

Legislative History for Connecticut Act

SA 14-5

SB413

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Senate	847-862, 872-873	18
Public Health	1288-1297, 1311-1329, 1405, 1408, 1512-1513, 1521, 1532-1537, 1566- 1574, 1708-1735, 1772, <u>2853-2865</u>	91
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DEPUTY SPEAKER GODFREY:

The resolution is adopted. And I wonder if we'll be suing North Carolina to get that line off of their license plates.

Mr. Clerk, Calendar 429.

THE CLERK:

On page -- what page number is that? On page 19, House Calendar 429, Favorable Report of the Joint Standing Committee on Public Health, substitute Senate Bill 413, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT.

DEPUTY SPEAKER GODFREY:

Distinguished Chairman of the Public Health Committee, Representative Johnson.

REP. JOHNSON (49th):

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

DEPUTY SPEAKER GODFREY:

Question is on acceptance and passage and concurrence. So would you explain the bill please, ma'am?

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This bill would allow the Department of Public Health, the Commissioner, to establish a program to -- for the use of medical orders for life-sustaining treatment.

It would allow them to establish an advisory committee to make recommendations regarding the -- a MOLST pilot program, and if the Commissioner adopts such a program, she must report the policies and procedures to the Legislature.

But the patient participation is voluntary and the agreement to participate in the program must be made in writing and signed by the patient or the patient's legally authorized representative.

After the termination of the program, the Commissioner must submit a report on the program to the Public Health Committee and any such program must end no later than October 1, 2016.

I move adoption.

DEPUTY SPEAKER GODFREY:

Thank you, madam. Will you remark further? The distinguished ranking member of the Public Health Committee, Representative Srinivasan.

REP. SRINIVASAN (31st):

Good evening, Mr. Speaker. Through you, Mr. Speaker, just a few questions to the proponent of the bill.

DEPUTY SPEAKER GODFREY:

Proceed.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker. Through you, Mr. Speaker, do we know now, in this pilot program, how many areas have been chosen or will be -- or may be chosen? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Before you respond, a little quieter. That's much more helpful. Thank you. Representative Johnson, do you care to respond?

REP. JOHNSON (49th):

I thank the good ranking member for the question. There are two areas that have been selected at this time by the Department of Public Health. One is the Yale-New Haven area and the other is the Windham Area. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, Line 2 talks about within available appropriations. So through you, Mr. Speaker, since two places -- two different locations have been chosen, are we to understand that there's enough appropriations for them to conduct this pilot study?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the -- when I look at the total file, I see that there is no fiscal note. So there shouldn't be an issue with respect -- with respect to appropriations. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Just a moment.

Dr. Srinivasan -- Representative Srinivasan, you still have the floor, sir.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker. Through you, Mr. Speaker, if the good Chairwoman could inform us as to what this piece of document that is going to be put together after the pilot program, what will it accomplish? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, this is an excellent piece of legislation that will inspire the connection between the patient and the doctor or the provider of healthcare to work at issues that affect the person who is facing a severe illness, a deterioration of the overall condition, or end of life types of issues that will be facing someone in terms of the -- the choices of treatments, the impact of the treatment, and to have the doctor and the patients sit down and make sure -- or the nurse, APRN of the patient, or the physician's assistant sit down with the patient and talk about the choices for treatment, what the outcomes will be, and have that decision be -- be made between the doctor and the patient.

The difference between that occurring -- what occurs today and what this legislation will do is it will allow those decisions to be carried from one institution to the next.

And I'll illustrate by example one of the problems that I am familiar with in my own -- my own work or my -- my work history, and that is with people

who are finding themselves in hospice programs and they have a whole plan of care, they have providers who are familiar with the treatment options and the plan, but then, they may need perhaps emergency medical services. And those plans are not transferable to the emergency medical services providers, is one example.

So what this plan will do, it will allow the patient to carry from one provider to the next this MOLST order, this order that was created in conjunction with a treating doctor, that's the very careful planning that will occur and be transferable from one type of provider to the other.

The other thing that's important to know, I think, about this is that the order between the doctor and the patient can be changed and followed.

So it's going to be part of the institutional guideline for that patient and it's going to be something that if it needs to be changed, that communication between the doctor and the patient will be ongoing and will be adjustable.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, as the good Chairwoman explained in -- in great detail, and I thank you very much for doing so, clarifying that this is an -- sets up an opportunity for the healthcare provider, the physician, the APRN, or the PA to have a very serious conversation with the patient and so they can then come up with the various options, which is the first part of what this bill tries to do.

And the second part, which is equally important, that message is not just left at the doctor's office or left at the nursing -- in a nursing home or where the patient is, but becomes a part of what the patient carries wherever he or she goes.

So therefore, if the appropriate treatment is therefore then administered as per the agreement between the physician and the -- and the patient, is that my understanding? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Thank you. Yeah. That is a very good explanation of -- of this process that we're developing here. It's something that many people who

are in the medical profession and people and families who find their -- their loves in this situation are -- have a great deal of concern when they know that they have worked out a -- a plan for -- between the patient and the doctor and then, all of a sudden, because of a transfer to another institution, that plan kind of doesn't make it there in time, and different types of orders and things are -- are done and they're not in compliance with what the patient expected, what the family expected, and it's a big disappointment to people who find themselves in this situation.

So this law will address those kinds of issues and will help the Department of Public Health create plans and to see what types of agreements need to be made so that when a patient is transferred from one level of care to another, from one institution to another, that those orders will follow them.

Through you, Mr. Speaker. .

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, from one institution to another, the transfer of paperwork is almost automatic or should happen, rarely should it fall through the

cracks. But if somebody is in a home setting, and we hope a lot of people have the comfort of being at home, you know, in their last days.

In that situation, if an emergency arises, an ambulance shows up there to transport them to the nearest facility, will those providers honor this -- this piece of information that the patient or the patient's family will provide?

As for example, if it is a DNR, do not resuscitate, will those requests be honored? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's an excellent example of why we need this legislation. Because oftentimes, the ambulance, emergency medical services providers, are under an obligation to try and revive somebody.

And if, in fact, they have a DNR, or do not resuscitate order, or if there -- if there is an agreement with that -- with the doctor and the patient, these MOLST orders will be given to the

emergency medical services providers and they follow these orders. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, as the good Representative had said a few minutes ago, that is not a document that is just written once and that's a be all and end all. I mean, changes can be made. You know, that's a decision between, obviously, the healthcare provider and the patient. And so document A could be replaced by document B and could go on and on and on.

Through you, Mr. Speaker, my concern -- or one of my questions is how do we make sure that the most recent document, document C, is the one that is given to the ambulance provider rather than the very first document in case the -- the wishes of the patient have changed? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the bill calls for having the Department of Public Health transfer the

order electronically. So access will be given to the -- to the provider electronically. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, this is one instance where we are thankful for the electronic age. So therefore, these various requests are current and up to date because if it is just in the paper form alone, you know, one does not know which one is handed out in that moment of distress and stress when somebody arrives at the door of a patient who is at their own home.

Through you, Mr. Speaker, what is the role of the advisory group? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

The advisory group, through you, Mr. Speaker, will work with the Commissioner to create -- create a policy, a plan, so that MOLST can be used throughout the state instead of these two -- two places that

we're going to have the pilot program. Through you,
Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Mr. Speaker, the Department of
Health will meet with this advisory group or advisory
council, whatever you call them, and will -- the
people sitting on the advisory group, will then come
up with what the form should look like, but can then
be taken out to the two towns that we just talked
about? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's correct.
They'll be working to create a way to implement the
pilot and also work in a way to actually determine how
the -- the pilot will be able to apply to the rest of
the state. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, Line 16 talks about Public Health may establish this advisory group. So through you, Mr. Speaker, is it possible that the Public Health may have the -- the plan -- the -- the pilot program, but may not have this advisory group? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, it's the intent of the legislation to have an advisory group that would consist of members; physicians; advanced practice nurses; physicians' assistants; emergency medical services providers; patient advocates, including but not limited to advocates for persons with disabilities, hospital representatives, or long-term care facilities.

So there is emphasis and interest in this bill that indicate that it would be very advisable for the Department to include all those parties to be able to set up this system, that is a coordination of these things.

Without having the voices of these different groups, it would be hard to create a system that will

take into consideration all the things that have to be considered for making sure these MOLST orders are transferred between one provider to the next.

So while it says may, it may give some -- it sounds like it gives some flexibility there because it's not a shall. On the other hand, it may be just that it's just a little bit permissive in terms of how it's formed rather than whether some type of advisory group would be put together. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, everyone here in the Chamber is well aware of the huge difference between a may and a shall. And so through you, Mr. Speaker, though the language says may, is it more of a shall than a may? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, it certainly is more of a -- perhaps a -- it leans very hard toward being a shall, but it still has the word may in there. So I

think that the -- that the reading of this just is -- is a little bit in the way permissive because of the structure, but not necessarily in -- in the -- whether or not to have any task force at all.

So I think it's -- that's -- that's how I would interpret it. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, for this advisory group, would there be a fiscal note or any appropriations that would be needed? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, there is no indication anywhere in the bill, in the file that we received, that addresses a fiscal note. I just looked and there's -- there's no fiscal note at all. The cost of this is -- is within the existing funds for the Department of Public Health.

So there is no fiscal note for this. Through -- through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, this advisory group, along with the DPH, comes up with an -- a form, an appropriate form that they feel is what is going to be used in the pilot program.

Through you, Mr. Speaker, that particular form that has now been created between the advisory group and the Department of Public Health, how will it be circulated into those two areas where the pilot program is being planned?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

They will be able to provide a way to circulate it based on the advice of the task force. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, who then, in these areas, will receive this information, whether it be by

regular mail, by electronic mail, whatever way be the way of communication?

I see a long list here in that -- in -- in Lines 25 through 38. So will each hospital, nursing home, physician, APRN, every single person in that community, will they be contacted and reached out to with this particular pilot program? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

That is the way I read this section as well, that the -- prior to the commencement of the pilot program, they'll -- the Commissioner will contact a representative, each one of those providers, as was kind of reflective of what's also in B, which is what we just went through in terms of the possibilities for participation in the advisory group.

And then, they will be able to look at that to see whether or not that functions within their systems. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

And through you, Mr. Speaker, I heard in the opening remarks of our good Chair that participation by anybody and everybody in this pilot program is voluntary? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, yes. That is exactly right. That -- that is the way that they will be able to see how our -- our systems will be able to work, how we will be able to coordinate. I think also, when you take a look at this list and you think about the two pilot program areas and hospitals that were used to -- they're two completely different areas.

So you have the Yale-New Haven area, which is a very intense urban area, with a large -- a large hospital and lots of providers, and then you go back to the Windham area and you see a very rural area, small hospital area, with, you know, a smaller group of providers.

So I think that -- they're looking at diversity when they look at the types of pilot programs that they're going to initiate. Because we do have all different types of systems all throughout the State of

Connecticut, depending on what -- what type of an area you're in.

So I think it's wise to take a look at all these different regions and -- at least these two different regions I think are different enough, where we'll -- we will have a lot of information on what the best way to implement the MOLST program will be. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you -- through you, Mr. Speaker, do we know now or will we wait for the advisory group and -- and the Department of Public Health to come with the numbers of -- the number of -- of providers that they're going to enroll and the number of patients that they're going to enroll in this pilot program? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so the regions would be a consideration in terms of what the area providers have. So I wouldn't know the exact number of

providers in either region, but it would take into consideration that region, a geographic area, and then you would -- would know the numbers of patients, either because each patient is asked to sign an agreement; it's totally voluntary.

Some patients may not want to participate and they're not -- they're -- they don't have to. So it would be hard to gauge how many patients. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, I definitely understand. It is hard to gauge the number of patients. But who will determine as to what that right number should be, whether it be for some place like Yale or a rural area like Windham? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the region -- so regions in terms of geography are set up according to a number of things; the certificate of need addresses

a region, catchment area is -- address a region.

Those kinds of considerations.

When someone's transferred from the hospital to a skilled nursing facility, they -- it's a real difficulty to sometimes make sure the person is transferred within the geographic area of that -- where that person lives.

So those are -- those are things that are determined and they're in some ways common sense type situations because you don't want to have people traveling across the state. That wouldn't be a good thing. So you want to make sure they're in that region where their providers are, their doctors are.

People tend to have medical services in -- in a region close to their homes or where they work. So the region would be probably taken into consideration; a number of those types of things. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, the program is voluntary and the information is then going to be collected and then, obviously, evaluated and reported

back first among themselves and then to us down the line.

Since this is going to be information that all of us will be able to look at, Through you, Mr. Speaker, would all the HIPAA guidelines and the rules be followed when these patients are being asked to participate in the study? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, HIPAA must be follow in all these circumstances. The only thing that will be addressed in terms of the transmission of information is how things worked, the numbers of people, but not who they are, and those types of things.

HIPAA must be followed in all circumstances.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, do we have an idea as to how long the study will be conducted for? Are we looking at a three-month study or a six-month study

before we get the recommendations? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so this bill will go into effect from -- from the day -- effective date is the date of passage, which would be the day the Governor signs it. And then, it would go all the way to October 2016, I believe. Yeah, 2016.

So that would be the final -- that would be the end of the pilot project and at that point in time, they would have to come back. It looks like October 2016 gives the Department of Public Health and the advisory committee enough time come up with the recommendations for the session of January 2017. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Mr. Speaker, then this information will come back here to the Chambers in that -- in the 2017 session? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

That is how I read the bill. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

This bill is an important one. It is -- bridges the gap that sometimes happen and we see that all the time. The patient's request is for one thing. That's what the doctors have agreed upon, signed upon.

But unfortunately, this communication does not occur in a situation or in multiple situations. So having such a program, having such a piece of information that is electronically transmitted, so all the caregivers, whether it, by and large, be an ambulance provider, is able to see what the request is of the patient and what the physician has agreed to, and honor that request.

So through you, Mr. Speaker, I -- I want to thank the good Chairwoman for her answers and for bringing up this very important piece of legislation for all us -- for all of us to debate and to review so that we

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serve our patients in Connecticut better. Thank you,
Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir. Representative Betts.

REP. BETTS (78th):

Good evening. Thank you, Mr. Speaker. A
question if I am -- a couple of questions for.

DEPUTY SPEAKER GODFREY:

Proceed, sir.

REP. BETTS (78th):

To the good Chairlady. In the bill, in Section
1, Line 6, it says medical order for life-sustaining
treatment means a written medical order by a
physician.

Could you explain to me what they mean by a
physician? Is it your primary care physician or is it
just any physician?

Could you give -- give us some clarification as
to what they mean by just a physician? Through you,
Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, it would be the treating physician for whatever the condition was of the -- of the patient. So you might have a primary care physician do the order or, if you have a -- an illness that requires a specialized doctor, a doctor that specializes, say an oncologist that would specialize in -- in the treatment of cancer. Then, the -- that oncologist would be able to write the MOLST order.

So actually, any -- any physician, advanced practice nurse, or a physician -- physician's assistant could effectuate a patient's request for life-sustaining treatment when the patient has been determined by a physician to be approaching the end stage of a serious limiting -- life-limiting illness or is in a condition of advanced chronic progressive fragility.

So that would be -- so it would -- could be the doctor or the provider who is specializing in that particular condition or it could be the primary care physician. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Betts.

REP. BETTS (78th):

Thank you. Thank you for that answer. The reason why I view that as important is you may have a close relationship with your primary care doctor who sends you to a specialist, but you've had a relationship for, you know, 20 years or more with that primary care doctor and you drop, if you will, what your desire is in terms of life-sustaining methods and, yet, the patient might come in over a week and feel particularly bad.

Condition -- the chronic condition gets worse -- or not chronic, but end of life or terminal. The condition gets worse and then the patient as a change of mind and tells the treating physician in the hospital these are my new wishes. Which takes precedent and which one -- which one is honored under those circumstances? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

I thank the good gentleman for his question because that is the crux of the issue in this bill. The bill is there to make sure that all the providers of the patient will have access to the MOLST orders once they are made with the -- with whichever

physician makes those orders or nurse practitioner or a physician's assistant. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Betts.

REP. BETTS (78th):

Thank you very much. So if I understand the good lady correctly, then that means that the most recent one that he or she has left is on electronic record file, which is something the treating doctor can refer to.

But if the patient decides at that point that they want to change that wish, because their deteriorating condition, is there any kind of psychological or any kind of evaluation required of the patient if they so change what was recorded on the medical file?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the idea of the -- this is to -- whoever -- whichever physician or provider, whether it be a nurse practitioner or a physician's assistant, that there be a -- once the treating doctor

makes a diagnosis of the -- overall condition, then the -- one of the -- either the treating doctor or those other professions that have the ability to make a medical order, sit down with the person and talk about all the medical options that are available. And those medical options -- and the consequences of one option on the other.

So depending on what the condition is, the types of treatments available, the wishes of the patient, all those things are taken into consideration, along with the person's, you know, overall, you know, social condition as well, that things are taken into consideration, such as ethnicity. Those types of things are also discussed as part of the, you know, life -- MOLST orders. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Betts.

REP. BETTS (78th):

Thank you. And in the case of somebody who has given a healthcare proxy to a family member or more than one family member, what role does that healthcare proxy play when the person is in the hospital, their condition is deteriorating, and they have a -- a, you

know, most recent recorded file of what the wishes were of that patient?

Does the healthcare proxy have the ability to override the -- the wishes that are recorded on file or does the healthcare proxy to which the, you know, patient has voluntarily given up to one or more family members or whoever? Do they have the ultimate say or final decision when the patient is being treated?

Through you, Mr. Speaker

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so healthcare proxy or living will, I believe the good gentleman is speaking of, those things are also in statute. But as a general rule, people who make those up do them -- do living wills, do healthcare proxies many times when they are not thinking about or they are not in an -- in a situation where they need a medical order for -- for a condition that's causing severe deterioration or they're not doing at the very near end of their lives.

They're -- they're doing that perhaps when they're doing their estate plan as part of a package. So that would be something that would be more general.

Their living will, as a -- as a general -- is a very general thing. It usually doesn't speak to a particular medical condition. It speaks to the overall -- the overall desires of the patient.

So the -- this MOLST order is a order that is different because the living will or those kinds of things are done between the lawyer and the -- and the person. And here, this MOLST order is between the doctor or the medical provider and the person and it's based on specific medical conditions. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Betts.

REP. BETTS (78th):

Okay. Thank you very much for those answers and I have no further questions. Thank you very much, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir. Representative Christopher Davis of the 57th.

REP. DAVIS (57th):

Thank you, Mr. Speaker, and good evening. Through you, a couple of questions to the proponent of the bill.

DEPUTY SPEAKER GODFREY:

Proceed, sir.

REP. DAVIS (57th):

Thank you. Through you to the kind Chairwoman of the Public Health Committee, what happens if a individual has a medical order for life-sustaining treatment but then gets in some unrelated accident, something happens? Say a -- in a -- like a car accident or -- or they fall down the stairs or something along those lines that wouldn't necessarily affect the condition that led to them wanting to put in a medical order of life-sustaining treatment, what would happen in that situation? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's a very excellent question from the Representative. So the MOLST order would really come into play only for the condition that the -- this causing the severe deterioration or near death circumstance.

If there is a automobile accident or a -- a fall down the stairs or some other type of situation, that

would be treated in -- in the standard medical practice way. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Davis.

REP. DAVIS (57th):

Thank you, Mr. Speaker. And what would happen if that patient in fact, due to their health conditions and -- and they kind of were in a situation where they had less than a year to live, as in most of these cases, and they do take a fall down the stairs or have some other accident and they are revived. What happens if that actually was against their wishes, that, in fact, if that accident did happen, they didn't want that life-sustaining treatment? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the -- the wishes would be made known to the treating doctor and the doctor, in many circumstances, will -- will follow the wishes of the patient. In this circumstance, the focus is on the condition.

So if it's -- say it's the oncologist and they have made a plan for treatment -- for the treatment of cancer and they have that all figured out and then someone gets into an accident, that would be something that would probably be fractures and bruises, that kind of thing, which would cause a great deal of pain, I would suspect, if they weren't being treated for those things. So I think that -- I think that would be between the -- the doctor and -- and the patient, but the MOLST order would still be there and the other -- other conditions would be treated separately.

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Davis.

REP. DAVIS (57th):

Thank you, Mr. Speaker. And I thank the gentlelady for her answers. I think it's important to know that the patient is still protected here, that they would still receive the medical treatment necessary to at least keep them going if they do get in that accident scenario, even if it doesn't necessarily relate to their medical order of life-sustaining treatment.

So I would recommend to my colleagues here in the House that this is a positive step in the right direction for those individuals that do have a condition that could lead to them having to make this very difficult decision on what kind of life-sustaining treatments they would like at end of life. So thank you, Mr. Speaker, and I encourage my colleagues to support the bill.

DEPUTY SPEAKER GODFREY:

Thank you, sir. Remark further on the bill? Will you remark further? If not, staff and guests, please come to the Well of the -- oh, no. Representative Smith.

