patient-centered and family-focused concurrent care.

Thank you for your consideration. Please do not hesitate to contact me at (860) 330-3341 or john.bailey@heart.org if I can provide anything further.

Testimony: Public Health Committee - March 15, 2013
An Act Concerning the Establishment of a Palliative Care and Quality of Life
Interdisciplinary Advisory Council SB 991

My name is Susan Richter. I am a registered nurse and I served as the Vice President of Quality of Life for the American Cancer Society for 23 years. In 1989 I initiated the creation of the CT Cancer Pain Initiative where our goal was to eliminate barriers and improve access to pain relief in CT. Currently, I am a two time cancer survivor and serve as the Co-Chair of the Survivorship Committee of the CT Cancer Partnership and I am here today in support of Senate Bill 991.

There is no doubt that there has been wonderful progress made in the treatment of cancer today, however there is still a need for significant improvement in quality of life, as patients live longer and reap the benefits that current therapies offer. I believe that along with the modern treatments we cannot forget the patient's comfort. These concerns are often overlooked while the focus is primarily on the latest treatment modality. I often hear from patients, and their family members, that are suffering from serious illness and are looking for ways to relieve symptoms from their disease, such as pain, nausea, depression, difficulty breathing.

Support for senate Bill 991 would establish an interdisciplinary council of select experts in the health care field that can review current palliative care policies, look for the deficits and together work toward improved and enhanced quality of life for all persons in Connecticut with a serious illness.

The concept of palliative care is somewhat new for many Americans, and the term palliative may be unfamiliar, but the philosophy of palliative care is one shared by many: *that people with serious illness need not suffer.*

Palliative Care is a term often mistaken for end of life care. While standard care for chronic illness focuses on treatment of the disease, palliative care is a comprehensive approach to treating serious illness that focuses on the physical, psychosocial, and spiritual needs of the patient and their loved ones. Its goal is to achieve the best quality of life available by relieving suffering, controlling pain and symptoms, and enabling the individual to live as normal a life as possible.

In other words, the goal of palliative care is to prevent, reduce, or relieve symptoms of a disease like cancer. The focus is on care, independent from efforts to cure the disease, but the two are not exclusive, and palliative care integrates both symptom control and cancer treatment.

Palliative care can help a patient at any age or stage of a serious illness. Early on, when curing the disease is the goal, palliative care focuses on reducing symptoms, managing patient distress, and providing support. Pain management, control of nausea and vomiting, and counseling for anxiety and depression are examples of palliative care approaches that can help people with a serious illness live as well as possible. There is

evidence that palliative care can also improve survival.

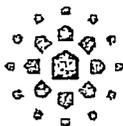
As a disease advances, the number and intensity of symptoms tend to increase. At this stage, members of a palliative care team can try to relieve pain and other distressing symptoms and to provide care that supports a person's comfort. As the end of life nears, the team guides and supports the person and their family through transitions in care and helps patients address issues of life completion.

The Palliative care team consists of a team of qualified health professionals and other specialists. They work together in a team-based approach in hospitals and home care settings to address the needs of life-threatening illnesses.

All patients deserve and should expect to have their care delivered by knowledgeable and sensitive health care providers. This bill can provide an opportunity to create a common understanding among providers that in turn will allow creation of a state wide palliative care plan for the citizens of Connecticut when they find themselves in need.

This approach is responsive to personal needs, wishes, and values, and it aims to prevent, reduce or relieve the symptoms of a disease and improve the quality of life for a person with a serious illness and his or her loved ones and caregivers.

Susan Richter
203-257-1915



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

TESTIMONY

Delivered by Tracy Wodatch, Vice President of Clinical and Regulatory Services
The Connecticut Association for Healthcare at Home

Before the Public Health Committee

March 15, 2013

Raised Bill No. 991

An Act Concerning An Advisory Council on Palliative Care

Senator Gerrratana, Representative Johnson and members of the Public Health Committee. My name is Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with 30 years experience in home health, hospice, long term and acute care.

The Association represents 60 licensed and certified home health and hospice agencies that perform 5-million home health and community-based visits in our inner cities and rural Connecticut towns each year.