A VOICE:

Well, Mr. Speaker, being a colleague from Danbury, I'll -- I'll take the oh no as it's late in the night and we're looking for to hearing your questions.

DEPUTY SPEAKER GODFREY:

My oh not was not directed at you. It's directed on those who are making distracting noises.

REP. SMITH (108th):

Oh, thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

You're welcome, sir.

REP. SMITH (108th):

Unfortunately, I was -- I was working on another project and I was kind of listening half-heartedly to what was going on and I'm sorry to hear healthcare proxies and -- and things of that nature. And I was reading the bill as -- we're again towards the end, I guess, of the questions and I apologize to Representative Johnson if this question has been asked.

But the healthcare proxies that are part of our current statutes and provide for people to make decisions, how they want to be treated if they're in a terminal condition with no hope of recovery, and not be kept alive by life-support systems, how does that differ from what we're talking about now that's before us in the Chamber and if there's -- are there conflicts between the -- the two of them? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so the healthcare proxy or living will is something that someone usually does

in combination with their estate plan and it's a more general type of thing done in conjunction with a -- with a lawyer and it has some general things spelled out in the -- in the living will.

It appoints a healthcare power of attorney and those types of things. And so that would be the healthcare proxy.

The MOLST order is done in conjunction with the person and the treating doctor, the doctor that will be the specialist in this particular person's overall condition, the -- the reason that the person is having a deterioration in the condition. Those things will be addressed in terms of options, the types of options specifically.

So their specific medical treatments, they are explained in terms of what the consequences of going with one treatment method or the other will be. And these orders are -- are followed by the doctor in the medical profession.

Not that the living will wouldn't be handed to the doctor, but the living will is a more general document. This is specific to the person's medical condition. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Smith. .

REP. SMITH (108th):

Thank you, Mr. Speaker. And then, so the situation where we have a -- a healthcare proxy in hand and the doctor is aware of that, does the Representative see that there would be any conflicts between the healthcare proxy and the document we're talking about with this bill? Because the healthcare proxy is, as we know, is designed to tell the world, listen.

If I'm in this condition, I wish not to be kept alive by life-support systems. Take me off of the life-saving instruments that we have and let me die in -- in peace, so to speak.

I'm wondering whether the language in this bill would counteract that in the sense that the treatment that may be prescribed by the doctor or is -- doctors who are trained to keep people alive may be in conflict with that very theory of I do not wish to be kept alive if my condition is deemed terminal.

So I'm just wondering if there is, in fact, a conflict? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Johnson.

REP. JOHNSON (49th):

I -- I don't see where this -- this piece of legislation will create a conflict with -- between the medical orders for life-sustaining treatment, which would be within the standard of care. Their -- the doctor has a duty to provide treatment within the standard of care, so we're not talking about going outside the standard of care. We're just talking about following the options that a patient might have with a deteriorating medical condition within the standard of care.

There are many options that are available and this is a conversation that is a really good way for people to connect with their medical provider, make sure that they understand exactly what their options are, have them put in writing and have them transfer it with them as they go from one place to the next.

So that is -- that is different than how a living will or healthcare proxy is -- is addressed. Those things are done, like I said, and they're done in a more general way. Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Smith.

REP. SMITH (108th):

And I thank Representative Johnson for the clarification and explanation of the -- of the bill. And hopefully, Mr. Speaker, now you can move on. Thank you.

DEPUTY SPEAKER GODFREY:

Well, let me ask. Thank you, Representative Smith. Will you remark further on this bill? Will you remark further? If not, staff and guests please come to the Well of the House, members take your seats. The machine will be open.

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 GODFREY:

Have all the members voted? Have all the members voted?

If all the members have voted, the machine will be locked. The Clerk will take a tally.

And Mr. Clerk, kindly announce the tally.

THE CLERK:

Senate Bill 413 in concurrence with the Senate.

Total number voting 145

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HOUSE OF REPRESENTATIVES

528
May 05, 2014

Necessary for passage	73
Those voting Yea	145
Those voting Nay	0
Absent and not voting	6

DEPUTY SPEAKER GODFREY:

The bill is passed in concurrence with the
Senate.

Representative Aresimowicz.

REP. ARESIMOWICZ (30th):

Thank you very much, Mr. Speaker. Mr. Speaker, I
move we immediately transmit to the Senate all items
that acted -- awaiting further action in the Senate
acted upon in the House earlier.

DEPUTY SPEAKER GODFREY:

Is there objection? Hearing none, the items are
immediately transmitted.

Mr. Clerk, if you could kindly call 446.

THE CLERK:

On page 21, House Calendar 446, Favorable Report
of the Joint Standing Committee on Planning and
Development, substitute Senate Bill 332, AN ACT
AMENDING THE CHARTER OF THE METROPOLITAN DISTRICT IN
HARTFORD COUNTY.

DEPUTY SPEAKER GODFREY:

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**CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2014**

**VOL. 57
PART 3
703 – 1013**

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Senator Looney.

SENATOR LOONEY:

Thank you, Madam President.

Madam President, I move that the -- the bill as amended be referred to the Committee on Planning and Development.

THE CHAIR:

So -- so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 23, Calendar 288, Substitute for Senate Bill Number 413, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT; Favorable Report of the Committee on Public Health.

THE CHAIR:

Good afternoon, Senator Gerratana.

SENATOR GERRATANA:

Good afternoon, Madam President.

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

THE CHAIR:

The motion is on acceptance and passage. Will you remark, ma'am?

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SENATOR GERRATANA:

Yes, Madam President. Thank you.

To members of the Chamber and the public, I introduce you to the Medical Orders for Life-Sustaining Treatment. This bill comes as part of a series of bills that have been put forth by the both, the Public Health Committee and the Department of Public Health, working together to talk about our citizenry and, of course, the inevitable, if you will, in a variety of ways.

We have already established a palliative care counsel. We have addressed the issues of chronic care and chronic illness. And this protocol, as most is known, it goes another steps; it goes to addressing those issues beyond what we call the end of life but actually the very words "life-sustaining treatment" are key in this protocol.

For many of us, we have been faced, of course in our lives, with taking care of our love us and loved ones, and very, very often they develop a life-limiting illness. This illness could be cancer or some other condition where a doctor under the bill has pronounced that this person is very close to the end of life. It's a conversation, if you will, as well as a protocol, and that conversation is with the loved one, with a family member, and most importantly with a practitioner, a primary care practitioner to decide what it is that he or she would like to see as they come to the inevitable end of their life.

The program under this bill is a pilot program; the language is enabling, and it would allow the Department of Public Health to establish in two -- one or more, I should say -- geographic areas, a pilot to -- to adopt the MOLST protocol.

There's already in existence a MOLST Advisory Committee, and that has been working very, very hard with what I would call all stakeholders, all of those people who are involved in this protocol to come together, and that includes people with disabilities; it includes our medical provider, EMS, hospitals to come together and talk about how to enact MOLST.

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This bill does not adopt, per se, any policies regarding MOLST but puts in action a protocol that would allow the very beginnings and start that very necessary conversation in our state.

So with that, Madam President, I urge adoption.

THE CHAIR:

Will you remark? Will you remark?

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

I, too, support this bill. I think it's a measured approach at considering some very serious issues with respect to life-sustaining treatment. Senator Gerratana said a lot of thought has gone into this. As medicine continues to take us to new frontiers, as it were, we struggle with more and more questions about how to use that medicine. And the answer to those questions is -- is individual in every case. So, Madam President, I believe that this is probably one of the best ways for us as policy makers to begin to explore the answers to those questions.

I do have a question, if I may, through you, Madam President, to the proponent of the bill.

THE CHAIR:

Please proceed, sir.

SENATOR WELCH:

Thank you, Madam President.

As I understand the state of the law today, there are already certain vehicles through which individuals can make known their wishes for end-of-life treatment. Two come to mind, a DNR, an order to not resuscitate and also living wills. And if I may, through you, Madam President, inquire of the proponent of the bill

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how MOLST is intended to interact with either of those. Does it supersede them? Are -- are -- does neither have precedent and then whatever one is appropriate to apply to the circumstances, is that what is applied?

Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

Through you, yes, MOLST is that conversation. Many people might -- might have advanced directives, such as a living will. We have enabling -- we actually have in statute currently a protocol for that, including what a living will would contain. This does not usurp this in any way.

But, you know, we use a term around here, Senator Welch, we call a work in progress. When someone is in those last stages of life, this is something that may change and may be modified over time. Hopefully that conversation starts well before the inevitable, and that's the intent of this legislation. So we are not in my way usurping current law; we are saying that as time goes on, that individual may have different ideas. Maybe they don't want a DNR. Maybe they do want a DNR. And this enables them to engage in that conversation with their primary care provider.

Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. I thank Senator Gerratana for that answer.

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One of the things I like about this bill as well is it requires DPH to come back to the General Assembly with essentially the findings of how this pilot program has worked. So I believe at the end of the day we'll be able to revisit the success or failure of this program and I think make better and more-informed decisions then.

Thank you, Madam President.

THE CHAIR:

Thank you.

Senator Boucher.

SENATOR BOUCHER:

Thank you, Madam President.

Madam President, I rise to thank the Chairs and Ranking Members of this committee for bringing this bill forward. I must tell you that over this session and even last session, it was very difficult for me in representing one of my towns where I have a very beloved constituent that was a proponent of the assisted suicide bill, came before us multiple times. Unfortunately, he is very ill right now as well.

I think this is the right way to go when it comes to these matters, when you're looking at long-term planning or even short-term planning for your own, personal health, end-of-life decisions, that this is a very positive way to approach it and a timely way as well. As so for that reason, I -- I really thank the committee and support it very strongly.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark?

Senator Kelly.

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SENATOR KELLY:

Thank you, Madam President.

I rise, too, to speak on this bill, because there is a recognition with regards to medical advancements that what we're doing is in many ways in lengthening life but not necessarily bringing more quality to life. And just as people age in -- in America and in Connecticut, we've seen a lot of development. I know when you go back a couple years, when people would retire, they'd retire at 65 or so and by 70, many were deceased. But what we're, where we're seeing the biggest increase in, I'm going to say demographics, are your 70, 80, 90-year-olds, because we are living longer with medical technology.

But what we also need to look at is ways that the law can keep up with that technology and enable people to maintain the quality of life that they deserve and have death with dignity. I think this is an initiative that aims to do that, and in that regard I think that this -- this idea is a worthy idea. And I do support and appreciate the efforts of the Chairwoman and Ranking Member for bringing this forward.

I do have a couple of questions that I would like to propose to the proponent of the bill for clarification and legislative intent --

THE CHAIR:

Please --

SENATOR KELLY:

-- through --

THE CHAIR:

-- proceed, sir.

SENATOR KELLY:

Thank you, Madam President.

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As I understand it; I heard what you had said before, Senator Gerratana, that this would complement the current law on living will and DNR. Just to be a little bit more focused on clear in this issue, as I understand it the MOLST document would actually be a document that is designed to memorialize the patient's wishes with regards to life-sustaining, life support so that they do not, I'm going to say be connected to that technology, science equipment.

Through you, Madam President, is that correct?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, yes.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, very much.

And that basically the MOLST is the precursor; in other words, we're going to withhold the delivery of those services to the patient, where a living will is more geared to and designed for if an individual were to be connected to life support, it's the legal mechanism to withhold that once the individual patient is actually connected.

Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, yes.

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Again, I just want to reiterate, it is a conversation and this protocol -- I refer to it as a protocol -- is ongoing. As the patient's condition may change, then the MOLST may change also.

Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, very much, Madam President, and thank you, very much, Senator Gerratana.

I do understand that this is a conversation and it's a conversation that I see in my legal practice on a daily basis when we talk with patients -- or not patients -- clients about living wills and advanced directives and the need to put something in place today for those events that may come forward in the future.

I think this bill is narrowly tailored in that we're looking at life-limiting illnesses, which I think makes it a much better document and something that as we evolve in Connecticut, as we look at hospice care, this is something that's important is to look at someone's last six months and have that conversation on an ongoing basis that maybe today we might look at it one way but in two or three months it may change and our -- our perspective on that and on that treatment may change. And I think that's the -- the flexibility in the document that patients deserve and want.

Madam President, the Clerk has an amendment, LCO Number 3711. Will the Clerk please call the amendment.

THE CHAIR:

Mr. Clerk.

THE CLERK:

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LCO Number 3711, Senate "A," offered by Senator Kelly.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

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

THE CHAIR:

Motion on adoption and there will be a roll call.
Please proceed, sir.

SENATOR KELLY:

Thank you, very much, Madam President.

This amendment would require APRNs to as part of their training to also be trained in the identification, diagnosis, and -- and treatment of patients with Alzheimer's. I think as we stated that when you're going to get into this dialogue with a patient during this end-of-life time, it's very important, and the Alzheimer's Task Force that convened over the fall demonstrated that we need to have a greater awareness of Alzheimer's and how to deal with that. One of the things here is that you want to make sure as people are making these decisions that they are cognizant of what their making the decision on, and I think this would go a long way to making sure that we not only understand individuals who are afflicted with Alzheimer's but also more sensitive and understanding in how to elicit the proper responses from them.

I think what this amendment does is it puts that awareness and training in place for the APRNs, and I would move its adoption.

Thank you.

THE CHAIR:

Will you remark?

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Senator Gerratana.

SENATOR GERRATANA:

Yes, Madam President; thank you, very much.

Senator Kelly, thank you for your amendment. I know we discussed it before when we had the APRN bill before us. The underlying bill, which you kept intact, says such continuing education shall be in an area of the advanced-practice nurse's practice, the actual area that they practice in. So you under this legislation will require an APRN who's a specialist in pediatrics, for instance, to get training in Alzheimer's.

I would have to speak against the amendment, as I did before, previously when you presented it in that the current requirement for continuing education is very flexible and also it certainly reflects, too, on what an APRN does. So at this time I would have to ask for a rejection.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

Senator Fasano.

SENATOR FASANO:

Thank you.

If I may, through you Madam President, to Senator Kelly.

THE CHAIR:

Please proceed, sir.

SENATOR FASANO:

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Senator Kelly, is it your concern with respect to this bill that because they're dealing with issues of what the medical orders will be for life-sustaining treatment you need to know and be able to recognize the ability of the, in legal terms, mens rea of the individual to ensure that they're comprehending the information and can decipher that information, and that is the reason for your amendment in that without knowing the signs of dementia, you would not be able to recognize whether or patient that you are now advising as to future medical understands the factors that you're relating to them. Is that the concern?

Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Yes it is, Senator Fasano, and you hit the nail right on the head. The concern is that although we may have a life-limiting illness, the population that we have is going to age and it's going to age significantly. And as it does, you're going to have more and more individuals with Alzheimer's and dementia-related illnesses that may also co-occur with the life-limiting illness.

And what we need to have is a -- a professional experience among people who come in contact with them, whether it's medical providers, police officers, whatever, court systems that come in contact with these individuals to understand that (a) to identify it, to understand how to deal with it, and oftentimes treat it. So as they go through these issues and when we talk about life-ending decisions, you want to make sure that the party that you're dealing with fully comprehends and understands what you're talking about.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

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And through -- thank you, Madam President.

Through you, Madam President, would it be fair to, based upon your experience that you've done -- I know you do a lot of elderly law; that's something that, you know, it's always important to our Circle that we have people in certain areas -- would it a fair statement to say that most issues related -- not all but most -- issues related to the medical care or medical order for sustaining life would be talked about at ages of which you'd reach, you know, senior age and above?

Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

I'm not so sure it would just be limited to seniors. I think in a life-limiting illness like Lou Gehrig's disease or Parkinson's can happen at different ages, but the concern is -- and -- and what we're trying to address here -- is that when you do confront an individual with a life-limiting illness, and that may often be people with Alzheimer's or dementia, you know how to deal with that clientele. I mean, I can't tell you how many times it's -- it's not just knowing it but how to deal with somebody, how to talk to them, how to elicit the information. Because people struggling with that illness have difficulty when they have the thought process of delivering the message, and to have the patience to deal with that is so critical.

Through you, Madam President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Madam President.

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Through you, I understand. I'm not saying it's limited to but I'm saying that would it be a fair statement to say that by a large part of the population who'll be dealing with a Medical Order for Life-Sustaining Treatment, would it be fair that most of those folks would probably be of and what we consider an elderly population; is that a fair statement?

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

Yes, I believe that's a fair statement.

SENATOR FASANO:

Okay; I thank Senator Kelly for the answers.

I support his bill because really what he's talking -- his amendment -- really what he's talking about is if this is for folks for life-sustaining treatment, one could argue -- and I think Senator Kelly has -- has sort of said that -- that this would be for an elderly population, all the more reason why. Although we have continuing education in that area, the reverse of that would be this. An APRN who does not have that background should not be allowed to give this information or to do these -- these orders. You can't have it both ways.

And I think what Senator Kelly is -- is trying to say is look, I believe in what you're trying to do, but to make sure it works properly and the person is trained properly, we should make a fair assumption that the people that that's going to affect are people of an elderly population. With that being more people you're going to run into than the other, then you need to make sure that the APRN who may not have the experience as other medical professions do, have to have that extra training so they're able to knowingly decipher, determine, and know when they see what they see. So I support the amendment.

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Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark?

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

I also think the amendment is a good idea, and -- and whether or not we do it with respect to this bill, I think it's an issue that we need to face not just with APRNs but with a majority of our primary medical providers, especially our first responders.

It wasn't too long ago that a friend of mine told me of this "Silver Tsunami" that is coming our way. And it's something that if we don't get ahead of it, I think it's going to catch us up.

So thank you, Madam President, for your indulgence, and I will be supporting the amendment.

THE CHAIR:

Thank you, Senator Welch.

Senator McLachlan.

SENATOR McLACHLAN:

Thank you, Madam President.

I stand in support of this amendment and thank Senator Kelly for his persistence about the terrible disease of Alzheimer's. Indeed, I've noticed from my own family and many friends of our family who have experienced this horrendous disease, and I will tell you that there are many people who are in the health care community who unfortunately don't have even the

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very basic training that Senator Kelly is asking for in this regard.

This five hours every two years of exposure to the proper treatment of persons with Alzheimer's disease frankly would be very beneficial to other levels of the health care community. Indeed, the -- the LPNs and the daily caregivers who are dealing with this very difficult disease and the -- the challenges that go along with it, they would be able to benefit from this as well. But I think this particular proposal is appropriate, minimal, but yet most important.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark further? Will you remark further?

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

THE CLERK:

There will be immediate roll call vote in the Senate,
an immediate roll call vote in the Senate. There'll
be immediate roll call vote in the Senate, an
immediate roll call vote in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed.

Mr. Clerk -- Mrs. Clerk, will you please tell and call a tally.

THE CLERK:

Senate Amendment LCO 3711.

Yea	13
Nay	21
Absent	2
Total Voting	34

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THE CHAIR:

Amendment fails.

Will you remark further? Will you remark further?

If not, oh, Senator Gerratana.

SENATOR GERRATANA:

Madam President, if there is no objection, I would like to place this item on Consent.

THE CHAIR:

Seeing no objection, so ordered.

Madam Clerk.

THE CLERK:

Page 23, Senate Calendar 290, Senate Bill 418.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President.

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

THE CHAIR:

The motion is on acceptance and passage. Will you remark, ma'am?

SENATOR GERRATANA:

Yes; thank you, Madam President.

The bill here before us sets a protocol in the area of medical spas, "med spas," as they're commonly known in our communities. And the bill sets out certain

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Page 8, Calendar 74, Senate Bill Number 95; also on page 8, Calendar 80, Senate Bill 188.

On Calendar page 9 -- I'm sorry -- on page, yeah, page 9, Calendar 110, Senate Bill 125; Calendar 112, Senate Bill 255; Calendar 113, Senate Bill Number 256; Calendar 122, Senate Bill 260.

On page 11, Calendar 163, Senate Bill 280; Calendar 177, Senate Bill 271.

On page 13, Calendar 207, Senate Bill Number 193.

On page 14, Calendar 225, Senate Bill Number 281.

On page 15, Calendar 244, Senate Bill 283.

Page 17, Calendar 255, Senate Bill 477.

On page 23, Calendar 288, Senate Bill 413; Calendar 290, Senate Bill 418.

And on page 25, Calendar 303, Senate Bill Number 217.

THE CHAIR:

I'm sorry. At this time, Mr. Clerk, will you call for a roll call vote, and the machine will be open on the second Consent Calendar.

THE CLERK:

Immediate roll call has been ordered in the Senate on the second Consent Calendar of the day. Immediate roll call has been ordered in the Senate.

THE CHAIR:

If all members voted, all members voted, the machine will be closed.

Mr. Clerk, will you please call the tally.

THE CLERK:

On the second Consent Calendar for today.

mhr/gbr
SENATE

142
April 17, 2014

Total Number Voting	35
Those voting Yea	35
Those voting Nay	0
Absent, not voting	1

THE CHAIR:

The Consent Calendar passes.