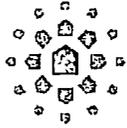
With a growing Connecticut workforce of 11,000 employees and skilled nurses, we are the *only* health providers that walk through the front doors of 14,000 state residents each day and understand the value that technology and interactive data communication brings to person-centered care.

The CT Association for Healthcare at Home supports Raised Bill 991 An Act Concerning An Advisory Council on Palliative Care.

There is much confusion over the differences between palliative care and hospice care. Both provide comfort, pain and symptom relief using a team approach. Hospice is for those in the last six months of life; whereas, palliative care can be provided along with curative treatment. The goal for both is improved quality of life.

Most of our CT licensed Hospice providers also provide Palliative Care. In addition, there is a growing presence of palliative care programs in hospitals throughout CT which are programs developed by the hospitals and generally not affiliated with our Hospice and Palliative Care providers.

For this reason, we request to be considered for an equal number of seats on the advisory council to ensure that palliative care in the hospital setting as well as the community setting is reviewed as part of the council's focus. Many of the Hospice and Palliative Care providers have physician and nurse nationally certified Hospice



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

and Palliative Care designation and would be highly recommended for this council. In addition, the providers have expert counseling staff including Licensed Certified Social Workers and Spiritual Counselors with decades of experience in this specialty.

Thank you for considering my testimony and if you have any questions, please contact me at Wodatch@cthealthcareathome.org or 203-774-4940.

Testimony of

Dr. Andrea Peterson, M.D.

on

SB 991, "An Act Concerning an Advisory Council on Palliative Care"

March 15, 2013

The Administration and clinical staff of The Connecticut Hospice thank the Committee on Public Health for allowing us to testify in support of Raised Bill 991, "An Act Concerning an Advisory Council on Palliative Care". We congratulate the State of Connecticut for its willingness to consider seriously the needs of patients with serious and advanced illnesses and their families. We applaud the initiative to review the current state of palliative care in Connecticut and to empower a council comprised of professionals working within this important field to make recommendations to the Department of Public Health as to how the care of patients with advanced illnesses can be improved throughout our state.

The Clinical Practice Guidelines for Quality Palliative Care, developed as part of the National Consensus Project, defines palliative care as follows: "The goal of palliative care is to prevent and relieve suffering, and to support the best possible quality of life for patients and their families, regardless of their stage of disease or the need for other therapies, in accordance with their values and preferences.... Palliative care is accomplished through effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/ family needs, values, beliefs, and culture(s)."

The State of Connecticut has a long history of support for excellence and care of patients with advanced and serious illness. The Connecticut Hospice was the first dedicated hospice in the United States and the first to obtain Joint Commission certification in Palliative Care. Five of our physicians and approximately 84 of our nurses are nationally certified in their discipline in Hospice and Palliative Care. Moreover, Connecticut has been at the forefront of supporting hospice and palliative care through appropriate licensure. Many hospitals and agencies throughout the state now offer palliative care and end-of-life services.

As the population of the state and the nation ages, and as the "Baby Boomer" generation grows older, the number of patients facing serious diagnoses such as cancer, heart failure, kidney disease, and chronic lung disease, among many others, will grow. Our medical system, as traditionally configured, is excellent at dealing with acute exacerbations of disease. However, as a patient's disease progresses, their exacerbations often become more frequent and more severe, often necessitating more frequent visits to the Emergency Room and more frequent and prolonged hospitalizations. Palliative care seeks to help patients and their families achieve

smoother control of distressing symptoms, with an overall goal of supporting the best possible quality of life.

As the Public Health Committee well knows, healthcare is in the midst of a sea change. The process of transformation from our past and current systems to the healthcare of the future is proving to be a painful one, through with challenges and difficult changes. Those of us who practice hospice and palliative medicine understand about difficult choices. We talk with our patients and their families about these choices every day and just as palliative care has become integral to the medical treatment of patients with serious and advanced illnesses, palliative care should be an integral part of the healthcare future. Once again, we at The Connecticut Hospice, Inc. applaud the Department of Public Health for its attention to palliative care; a discipline which we firmly believe will benefit patients, families, communities, and our society in the years to come.