Mr. Clerk -- oh, I'm sorry -- Senator Looney.

SENATOR LOONEY:

Thank you, Madam President.

Madam President, if we might go back to the item that was removed from Consent and ask for a roll call vote on that item. That was Calendar page 8, Calendar 78, Senate Bill 186.

THE CHAIR:

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.
Immediate roll call has been ordered in the Senate.
Immediate roll call ordered in the Senate. An
immediate roll call has been ordered in the Senate.

THE CHAIR:

Have all members voted; all members voted? The machine will be closed.

Mr. Clerk, will you please call the tally.

THE CLERK:

Senate Bill Number 186.

Total Number Voting	33
Those voting Yea	23
Those voting Nay	10
Absent, not voting	3

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 4
1268 – 1862**

2014

1
cip/gbr PUBLIC HEALTH COMMITTEE

March 14, 2014
9:00 A.M.

fif

CHAIRMEN:

Senator Gerratana
Representative Johnson

MEMBERS PRESENT:

SENATORS:

Holder-Winfield, Kane,
Musto, Slossberg, Welch

REPRESENTATIVES:

Arconti, Betts, Cook,
Conroy, Davis, Demicco,
Hovey, Klarides, Maroney,
P. Miller, Perillo, Riley,
Ryan, Sayers, Scribner,
Srinivasan, Tercyak,
Widlitz, Zoni, Ziobron

SENATOR GERRATANA: (Inaudible) for the Public Health Committee here on Friday, the 14th, and we will start with James McGaughey from the Office of Protection and Advocacy. When you do come up, please identify who you are, put the little button on there, as Mr. McGaughey did, and you'll see that the microphone turns red, which means it's live. And state your name, and you can proceed from there. Welcome, sir.

JAMES MCGAUGHEY: Yes. Good morning, Senator Gerratana, Representative Johnson, Members of the Committee. My name is Jim McGaughey. I am director of the Office of Protection and Advocacy for persons with disabilities. And I'm here to speak about one of the bills on your agenda this morning, Raised Bill Number 413, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATION REGARDING MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT.

Basically, this bill would authorize DPH to establish two pilot programs in different regions of the state where medical orders for

life sustaining treatment could be used to document decisions about treatment options that have been made by people who are approaching the ends of their lives after discussions with their physicians and other healthcare providers. Our office is support for this. I have submitted written testimony, so I'm just going to summarize if that's all right.

SENATOR GERRATANA: Certainly.

JAMES MCGAUGHEY: Basically, I became aware of this proposal and of the need for it through experience we gained conducting fatality reviews for people with disabilities. We -- we run a -- we operate a -- the state's Fatality Review Board for individuals with disabilities. And in the process of that, we review the deaths of all people who are clients of the Department of Developmental Services and many other folks with developmental or intellectual disability.

And we come across situations where there are individuals who were quite capable of making decisions about what they wanted in terms of end-of-life care and who had communicated those decisions and who, in fact, in some cases had even executed advance directives. But their -- their wishes were not honored, because -- not because of their disability but rather because they had been transferred from one facility to another or because somebody couldn't find the paperwork or something like that happened. And it was -- it -- it sort of troubled us that this was occurring.

Now you may recall that last year there was a proposal similar to this. It was not exactly the same. And that proposal had come forward based on language that was suggested by a national paradigm for what they call POLST,

Physician Order for Life Sustaining Treatment. And in Connecticut, we decided to use the term medical order, because it's not just physicians who can sign these orders. It's -- it's also advanced practice registered nurses and physician assistants. So we're calling it Medical Orders for Life Sustaining Treatment.

But the proposal last year raised concerns in the disability community, and, in fact, there were disability advocates who testified against it. Our office raised -- raised concerns. And those concerns had to do with the way that similar programs had rolled out in other states. And there was a good deal of research that was done by an organization, Second Thoughts Connecticut, and -- and Stephen Mendelsohn found a lot of this information. He's going to be testifying later in support of this -- of -- in support of this bill as well.

But there were situations where people -- physicians rewrote MOLST orders or POLST orders without consulting with the individual. There were situations where long-term care facilities insisted that every single person who was admitted execute a -- a MOLST order or -- or have a MOLST order in place, all of which are against sort of what the fundamental idea and principle that the -- the national paradigm was working towards, but nonetheless there was this potential for -- for these -- the -- these orders to become just another routine piece of paper that is filed like a checklist and does not really occasion a -- a thoughtful conversation with the patient to determine what their wishes really are.

Department of Public Health pulled us all together over the summer, and we have worked together in a working group to come up with language that we think really meets these

concerns. And you will find that there is broad support in the disability community for the current language and of this bill and that it has safeguards that are built in to ensure that the discussions that occur with people do, in fact, elicit what their treatment goals are, that the -- that the physicians and the advanced practice registered nurses and the physician assistants who will be participating in this pilot will, in fact, have to have some training before they -- they are allowed to do so and that those -- the training will -- will involve quite a bit of emphasis on how to approach these conversations in such a way that you're not steering people away from certain types of things or into other -- into other options.

So we are -- we are actually very supportive of this legislation, and we -- we would urge that you -- you consider it and act favorably upon it. And I don't have anything further to say, but if there's any questions, I'll try and answer them.

SENATOR GERRATANA: Thank you very much for giving your testimony. And, yes, we do on the Committee recognize that there was quite a -- a intensive workgroup going on to address this very important issue. Actually, my Co-Chair, Representative Johnson, has some questions.

JAMES MCGAUGHEY: Okay.

REP. JOHNSON: Thank you so much for your very well-delivered testimony and also, you know, the comparison and contrast between last year's bill and this year's bill. It's -- it's very helpful. One of the things that I've -- I've noticed is that there seems to be in the -- in the bill -- is that there is allowance for someone who has a power of attorney -- a

healthcare power of attorney to work with the treating doctor as opposed to having the actual individual make the decision for the treating doctor. Could you speak to that?

JAMES MCGAUGHEY: Well, the only -- the only discussions that we've had about that issue is to make sure that legally authorized representatives would not be cut out of this possibility. There are -- there are times when someone has designated someone to -- to make those decisions, and, in fact, that's a -- that's a practice that's -- that's encouraged.

But the -- the -- I guess the -- the problem can arise when an individual is no longer able to articulate their preferences and to participate in that discussion, but they have now -- they have designated someone and in fact formally done so as their legally authorized representative, their power of attorney as you say.

And so that -- that individual -- we didn't want to deprive people in that circumstance of the opportunity to also have a MOLST, because medical order, this -- this is portable. This will follow the person. It will accompany them when they move from one location to another. And it's a way of making sure that if 911 is called or some other emergency occurs that people are very clear as to what is supposed to happen and what is not supposed to happen.

REP. JOHNSON: Yeah, and I -- I think that that's excellent. I think the way that the bill is presented now addresses that very nicely. I'm -- the -- the focus really, when I was looking at the bill, is when a person say had never had any competency at all and never had advance directives. In that circumstance, it seemed as though that the power of --

healthcare power of attorney conservator
might -- might step in.

JAMES MCGAUGHEY: Well, I think that's -- that's, yeah, that's always a difficult situation, but most -- most of those -- it's not so much a healthcare power of attorney. It would be either a conservator or a guardian of a person with intellectual disability in some cases who -- who've been specifically authorized to enter into those decisions usually following some probate proceeding.

But it's always -- those are some of the most difficult things, because it's -- it's -- invariably it's somebody -- somebody who's never had the opportunity to -- to even develop their own preferences much less articulate them, and somebody else is making those decisions usually bringing their own value system into that and trying to -- there's -- there's different theories as to how to go about it and, you know, whether you should put yourself in that person's situation and try to imagine what it's like, but whether -- in the end it's still -- you're trusting somebody else to -- to make -- to make that decision.

I don't think we can solve all the problems through this mechanism, but there's -- there's -- at least there'll be something that will -- you know, when -- when the parameds show up, there'll be something that they know they can count on and not get in trouble if they -- if they act in accordance with it.

REP. JOHNSON: So just briefly, how are those circumstances address today? Are -- are there advance directives or some living wills for people who have developmental disabilities and perhaps wouldn't be able to make their own advance directives?

JAMES MCGAUGHEY: Absolutely, that does happen.

There are people who are very clear as to what they want, and they understand what -- what they're deciding. But there -- there's no -- what often happens with the advance directives -- I mean, I -- I certainly have one. I -- I have a will. I have all those things.

That was done 20 years ago, literally, and I haven't looked at it since in spite of the fact that -- I remember the attorney saying, now you should review this periodically and talk to your doctor and so forth, and I think that's the -- the way it is for a lot of folks. It's something -- it's a piece of paper that's on file somewhere, and then, you know, the -- nobody can find it when they need it, or there's some dispute as to whether or not you -- you may have changed your mind in the intervening 20 or 30 years.

S o this is something that is -- that there's recency to it, and also most folks who are going through some kind of a progressive illness that is -- that is terminal will periodically be -- be revisiting their doctors, and it can come up over time. Every time you go back to the doctor they can review the order as they review all the other orders and say, is this still what you want? Is this -- and so there's -- they can actually replace replacement orders. You can change your mind on things over time. So it's -- it's much more apt to be current, and it certainly would be more effective -- recognize the medical environments.

REP. JOHNSON: Thank you so much for your answers, and thank you, Madam Chair.

SENATOR GERRATANA: Thank you. Are there any other questions? Representative Ziobron.

REP. ZIOBRON: Thank you, Madam Chair. Thank you -- good morning -- for being here. I'm reviewing the bill, and -- and I'm curious on a couple things. Can you tell me what the definition of the geographic area is?

JAMES MCGAUGHEY: The -- the -- well, there isn't a -- there -- it's not, I think, specified in the -- in the legislation itself. There's been discussions the Health Department would make that determination, but I think they want it to have an urban area and a rural area for the purposes of conducting the pilot.

So there -- I believe that there is enthusiasm for participating in this in the -- in the New Haven area with Yale and the extended physician network and facilities that are part of that -- that medical groups -- the medical groups and the hospital affiliations there and also in -- excuse me -- in the Windham area as well, so -- so you'll get -- I think that's -- that's kind of been -- those are the tentative decisions that have been made about where it would roll out first.

But it's a pilot, so we want to be careful, I think, and the -- the working group that has -- that has been part of the drafting of this intends to be part of the rollout as well and to watch what's going on, so there'd be a report back. And I believe the one thing that's -- that in this legislation -- let me just mention this now -- that you may get a request to change -- is there is a date at the end of it. And -- and it's -- they're -- they're asking -- that date is like left over from last year's draft of the bill.

So they're asking to extend it one year beyond so the actual pilot would run until I believe 2016, so you'd have time to do that. But you'll hear more from the Health Department on that issue. I think they're taking responsibility for seeing that that happens, but --

REP. ZIOBRON: Thank you, and -- and further, there -- there doesn't seem to be any language in the bill regarding the number of patients. It just talked about a geographic area. So I'm just curious on, you know, what -- what do you believe that will be? I understand it's a voluntary on the patient's part, but I'd like to have an idea of how many patients you're talking about. In the bill, it says that all the doctors in the geographic area are going to be contacted, but it doesn't say anything about the number of patients.

JAMES MCGAUGHEY: I don't think anybody knows the -- knows the number of patients. Obviously, if you're running a pilot, you would hope it would be enough patients so that you would be able to get some sense of does this or does this not make a difference for people? Is this -- you know, you have to have some numbers -- some quantity to -- to validate the -- the idea.

But, you know, the -- the potential for a large urban area is, you know, several hundred at least. In the rural area, it may be, you know, between 50 and 200 people. It's not -- it's not -- I mean, nobody knows for sure. It's more -- it's more to get the practice established in -- in the provider organizations, and, you know, the -- that -- you can't impose this on people right now. We want it to encourage people to participate, so --

REP. ZIOBRON: Okay. Thank you. Thank you, Madam Chair.

SENATOR GERRATANA: Thank you. I don't think there are other questions or comments. Thank you for coming today and giving your testimony. We do appreciate it.

JAMES MCGAUGHEY: Okay. Thank you very much.

SENATOR GERRATANA: Next is Senator Don Williams, followed by Jewel Mullen.

SENATOR D. WILLIAMS: Good morning, Senator Gerratana, Representative Johnson --

SENATOR GERRATANA: Morning.

SENATOR D. WILLIAMS: -- and Distinguished Members of the Public Health Committee. I'm here today to support House Bill 5330, AN ACT CONCERNING THE APPLICATION OF PESTICIDES AT PARKS, PLAYGROUNDS, ATHLETIC FIELDS, AND MUNICIPAL GREENS and to bring to your attention a related issue of significant concern to the public health and our state's parks, playgrounds, and other green spaces.

Let me begin by expressing my support for the underlying bill. Connecticut set an important example for the rest of the country when we adopted a ban on the use of pesticides on the grounds of our elementary and middle schools. Scientific studies have concluded what may seem obvious. Exposure to pesticides is harmful to children's health, and it makes sense to limit the use of these poisons in additional public spaces.

I'd like to draw your attention specifically to the chemical glyphosate, more commonly known by its trade name, Roundup. As an herbicide, it

And, of course, if there is any emergency, you know, blocking the doors would be very dangerous. So I ask that please everyone take a seat -- seat if they can, and we appreciate it so much. Safety first. Next is Jewel Mullen followed by Representative Elissa Wright.

COMMISSIONER JEWEL MULLEN: Good morning, Senator Gerratana --

SENATOR GERRATANA: Good morning.

COMMISSIONER JEWEL MULLEN: -- and Representative Johnson. I'm Dr. Jewel Mullen, Commissioner of the Connecticut Department of Public Health, and I'm here to testify this morning on behalf of a number of the Department's bills. First, I would like to take us back to Medical Orders for Life-Sustaining Treatment, Senate Bill Number 413, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATION REGARDING MEDICAL ORDERS OF LIFE-SUSTAINING TREATMENT -- MOLST.

3B418

The Department of Public Health supports Senate Bill 413 and would like to thank the Committee for raising our bill. In 1990, under Title 42 U.S.C. 1395 CCA of the Omnibus Reconciliation Act, Congress passed an amendment known as the Patient Self-Determination Act, which gives individuals the right to make their own healthcare decisions and to prepare advance directives.

Medical Orders for Life-Sustaining Treatment, MOLST, is an adjunct to a formal written advance directive and will benefit Connecticut residents with life-limiting illnesses for residents of advanced age who wish to make their choices known by exercising their rights and articulating their choices about the

medical life-sustaining treatments they will accept at the end of life.

The MOLST paradigm is an advanced care planning tool that utilizes a structured process of shared decision making so providers can elicit patient preferences about probable medical intervention. The patient's preferences are then translated into an actionable medical order on a highly visible standardized form that travels with the patient across all care settings to ensure continuity of care.

MOLST reflects the patient's current goals for medical decisions that she or he will likely confront within the near future. Currently, there are 15 states with approved MOLST programs, 28 states, including Connecticut, with developing programs, and 7 states without a MOLST program. The bill gives the Department the authority to pilot MOLST to a voluntary program that involves healthcare professionals and institutions in designated areas of the state.

A pilot program will provide opportunity to collect and analyze data on the use, effectiveness, and limitations of MOLST. If the program is successful, the Legislature may elect to implement the program statewide through a comprehensive educational program that targets specific groups of healthcare providers. Thank you for your consideration on the Department's bill.

SENATOR GERRATANA: Commissioner Mullen, I'm -- Mullen -- I'm sorry -- I -- I know there are many questions on this bill. If you don't mind, I know you have, you're going to be testifying on other bills, but we do have some questions, and I have one.

COMMISSIONER JEWEL MULLEN: Uh-huh.

SENATOR GERRATANA: And that is, could you walk us through -- I've been asked so many questions about people -- from people here in the building and outside -- how this protocol would work. And I think it would be helpful for you to give your vision. I know you've worked so very hard on this legislation of how this would work. I understand the pilot would be perhaps in two different geographic areas, but what is your vision on this? I -- I would appreciate your input. Thank you.

COMMISSIONER JEWEL MULLEN: So my vision after over 30 years of medical practice with patients at various stages of wellness and illness would be that we would finally create a system that supports individuals' ability to say how they want to live as they course through an illness that is oftentimes terminal or when they know that they are nearing the end of their life.

And I -- and I put that out there as the first vision, because the vision isn't -- isn't really about the Department or anybody here testifying. The vision is about improving the lives of people and their not having to continue to fear some of what we know happens right now except their wishes aren't known, or even if their wishes are known, they're not upheld and that care providers who always want to do their best not to harm but to -- and to care for people sometimes are left with uncertainty, because they don't know what those patients are.

So with that being my preamble, what I would -- what I would say is that these are the kinds of conversations that people have on a so-called good day. They're not the kind of conversations that I think many of us have

experienced when we've had a close -- someone close to us in a hospital or in a situation, maybe even with EMS in their home saying what do you want us to do? And you're faced at that moment with trying to figure out what you remember or realize that you never had the conversation that you've been putting off or saying to yourself -- am I giving you more than you want -- or saying to yourself if I answer the way I know I should, maybe somebody else in my family or in my -- in my circle will be upset, because they disagree. And then all of that removes the focus from the patient.

So when -- when I -- say it's a conversation that you have on a so-called good day. It's because it's a conversation that's initiated between the healthcare provider who knows the patient well and the patient when the patient is able to engage in that discussion or, as you've already heard, when there is a surrogate who is aware of what a patient's preferences would be and would be able to have that conversation on behalf of -- and -- and then it doesn't just become information that's shared between the physician or the care -- and the patient, but it becomes information that others will be able to see and know and uphold, because you do have a form, you have a documentation, and it enables the rest of the conversation with other people close to the patient.

In a statewide work (inaudible) that has a -- a program, we -- we talked about how people could have one in their pocket, on their refrigerator, next to their bed so that if someone calls 911 and EMS arrives, the information is there. The information travels with the patient to any care setting, and it becomes the guide that actually is speaking on

behalf of the wishes that the patient designated.

Now I can tell you that any time I've had conversations with patients about their wishes, you know, I've always done what our bill also says, is that no conversation is a final one, so you revisit things, you know. And my biggest example of that is I had a patient that signed out hospice once and lived a lot longer than she thought she was going to.

See, always you revisit things. You revisit things, and -- and that happens with MOLST as well. And -- and because, you know, as I describe MOLST, because I look at MOLST as a document that I will continue to say helps design how people are going to live with their disease and not how to hasten their death, it's -- it's -- it also enables someone to say something like, well, you know, at one point, I would have wanted to have a feeding tube, but I've changed my mind or vice versa. So it's a -- it's a living document with a living person.

SENATOR GERRATANA: I think you articulated that very well. Some of the questions that I have gotten are, would this be applicable to -- this travels with the individual once the protocol is initiated.

COMMISSIONER JEWEL MULLEN: Uh-huh.

SENATOR GERRATANA: Now I had to go to other states to read about the process, if you will, and there are some very good websites -- POLST is one -- that explains that this is -- this is initiated or comes about when the individual, you know, may recognize that, you know, there has to be some sort of advance directive.

I was reading our living will statutes and, you know, the form that is embodied therein also for those individuals who want to, you know, take advantage of that, of the living will so that there's no, I guess, mixed message or confusion or whatever that you were, you know, also describing.

But when we're talking about the individual, it could be an individual at home. It could be an individual in a nursing home. It could be anyone at any point in their life who may want to enact, if you will, a living will of one kind or advance directives. So I just wanted to make that very clear that it could be in a variety of settings, and it could be anyone at any age, if you will, who wants to embark on this advance directive and the management, if you will, of their life decisions, which is appropriate.

The other concern that I've heard is what about individuals? You say that things can change. For instance, somebody leaves hospice, as you used the example, but what about a situation -- and I know I face it -- I take care -- have taken care of my parents, and, you know, that sort of thing as they age -- a situation whereas perhaps somebody lapses into a coma, has advance directives, that sort of thing, and is no longer able to, if you will, participate in making those decisions or changing situations. How do we go about dealing with that particular issue?

COMMISSIONER JEWEL MULLEN: That's -- that's why it's important to -- to differentiate between the advance directive that anybody -- everybody should have that -- that ensures that there's someone that -- who -- who will be a spokesperson for them if they can't make decisions for themselves and can make some of

those end-of-life decisions, which is not what -- strictly what MOLST is about as -- as you just articulated.

But when you -- when you've designated someone to act as your proxy or decision maker, they are -- they are in that (inaudible), are representing what your wishes are, what your wishes would have been, which also means people have to have conversations. But I'm so sorry. I'm just using this as a teaching moment for everybody in the room, which is important.

SENATOR GERRATANA: That's what we want.

COMMISSIONER JEWEL MULLEN: Yeah. Okay. So -- so in that -- in that circumstance with that designation, the person who has that proxy status can actually, as Mr. McGaughey also alluded to, be the spokesperson for the person who has a MOLST but no -- can no longer speak to the MOLST.