This testimony is submitted by Dr. Andrea Peterson, M.D., Associate Medical Director, The Connecticut Hospice, Inc., on behalf of Dr. Joseph Andrews, M.D., Chairman of the Connecticut Palliative Physicians Group and the Administration of The Connecticut Hospice, Inc. and The John D. Thompson Institute for Education, Training and Research, Inc.



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Friday, March 15, 2013**

SB 991, An Act Concerning An Advisory Council On Palliative Care

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 991, An Act Concerning An Advisory Council On Palliative Care**. CHA supports this bill and respectfully requests that it be amended to increase the Advisory Council by one person, with dedicated membership to include both hospital and nursing home representatives.

Among other provisions, SB 991 seeks to improve quality of care and delivery of patient-centered and family-focused care in Connecticut by establishing a state Palliative Care Advisory Council within the Department of Public Health. The Council is tasked with analyzing existing policies and practices related to palliative care in Connecticut and advising the Department on palliative care issues, with the goal of improving quality of life for those with serious or chronic illnesses. Connecticut hospitals play an important role in the delivery of care at the end of one's life and, because of this important role, we believe dedicated hospital representation on the Advisory Board is prudent and warranted. Specifically, we request that Section 1(b) (2) of the bill be amended as such:

(2) Six appointed by the Commissioner of Public Health, one each who shall be a licensed healthcare provider with experience or expertise in the provision of: (A) inpatient palliative care in a hospital; (B) inpatient palliative care in a nursing home facility; (C) palliative care in the patient's home or a community setting; (D) pediatric palliative care; (E) palliative care for young adults; and (F) palliative care for adults or elderly persons;

Thank you for your consideration of our position.

For additional information, contact CHA Government Relations at (203) 294-7310.

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**CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2013**

**VOL. 56
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May 8, 2013

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

I rise simply to voice my support for this bill. One of the things that I think impacted me the most during the public hearing was really the -- the overwhelming support by all facets of the communities impacted here, saying this is something we really need, I think much for some of the reasons that Senator Ayala mentioned.

But, again, there was literally no opposition, and I think this will go a long way into improving the services that we provide in various and diverse communities.

Thank you, Madam President.

THE CHAIR:

Thank you, Senators.

Will you remark? Will you remark?

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

If there's no objection, I ask that this item be moved to our Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered.

Mr. Clerk.

THE CLERK:

On Page 20, Calendar 396, Substitute for Senate Bill Number 991, AN ACT CONCERNING AN ADVISORY COUNCIL ON

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PALLIATIVE CARE, Favorable Report of the Committee on
Public Health.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

I move acceptance of the joint committee's Favorable
Report and passage of the bill.

THE CHAIR:

Motion is on acceptance of the bill and passage. Will
you remark?

SENATOR GERRATANA:

Thank you. Thank you, Madam President. I will.

Right now the Clerk has an amendment, and it is LCO
176; if he would call, please, and I be allowed to
summarize?

THE CHAIR:

Mr. Clerk; 176.

SENATOR GERRATANA:

Sorry, Madam President; 6176.

THE CHAIR:

That's okay; 6176.

SENATOR GERRATANA:

Thank you.

THE CHAIR:

How about that number?

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THE CLERK:

LCO Number 6176, Senate "A," offered by Senator Gerratana and Representative Johnson.

THE CHAIR:

Senate -- Senator Gerratana.

SENATOR GERRATANA:

Thank you. I move adoption.

THE CHAIR:

The motion is on adoption. Will you remark?

SENATOR GERRATANA:

Thank you, Madam President.

This amendment makes some changes to reflect some input and some discussion that we had on the bill, including some testimony. We added in an additional person to the council and it made some other technical changes.

Thank you --

THE CHAIR:

Will you --

SENATOR GERRATANA:

-- Madam President.

THE CHAIR:

Will you remark? Will you remark?

Seeing none, I'll try your minds. All -- all in favor, please say Aye.

SENATORS:

Aye.

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THE CHAIR:

Opposed?

The amendment is carried.

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

Madam President, the underlying bill establishes a Palliative Care Advisory Council. I want to let the Chamber know that this year Public Health had much discussion on palliative care. Palliative care can be long-term care of a chronic illness; sometimes it is end-of-life care too.

One of the issues or concerns or actually some of the testimony that was given was around the fact that Connecticut tends to look at, by and large in the health care professions, that palliative care is only end-of-life care. But, Madam President, people are living much, much longer with serious or chronic illnesses, and the testimony was very compelling to come forth and have an advisory council to take up the issues that we direct them to in the bill.

I hope the Chamber will support this advisory council. And I, of course, ask for a favorable vote.

Thank you, Madam President.

THE CHAIR:

Will you remark? Will you remark?

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

I also rise to support this bill. We spent a lot of time, this last session, focusing on various issues

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including palliative care. And one of the things that became patently obvious to me is how much, how much there is here to be done, how much we, how much we underutilize the concept of palliative care in the State of Connecticut.

Indeed, this is all about patient-centered; this is all about family centered decisions. And most of, most of the agencies, I think most concerned with those, with terminal illnesses, such as the -- the American Cancer Society, the -- excuse me -- the American Lung Society, et cetera all support this. It's a, it's a concept that is long overdue, and I really would urge this Circle's support in passing this bill and getting this council up and running so we can begin to make some good decisions with respect to palliative care.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark?

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

This area of the law is -- is an important area, as Connecticut as well as our country ages. It's -- it's extremely important, particularly as we get on the -- the chronic-care continuum that, you know, how we deal with living as we age is -- is such an important component, and -- and how as a society are we going to go forth and -- and deal with that.

So I -- I like what this -- this task force, this advisory council is being assembled for and what it's going to do. But one of the things that does concern me in this area is the public policy choice that we're making in our budget with regards to end-of-life decisions and hospice, where if you're on Medicaid, we are going to look at reducing the reimbursement rate

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for providers of hospice care. And what that in a sense does is it creates a situation where we put pressure on the providers of these important services, which I think impacts the actual quality of the service, itself.

And when we're dealing with people on Medicaid, I don't believe that they should be treated any less than people in the general public, and for that reason, Madam President, the Clerk has an amendment, LCO Number 6151. Will the Clerk please call the amendment.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO Number 6151, Senate "B," offered by Senator Kelly.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

I move adoption by roll call and seek leave to summarize.

THE CHAIR:

Motion is on adoption and roll call will be had.

Please proceed, sir.

SENATOR KELLY:

Thank you, Madam President.

This amendment would add to the advisory council the task of assessing the effect of any reduction in state funding of reimbursement rates for hospital -- hospice services on the affordability and the availability of such services. And I think this is an important

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component. I think individuals on Medicaid should have the same quality care as other individuals, and for that reason, I would ask that the Circle approve this to have this council evaluate that. And I urge adoption.

Thank you.

THE CHAIR:

Will you remark?

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

Madam President, I thank Senator Kelly for bringing this issue to us here in the Circle, but I will have to speak against his amendment. And, basically, with the establishment of this advisory council, we are hoping that they will focus and focus only on the care at this point.

Fiscal matters and such, of course, are open to discussion when we discuss the budget. I would really feel that the council should be focusing on palliative care and the long-term care. This is a big issue for them to tackle, certainly one of importance. So I really urge my colleagues to reject the amendment.

Thank you.

THE CHAIR:

Will you remark?

Senator McLachlan.

SENATOR McLACHLAN:

Thank you, Madam President.

I rise to support Senator Kelly's amendment. I'd like to thank him for bringing that forward. I, too, share his concern about budget cuts that seem to be having a

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terrible negative impact on hospice care which is relatively inexpensive in the big picture of -- of what we have in the big healthcare challenges in the state of Connecticut. And I very much appreciate the opportunity for the Council on Palliative Care to consider this issue, certainly if they are concerned about care then they will -- they will have to consider some of the fiscal restraints that come along with the challenges of care, so I think this amendment makes perfect sense.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark further?

Senator Welch -- sorry.