SENATOR GERRATANA: Okay. Just this morning I was reading The New Yorker magazine, the March 10th issue, and Liz Chaz, who is a cartoonist, if you will, one of the very famous cartoonists for that magazine, did a whole series on how she dealt with her parents and their end-of-life decisions. It was humorous, of course, but also very poignant, so just coincidentally that's what I reading this morning.

COMMISSIONER JEWEL MULLEN: Right, and -- and that's where it's so important not to just -- not to just think of these as end-of-life even though that's how most of them -- of us construe them, because I think most people who are sick, even in hospitals, don't die as quickly as we think they're going to. They just don't. And they're some of the hardest conversations.

And along the way, when they're in those settings, it's not as if they're just there. Things can be done. Interventions can be applied. So -- so it makes it even more important, and that's why I keep talking about this as -- as something that's important to people who are living.

SENATOR GERRATANA: Thank you so much, Commissioner. Does anyone else have questions of the Commissioner on this legislation? Okay. Representative Srinivasan followed by Representative Ziobron.

REP. SRINIVASAN: Thank you, Madam Chair. Good morning, Commissioner.

COMMISSIONER JEWEL MULLEN: Morning.

REP. SRINIVASAN: And thank you for your testimony. And more important, thank you for all the advocacy that you've done on this, which we feel we definitely need in our state. And it's starting, you know, into the first step, the pilot program.

It's just about the right way to go, so we, you know, the -- the entire Committee then, under your supervision, would be able to analyze, you know, what we have accomplished, what we need to accomplish even further, and it's a very, very good first step, and I want to thank you for your support on this. And when we brought up last year, we can move certain places but didn't go all the way, and I'm glad you're back here again to discuss this very important thing which I think our patients in our state definitely need.

COMMISSIONER JEWEL MULLEN: Thank you.

REP. SRINIVASAN: And just one quick question. In the -- in the 15 states, and one of them being where you had worked before coming to Connecticut, and I'm glad you're here, is were there any -- any situations that arose to -- to the best of your knowledge which were -- which were concerning or red flags? Any -- any of that that you're aware of in these states that have this program already?

COMMISSIONER JEWEL MULLEN: Not specifically, and I -- I think -- let me -- I just want to thank everybody who submitted testimony and everybody who affirmed the Department's work, because I read all the testimony last night, and it was actually very touching to me, because I felt as if, you know, what was in our heart last year actually conveyed through our actions in our working with -- especially with the -- the disability community that wanted to be sure that -- that this was not going to be -- MOLST would be a mechanic through which people would not get the cure that they needed.

And to get to the testimony that we received yesterday, I think we established a level of trust. That's really important for us going forward. Reading -- now I'm not -- I can't tell you about everything that's happened in some of the other states, but from reading their testimonies, I think part of what some of our proponents have sited is that there have been more concerns about whether or not medical providers use the order form in -- in a more prescriptive way than they should have or whether or not there were appropriate provisions to ensure equity.

In -- in Massachusetts where we were just starting to pilot it before I left, I -- I did not hear about anything. I talked to the person who led the -- one of the people who led

the pilot last year, and she did not report anything. I can follow up again, but thank you.

SENATOR GERRATANA: Oh, certainly. Representative Ziobron.

REP. ZIOBRON: Thank you, Madam Chair, and welcome. Nice to see you again.

COMMISSIONER JEWEL MULLEN: You too.

REP. ZIOBRON: I has asked, well, one of the first gentlemen who came up and testified -- I'm not sure if you were in the room or not, so I'm going to ask you to clarify those two questions. The first was what is the -- I understand the geographic area now, but I'm looking to understand the population of the patients that you're targeting, and then secondly, I also did notice that date of October 1, 2015, and I was curious on such a short window when we were planning on starting, so maybe you could address that as well.

COMMISSIONER JEWEL MULLEN: Right. So we -- we don't have a fixed number, a goal. It's important for us, because the -- the health systems are somewhat different in rural than urban areas to be able to pilot in both, and we know already that there are provider groups and hospitals interested in being in a pilot. So I -- I can't tell you specifically what that number is going to be. I would say that when we come back to you, and I'll get to the date after. I don't think it's just going to be a handful of patients. Okay. Thanks.

Now there were more conversations about the -- what might be an ideal time for the pilot after we had written the bill. And we're certainly open to extending the timeframe from what we

had originally said to get the pilot up and going. So that's some discussion that we'll continue to have after. Okay?

A VOICE: Uh-huh.

SENATOR GERRATANA: Thank you. Also, I'm going to recognize Representative Johnson in just a minute, but we do see there is a reporting mechanism in line 82 after the termination of the pilot program. Said commissioner may submit a report in accordance with the provisions and so forth to the governor and Joint Standing Committee of the General Assembly having cognizance over public health.

I -- I don't know how you feel about that, but I -- we'll probably discuss it in screening, but we may want to say that you shall submit a report and a particular date by a, you know, after the pilot closes. I don't know how you feel about that, but I thought I'd ask for your input at this point.

COMMISSIONER JEWEL MULLEN: I am sure we'll be happy to submit a report.

SENATOR GERRATANA: Good, good.

COMMISSIONER JEWEL MULLEN: Well, actually, we'll be proud to submit it.

SENATOR GERRATANA: Proud to submit it. Okay. Thank you very much. Let's see, Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair. Thank you, Commissioner, for your testimony and your good work on this bill, really very much appreciated. It's a dramatic change from what we saw last year, and I do have a couple questions though.

In terms -- I -- I really appreciate your remarks before about the idea of -- the differences between advance directives and MOLST and how perhaps they could work together, or if you have a MOLST agreement in -- in terms of, you know, the -- how the medical profession without advance directives might work with the patient. If you could just compare and contrast that so people would have a real understanding of the differences.

COMMISSIONER JEWEL MULLEN: Well, I think I wrote my first advance directive -- I -- I think I'm like a lot of other people -- maybe when I was 30. And I'm still married to my husband, but, you know, I have to say I haven't really looked at it since, so it's a good thing I'm still married to him, because he's my proxy. And so that's a reminder. Look at your advance directives because things change. I'm -- I'm really respectful of you. I really am. But, I mean, it's -- it's a -- it's a -- it's, I think it's a salient point.

So I know who -- who, if I couldn't speak for myself, would be able to speak for me. And he and I have had lots of conversations. But, you know, I also come from a family where we talk a lot, so I think my -- my siblings wouldn't be suspicious of him or my mother wouldn't be suspicious of him, because, yeah, we -- we have those kinds of conversations. And those are some -- they're some of the hardest things we ever do in life.

But a -- a lot of what the advance directive gets to is so specific about, you know, very end of life and the most aggressive life-sustaining interventions. MOLST -- MOLST, by comparison, is -- is -- and -- and I -- I will keep saying, because people live with terminal

illnesses for a long time, and there are so many decisions that they have to make where they might elect to do or not do something, but it doesn't even necessarily mean that decision is going to hasten their death.

But it might start those -- those treatments could change the quality of their life in a way that they would rather not endure. And that's -- that's part of what a MOLST allows, is to really think about the different scenarios that someone might confront, and then have the, well, given where you are and what your condition is now, if you -- if you -- this is happening with you, would you really want this done?

And then it enables you to differentiate between basic hydration, not to become dehydrated, from a -- a -- something like a feeding tube for calories and nutrition and vitamins. Using antibiotics might not, so it's much more specific. And the -- the DNR piece of it or -- or to -- to be resuscitated is another choice. So a lot of times people just skip that question. Is somebody a DNR?

The MOLST actually allows another level of decision making just about whether or not the person would want compression of their heart if it stops beating or to have artificial breathing if they're, if they stop breathing on their own. So it's much more detailed. And -- and to have the individual be able to think those things through -- I don't know if anybody has ever been in a position where a doctor just looks at a family and says, so what do you want us to do? I think that's one of the harshest things a -- a clinician can do to someone. And -- and a -- a MOLST helps remove that possibility.

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REP. JOHNSON: Very good. So there's an interaction between the -- the patient and the -- and the provider --

COMMISSIONER JEWEL MULLEN: Right.

REP. JOHNSON: -- so that they come to an agreement, which is the best possible situation and when you're looking at patient care to have the interaction with your provider --

COMMISSIONER JEWEL MULLEN: Uh-huh.

REP. JOHNSON: -- so you make these decisions jointly --

COMMISSIONER JEWEL MULLEN: Uh-huh.

REP. JOHNSON: -- and you move forward with whatever is available. And also as you -- going back to the advance directives or livings wills, some people might be more familiar with living wills than advance directives. They're one in the same.

So when you have those kinds of situations, and as you said, you know, you -- you did yours some time ago, sometimes the language in the living will might need to change because of -- not just because of your changes in circumstances but perhaps because of the changes in the types of care that are available today versus what was available when you -- when you -- did you want to speak to that a little bit?

COMMISSIONER JEWEL MULLEN: Well, I, you know, I think you just said it, but -- but in general, I think, you know, since the Patient Self-Determination act became law, I think the living will, that those type of documents evolved a lot less. I think they've -- I --

it's my opinion -- I don't think they've changed quite as much, so --

REP. JOHNSON: So -- so and then the other thing, so we -- Senator Gerratana was speaking of having advance directives or a living will and then having a situation where someone becomes incapacitated and then needing the family member to work together with the provider and try -- because they're appointed in the living will --

COMMISSIONER JEWEL MULLEN: Uh-huh.

REP. JOHNSON: -- and, or they might even be appointed by the -- the probate court as conservator.

COMMISSIONER JEWEL MULLEN: Uh-huh.

REP. JOHNSON: In those circumstances, talking a little bit first about the advance directive situation where there's a healthcare power of -- durable power of attorney, and in those circumstances --

COMMISSIONER JEWEL MULLEN: Uh-huh.

REP. JOHNSON: -- you would have a guideline. Do you want to talk about the interaction between that guideline and MOLST?

COMMISSIONER JEWEL MULLEN: But -- but I look at the durable power of attorney as a document that assigns, you know, tremendous responsibility to an individual still to -- to make considerations that keep the patient as -- as the primary focus and to act with the information presented about the patient status and the potential benefit or lack thereof of any kinds of treatment and -- and take a real, you know, serious and -- and solemn approach to

then what MOLST upholds that patient's autonomy if acting for that patient but also other ethical principles like to -- to do no harm and -- and, you know, beneficence, to really do well by -- by that person.

And -- and, you know, in the situations in which I've needed to work with someone's conservator, I -- I think that the people in those roles have always been careful in their questions about what was going on. And I -- I have to say I -- I haven't felt that they -- that they've imposed their personal feelings on a decision but really tried to act on a patient's behalf.

So, you know, it's very possible that, you know, and I think you alluded to this in -- in the first series of questions with Mr. McGaughey, do you -- there -- it gets much more tricky when you have -- have someone acting on behalf of an individual who perhaps never had decision making capacity. But on the other hand, if that person has had a conservator for a long time, they've had -- they've had that other person who's been able to course through what their life has been for a long time too, and I -- I think there's actually some value and benefit to that as well.

It -- it may actually be a little bit trickier when the -- the conservator ends up being someone who hasn't known the person over a course of a long time. But that's where I think it gets to the individual circumstance. I have some ethical experts sitting behind me, and I have no idea how they're feeling about what I'm saying. Am I doing okay?

A VOICE: You mentioned -- you mentioned that (inaudible).

COMMISSIONER JEWEL MULLEN: But -- but your, I mean, but your questions also reflect that -- that no matter how easily a -- a program might be applied for most of the population, there are going to be circumstances in which it's -- it's more complicated.

REP. JOHNSON: So perhaps -- and I'm thinking this through as you're speaking, because this is very, very helpful -- perhaps in the past, maybe before this legislation and the pilot project and our -- our ability to take a look at this in a more formal way, perhaps these sorts of things were ongoing without MOLST, and now in some ways MOLST will help formalize the -- the situations where people may not have advance directives or capacity.

COMMISSIONER JEWEL MULLEN: Yes.

REP. JOHNSON: And then -- then finally with respect (inaudible), just one of the things that I had noticed when I was an advocate for Medicare beneficiaries, and people would sign themselves into hospice as you -- as you presented in -- in some other testimony you gave, and they would find that if they had to be transported for other circumstances by ambulance, the ambulance provider would be -- would be there and would have to provide the resuscitation whether or not there was a DNR or not.

So did you want to just speak to that and how this would address that? I know the emergency medical services providers, at least many of them, are -- are very happy to see this legislation.

COMMISSIONER JEWEL MULLEN: Because the default action is to treat, and -- and treating is not necessarily what an individual would want. And

one of the -- one of the biggest challenges for many people who take it as their primary responsibility to treat and care for people is that it becomes harder for them to see when the best treatment is not to treat.

So for EMS providers and even for people in hospitals to be able to have that guide through a patient's voice actually lets them know that they're administering the best treatment as designated by the patient.

REP. JOHNSON: Thank you so much for your work on this and your wonderful testimony.

COMMISSIONER JEWEL MULLEN: You're welcome.

REP. JOHNSON: And welcome. Glad you're here. Thank you.

COMMISSIONER JEWEL MULLEN: Thank you.

REP. JOHNSON: Thank you, Madam Chair.

SENATOR GERRATANA: Oh, my, one follow-up question, I know.

COMMISSIONER JEWEL MULLEN: Oh.

SENATOR GERRATANA: I'm -- I'm reading about the Patient Self-Determination Act, the PSDA, which was passed in 1990, became law in December of 1991. And my only comment is this is a requirement that certain health institutions, hospices, nursing homes, and so forth, give information to the adult person who may be admitted into that institution for care about the advance directives.

I must say that in taking care of my dad as well as elderly individuals, I don't recall that that was ever disbursed or given to us.

It would have been very helpful, I think. So I'm just going to follow up with OLR and ask them to understand how that's being promulgated in our states and if it's indeed a federal law. So --

COMMISSIONER JEWEL MULLEN: Yeah. I -- I think what happens is that it becomes another form that people sign, and they don't even realize what they're signing anymore.

SENATOR GERRATANA: Ah, interesting, yeah. Certainly, I try to pay attention to details.

COMMISSIONER JEWEL MULLEN: Uh-huh.

SENATOR GERRATANA: Well, thank you, Commissioner. Please proceed with the rest of your testimony. I think -- I don't think there's any more questions here, but I know the Committee feels this is a very important issue.

COMMISSIONER JEWEL MULLEN: Thank you.

SENATOR GERRATANA: They all are, but --

COMMISSIONER JEWEL MULLEN: Thank you.

SENATOR GERRATANA: -- this one in particular had a lot of questions attached to it.

COMMISSIONER JEWEL MULLEN: Thank you.

SENATOR GERRATANA: Thank you, Commissioner.

COMMISSIONER JEWEL MULLEN: So I thought you said, oh, my, because you knew that our tech bill was coming next, and it -- I have about ten pages here. So I'm actually going to go through the sections but only just maybe read the first sentence, and then if people have -- if that's okay with you (inaudible) --

status and that -- those problems with those billing coding and rules are causing these lengthy stays, that aren't actually -- they're not inpatient and they really don't look anything different than, than -- you would go visit somebody, you would not be able to tell. A person in the hospital bed would not know ; unless they specifically asked. In fact, I have had the experience several times over the last year or so with family members and me advising, "Make sure you find out. Please ask are you observation status because unless you know, you could be stuck with some really significant bills." And that's the time that you potentially could advocate for a change in status if that's possible.

REP. KLARIDES: Thank you.

DEB MIGNEAULT: Uh-huh.

REP. JOHNSON: Very good. Are there any additional questions?

Thank you so much for being here, for your testimony. It's very much appreciated.

DEB MIGNEAULT: Thank you.

REP. JOHNSON: Next on our list is Jim Iacobellis.

JIM IACOBELLIS: Good afternoon. My name is Jim Iacobellis. I'm the Senior Vice President of Government and Regulatory Affairs for Connecticut Hospital Association. It's a pleasure to be able to testify here this afternoon on House Bill 5535 and three other bills and I'm going to try to do that in three minutes.

With respect to H.B. 5535, it's broken down into two sections and I'll take the first

SB257

SB413

HB5537

We support the Senate Bill 413, the MOFLT bill. We are part of that working group and we look forward to working with the Department and implementing that.

And with respect to 5537, the DPH revision bill -- and I bring this up, we have written testimony on it because I want to talk about it publicly. We've asked for a section to be added. We have a section in Connecticut statutes which governs access to laboratory records. We are always waiting for the Federal government to come in and do their Federal regs on clinical laboratories and HIPAA. They have now done so. It is a way in which I think goes exactly where we want to go as a state, giving patients access to their lab results. Our language hopefully just conforms those two so we're on the same page so there's no confusion, but the result is exactly where we wanted to go for a number of years and the Federal government has just caught up with us.

Took longer than three minutes.

REP. JOHNSON: But you covered so much ground. Very nice.

So, yes, I think the Committee is definitely willing to work with you on, on the language issues that you raise, and the fact that -- you mention in your testimony regarding House Bill 5535 Section 1, the fact that other states have passed legislation that are similar to what we're proposing here. And, so, I think the state of New York has certainly done that and I, I respectfully ask you to take a look and make sure that, you know, we're not doing anything that will complicate the issue, but just make sure that the patient and the family of the patient understands the circumstances that they're in and the change, although

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SENATOR GERRATANA: And Hadiyah Charles. So the rest are here. Okay, I -- I'm just trying to.

CATHERINE LUTZ: Yeah, they are the folks that left.

SENATOR GERRATANA: Stuart and Hadiyah Charles. Okay. So we would go next to Dan Munson, Mussen. Sorry. Dan Mussen? Thank you very much, Catherine.

DAN MUSSEN: Good afternoon.

SENATOR GERRATANA: Good afternoon.

DAN MUSSEN: I'm here as a representative of the Connecticut Academy of Physician Assistants. Committee Members, thank you for your time today.

I'm going to actually summarize on three bills and try to save some time for you today if I can real quickly. My testimony is already submitted.

SENATOR GERRATANA: We left you out, huh?

DAN MUSSEN: No, you did not. So I want to, first of all, iterate that physician assistants are members of the health care team. We still are very devoted to that -- that role model, and as part of that role, as part of the health care team, I want to summarize ConnAPA's, Connecticut Academy of PA's position on three bills.

One is 257, hepatitis C, where primary care providers will be needed to be tested for hepatitis C. We feel that physician assistants should be part of that bill. As of right now, they are not included in that legislation, so we just -- we feel that as primary care

SB418
HB5537

providers that if there's a requirement for testing, PAs should also be there.

I'm going to jump to the Medi-Spa bill which is 418, and I'll just say that ConnAPA was very involved with the development of that legislation. We're very much in favor of compromised language that was presented with that package, and so we are very in favor of that bill as well.

And finally, I'd like to comment on House Bill 5537, the Department of Health Revisions. In Section 43 -- I know you don't have it in front of you, but in Section 43, there is a section that allows for primary care providers to give exemptions for college students receiving meningitis vaccines. So it will be required that all students receive meningitis vaccines, but physicians and PAs should be included in that section, to be allowed to provide that exemption to the college students when applicable.

That's a summary of our positions on all three bills and I wonder if there's any questions.

SENATOR GERRATANA: Thank you. No, you summarized it very well. Are there any questions? No, but thank you for coming and thank you for covering all three pieces of legislation.

Next is Shawn Lang, followed by Carol Steinke.
'Is Shawn here?

A VOICE: (Inaudible.)

SENATOR GERRATANA: I'm sorry?

A VOICE: He left.

SENATOR GERRATANA: Okay, so Carol, I thought it was

that's -- that's on House Bill 5503, and then we go to Senate Bill 414, Nora Galvin. Mr. Quinlavin, am I saying that right?

JOHN QUINLAVIN: Yes, you are. Thank you very much.

SENATOR GERRATANA: Thank you, sir.

HB5537
JOHN QUINLAVIN: Thank you for the opportunity. I'm here as the chairman of the Connecticut EMS Advisory Board to share with you the position of the board. These positions were established after a vote at our meeting this past week. We are here to support Raised Bill 5503 with the understanding that this is a bill that was crafted with very narrow focus to identify specific purpose at a very specific location, and we ask that this in no way be misinterpreted to change our position on 5542, which does not support recommendation 5. That's not -- not up here for you today, but just as a future comment.

Moving on, if you don't mind, I'd like to just comment on a few other bills. Thank you very much. We are here to support 413, the MOS bill. We are also here to support 416, the Advanced EMT bill.

A couple of points on that bill: That has been in the works for over a decade. I would ask that the committee members try to separate the emotional arguments from the medical and patient care arguments. We've done a lot of work and tried to identify from the science perspective any clear impact on patient outcomes from that level of care which is provided and we failed to do so. We've asked proponents of that bill, not of the bill, but of maintaining the level to produce anything, even anecdotal, that would support that lives have been saved, and shy of one episode, we've

your testimony which is extensive and makes some very good points, and we appreciate very much that you did take the time to come up and share your opinions with us. They are important.

Any other questions or concerns? If not, thank you very much. Have a very good weekend.

Just making one detour onto Senate Bill 413, Stephen Mendelsohn.

STEPHEN MENDELSON: Thanks for the accommodation there.

SENATOR GERRATANA: Certainly, understood.

STEPHEN MENDELSON: My name is Stephen Mendelsohn. I'm from the Second Thoughts Connecticut. I also serve on the MOLST steering committee regarding Senate Bill 413. Senator Gerratana, Representative Johnson, members of the Public Health Committee, we in the disability community have a motto: Nothing about us without us.

Last year we opposed the bill to establish the MOLST pilot, in part because of policies that affected not only our lives, but also our deaths as being made without our input. I am happy to say that the Department of Public Health got the message, and has fully included us in the process. I want to thank Suzanne Blancaflor in particular for her support of our concerns. I am also happy to say that we are here to support Senate Bill 413, condition on new language in the bill.

I'll summarize the rest of my testimony. I also want to refer to the testimony of Cathy Ludlum, and also of attorney, Jason Manne, on whom the new language is based. Some of the

concerns that we have found is the news that this bill now limits the use of MOLST to people who have an end-stage -- approaching an end-stage condition, or have advanced, chronic progressive frailty, unlike New Jersey, Nevada, and a number of other states. Those two states allow up to people with five years, and the danger of that is of non-stable treatment orders where somebody might fear a lingering death check to refuse the treatments on the form, wind up having a car accident and anaphylactic shock the next day, and they wind up dying. We don't want that.

We also mandate that people be informed of that risk before they get a MOLST. This pink form is very powerful. You know, advanced directive might not be powerful enough. This might be a little too powerful. We want people to know exactly what the risks and benefits are, just like anything else in medicine. We also have the problem of unilateral physician completion, so we require the signature of the patient. I cite, and Jim McGauhey cited a course from California's Protection and Advocacy Agency where that -- where that happened prematurely, killing a patient. We require -- we actually require that there be a conversation about goals for care before we actually use this form, because otherwise what ends up happening is a checklist.

We also have issues with steering people away from burden -- basically so much of the literature tends to demonize, or stigmatize things like feeding tubes, BiPAPs which are used by members of our own organization for long term to live productive lives, and such; I had a bunch of things there.

I cite John Kelly's story in Massachusetts where he was presented with -- he and others

who were presented with a form involuntarily. Yet we do want to solve the over-treatment problem, but, you know, there's the clutch factor. There's the problem of the -- the research is not -- the research does not -- is not entirely, so we need -- that's why we need to pilot this, and I also suggest three changes -- three particular changes to improve the bill there.

SENATOR GERRATANA: Oh.

STEPHEN MENDELSON: I'd be happy to answer any questions.

SENATOR GERRATANA: Thank you. Yes, we have your four pages of testimony here.

STEPHEN MENDELSON: Yes.

SENATOR GERRATANA: And I appreciate all the links also, the hyperlinks --

STEPHEN MENDELSON: The links, yes.

SENATOR GERRATANA: -- you know, if you will. And -- and you have in your testimony a couple of recommendations, some tweaking, if you will, to the language?

STEPHEN MENDELSON: Yes, there's one type -- there's one thing that's clearly a typo. I'm on the autism spectrum; I correct errors. That's, you know, that's how I am.

SENATOR GERRATANA: Okay. All right. Very good.

STEPHEN MENDELSON: Yeah.

SENATOR GERRATANA: All right, and of course we very much appreciate both your work with the department --

STEPHEN MENDELSON: Yeah.

SENATOR GERRATANA: -- that is very appreciated. I'm so glad that you were tapped to do that.

STEPHEN MENDELSON: This is -- if it still is going to set a role model for the nation to fix many of the problems that we've seen in -- in the other states --

SENATOR GERRATANA: Yes.

STEPHEN MENDELSON: -- in so many of the areas that I've cited here.

SENATOR GERRATANA: Yes, yes. It offers protection. It does. You're absolutely right. Thank you, sir. Are there any questions?

Yes, Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair. Good afternoon, and thank you for your testimony.

STEPHEN MENDELSON: You're welcome.

REP. SRINIVASAN: Am I to understand that the -- your recommendations will be incorporated -- is that what you've suggested that we do with the new language, that you're saying, in this bill --

STEPHEN MENDELSON: Yeah.

REP. SRINIVASAN: -- the new language that you're -- that you're suggesting?

STEPHEN MENDELSON: The additional things -- the additional recommendations at the end of my testimony, you're referring to?

REP. SRINIVASAN: Right. Correct.

STEPHEN MENDELSON: Yeah, I think Jim McGahey mentioned the last one about the pilot needing -- needing to go -- needing to be two years instead of one.

REP. SRINIVASAN: Right.

STEPHEN MENDELSON: I mean we're dealing with people -- we're dealing with people who have a life -- the target for this is people who have a -- roughly a life expectancy starting with about 6 to 12 months. We don't want to go through the problem again. As I said before, if you go, you know, too far, then you're having these -- these refusal orders on people who cannot possibly have stable treatment preferences. But we want to have a situation where we can have, you know, people go through that part of the lifespan, and also have enough time to train new people. It's going to take a while to get this up and running properly. It's a very complex and difficult issue. It's not just, you know, people will say it's just about choice and, you know. It's very -- these are very complicated and difficult issues.

REP. SRINIVASAN: Thank you.

STEPHEN MENDELSON: The one about religion. Let me just ask that. I don't know if it -- some people -- as I noted particularly in the Catholic world, there's been a lot of -- there's been a lot of controversy. I know people see in the Catholic Medical Association's white paper which opposes this paradigm, it's been very controversial. But, I mean they do -- a number of the concerns we got were actually -- were actually listed in there. What we're seeing -- what we're trying to see is if we can actually fix them. This is -- this will -- what we are trying to do here in

Connecticut is to see whether the problems that many of the critics have said are -- are actually fixable. And in order to -- one of the things that we need to understand is, you know, some religious people, for instance, were having difficulty dealing with the checkbox format where you have to check things off ahead of time when, you know, their faith would say it really depends on the situation. So how do we make this compatible? And that's why I think religion belongs in that list along with, you know, race, and language, and disability, and people who tend to have serious issues of undertreatment.

REP. SRINIVASAN: Thank you. Thank you, Madam Chair.

SENATOR GERRATANA: Thank you.

Representative Johnson.

REP. JOHNSON: I want to thank you for your testimony and work on this very important legislation. I think your testimony is very, very excellent, and I just want to thank you for all your -- all your work. Much appreciated.

SENATOR GERRATANA: Thank you, Representative. Any other questions or comments? If not, thank you very much.

STEPHEN MENDELSON: I do want to mention one thing though. I just wonder, though, where -- where's compassion and choices on this. They always say they're for choice at the end of life, and they seem to be AWOL on this, and you might want to check out Arielle Levin Becker's article today in *CT Mirror*.

SENATOR GERRATANA: Thank you. Thank you for coming.

STEPHEN MENDELSON: Yeah.

MARK GINELLA: This is unbelievable, what you guys go through, fire drills and all (inaudible).

SENATOR GERRATANA: This is out job, so thank -- thank you, sir.

Yes, John Lynch, thank you, followed by Susan Yolen.

JOHN LYNCH: Senator Gerratana, Representative Johnson, and members of the Public Health Committee, on behalf of ProHealth Physicians, its 351 primary care providers and its over 350,000 patients, thank you for the opportunity to testify today.

My name is John Lynch. I am vice president for research at ProHealth. I am here today to support passage of Senate Bill 413. We applaud the Department of Public Health and the Governor's Office for bringing forward this legislation that will provide our patients an opportunity to discuss their desires for life-sustaining treatment with their primary care provider well in advance of crises of a life-threatening situation, and to have their desires be part of their ongoing medical record.

In this patient-centered medical home environment, more and more of our patients are expressing a desire to avoid spending their final days hooked up to all kinds of medical equipment in a critical care unit. They would rather spend their final days in their home, surrounded by family and friends, in a warm and comforting environment.

The MOLST would be a portable document, both paper and digital, that would accompany medical records, and allow the patient to choose

medical treatments they want to receive, as well as medical treatments they do not want. These documents will provide healthcare providers directions during serious illness, and allows healthcare providers to know, and to honor wishes for end-of-life care. These documents will transform the patient's treatment plan into actionable medical orders, to be followed regardless of the patient's healthcare setting.

I would recommend one minor change to the proposal. Limiting the pilot to one year is extremely short. It will take time for the Department of Public Health to develop regulations, and for pilots to be selected and gear up. If the results of the pilot work as good as we expect, we wouldn't want to deny the opportunity to patients while waiting for the next legislative session to approve full deployment.

Please provide sufficient time for the pilot and the opportunity for the Legislature to reconvene and pass followup legislation. We are willing to work with the Department of Public Health to develop mechanisms to make the most documents workable and flow smoothly with our electronic health records. We have attached to this testimony a model MOLST document that is used in Massachusetts, to provide members of the committee with the best idea of what these proposals could look like if implemented.

Thank you for your time and attention, and I hope you can support Senate Bill 413.

SENATOR GERRATANA: Thank you very much for your testimony today. I have gone online also just to see what some of these forms look like, if you will, so that is very helpful that you

attached it.

Does anyone have any -- yes, Representative Sayers.

REP. SAYERS: Thank you, doctor. I'm just curious. How is this different from what we have now for Advanced Directives, or a Living Will?

JOHN LYNCH: This goes beyond those, in that this is a situation where a physician and a patient can sit down, not even just a physician, but primary care, practicing APRNs, PAs, et cetera, can sit down in a conversation with the patient well in advance. If you look at the sample forms, for example, it talks about, you know, are you willing to -- do you want intubation? Do you want noninvasive ventilation? Would you like dialysis, artificial nutrition, et cetera? So I think it goes well beyond many of those other aspects.

REP. SAYERS: And one of the reasons why I asked the question is I do some home-care nursing, and one of the things I find, because on the Oasis, which is the Federal form for -- assessment form, it asks them if they have made these decisions or filled out any of these forms, and I find most people have not. And, in fact, when you ask them the question on the Living Will, the response I get is, "I know who my money is going to, but I haven't written it down yet." So it tells me they truly don't --

JOHN LYNCH: Right.

REP. SAYERS: -- even have an understanding of what the question that I'm asking them. So I'm just wondering, that was one of the reasons why I'm asking --

JOHN LYNCH: Yes.

REP. SAYERS: -- why is this different. And we're not really -- we're not seeing, and yet I know frequently, when I go to health fair, sometimes from the AG's Office I'll get copies of the information for making those out, and they -- they disappear because people are interested in looking at that, but they just --

JOHN LYNCH: I think they're looking for education.

REP. SAYERS: -- they don't take it to the next step.

JOHN LYNCH: They're looking for education. I think they're looking to express their patient-centered opinion, and I think that's what this bill potentially opens up is that opportunity to have that frank and honest discussion about what they want.

REP. SAYERS: Then I think maybe the next question: Do you -- do you think that most physicians are comfortable having this discussion, because I think that is somewhat -- could be somewhat problematic.

JOHN LYNCH: I -- I can't say that physicians are all comfortable, but I -- I do know that we have a number of physicians that are very interested in this bill because they believe in it. I know we're having a lot of new discussions going on with nursing homes, home care, et cetera, how do we work better together, and this is one example of where -- how do we help each other out in that whole process between primary care, nursing home, home care, et cetera. We've got to work -- work these things out and be able to allow the patient to express their opinion so that all of us understand what it is, across the continuum is traditionally tough to follow.

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REP. SAYERS: Yeah, and I know from past legislation we've done around Do Not Resuscitate orders in nursing homes, it's problematic when you have someone that is 98 years old and at the time. A lot has since changed. The EMS comes and has to do CPR on someone who's really frail and really not a candidate to do CPR, because it's not in their best interest, so thank you.

SENATOR GERRATANA: Thank you very much.

Next is Susan Yolen followed by Carin Van Gelder, Dr. Van Gelder.

A VOICE: Dr. Van Gelder had to go to work.

SENATOR GERRATANA: Oh, well.

A VOICE: (Inaudible.)

SENATOR GERRATANA: Okay, and I don't see Susan Yolen.

Tracy Wodatch. Is Tracy here? She's not here either. Okay. I know their testimony is online. Cathy Ludlum would be the next person, and she had to go home, also. Okay. Christopher O'Brien. Okay; you're up.

CHRISTOPHER O'BRIEN: Does that mean we went from the beginning of that list to the end already?

SENATOR GERRATANA: There you go.

CHRISTOPHER O'BRIEN: Before I begin my testimony, I did send a copy of the MOLST form from Massachusetts for your review if you need to. I know Senator Gerratana, you already looked at that.

SENATOR GERRATANA: Thank you.

CHRISTOPHER O'BRIEN: Good -- good afternoon. How are you feeling today? It's a nice day, and we're all sitting in a comfortable setting. Does anybody here feel that they need antibiotics today? I'm sure you feel fine, so you'll probably decline. How about an I.V.? Does anybody in the room need an I.V. today? No? What about next month? What about next year? Probably not, but I ask you that question because --

SENATOR GERRATANA: Mr. O'Brien, I'm sorry, could you identify yourself (inaudible).

CHRISTOPHER O'BRIEN: Oh, I apologize, I'm sorry.

SENATOR GERRATANA: So sorry. I didn't hear that.

CHRISTOPHER O'BRIEN: My name is Christopher O'Brien. I'm a certified paramedic.

SENATOR GERRATANA: Thank you.

CHRISTOPHER O'BRIEN: Thank you. I had had asked you if you would like an antibiotic, or an I.V. today, or see a foreseeable need that you might in the next year or two. Many of us can't answer that question because we don't know what will happen as our health progresses. Many of us are optimistic, so we'll probably say no, we won't. But that might change. At some point in the future we might get sick; we might have an infection. If we are achy or have a fever, certainly we would want to have that type of medical intervention.

I ask these questions because that's the type of question that will appear on a MOLST form that we're discussing today under S.B. 413. I was strongly opposed to the proposal last year, but see that much progress has been made to improve this program that's proposed today.

There is some utility in a MOLST form, covering a very limited number of foreseeable medical procedures such as CPR or ventilation, but at the -- these should probably only be used -- but going beyond that should probably only be contemplated at the very last stages of chronic disease. I believe that the overall effort is overbroad. We have seen instances where healthy persons have been enrolled in the MOLST process in Worcester at assisted living facilities. Fraudulent documents were drawn up in California, and the program in Delaware was suspended for at least a couple of years.

As a paramedic I'll testify that the best interest of any patient lie on a Durable Power of Attorney which already exists under Connecticut State Law. Most of the time such healthcare advocates can be reached within a reasonable amount of time in an emergency and can make the decisions in the best interest of the patient that cannot be reduced to a checkbox document such as a MOLST form.

As I testified then, I remain very concerned that the MOLST implementation can trump rules for informed consent, and in order to have true informed consent, or conversely refusal of medical interventions a patient does or doesn't need, must make medical decisions within the context of a medical problem. For instance, hydration. The human body is composed of approximately 65 percent water and fluids. When this percentage is altered, various activities are thrown off including cognition, awareness, and proper absorption of medications to relieve pain. Antibiotics are also inappropriate, I believe, to be used on this form. When a Hospice patient develops a fever, as I witnessed one day, family members and nursing home employees out of the hospital

setting are unable to determine what's causing it. Could it be a UTI, or a treatable respiratory infection? Or would it be the continuation of sepsis of the underlying disease which might be extraordinary means for that -- for that family to decide to pursue.

I have witnessed patients that have been -- that have been denied fluids because they signed a Living Will long in advance of foreseeing that. This one patient I had, she had very parched lips, chapped, almost bleeding. You could tell through her eyes she understood what was going on. She had a Power of Attorney that lived in Florida who was not able to be reached, but she had a family member nearby that tried to have to go to different hospitals, including to a Catholic hospital, but because of the legal ramifications, they were not able to do that, so --

SENATOR GERRATANA: Mr. O'Brien, could you please summarize for us?

CHRISTOPHER O'BRIEN: Absolutely.

SENATOR GERRATANA: Thank you.

CHRISTOPHER O'BRIEN: EMS providers will tell you that there's a lot of misinformation out there regarding end-of-life care. Sometimes documents such as DNRs are misplaced, or Living Wills are misplaced, and the public is not well educated sometimes in the biological sciences, and are sometimes unprepared to handle end-of-life decisions, even when they are in the context of lengthy illnesses.

At the same time there are families that are very well prepared and handle them very well. Those families often are very well -- very engaged on a daily basis within their care and

investigating their options.

I think I'll just reiterate that I believe that is a good document when it's very limited, but I think that overall I'd be very careful moving forward on how many different interventions the MOLST program will include. Thank you.

SENATOR GERRATANA: Thank you, sir. Are there any questions? If not, thank you for coming today.

I do have one. Did you submit your testimony to our committee?

CHRISTOPHER O'BRIEN: I did, just within the last hour.

SENATOR GERRATANA: Okay. Very good. Thank you so much.

Okay, we'll go onto Senate Bill 416. Arthur Grouf, or Group? Groux? Maybe it's G-r-o-u-x? Ge-roo? Okay, sorry.

ARTHUR GROUX: Groux, that works.

SENATOR GERRATANA: There you are. Groux works. All right.

ARTHUR GROUX: (Inaudible). It's 5 o'clock, I'll answer, so.

SENATOR GERRATANA: All right. Thank you. Thank you for waiting, too.

ARTHUR GROUX: Thank you very much, members of the committee. I did submit my written testimony so I'm not going to re-read that. I think you can all read it probably better than I can re-read it, so.

I do want to touch on a few things that were



**Testimony on Senate Bill 413 Act Concerning Department of Public Health Recommendations
Regarding Medical Orders for Life-Sustaining Treatment
Public Health Committee
March 13, 2014**

Senator Gerratana, Representative Johnson and members of the Public Health Committee, on behalf of physicians and physicians in training of the Connecticut State Medical Society (CSMS) and American College of Physicians Connecticut Chapter (ACP) thank you for the opportunity to provide this testimony to you today on Senate Bill 413 An Act Concerning Medical Orders for Life-Sustaining Treatment (MOLST)

On a daily basis many of our members deal with patients in end of life situations. Not only are these emotional and difficult situations, but understanding and more importantly fulfilling the wishes of the patient is critical. In addition, the wishes of the patient as formulated in Living Wills or Advanced Directives are often misinterpreted or unavailable when needed. This often exacerbates the situation and even leads to increased costs associated with end of life care.

In recent years, national initiatives aimed at better translating a patient's end-of-life goals have gained traction. This led to the development of MOLST projects either approved or in development in almost every state. Unlike Advanced Directives or Living Wills MOLST creates a situation in which the patient's preferences for end of life care are clearly expressed into an actionable medical order that follow the patient through all health care settings along the continuum of care.

Our organizations support the establishment of a pilot project for a MOLST program in Connecticut. However, it is critical that appropriate education exists of health care providers involved in the program, and a cautious approach as to what level of health care provider is appropriately trained to participate in such a program. Education must also be provided to the individuals who are eligible to participate in the program as well as their families.

It is imperative that physicians and appropriately trained medical professionals are involved in the pilot program from its development, through implementation to the collection and analyzing of results. If done correctly we fully agree with many other organizations providing testimony today that a comprehensive and functional MOLST program in Connecticut will facilitate implementation of end of life decisions and increase the probability that the wishes of the patient are appropriately interpreted .



Nationally Recognized for Patient-Centered Care



ProHealth Physicians Testimony
John Lynch, MPH
Regarding Senate Bill 413, An Act Concerning the Department of Public Health's
Recommendations Regarding Medical Orders for Life-Sustaining Treatment

Public Health Committee
March 14, 2014

Senator Gerratana, Representative Johnson, and members of the Public Health Committee, on behalf of the ProHealth Physicians, its 351 primary care providers, and its over 350,000 patients, thank you for the opportunity to testify today.

My name is John Lynch, MPH. I am the Vice President for Research at ProHealth.

I am here today SUPPORT passage of Senate Bill 413.

We applaud the Department of Public Health and the Governor's Office for bringing forward this legislation that will provide our patients an opportunity to discuss their desires for Life Sustaining Treatment with their primary care provider well in advance of the crises of a life threatening situation, and have their desires be part of their ongoing medical record. In this Patient Centered Medical Home environment, more and more of our patients are expressing a desire to avoid spending their final days hooked up to all kinds of medical equipment in a critical care unit. They would rather spend their final days in their home, surrounded by family and friends, in a warm and comforting environment.

The MOLST would be a portable document (both paper and digital) that would accompany medical records and allow the patient to choose medical treatments they want to receive, and medical treatments they do not want. These documents will provide healthcare providers directions during serious illness and allows healthcare providers to know and honor wishes for end-of-life care. These documents will transform the patient's treatment plan into actionable medical orders to be followed regardless of a patient's health care setting.

I would recommend one minor change to the proposal. Limiting the pilot to one year is extremely short. It will take time for the Department of Public Health to develop regulations and for pilots to be selected and gear up. If the results of the pilot work as well as we expect, we wouldn't want to deny the opportunity to our patients while waiting for the next legislative session to approve full deployment. Please provide a sufficient time for the pilot and opportunity for the legislature to reconvene and pass follow-up legislation.

We are willing to work with the Department of Public Health to develop mechanisms to make the MOLST documents workable and flow smoothly with our electronic health records.

We have attached to this testimony a model MOLST document that's used in Massachusetts to provide members of the committee with the best idea of what these proposals could look like if implemented.

Thank you for your time and attention and hope you can support SB413.

**MASSACHUSETTS MEDICAL ORDERS
for LIFE-SUSTAINING TREATMENT**



Patient's Name _____
Date of Birth _____
Medical Record Number if applicable: _____

(MOLST) www.molst-ma.org

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

- This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
- Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- If any section is not completed, there is no limitation on the treatment indicated in that section.
- The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A	CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest	
Mark one circle →	<input type="radio"/> Do Not Resuscitate	<input type="radio"/> Attempt Resuscitation
B	VENTILATION: for a patient in respiratory distress	
Mark one circle →	<input type="radio"/> Do Not Intubate and Ventilate	<input type="radio"/> Intubate and Ventilate
Mark one circle →	<input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP)	<input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)
C	TRANSFER TO HOSPITAL	
Mark one circle →	<input type="radio"/> Do Not Transfer to Hospital (<i>unless needed for comfort</i>)	<input type="radio"/> Transfer to Hospital
PATIENT or patient's representative signature D <i>Required</i> Mark one circle and fill in every line for valid Page 1.	Mark one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i>	
	<input checked="" type="checkbox"/> _____ Signature of Patient (or Person Representing the Patient)	_____ Date of Signature
	_____ Legible Printed Name of Signer	_____ Telephone Number of Signer
CLINICIAN signature E <i>Required</i> Fill in every line for valid Page 1	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D	
	<input checked="" type="checkbox"/> _____ Signature of Physician, Nurse Practitioner, or Physician Assistant	_____ Date and Time of Signature
	_____ Legible Printed Name of Signer	_____ Telephone Number of Signer
Optional Expiration date (if any) and other information	This form does not expire unless expressly stated. <i>Expiration date (if any) of this form</i> _____ Health Care Agent Printed Name _____ Telephone Number _____ Primary Care Provider Printed Name _____ Telephone Number _____	

SEND THIS FORM WITH THE PATIENT AT ALL TIMES

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable _____

F	Statement of Patient Preferences for Other Medically-Indicated Treatments			
	INTUBATION AND VENTILATION			
	Mark one circle →	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use intubation and ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
	Mark one circle →	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use non-invasive ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	DIALYSIS			
Mark one circle →	<input type="radio"/> No dialysis	<input type="radio"/> Use dialysis <input type="radio"/> Use dialysis, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss	
ARTIFICIAL NUTRITION				
Mark one circle →	<input type="radio"/> No artificial nutrition	<input type="radio"/> Use artificial nutrition <input type="radio"/> Use artificial nutrition, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss	
ARTIFICIAL HYDRATION				
Mark one circle →	<input type="radio"/> No artificial hydration	<input type="radio"/> Use artificial hydration <input type="radio"/> Use artificial hydration, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss	
Other treatment preferences specific to the patient's medical condition and care _____				

G <i>Required</i>	PATIENT or patient's representative signature Mark one circle below to indicate who is signing Section G: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor		
	Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i>		
	Mark one circle and fill in every line for valid Page 2	Signature of Patient (or Person Representing the Patient) _____ Legible Printed Name of Signer _____	Date of Signature _____ Telephone Number of Signer _____

H <i>Required</i>	CLINICIAN signature Fill in every line for valid Page 2	
	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G Signature of Physician, Nurse Practitioner, or Physician Assistant _____ Legible Printed Name of Signer _____	Date and Time of Signature _____ Telephone Number of Signer _____

Additional Instructions For Health Care Professionals

- Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided*
- Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences
- The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority*



IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.
- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.
- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.
- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: <http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients>.
- Listen to *MOLST Overview for Health Professionals* at: <http://www.molst-ma.org/molst-training-line>.
- Access the MOLST website at: <http://www.molst-ma.org> periodically for MOLST form updates.
- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit <http://www.molst-ma.org>.

* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at <http://www.staples.com>, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at <http://www.officedepot.com>.

Catherine D. Ludlum
46 St. James Street, Unit 16
Manchester, CT 06040-5982

860-649-7110
cathyludlum@cox.net

PUBLIC HEALTH COMMITTEE
Testimony regarding Raised Bill 413
An Act Concerning the Department of Public Health's Recommendations
Regarding Medical Orders for Life-Sustaining Treatment
March 14, 2013

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

My name is Cathy Ludlum, and I am here to express my support for Connecticut's pilot project around Medical Orders for Life-Sustaining Treatment, Raised Bill 413.

You may recall that last year I joined my colleagues in the disability community in fighting against an earlier version of the bill. It wasn't that we opposed the concept. Of course people should have choices over what treatments they receive and when enough is simply enough. On the other hand, as similar efforts in other states have demonstrated, if this type of program is not well designed, it can result in premature and unintended death.

So what changed?

The Connecticut Department of Public Health, and especially Suzanne Blancaflor, invited the disability community to the table. Our concerns were listened to, and together we have created what we all think is a good piece of legislation.

What the Connecticut MOLST bill has that the other states lack is Section (e). This carefully crafted section contains guidelines and safeguards to make these medical orders more reflective of people's choices. Although it can never eliminate the risk of death from unconscious biases and mistakes, this language should significantly reduce the risk. It requires that people be made fully aware of the risks as well as the benefits of their choices. Everyone who has ever had a medical procedure or taken a prescription medicine has seen

consent forms or other literature outlining the intended outcomes as well as the possible side effects. As a tool, MOLST is just as powerful, and it needs to be treated with the same level of respect and caution.

It is significant that Section (e) requires a patient's or surrogate's signature for the MOLST form to be valid. Some other states have fallen short in this area. The same section requires that medical practitioners sit down with their patients and have serious discussions about their illness and possible courses of treatment. Only in this way can the true wishes of the patient be identified, documented, and implemented. MOLST is not a checklist, and it should never be handed to someone with the words, "Here, just fill this out."

The Department of Public Health has worked hard to make sure that diverse voices were heard in the creation of this bill. As a member of the MOLST Steering Committee and Co-Chair of the Underserved Populations Workgroup, I know how much has been involved in trying to get this right. But I think we are pretty close.

There are three changes that I think would make the bill even better.

First, Section (e)(4)(D) needs a comma between "language" and "disability." Otherwise, you end up with "language disability." I suppose there is such a thing, but that is not what the sentence is about.

Second, in the same section, there is a list of personal characteristics that may affect how MOLST is explained or implemented. As it stands, this list reads, "Race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language disability, homelessness, mental illness and geographic area of residence." Notably absent is "religion." I suggest that this category be added, as people's religious beliefs and practices will undoubtedly affect their perceptions and choices.

Third, I know how long it takes to get a new effort off the ground. I do not think one year is sufficient for the pilot to give us the information we need going forward. I therefore recommend that the length of the pilot be increased to two years.

Once again, I am pleased to offer my support to Raised Bill 413 as long as the safeguards in Section (e) remain in the legislation. Connecticut has developed a MOLST program that is unique, better designed, and more collaborative than any other in the country. I am proud to be a part of that.

Thank you for your time and attention.



Connecticut Department of Public Health
 Testimony Presented Before the Public Health Committee

March 14, 2014

Commissioner Jewel Mullen, MD, MPH, MPA
 860-509-7101

**Senate Bill 413 - An Act Concerning The Department of Public Health's Recommendations
 Regarding Medical Orders for Life Sustaining Treatment**

The Department of Public Health supports Senate Bill 413 and would like to thank the committee for raising the Department's bill.

In 1990, under Title 42 U.S.C. 1395 cc (a) of the Omnibus Reconciliation Act, Congress passed an amendment, known as the Patient Self Determination Act, which gives individuals the right to make their own health care decisions and to prepare advance directives (ADs). Medical Orders for Life Sustaining Treatment (MOLST) is an adjunct to a formal written advance directive and will benefit Connecticut residents with life limiting illnesses or residents of an advanced age who wish to make their choices known by exercising their rights and articulating their choices about the medical life sustaining treatments they will accept at the end of life.

The MOLST paradigm is an advanced care planning tool that uses a structured process of shared decision-making so providers can elicit patient preferences about probable medical interventions. The patient's preferences are then translated into an actionable medical order on a highly visible standardized form that travels with the patient across all care settings to ensure continuity of care. MOLST reflects the patient's current goals for medical decisions that s/he will likely confront within the near future. Currently there are 15 states with approved MOLST programs; 28 states, including Connecticut, with developing programs; and seven states without a program.

The bill gives the Department the authority to pilot test MOLST through a voluntary program that involves health care professionals and institutions in designated areas of the state. A pilot program will provide the opportunity to collect and analyze data on the use, effectiveness and limitations of MOLST. If the program is successful, the legislature may elect to implement the program statewide, through a comprehensive educational program that targets specific groups of health care providers.

Thank you for your consideration of the Department's views on this bill.

*Phone: (860) 509-7269, Fax: (860) 509-7100, Telephone Device for the Deaf (860) 509-7191
 410 Capitol Avenue - MS # 13GRE, P.O. Box 340308 Hartford, CT 06134
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JASON W. MANNE, J.D., Dr.PH

P.O. Box 23297
PITTSBURGH, PA. 15222
Web:

Telephone. (724) 635-5718
Facsimile (412) 421-8571
E-mail: JManne@lawmanne.com

March 12, 2014

VIA EMAIL TO: -----

The Hon. Terry B. Gerratana
The Hon. Susan M. Johnson
Co-Chairs
Public Health Committee
Room 3000, Legislative Office Bldg
Hartford, CT 06106

Re: Medical Orders for Life Sustaining Treatment
SB 413, LCO No 2057

Dear Senator Gerratana and Representative Johnson:

I am writing to provide testimony relative to SB 413, LCO No. 2057 relating to Medical Orders for Life Sustaining Treatment (MOLST). This LCO version of the MOLST law can serve as a model for the Nation of a statute that accomplishes the dual purposes of promoting the use of physician orders for life sustaining treatment as an improvement in end-of-life advance care planning, while simultaneously providing needed patient protections against the form being implemented in a way that tramples upon patient autonomy rather than promoting it.

By way of background, I am sure you already know that forms like the MOLST are generically referred to as Physician Orders for Life-Sustaining Treatment or POLST forms. I did both my masters in bioethics dissertation and my doctoral thesis on the POLST. I also write a blog on the POLST located at www.polst-views.blogspot.com. Although I am generally supportive of the POLST, I contend the form is often improperly marketed to individuals who are not anywhere near the end of life, and that a POLST may cause unintended death if treatment withholding orders on the form do not reflect authentic and stable preferences relative to end of life care. I write exclusively from the perspective of secular bioethics.

www.lawmanne.com

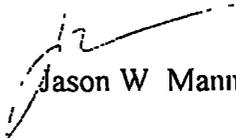
SB 413, LCO No. 2057 addresses most of the criticisms that have been aimed at the form. Section one includes language limiting use of the form to individuals who are near the end of life. The Connecticut MOLST cannot be marketed to healthy individuals who should have an advance directive rather than a MOLST. It requires a patient or surrogate signature on the form to insure that unilateral MOLST forms are not executed by clinicians. Most importantly, the bill contains detailed standards for both clinician training and the MOLST conversation to insure that the patient's goals for care are elicited, that patients are not steered to reject care, and that the risks and benefits of the form are explained to patients. The fact the MOLST is a pilot-project with a defined expiration date is also important there are significant gaps in the research literature on the POLST.

One thing missing from the bill is a requirement for an evaluation of the MOLST program on an ongoing basis to see if health care facilities have, in fact, implemented the pilot project in accordance with the Legislature's instructions. Even members of the National POLST Paradigm Task force will acknowledge that with "poor training, inadequate resources, and insufficient evaluation, the process can regrettably morph into another systematic trampling of patient autonomy."¹ Your committee should urge the Department of Public Health to include an evaluation component in its pilot project.

Your medical provider community may seek a tort immunity provision as part of this bill. Given that facilities have no control over the privileging and credentialing of clinicians who sign MOLST forms outside of the facility, this is a reasonable request. However, I urge the committee to condition tort immunity arising out of the honoring a MOLST form in a health care facility to the presence of an ongoing MOLST quality control program within the facility that insures compliance with legislative and regulatory standards.

Thank you for considering these comments

Very truly yours,


Jason W. Manne, J.D., Dr. PH

¹ Bomba, P. A., & Sabatino, C. P. (2009). POLST: An emerging model for end-of-life care planning. *The Elder Law Report*, 20, 1-5.



STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
60B WESTON STREET HARTFORD, CONNECTICUT 06120-1551

James D. McGaughey
Executive Director

Phone 1-860-297-4307
Confidential Fax 1-860-297-4305

Testimony of the Office of Protection and Advocacy for Persons with Disabilities
before the
Public Health Committee

Presented by: James D. McGaughey
Executive Director
March 14, 2014

Good morning and thank you for this opportunity to comment on Raised Bill No. 413, An Act Concerning the Department of Public Health's Recommendation Regarding Medical Orders for Life-Sustaining Treatment. This bill would authorize the Department of Public Health to establish two pilot programs in different regions of the State where Medical Orders for Life-Sustaining Treatment (MOLST) could be used to document decisions about treatment options that have been made by people who are approaching the end of their lives after discussions with their physicians or other healthcare providers.

Our Office's support for this measure is rooted, in part, in experience we have gained from participating on the Connecticut Fatality Review Board for Persons with Disabilities – a group of professionals with backgrounds in medicine, human services and law enforcement that is charged by an Executive Order with reviewing circumstances surrounding the deaths of people with intellectual and developmental disability and investigating selected matters. In the process of conducting those fatality reviews we have encountered situations where the wishes of people who were approaching the ends of their lives were not respected. These were people who were quite capable of making their own decisions about medical treatment, and who had been clear about the types of interventions they did and did not want. In some cases they had even executed advance directives. Their Intellectual Disability was not the issue, but the fact that they had been transferred between facilities and the “paperwork” had not caught up to them was. I believe that the MOLST program contemplated in this bill could have made a difference for those individuals. Because MOLSTs are medical orders, dated and issued by a physician, nurse practitioner or physician assistant, utilizing a standardized format and specifying the types of life-sustaining measures a person who is approaching the end of his or her life has decided he or she wants, they can accompany a person wherever they go, and can be relied on by liability-wary healthcare providers, including hospitals and Emergency Medical Services.

The concept underlying this legislation derives from the work of the National POLST Paradigm Task Force. (POLST stands for Physician Orders for Life-Sustaining Treatment; the term “medical orders” is now preferred because it is recognized that providers other than physicians may be in a better position to have the thoughtful and sometimes lengthy discussions with people who are making choices and decisions, and because state statutes are increasingly authorizing nurse practitioners and physician assistants to write and sign medical orders.) Ideally, the decisions reflected on a MOLST are made after a series of conversations between the patient and medical provider, and they are subject to regular reviews and updates as the patient returns for follow-up care and monitoring, and, possibly experiences changes in his or her health status. To date, POLST/MOLST programs exist in some form in 15 states, and efforts are underway to develop them in 28 others.

(over please)

The experience in those states has not been uniformly positive: the program in Delaware had to be suspended for a time because providers were routinely completing the forms without regard to whether patients were terminally ill; and, notwithstanding the voluntary nature of POLST/MOLST programs, in other states some long term care facilities have been found to be routinely insisting on the completion of POLST/MOLST forms for all residents. Indeed, our sister Protection and Advocacy agency in California investigated a situation where a physician unilaterally re-wrote the POLST for a patient with intellectual and developmental disabilities, leading to a denial of life-sustaining treatment the person had chosen. Equally troubling, training materials and checklists that have been developed in some states clearly steer people away from things like feeding tubes and Bi-PAPs, even though people with certain types of progressive disabilities find that using such technology has significantly improved the quality of their lives and enabled them to live for many years – even decades - longer than would have otherwise been the case. Even a member of the National POLST Paradigm Task Force sees problems with the way POLST/MOLST is being implemented in some jurisdictions:

I think it's way too easy for the POLST to be treated like a checklist. It really should be about the conversation but right now we don't have a system that really incentivizes organizations to invest in education, in time, in people who have the skills to hold these conversations. (Susan B Hickman, Ph.D , testimony before the Institute of Medicine, August 12, 2013.)

Against this background of problematic implementation in other states, when a proposal for a MOLST pilot came before this Committee last year, disability advocates testified in opposition. The basic concept was not the problem. But, there were real concerns about the details of implementation. What kind of safeguards would be in place to ensure that MOLST forms truly reflected people's wishes? How would people be informed about their options? What kind of training would providers receive about presenting and properly using MOLST, especially with people with disabilities and other discrete populations? How could Connecticut ensure that MOLST would not become just another "checklist" that routinely discouraged people with significant or progressive disabilities from choosing the kinds of assistive interventions and care that could help them live good quality lives for many years, just because this might involve "tubes and wires"?

Questions like these prompted DPH to convene an expanded MOLST working group which included our Office, the Department of Developmental Services, and representatives from the disability community. The result is the language in the bill before you – a much improved proposal. It is now clear that MOLST will only be used to effectuate a patient's request for life-sustaining treatment when a physician has determined that the patient is "approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic, progressive frailty". The patient, or the patient's legally authorized representative must countersign the MOLST form, and must promptly be given a copy. Prior to participating in the pilot program, providers who will be signing MOLSTs must participate in a training program that stresses the importance of discussing patients' goals and covers a number of specific, relevant topics. Lastly, the advisory group for the pilot will now include patient advocates, including but not limited to advocates for persons with disabilities. (In fact, such a working group already exists and is diligently exploring various questions related to underserved populations; provider, patient and public education; possibilities for policy development and regulatory frameworks; and, data gathering and analysis.)

With these improvements, our Office believes the MOLST pilots that would be authorized by this legislation will be able to explore, and, hopefully demonstrate the value of the MOLST concept without encountering the problems experienced in other states. Accordingly, I urge you to act favorably on this bill.

Thank you for your attention. If there are any questions I will try to answer them.

Second Thoughts Connecticut

Advocates against the legalization of assisted suicide

Testimony regarding SB 413, An Act Concerning the Department of Public Health's Recommendations Regarding Medical Orders for Life-Sustaining Treatment

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

We in the disability community have a motto: Nothing About Us Without Us. Last year we opposed a bill to establish a MOLST pilot, in part because a policy that affected not only our lives, but also our deaths, was being made without our input. I am happy to say that the Department of Public Health got the message and has fully included us in the process. I want to thank Suzanne Blancaflor in particular for her support of our concerns. I am also happy to say that we are here to support SB 413 conditioned on the new language in the bill.

Others from the field of hospice and palliative medicine will be testifying regarding the potential benefits of MOLST. We at Second Thoughts Connecticut are here to offer balance and show why the new safeguards and guidance in SB 413 are absolutely essential. These safeguards are adapted from attorney Jason Manne's model POLST statute, available online at <http://polst-views.blogspot.com/2013/10/model-polst-statute-updated.html>. As we noted last year, there are significant problems with the POLST paradigm nationally, and it is vital that Connecticut learn from the mistakes of other states.

SB 413 limits the use of MOLST to people who are nearing the end stage of a serious life-limiting illness or are in a condition of advanced chronic progressive frailty, unlike the dangerous POLST laws of New Jersey (<http://polst-views.blogspot.com/2013/07/new-jerseys-new-polst-law-and-risk-of.html>) and Nevada (<http://polst-views.blogspot.com/2013/08/nevadas-new-polst-statute-one-more-step.html>), which recommend POLST for people with five years life expectancy. Nevada mandates that doctors promote POLST for anyone with either five years life expectancy or whose condition falls under that state's expansive definition of "terminal," encompassing many people with long-term disabilities. As Manne (whose doctoral thesis was on the POLST) points out on his excellent blog, POLST: Critical Analysis and Comment (<http://polst-views.blogspot.com>), the risk of unintended death is significant when used with people who could live a long time. Someone who fears a lingering death may refuse life-sustaining treatment, wind up in a car accident or go into anaphylactic shock the next day, and be denied what would have been wanted lifesaving care.

Moreover, to further minimize this risk, the legislation mandates that patients be fully informed of the risks as well as the benefits of MOLST in documenting their treatment preferences. Unlike an advance directive, MOLST is an immediately effective set of medical orders. If an advance directive may not be powerful enough, MOLST may in some circumstances be too powerful, risking denial of wanted and beneficial care. It is particularly important that patients give fully informed, stable (over both time and different scenarios), and authentic consent to MOLST.

Section (e) of SB 413 requires the signature of the patient or surrogate on the MOLST form as a safeguard against both forgery and unilateral physician completion. The latter is a significant issue. Disability Rights California (California's Protection and Advocacy agency) issued a scathing report of a case where a hospitalist wrote out a unilateral POLST for comfort care only overriding the patient's POLST and repeatedly expressed wished for full treatment, resulting in the patient's premature death. <http://www.disabilityrightsca.org/pubs/702601.pdf>. Moreover, no one was held accountable for disregarding the patient's wishes and killing him. We would appreciate a clarification that such behavior by medical staff should be a criminal offense, and will seek explicit criminal penalties if and when we get to statewide implementation.

Section (e) also requires nuanced conversations about goals of care before filling out the MOLST form. While MOLST is supposed to be about having these conversations, this is all too often not the case in other states. Both the California Association for Nursing Home Reform (which has documented many problems with POLST in that state: http://www.canhr.org/reports/2010/POLST_WhitePaper.pdf) and Susan Hickman, formerly of the National POLST Paradigm Task Force (<http://polst-views.blogspot.com/2013/08/i-think-its-way-too-easy-for-polst-to.html>) have noted the widespread tendency to use the POLST as a checklist, foregoing these critical conversations.

The same section requires that these conversations genuinely elicit patient preferences and not use biased information to steer people away from otherwise wanted and beneficial care. We have seen training videos from California (<http://www.uctv.tv/shows/POLST-Having-the-POLST-Conversation-18360>) and New York (<http://www.youtube.com/watch?v=dSZ3UGAlwl>), a "cue card" from California (<http://med.fsu.edu/userFiles/file/POLST%20Cue%20Card-short%20version%20with%20Doc%20Tool.pdf>), and a number of "fact sheets" which are clearly aimed at manipulating patient choices toward refusing life-sustaining treatment. Perhaps the most egregious are two "fact sheets" regarding tube feeding (<http://www.hospiceofcincinnati.org/downloads/Tube%20Feeding%20-%20What%20You%20Should%20Know.pdf>) and breathing support (<http://www.hospiceofcincinnati.org/downloads/BiPaP%20and%20Ventilators%20-%20What%20You%20Should%20Know.pdf>) put out by Gunderson Health System's "Respecting Choices" program out of La Crosse, Wisconsin, widely used with POLST programs nationally. Recently our organization and many other groups and individuals in the disability community, including the CT Office of Protection and Advocacy and The Arc of the United States, signed on to an open letter from Not Dead Yet to Dr. Bud Hammes which we helped draft, demanding the recall of these biased "fact sheets".

Open letter: <http://www.notdeadyet.org/national-disability-letter-of-living-with-feeding-tubes-and-breathing-support>

Press release: <http://www.prweb.com/releases/2013/12/prweb11442713.htm>

This extreme bias against tube feeding, CPAP and BiPAP breathing devices, and ventilators is life-threatening to tens of thousands of people with disabilities, including members of our organization, who use these devices long-term to live happy and productive lives.

This bill also recognize that issues of undertreatment affect not only people with disabilities, but also others, including African-Americans, Latinos, and those of lower socioeconomic means.

In addition to what is spelled out in SB 413, DPH is also issuing guidance to further prevent misuse of MOLST. We have developed a guidance document regarding proper use of MOLST for people with disabilities. Many people with significant disabilities are often misperceived as having end-of-life conditions. We clarify that MOLST is inappropriate for use with people with long-term stable or mildly progressive disabilities who are not approaching an end-stage condition. This has been a problem in other states. John Kelly, New England Regional Director of Not Dead Yet and director of Second Thoughts Massachusetts, was recently "MOLeSTed" by Massachusetts MOLST, he and others with disabilities were presented with the MOLST form as if it were mandatory. He writes of his experience: <http://alexschadenberg.blogspot.com/2013/11/john-kelly-responds-to-iom-online-survey.html>

Three months ago, my nurse brought me the Massachusetts MOLST form, with its preferences for certain treatments in extremis. She had been told that they were to complete these forms with every disabled person she follows. I found the form oppressive, and have never in my life seen a questionnaire in which "No" was on the left and "Yes" was on the right. I thought these forms were for people near death.

I asked her what she had been instructed about the form, and whether there were any materials for me. A few minutes earlier, she had given me the notification form for my annual flu shot. But nothing to accompany the MOLST form. She didn't receive any training, either. And while I was confident filling out the form, others may not be. I believe people should receive notice that they will be hit with this kind of form, and be able to have another person present when the discussion happens.

I know people in my community who have been badgered about having a DNR. We hear stories in the media about disabled children having DNRs slapped on them. We have friends who use ventilators, and don't think that they are extreme interventions. Two of my best friends – a writer and a playwright – used ventilators for years.

The characterization of a feeding tube as "artificial" is insulting. I am very happy with my suprapubic tube, a simple rubber catheter that takes care of my urological needs very well. My writer friend also got a feeding tube and she loved it for keeping her alive. The food that went into it was cooked with just as much love as anything someone else would put in their mouth.

One of my friends works for a man with a head injury. When the nurse approached him with the MOLST form, he became extremely agitated, as this kind of harassment has gone on for years. He says over and over that he wants to stay alive, and gets angry when questioned on that decision.

In contrast to Massachusetts and most other states, Connecticut will be consistently listing full treatment first on the MOLST form.

I hope this lengthy discussion shows why we need the safeguards in section (e) in particular of SB 413. That is why we are piloting MOLST first, prior to full statewide

implementation. It will require a lot of educating of the medical profession to get this done right. We need to test for the "klutz factor" and to see that people actually do get the treatments they want. Current research on the POLST paradigm is unfortunately contaminated by investigator bias, with POLST advocates doing almost all of the research claiming to support the paradigm. While the evidence tends to indicate that refusal orders are usually honored, the same cannot necessarily be said regarding full treatment orders. There will be an independent evaluation of the pilot to see that patient wishes are consistently honored.

Having noted a number of major problems with the POLST paradigm, I do want to emphasize that it is very much in our interest to solve the problem of overtreatment. As staunch opponents of assisted suicide / "aid-in-dying," we want to make it clear that people have the right to refuse unwanted and burdensome life-sustaining treatment. In this area, MOLST should help to ensure this right is respected in practice.

Finally, I would suggest three changes to the bill. In section (e)(4)(D), there is a comma missing between "language" and "disability" which changes the intended meaning and needs to be added so these read as separate categories. In the same section, regarding awareness of factors that may affect use of MOLST, I would also suggest adding "religious affiliation" to the list, as religious belief and practice significantly affect the use of MOLST. The debate over POLST among Catholic authorities tells us that this is a major issue, though it certainly affects people of other faiths whose need for flexibility and nuance may well conflict with the checkbox format on the MOLST form. I would also suggest that the pilot extend to two years, to October 1, 2016. One year is insufficient time to train medical personnel and evaluate a pilot in which MOLST is intended for people with 6-12 months life expectancy.

Connecticut should be proud of being the first state in the nation to fully include people with disabilities in designing its POLST paradigm program and doing so in a careful and thoughtful manner. These are complex issues; it is important to take the time to get them right

Stephen Mendelsohn
171 Hartford Road, #19
New Britain, CT 06053-1532
smendelsohn5845@att.net



Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

**DEPARTMENT OF DEVELOPMENTAL SERVICES TESTIMONY
BEFORE THE PUBLIC HEALTH COMMITTEE**

March 14, 2014

Senator Gerratana, Representative Johnson, and members of the Public Health Committee I am Terrence W. Macy, Ph.D., Commissioner of the Department of Developmental Services (DDS). Thank you for the opportunity to submit testimony in support of Senate Bill No. 413, An Act Concerning Medical Orders for Life Sustaining Treatment (MOLST).

S.B. 413 would establish a pilot program to implement the use of medical orders for life-sustaining treatment. DDS supports the concept of MOLST and the pilot. DDS hopes that individuals with intellectual disability will participate in the pilot.

DDS is appreciative that the Department of Public Health (DPH) has consistently invited DDS to participate in discussions on this issue and in the development of the pilot program. DPH has been respectful and mindful of the rights of individuals with intellectual disability and how this process might impact them and we fully expect this commitment to continue.

Thank you again for the opportunity to testify in support of SB 413. Please contact Christine Pollio Cooney, DDS Director of Legislative Affairs at 860 418-6066 if you have any questions for us regarding this bill.

Dear Senator Gerratana, Representative Johnson and members of the Public Health Committee, (in particular, Representative Miller, as I heard you speak this morning at the Middlesex Coalition for Children's Legislative breakfast)

Thank you for supporting HB 5330, An Act Concerning the Application of Pesticides at Parks, Playgrounds, Athletic Fields and Municipal Grounds. It is an important and necessary additional step forward to protect the health of all children in Connecticut. Currently, state law does not allow lawn care pesticides on school grounds K-8. This bill will extend that ban of these toxic chemicals to all public areas, where our children can still be involuntarily exposed despite the known health risks.

There are compelling reasons not to allow lawn care pesticides on public grounds. Numerous studies have linked the 30 commonly used lawn pesticides with serious health effects, including 19 studies linking these pesticides with cancer, 13 with birth defects, 21 with reproductive effects, and 15 with neurotoxicity or abnormal brain development. Other studies have linked these pesticides with hyperactivity, developmental delays, behavioral disorders and motor dysfunction. Children are particularly vulnerable due to their rapidly developing bodies. When pesticides are applied, children can be exposed when they walk on or play in the grass. The pesticides can also be tracked inside the schools (and our homes), where they can persist for long periods of time, exposing children even if they were not in contact with the grass.

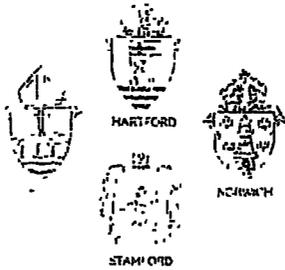
Given the overwhelming evidence, why would we put our children's health at risk for cosmetic reasons?

There are safe, effective and affordable alternatives to these toxic pesticides for both grounds and fields. Lawns and fields can be maintained to the highest of standards without the use of dangerous chemicals. It may be a different way of doing business for typical municipal grounds employees and landscapers and require retraining, but safe, proven methods do exist and many municipalities have made the switch successfully, including Branford and Cheshire. Our friends in New York have a state law that bans lawn care pesticides on all schools, providing numerous examples of beautiful turfs maintained organically.

Considering there are so many unknowns and so much plausible evidence about the dangers of these chemicals, it seems unconscionable to continue to expose our children to these risks. CT made the important step of protecting its younger school children, but now it is time to protect all our children as well.

Thank you!
-Monica Belyea

Monica J Belyea, MPH, RD
Food & Nutrition Consulting
186 College Street
Middletown, CT 06457
860-833-2365
mbelyea@att.net



MICHAEL C. CULHANE
EXECUTIVE DIRECTOR
DEACON DAVID W. REYNOLDS
L.S.J. APRIL 1994

CONNECTICUT CATHOLIC PUBLIC AFFAIRS CONFERENCE, INC.
134 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06105-5784

Testimony of Michael C. Culhane
Executive Director
Connecticut Catholic Public Affairs Conference

Public Health Committee
March 14, 2014
Legislative Office Building, Room 1D

SB 413, "An Act Concerning the Department of Public Health's Recommendations Regarding Medical Orders for Life-Sustaining Treatment"

The Connecticut Catholic Public Affairs Conference (CCPAC), the public policy office of Connecticut's Catholic Bishops, would urge the members of the Public Health Committee to *support in concept* SB 413, "An Act Concerning the Department of Public Health's Recommendations Regarding Medical Orders for Life-Sustaining Treatment".

The underlying goal of SB 413 is to clarify the health care wishes of patients with serious, life threatening illnesses and the use of extraordinary means to keep an individual alive. The CCPAC notes that SB 413 reiterates the same provisions of HB 6521 from the January 2013 Session, but includes a new Section 1 (e) to this current legislation. It is noted that this section addresses the specific requirements as to MOLST procedures and forms, which includes the training of medical providers relative to *talking points* on MOLST, the methods of choice, the importance of properly informing patients, as well as the procedures for properly completing the MOLST form. The concern of the CCPAC is that this legislation *should place more* emphasis on the involvement of family members and trusted friends as opposed to a medical provider who may not have a relationship or knowledge of a patient's medical history. More emphasis should also be placed on a patient's wishes and actual circumstances at the time of need. Therefore, the CCPAC prefers the utilization of an Advanced Directive which would clearly involve a close individual in the decision-making process at a very delicate time.

It must be noted that Catholic Moral Teaching allows for the withholding or discontinuation of medical treatment in certain circumstances when life expectancy could be prolonged or excessively burdensome to a patient; decisions to discontinue treatment must be made based on the actual circumstances and the medical situation of the patient at a specific point in time.

The CCPAC also notes that the Department of Public Health must establish a pilot program in one or more geographic areas and it is our hope that our concerns are addressed during the regulatory process regarding this legislation.

With the aforementioned points noted, CCPAC supports SB 413 in concept.


Michael C. Culhane

Testimony of Gregory B Allard, Vice President
American Ambulance Service, Inc. &
Association of Connecticut Ambulance Providers

Public Health Committee

Friday, March 14, 2014

Senator Gerratana, Representative Johnson and distinguished members of the Public Health Committee.

My name is Greg Allard and I am the Vice President of American Ambulance Service, Inc. located in Norwich, CT and of the Association of CT Ambulance Providers.

The Association of CT Ambulance Providers includes companies that provide emergency medical services to approximately 200,000 patients annually. Our membership provides care in over 35 municipalities and offers mutual aid to an additional 50 municipalities. These urban and suburban municipalities include areas such as East Hartford, Hartford, Manchester, Mashantucket Pequot Tribal Nation, Middletown, Meriden, Waterbury and Torrington. The estimated population served is over 800,000. Our mobile integrated healthcare team has a network of 136 ambulances and approximately 1600 professionals that we employ. In addition to the patient care we provide we are all very active in our communities.

My testimony today is in favor of ***Raised Bill No. 413, An Act Concerning the Department of Public Health's Recommendations Regarding Medical Orders for Life-Sustaining Treatment (MOLST)***.

The Association of CT Ambulance Providers supports the idea of a pilot program like this in the State of Connecticut. We are surrounded by states that have instituted the MOLST program years ago. Our current DNR system is very cumbersome and in our opinion underutilized as a result. If CT adopts the MOLST program it makes it easier for us when we cross state lines into Massachusetts, New York and Rhode Island. It will also be beneficial to out-of-state patients in CT. Right now EMS providers don't recognize these medical orders. This can be confusing to the patient, their family and the EMS professional. The last thing we want to do as a patient care provider is add to the stress of an already difficult situation. Although these points are brief we think they are worthwhile and again we encourage you to support this bill.

In closing I'd like to add that any member of the Association of CT Ambulance Providers would welcome the opportunity to be an active participant in the pilot program.

Respectfully submitted,

Gregory B. Allard



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Friday, March 14, 2014**

**SB 413, An Act Concerning The Department Of Public Health's Recommendations
Regarding Medical Orders For Life-Sustaining Treatment**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 413, An Act Concerning The Department Of Public Health's Recommendations Regarding Medical Orders For Life-Sustaining Treatment**. While CHA supports this bill, we wish to offer some recommendations regarding its implementation.

Before addressing the merits of the bill, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

As frontline caregivers, Connecticut hospitals are absolutely committed to initiatives that improve access to safe, high-quality care and expand access to coverage. Our hospitals are dedicated to working with state agencies and others to clarify the options available to patients, and improving communication between patients and their healthcare providers on end-of-life care and decision making.

One such initiative that is worthy of consideration involves the use of medical orders for life sustaining treatment (MOLST). MOLST provides a framework for healthcare providers to put in place orders that ensure patients approaching the end-stage of a serious, life-limiting illness

or in a condition of advanced, chronic progressive frailty receive the treatment they want and avoid treatments they do not want.

The MOLST paradigm is an advance care planning tool that uses a structured process of shared decision making to enable patients to express their preferences about probable medical interventions. MOLST provides a mechanism to assure that physicians and patients discuss and reach an understanding and agreement regarding end of life care and that medical orders are entered to implement these decisions.

We recognize that communicating with patients is a critically important aspect of providing appropriate healthcare. When patients are unable to communicate their preferences for the complex array of medical interventions available, they may be at risk for not receiving desired treatments or receiving treatments that would be beyond what they would choose if they were able to participate in a thoughtful discussion of options. MOLST is intended to facilitate a discussion between a patient and a trained healthcare provider that is focused on the patient's needs and documented in the MOLST order.

CHA is grateful to have joined with a group of concerned citizens, healthcare providers, public health leaders, and advocates for persons with disabilities working under the auspices of the Department of Public Health (DPH) to consider the viability of MOLST in Connecticut. We acknowledge that each of our neighboring states have adopted some form of MOLST.

SB 413 will empower the Commissioner of Public Health to authorize the establishment of a voluntary MOLST pilot program in Connecticut, evaluate the MOLST framework, and gather information and experiences related to the potential challenges of implementing MOLST in our state.

CHA is pleased that SB 413 addresses the need for transparency in the execution of the pilot program and the need to collaborate with healthcare providers in the establishment of forms, policies, and procedures. We support the requirement that DPH develop education and training programs for those healthcare providers who volunteer to participate in the program.

While CHA supports the establishment of a MOLST pilot program, we recommend that DPH conduct communication and education programs to inform persons residing within the designated geographic areas about MOLST.

We also recommend that DPH establish clarity with respect to how the pilot program will intersect with existing law, including constitutional, judicial, and statutory constraints. Specifically, those planning for the MOLST pilot would need to carefully consider, at a minimum, the rights and protections provided in the federal Patient Self-Determination Act, the Medicare Conditions of Participation for hospitals, Chapters 7c and 368w of the Connecticut General Statutes, and the case law that clarifies the process and methods for individuals to make their own healthcare decisions or delegate those decisions to others.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

 **HEALTHCARE 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 14, 2014

**In Support of Raised SB 413:
AAC THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS
REGARDING MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)**

Good morning Senator Gerratana, 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 an RN with over 30 years experience in home health, hospice, long term and acute care. I am also a member of the current CT MOLST Committee.

The Association represents 60 Connecticut licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home. Collectively, our agency providers deliver care to more CT residents each day than those housed in CT hospitals and nursing homes combined.

The CT Association for Healthcare at Home supports Raised SB 413 that would establish a pilot program to implement the use of Medical Orders for Life-Sustaining Treatment or MOLST.

MOLST is known nationally as POLST or Physician Orders for Life-Sustaining Treatment. <http://www.polst.org/> is an excellent resource website offering education to both consumers and providers, a review of literature, other state activity/support, protocols, etc. Currently, 15 states have mature or endorsed programs, 31 have developing programs (CT included) and 5 have no programs.

The primary goal of a MOLST program is to encourage conversations between the person and the primary care provider about end-of-life care before the person's condition becomes a crisis. Too often, this conversation doesn't occur until the person is in crisis in the emergency department or in the ICU at a hospital and it's with a care provider who doesn't know the person or their history. And, all too often, the conversation never occurs. MOLST helps ensure that these conversations take place between the person and the physician or APRN with whom they have an established relationship.

 **HEALTHCARE HOME**

The MOLST Program is targeted for specific populations, including persons with serious life-limiting illnesses or persons of advanced age who are interested in defining their wishes relating to end-of-life care. These wishes are documented on a state-approved standardized form that includes medical orders written by a physician or APRN—Should this pilot be approved, the outcomes of the pilot will help guide us to a MOLST form that fits the needs of our CT residents.

The MOLST form will enhance the effectiveness of a living will or advanced directives by identifying the person's specific wishes on key medical decisions based on their current medical condition. Advanced Directives and Living Wills are not medical orders and may not have been completed in consultation with the person's health care provider. They are also usually completed one time and not reviewed again. MOLST would be initiated and reviewed and updated with each visit to the healthcare provider.

As a united voice for the home health and hospice providers in CT, the CT Association for Healthcare at Home promotes and supports coordinated person-centered informed decision-making especially with regard to end-of-life care. It's unfortunate that CT who is the founding state in the United States of hospice care some 40 years ago is and has been ranked 51st in the country (including Washington DC) in hospice length of stay. This translates into "last minute hospice care" which means we are not doing an adequate job having the difficult conversations early enough in the disease process.

The MOLST pilot will include an educational component to help care providers have the difficult conversations and it will be earlier in the disease process which may encourage more life review, more questions, more information, which should translate into a greater likelihood that the person is making informed healthcare decisions, not last minute decisions in the midst of a crisis.

Thank you and if you have any further questions, please contact me directly at Wodatch@cthealthcareathome.org or 203-774-4940.



Testimony on Senate Bill 413 Act Concerning Department of Public Health Recommendations
Regarding Medical Orders for Life-Sustaining Treatment
Public Health Committee
March 13, 2014

Senator Gerratana, Representative Johnson and members of the Public Health Committee, on behalf of physicians and physicians in training of the Connecticut State Medical Society (CSMS) and American College of Physicians Connecticut Chapter (ACP) thank you for the opportunity to provide this testimony to you today on Senate Bill 4131 An Act Concerning Medical Orders for Life-Sustaining Treatment (MOLST)

On a daily basis many of our members deal with patients in end of life situations. Not only are these emotional and difficult situations, but understanding and more importantly fulfilling the wishes of the patient is critical. In addition, the wishes of the patient as formulated in Living Wills or Advanced Directives are often misinterpreted or unavailable when needed. This often exacerbates the situation and even leads to increased costs associated with end of life care.

In recent years, national initiatives aimed at better translating a patient's end-of-life goals have gained traction. This led to the development of MOLST projects either approved or in development in almost every state. Unlike Advanced Directives or Living Wills MOLST creates a situation in which the patient's preferences for end of life care are clearly expressed into an actionable medical order that follow the patient through all health care settings along the continuum of care.

Our organizations support the establishment of a pilot project for a MOLST program in Connecticut. However, it is critical that appropriate education exists of health care providers involved in the program, and a cautious approach at to what level of health care provider is appropriately trained to participate in such a program. Education must also be provided to the individuals who are eligible to participate in the program as well as their families.

It is imperative that physicians and appropriately trained medical professionals are involved in the pilot program from its development, through implementation to the collection and analyzing of results. If done correctly we fully agree with many other organizations providing testimony today that a comprehensive and functional MOLST program in Connecticut will facilitate implementation of end of life decisions and increase the probability that the wishes of the patient are appropriately interpreted .

Testimony in Support of Raised Bill #414
Connecticut Advanced Practice Registered Nurse Society

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATION REGARDING
MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT

March 13, 2014

Concerning the Raised Bill No. 413, an Act Concerning the Department of Public Health's Recommendations Regarding Medical Orders for Life Sustaining Treatment (MOLST) receives full support from the Connecticut Advance Practice Registered Nurse Society (CTAPRNS). This bill is in the best interest of the citizens of Connecticut and will impact all of them at some time in their life. The ability to pilot this program for potential use in the entire state will allow Connecticut to align with other New England states in End-of-Life care.

A goal of this bill is to educate all providers, APRN, MD, & PA, to have a conversation regarding the patient's wishes at end of life. This is patient centric conversation with the aim of documenting and implementing the patient wishes in a way that can be carried out by all medical personnel. This is a conversation that should be started prior to the patient's condition becoming a crisis, as well is as it is a conversation that is ongoing. This bill and the pilot program it outlines will encourage that conversation to take place with the patient Primary Care Provider, the person the patient has an established relationship.

Connecticut Advance Practice Registered Nurse Society supports Raised Bill #413 and encourages the Public Health Committee advance this bill to the full legislature.

CTAPRNS Board of Directors

Elizabeth MB Visone, DNP, ANP-BC, FNP-BC, APRN

CTAPRNS representative on the MOLST Task Force

**Testimony of Susan Lloyd Yolen, Vice President, Public Policy & Advocacy,
Planned Parenthood of Southern New England
CT General Assembly Public Health Committee, March 14, 2014**

**Raised Bill 413: An Act Concerning the Department of Public Health's Recommendations Regarding
Medical Orders for Life Sustaining Treatment**

Thank you for this opportunity to provide testimony on the important and timely matter of medical orders for life sustaining treatment. Planned Parenthood of Southern New England is the state's largest provider of family planning and basic reproductive health care. We operate 17 health centers in Connecticut and serve over 65,000 patients annually. We offer education and training programs to youth, youth-serving professionals and parents. And we advocate for public policies that protect our services and the individuals who access them.

While PPSNE does not provide prenatal care, we offer pregnancy testing and counseling to a wide range of women of reproductive age, and we often refer women for prenatal care. We know that women take impending motherhood seriously and they weigh their personal life situation carefully as they consider their options when pregnant. We also know that unexpected events occur---accidents, acute and chronic illness---which impact pregnant women just as they do all others in a population. Healthy pregnancies can and do turn tragic under some circumstances, even with modern interventions available. Women facing wanted pregnancies may become acutely ill or face life threatening situations when a discussion of medical orders for life sustaining treatment could become necessary.

PPSNE recommends that this raised bill to create pilot programs be amended to include "pregnancy status" on the list of factors that may influence the use of medical orders for life-sustaining treatment, including but not limited to: "*Race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language disability, homelessness, mental illness and geographic area of residence.* "

The bill anticipates reasons to consider the impact of medical orders on individuals experiencing any of these life or health status experiences. A pregnant woman could experience more than one of these factors, and yet the critical issue of her pregnancy status (and impact of serious illness or injury on a child she hopes and may still expect to bear) has not been addressed by the legislation. While we cannot cite studies to prove this, it seems likely that pregnant women experiencing serious, potentially terminal illness would welcome the reassurance of a frank conversation and a plan for how she will be treated medically should her illness progress before she delivers.

Testimony in Support of Raised Bill #414
Connecticut Advanced Practice Registered Nurse Society

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATION REGARDING
MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT

March 13, 2014

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A goal of this bill is to educate all providers, APRN, MD, & PA, to have a conversation regarding the patient's wishes at end of life. This is patient centric conversation with the aim of documenting and implementing the patient wishes in a way that can be carried out by all medical personnel. This is a conversation that should be started prior to the patient's condition becoming a crisis, as well as it is a conversation that is ongoing. This bill and the pilot program it outlines will encourage that conversation to take place with the patient Primary Care Provider, the person the patient has an established relationship.

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CTAPRNS Board of Directors

Elizabeth MB Visone, DNP, ANP-BC, FNP-BC, APRN

CTAPRNS representative on the MOLST Task Force

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 7
2693 – 3194**

2014

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jmf/gbr PUBLIC HEALTH COMMITTEE

March 17, 2014
10:30 A.M.
ROOM 1D

untenable and unimaginable that someone could come up with the suggestion that the creator who gives rights has established a right to die.

REP. SRINIVASAN: Thank you very much. Thank you, Madam Chair.

SENATOR GERRATANA: Thank you for your testimony.

Next is Tracy Wodatch. Is Tracy here? There she is, to be followed by Eileen Bianchini.

TRACY WODATCH: Good evening. It's been a long night for everyone. I appreciate everybody still being here. My name is Tracy Wodatch, I'm the Vice President of Clinical and Regulatory Services at the Connecticut Association for Health Care at Home. I'm also an R.N. with over 30 years of experience in primarily home health and hospice care, but I've worked across the care continuum. We do have several people testifying. We managed to pick some really late numbers today, so we're all together. And I am hoping some of the questions that you did ask some of the previous testifiers, I think you will find you'll be able to get some good answers from -- from our testifiers, hospice providers with excellent pain management, symptom management, holistic approach to hospice and palliative care. So please utilize that if you would.

Our association is a united voice for 26 of the 27 hospice and palliative care providers in the state. The 27th is Connecticut Hospice, and Dr. Andrews was here earlier today testifying and he did a superb job with his testimony and really hitting all the key points on why we at our association as well as Connecticut Hospice are opposed to H.B.. 5326. Another thing that

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-- I'm just going to try to hit some key points because a lot has been said, so I don't need to be repetitive.

I think the biggest point that I want to make sure everybody understands is that we in Connecticut nor in this country still fully understand what is capable in provision of hospice and palliative care. Hospice, throughout today's testimony has been referred to as a place. They say leaving this place or that place, hospice is not a place. Hospice is a philosophy of care, a holistic approach both physical, psychological, spiritual, social, hitting the -- really trying to help with the family unit, friends, support. And it's support in helping the dying patient die a peaceful death and in helping the family and the friends who are left behind in -- in dealing with the bereavement and grief that goes along with -- with the dying patient.

We have supported the MOST bill, Senate Bill 413, and we are in full support of that and we're also -- last year in support of the Palliative Care Advisory Council and are very pleased to see how far along that's already come in just a couple of meetings. Those two pieces alone if we can pass the MOST bill and we can move forward on palliative care, I think we'll be laying a better groundwork for -- for Connecticut. We are last in the country -- in Connecticut we are last in the country in length of stay for hospice care. That means that we're providing last-minute hospice care. We're not getting our patients on soon enough. We are the founders of hospice. Connecticut Hospice is the pioneer in the country, yet we are last in the country in being able to refer people early enough to hospice. So that is really where we need to focus our point.

In my testimony, I know -- I know that my time is limited here, but in my testimony I want you to really focus on the physician viewpoint. We've heard from several physicians today, only one being in support and all the rest being opposed to the bill and for the obvious reasons that have already been stated. I ask that physicians should go out on hospice and palliative visits.

SENATOR GERRATANA: Tracy, can you summarize your testimony.

TRACY WODATCH: The other pieces that I want to make sure hopefully that you'll look at is within my last couple of pages I highlight several areas of the bill should you consider actually passing this bill, there are several areas that are in need of -- of being addressed and they're clearly outlined in -- in my testimony.

SENATOR GERRATANA: I actually read your testimony a while ago, I think earlier in the day too. But we really appreciate your giving your testimony and you're absolutely right. I think one of the challenges here is that people misunderstand end of life, advanced directives, what's available in terms of hospice care, palliative care, all of these issues that I'm happy that my co-Chair and I and the Committee decided that we really need to step up a little bit to address that -- those very issues. So we appreciate that.

Actually, Representative Johnson has some questions for you.

REP. JOHNSON: Thank you so much, Madam Chair. And so going back to the testimony earlier in the day, there was testimony from somebody who

had -- had an experience in hospice that wasn't as positive as -- as, you know, most of -- most of the experiences are. And, of course, you know, nothing is 100 percent. So I was -- I asked the presenter whether or not, you know, there was an issue in terms of maybe finding another doctor to maybe look at the situation so that they could, you know, maybe make a different selection in terms of the types of pain medication or the types of palliative care that the patient was receiving. So the person didn't know how that could be done.

And I wondered if it had something to do with networks, in-system, out-of-system. I know that the hospices are affiliated with other providers because part of -- at least if they're Medicare certified, they have to have contracts with -- with other providers so that they can provide the full spectrum of care with hospital care, skilled nursing facility care, home care. And so I just wondered is it because of the network that they couldn't find a different physician to help out with the palliation or was it something else?

TRACY WODATCH: Well, I believe it was Representative Sayers earlier today that spoke to the large percentage of Medicare and Medicaid beneficiaries that utilize hospice and palliative care. That is the largest population, however, and when you look at that population whether it's Medicare or Medicaid, that is paying for the hospice benefit, it's a wide open network. They can choose whichever provider they -- they would like. As far as commercial providers or commercial payers are concerned, they do tend to have contracts with certain providers.

So perhaps that might be one of the issues. I

think primarily what the issue probably was in what you just phrased to me as a question was it didn't sound as though the person was informed as to what their choices are and what they can do and what's capable of -- of good hospice and palliative care. We recognize that it can't be perfect every time. And I know some of the things that Senator Holder-Winfield went through, I'm so sorry for what you've been through. That's not the way it needs to be and -- and I do hope that if we can do more with having the conversation in advance, for caring for people, helping them understand their choices, and navigating them through the system which is an extremely difficult system, and I think we can get a lot further along.

I think MOST will help that. I think the national initiatives for advanced care planning, goals of care, having the conversation, those things are all happening now which, you know, some of the deaths that were referred to earlier today, in 2007, 1999, we've come a long way even in that short period of time. But we are nowhere near where we need to be.

REP. JOHNSON: Thank you for that. And I hope that, you know, this -- this conversation will help us reconnect with the Palliative Care Task Force so that we can try and make sure that information is spread throughout the state about the types of services that are available, maybe make more flexibility available to the hospices so that they'll maybe all participate whether they are private and non-certified Medicare hospices or they're certified Medicare hospices. Thank you for that.

TRACY WODATCH: They're all certified -- all the hospices in the state are certified.

REP. JOHNSON: Well, they're all certified, I understand that they're certified but they're not necessarily Medicare certified.

TRACY WODATCH: They're all Medicare certified.

REP. JOHNSON: Not -- there are some that are -- that are difference.

TRACY WODATCH: Well, then they're not licensed by the Department of Public Health.

REP. JOHNSON: Perhaps. But in any event we won't have that conversation, I just want to make sure everybody. Thank you.

SENATOR GERRATANA: Thank you.

Representative Cook.

REP. COOK: Thank you, Madam Chair. Hi, Tracy.

TRACY WODATCH: Hi. How are you?

REP. COOK: Good. How are you?

TRACY WODATCH: Good.

REP. COOK: My question is as we've sat here for many hours today we've heard a variety of different opinions. And I think one of the themes was that people felt that they could not get into hospice early enough, that it was a constant problem that, you know, a week or two weeks before somebody, you know, the end of life is coming then that's when hospice gets on board. With the conversations that we're having, is there a possibility that we can alter the way that that happens? Are we missing something? Do people actually -- can

they go on hospice earlier? What can we do to rectify some of those situations that might help this situation?

TRACY WODATCH: Well, I think some of the things that we've been doing in the state over the last couple of years are -- we're going to start to be able to see the effect of that. Our association is involved in a collaborative approach with all the other state association and providers of care, the Connecticut State Medical Society, the hospital association, the two nursing home Leading Age and CAHCF, we get together on a regular basis and look to what we can do to help care across the continuum. We're actually in the middle of providing an end-of-life series that started with looking at advanced directives, living wills, helping everybody understand that what the law says, and then also informing them a little bit about the potential for MOST should that go into place.

We just recently had an Alzheimer's end-of-life series with a panel of experts from across the care continuum. We've been working with other care providers, with Qualidigm, our state quality improvement organization, and we've had several statewide programs, one specific to hospice and palliative care and then one was a statewide conference open to consumers as well. And we brought in national speakers on advanced care planning. So we're really trying to do what we can to at least get the word out. We need to all work together and really make it a team effort.

REP. COOK: So with the understanding that every situation is different, we know that every cancer progresses at a different rate and we know it affects everyone differently. What

right now currently is the earliest someone could get involved with hospice to start helping that transition towards their end of life versus the whole a week out or two weeks out?

TRACY WODATCH: Well, I guess first off, palliative care can be provided throughout a serious illness from the initial diagnosis. And palliative care in the bill is actually defined incorrectly and that's part of my statement that was in my testimony. It's not for terminal -- terminally ill, it's -- it is eventually, but it's for people with serious illness not just cancer but many chronic conditions. So what we can do is we can really work with the physicians to have those conversations very early on. And as someone is diagnosed with lung cancer, as someone is diagnosed with end-stage chronic pulmonary obstructive -- I can't even speak, I'm sorry, COPD, chronic obstructive pulmonary disease, they should be aware that there are choices and things that they'll be facing coming down the road.

And it's unfortunate that, you know, in the work that we do, hospice many times is a word that is the last to come out of any practitioners mouth because it is equated with death. And so palliative care becomes a more palatable way to talk about it, but it's overall comprehensive holistic care just as hospice is and we can transition them a lot sooner. Prognosis does need to be, you know, it's not an exact science, but it does need to be within six months. So trying to get them on at the six month mark versus the one week or two week mark makes a world of difference in the overall ability for the providers to give the care needed.

REP. COOK: One last question, Madam Chair? And do we find that as -- you were saying that things have obviously changed over the years and we've heard horror stories, do you find that the medical professions -- professionals are starting to understand and reach out to you guys a little bit more earlier or are we still stuck in that two week, three week mode and this is an individual responsibility now to come and find, you know, the home care and hospice groups?

TRACY WODATCH: I think we're still struggling, but I think that there are some physicians that truly have started to -- to see the value. It's the work of all the hospice and palliative care providers in the state that have to, you know, do the marketing and really help them understand -- help the physicians understand. The whole piece about having the conversation, I know I think it was Dr. Giles had said that -- that it's taught -- she was taught to do -- have the conversation.

Dr. Zeidler who is going to be testifying for us shortly was also taught, but there are many physicians who were never taught to have that conversation in med school and they're put in a situation where they're just not comfortable. So they really need practice and that's part of what we're trying to do with the MOST bill, to help them have difficult conversations and then be able to document it and put some -- some orders in place for what that person really wants for their -- for their end of life care.

REP. COOK: Thank you. Thank you so much for all your information and all of your help that you've given us over the past couple of years in my family and knowledge. And thank you,

Madam Chair.

SENATOR GERRATANA: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair. Thank you very much for your testimony this evening. As you said very appropriately that we are the pioneer state as far as this care is concerned. And unfortunately we are now if not at the bottom of the ladder, very close to that. So - - and I know as you outlined that, you know, over time we will see the results of all these conversations you're having with the medical group, the hospital group, and so on and so forth. Obviously those results don't happen overnight, they will take time, and I'm hoping -- I'm sure we're heading in the right direction which is -- which is what we need to be at.

My question to you is in comparison to those who are at the top of the rung of the ladder or close enough to that, what is it that the other states are doing so that their -- their patients don't come in a week before or ten days or two weeks before compared to the six month as what we are doing other than, you know, what you just outlined time will tell us.

TRACY WODATCH: It's a difficult answer to give without addressing some of the federal scrutiny that's going on states right now that are utilizing hospice way too much and not necessarily appropriately. So it's a fine balance to make sure that you're following the hospice benefit as laid out through -- through Medicare. It's for six months or less prognosis, if someone falls into that six month prognosis, you can -- you can put them under the benefit. But if they improve, Dr. Andrews spoke earlier today that they have a 20 to 25

live discharge rate from their hospice facility down in Branford. That's because people do improve and they take them off. So we're kind of caught.

We're doing the right thing by taking them off when they should be taken off, but we're not getting them soon enough. So the other states -- there are some states that have well evolved programs, there are other states that have way too high of a length of stay. So it's the median where we would really like to be versus the bottom or the top I think because that's probably a better indicator. And they're having conversations and they're, you know, I think perhaps just a little bit -- I don't even -- I can't even answer truly why they have a higher length of stay than we do. I know we have a very short length of stay as far as a lot of hospital admissions that end up turning into one and two day hospice stays and then the person passes. So that really affects our length of stay overall.

REP. SRINIVASAN: Thank you very much. You would naturally and obviously have to be federal compliant, there's no question about that at all. So as you very appropriately said, that fine line as to where you are overdoing it is obviously going to be raising red flags and concern to you, that particular state, and obviously the authorities involved in the process. So you feel that since we are -- as you chose the word appropriately, marketing the services available and the length of time these people can actually come into as opposed to the last few weeks that we should soon be able to reap the results and see people coming into this hospice treatments much earlier in a relatively short period of time?

TRACY WODATCH: I don't know about a relatively short period of time. We're hoping to see a swing in the next five to ten years absolutely. I think one thing that's really important for the Committee to understand is that hospice is not just for people with cancer. Hospice is for people of all different diseases and cancer is not even the highest percentage of -- of those that are on hospice. Heart -- heart failure, cardiac, pulmonary, dementia, those are all diagnoses that now are the top diagnoses of people that are cared for under hospice.

REP. SRINIVASAN: Thank you. And my final question to you, maybe you're the right person to answer or you said others are coming after you and I'll leave that to your judgment as to who would be best to answer the question. As both Representative Demicco and I asked the previous speaker that in terms of how well can you control the pain in these patients who are in the hospice care? Is that very, very controlled? Obviously nothing can be controlled 100 percent, we understand that. But could you give us an idea or maybe somebody speaking after you could enlighten us.

TRACY WODATCH: I definitely experts here that -- that can speak to that for you. I think that it was answered very well. And since she, you know, she had said, there are very few that we're not able to control. And we work very hard to try to get that control to happen. I think the other piece that's been talked a lot about today is morphine and morphine drip and hastening death, and I really want to make sure that -- that our group addresses that. Because I think to hear it from -- from those that provide the care, you'll -- you'll have a better comfort level I think.

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10:30 A.M.
ROOM 1D

REP. SRINIVASAN: Thank you very much for your testimony. Thank you, Madam Chair.

SENATOR GERRATANA: You're welcome.

Are there any other questions?

If not, thank you so much for your testimony.

TRACY WODATCH: Thank you very much.

SENATOR GERRATANA: Certainly.

Next is Eileen Bianchini -- Bianchini, followed by Dr. William Zeidler.

EILEEN BIANCHINI: Hello. I'm Eileen Bianchini and -- are you hearing me okay? I'm with the Connecticut Right to Life, I'm the Chair. And my team and I are very, very happy to be here to speak and testify against H.B.. 5326. We thought we'd talk about it from a high level. We see the bill as being a result of an outgrowth of the infrastructure, the physician (inaudible) infrastructure. And that's where we find out greatest fault. The bill we have fault with it too, we think it's (inaudible) actual infrastructure. What we have observed in Oregon (inaudible) Oregon reports. We've talked with doctors, you have a lot of my information in my testimony, and doctor's letters. And what we have observed is that we see that the infrastructure does not really integrate well with today's multidisciplinary medical models.

That is actually a stand-alone structure. And being a stand-alone structure, what that means it doesn't coexist and with the multidisciplinary models and it presents undue