SENATOR WELCH:

Got you all choked up, huh? Thank you, Madam President.

I want to thank Senator Kelly for -- for raising this issue, because this is really an incredibly important issue. One of the things, in addition, to our need to focus on palliative care that was underscored in my mind like never before is -- is hospice, and in fact, the dearth of our use of hospice in the state of Connecticut, we actually are underutilize hospice care probably more so than any of the other states, so this is an incredibly important issue. It's worth having the dialogue. If the dialogue ends today here, I would encourage us to continue that dialogue heretofore, because, Madam President, I think as Senator Kelly noted, this is critical and it's something that not just those who have means should be availing themselves of.

Thank you, Madam President.

THE CHAIR:

Thank you.

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Will you remark further? Will you remark further?

If not, Mr. Clerk, will you call for a roll call vote and the machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate.
Voting Senate Amendment Schedule "B." Immediate roll call has been ordered in the Senate. Senators please return to the chamber.

THE CHAIR:

All members have voted, all members have voted? The machine will be closed.

Mr. Clerk, will you call the tally, please.

THE CLERK:

On Senate "B."

Total Number Voting	36
Those voting Yea	13
Those voting Nay	23
Those absent and not voting	0.

THE CHAIR:

The amendment fails.

Will you remark further? Will you remark further?

Senator Gerratana.

SENATOR GERRATANA:

Madam President, if there is no objection, I ask that this item be placed on Consent.

THE CHAIR:

Seeing no objection so ordered.

Mr. Clerk -- oh, sorry -- Senator Looney.

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So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President.

Calendar page 48, Calendar 309, Senate Bill Number 899, Madam President, move to place this item on the foot of the Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President.

And Madam President, on Calendar page 50, Calendar 405, Senate Bill Number 848, Madam President, move to refer this item to the Committee on Finance, Revenue and Bonding.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President.

Madam President, if the Clerk would now read the items on the first Consent Calendar and then if we might proceed to a vote on that first Consent Calendar.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 1, Calendar 496, House Joint Resolution Number 98; Calendar 497, House Joint Resolution Number 99.

On page 2, Calendar 498, House Joint Resolution Number 100; Calendar 499, House Joint Resolution Number 101;

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also on page 2, Calendar 500, House Joint Resolution
Number 102.

On page 4, Calendar 119, Senate Bill 564.

On page 5, Calendar 155, Senate Bill 231.

On page 6, Calendar 169, Senate Bill 881; and Calendar
188, Senate Bill 1029.

On page 7, Calendar 192, Senate Bill 835.

On page 12, Calendar 284, Senate Bill 964.

Page 16, Calendar 353, House Bill 6481.

On page 18, Calendar 376, Senate Bill 878; Calendar
372, Senate Bill 977.

On page 19, Calendar 387, Senate Bill 386; and
Calendar 392, Senate Bill 366.

On page 20, Calendar 396, Senate Bill 991; and
Calendar 413, Senate Bill 1049.

On page 21, Calendar for 424, House Bill 6212.

And on page 25, Calendar 463, House Bill 6405.

THE CHAIR:

Those are all the bills on the Calendar.

At this point, Mr. Clerk, will you call for a roll
call vote of the first Consent Calendar of the day and
the machine will be open.

THE CLERK:

~~Immediate roll call has been ordered in the Senate.~~
Voting the first Consent Calendar of the day.
Immediate roll call has been ordered in the Senate.
Senators please return to the chamber.

(Senator Coleman of the 2nd in the Chair.)

THE CHAIR:

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Would members please check the board to see that your vote has been properly recorded? If all members have voted and all votes have been properly recorded, the machine will be closed.

And would the Clerk please take and announce the tally.

THE CLERK:

On the first Consent Calendar of the day.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar has passed.

Senator Looney.

SENATOR LOONEY:

Yes, thank you, Mr. President.

If we might stand at ease for -- for just a moment.
Thank you.

THE CHAIR:

The Chamber please stand at ease.

(Chamber at ease.)

SENATOR LOONEY:

Mr. President.

THE CHAIR:

Senator Looney.

SENATOR LOONEY: