NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LINDA ROSEN, M.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

Senate Committee on Health

HB 2052, HD 2, Relating to Provider Orders for Life-Sustaining Treatment

Testimony of Linda Rosen, M.D., M.P.H.
Director of Health

Monday, March 17, 2014

Department's Position: The department SUPPORTS the intent of this bill WITH COMMENTS AND RESERVATIONS on specific parts.

Fiscal Implications: The fiscal implications are undetermined.

Purpose and Justification: Following passage of the original POLST bill in 2009, the department remained a voluntary and active participant along with local practicing physicians and clinical and professional experts to help shape POLST and the current POLST form. The department supports the intent of POLST and the aim of the current and companion bills to expand signatory authority to advance practice nurses. The department also recognizes the differences between this HB2052, HD 2 and SB 2227 and prefers the language in SB 2227. On HB 2052, HD 2, the department defers to legal and technical experts on language concerning the capacity of patients and other technical language changes. However, the department opposes the requirement for the department to develop and adopt a sample POLST form. Such a requirement would be unnecssary since a POLST form has already been developed and adopted and it is recognized state-wide by 1st responders and healthcare professionals. The form is used to write medical orders, and as with other medical orders forms should not be regulated. The form was modeled after forms used in other parts of the country and the local physicians

and experts continually review the form for improvement based on national standards and as best practices emerge through study and experience. Requiring the DOH or any other state agency to develop and adopt a sample form would undermine the current process and be a disservice to the community. It would require DOH to adopt administrative rules that would create an unintended burden on the currently successful process without any measurable improvement or benefit to the public. This process would create a *de facto* POLST form rather than a sample form and the department would then become responsible to track national standards and best practices without the financial or professional resources required for the job.

As a result, the Department of Health favors SB 2227 and respectfully requests that any requirement in HB 2052, HD 2 for the department to develop and adopt a sample POLST form be removed.

Thank you for the opportunity to testify.

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LINDA ROSEN, MD, MPH
DIRECTOR OF HEALTH

WESLEY LUM, PH.D., MPH
DIRECTOR

Telephone
(808) 586-0100

Fax
(808) 586-0185

STATE OF HAWAII
EXECUTIVE OFFICE ON AGING
NO. 1 CAPITOL DISTRICT
250 SOUTH HOTEL STREET, SUITE 406
HONOLULU, HAWAII 96813-2831

Committee on Health

HB2052, HD2, RELATING TO PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT

Testimony of Wes Lum
Director, Executive Office on Aging
Attached Agency to the Department of Health

Monday, March 17, 2014; Conference Room 229

1:45 p.m.

EOA's Position: The Executive Office on Aging (EOA) opposes HB2052, HD2, but supports the original wording of HB2052 with suggested technical amendments as specified below.

Purpose and Justification: EOA recommends the following amendments:

1. Replace HD2 with the original language of HB2052 with these additional amendments:
    a. Section 327K-2(b) and (c), HRS, should be amended to reflect the changes in terminology made in this bill.
    b. Section 327K-2(a)(3), HRS, should be amended to add the word "patient's" before legally authorized representative on page 5, line 19.

This bill expands healthcare provider signatory authority to include advanced practice registered nurses (APRN), which EOA supports. However, HB2052, HD2 only allows a previously appointed designated decision maker (appointed in writing by the patient through an advance

directive) to complete a POLST, which would deny many individuals from having the benefits of a POLST; EOA does not support this provision.

EOA believes that the mandate to require DOH to adopt a sample POLST form pursuant to Chapter 91, HRS, is unnecessary because Hawaii has a voluntary universal POLST Orders Form that is currently used throughout the state.

The initial wording of this measure reflects the recommendation of the State Plan on Alzheimer's Disease and Related Dementias (ADRD) to realize the goal of enhancing care quality and efficiency. We believe that in order for Hawaii to achieve the vision of the best quality of life for those touched by dementia, it is imperative to achieve the highest quality of culturally competent care possible and a state infrastructure sensitive to the needs of people with ADRD and their care partners. Consumers and their families need to have all appropriate services and care to maximize quality of life, delivered in a coordinated way from early and accurate diagnosis to the end of life. POLST is a holistic method of planning for end of life care and a specific set of medical orders that ensure that patients' wishes are honored. Therefore, expanding healthcare provider signatory authority to include APRNs will assist with a timely completion of a POLST for persons with dementia.

Thank you for the opportunity to testify.

HAWAI'I STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Written Testimony Presented Before the
Senate Committee on Health
March 17, 2014 1:45 p.m.
Conference Room 229
.
by
Kathy Yokouchi, Policy Analyst
Member, HSCN Advisory Board
Hawaii State Center for Nurisng
University of Hawai'i at Manoa

HB 2052, HD1 RELATING TO PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.

Chair Green, Vice Chair Baker, and members of the Sentee Committee on Health, thank you for this opportunity to provide testimony in strong support of this bill, HB 2052, HD1, except for the effective date.

The Hawaii State Center for Nursing supports increasing access to POLST by updating references from "physician orders for life-sustaining treatment" to "provider orders for life-sustaining treatment" throughout chapter 327K, HRS; particularly, expanding health care provider signatory authority to include advanced practice registered nurses (APRNs); and correcting inconsistencies over terms used to describe who may sign a POLST form on behalf of a patient. POLST is a tool to help ensure that patients make informed decisions and that their wishes are honored across health care settings. POLST requires a meaningful dialog between patients and their physicians or APRNs (especially in rural, medically underserved areas of Hawai'i.

HB 2052, HD1 is consistent with barrier-breaking legislation made between 2009-2011, when the Legislature authorized[1] APRNs to function independently as primary care providers to help relieve the oncoming shortage of primary care physicians[2].

[1] **Act 169, SLH 2009** required insurers/HMOs/benefit societies to recognize APRNs as PCPs; authorized APRNs to sign, certify, or endorse all documents relating to health care within their scope of practice provided for their patients including workers' compensation, verification documents,

However, the Hawaii State Center for Nursing is strongly opposed to the change in the effective date of July 1, **2112** and requests that the language in HB 2052 “This Act shall take effect pon its approval” be restored.

Therefore, the Hawaii State Center for Nursing respectfully requests passage of this measure. We appreciate your continuing support of nursing and education in Hawai'i.

Thank you for the opportunity to testify.

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verification and evaluation forms the DHS and DOE, verification and authorization forms of the DOH and physical examination forms.

Act 57, SLH 2010 the adoption of the National Council of State Boards of Nursing’s Model Nurse Practice Act and Model Nursing Administrative Rules.

Act 110, SLH 2011 required each hospital in the State licensed under Hawai`i Revised Statutes (HRS), § 321-14.5 is required to allow[1] APRNs [1] and qualified APRNs granted prescriptive authority to practice within the full scope of practice including as a primary care provider. APRNs granted prescriptive authority to prescribe controlled drugs (Schedule II-V) within formulary appropriate to the APRN’s specialty. Able to prescribe drugs without working relationship agreement with a licensed physician

[2] A 2010 study by the John A. Burns School of Medicine reported a current shortage of 600 physicians (more than 20% of the current supply) and an impending shortage of 1,600 by 2020. "Because physician shortages of the magnitude described will directly impact the health and well-being of virtually all residents of Hawai‘i, something must be done. Unfortunately, there is no easy fix to the problem. The problem is most acute on the island of Hawai‘i, but people everywhere, including urban O‘ahu are also starting to feel the effects in a variety of specialties… If Hawai‘i’s utilization of physician services were to match the average mainland usage, our current demand for physicians would be about 3,500. If Hawai‘i’s population grows as anticipated without change being made in the system of care or current utilization patterns, our state will need over 4,000 doctors by the year 2020. It is expected that even with active recruitment Hawai‘i will probably suffer a net loss of approximately 50 physicians every year in the face of dramatically rising demand. If the delivery system remains the same as today, many Hawai‘i residents will not have timely access to care. The indigent and elderly will feel it first. As the shortage deepens, we’ll all experience the effects". The ten top solutions identified by the working groups to be addressed most urgently include the use of non-physician clinicians (*Report to the 2011 Hawaii State Legislature: Report on Findings from the Hawaii Physician Workforce Assessment Project.* Withy, K. and Sakamoto, D.T. John A. Burns School of Medicine, December, 2010).

THE QUEEN'S HEALTH SYSTEMS

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 691-5900

H.B. 2052, H.D.2
RELATING TO PROVIDER ORDERS FOR LIFE SUSTAINING TREATMENT
Senate Committee on Health
March 17, 2014; 1:45 p.m.

We are Cherylee Chang, M.D., Director of the Stroke Center and Medical Director of the Neuroscience Institute/Neurocritical Care and Daniel Fischberg, MD, PhD, FAAHPM, Medical Director for the largest hospital-based palliative care program in Hawaii at The Queen's Medical Center and Vice-Chair of the Board of Kokua Mau, Hawaii's hospice and palliative care organization. While we strongly support the original intent of H.B. 2052, to allow Physician Orders for Life Sustaining Treatments (POLST) to participate in signatory authority, we are so concerned about the language currently in H.B. 2052, H.D. 2 that we must now provide testimony in **opposition** to this measure, as currently written, as it would severely impact the utilization and effectiveness of POLST. However, we would like to respectfully address these problematic areas and make recommendations for amendments for the committee's consideration.

H.B. 2052, as originally submitted to the legislature seeks to expand POLST access by allowing APRNs to participate in signatory authority. When it comes to avoiding unwanted medical treatments at the end of life, Physician Orders for Life Sustaining Treatments have been shown to be nearly 100% effective in preventing unwanted treatments while other directives, such as living wills, have not been shown effective. POLST have never been shown to be a barrier to people receiving the treatments that they do desire. Unfortunately, access to care continues to be an issue, particularly for those with advanced illness. Many patients that would wish to complete a POLST to avoid unwanted medical treatment are confined to their beds at home, in a nursing facility, or a hospice. Advanced practice nurses have been critical in providing needed medical care to these patients. Not permitting Advanced Practice Nurses to sign POLST forms means many patients in need cannot complete them, leaving them vulnerable to unwanted, aggressive and painful treatment, such as electric shocks to the chest or tubes put in the nose or mouth and placement on an artificial respirator/breathing machine, at the end of life when most people would prefer to focus on their comfort and dignity.

HB2052, HD2, as written, has made substantive changes to the existing statutory law, largely in response to two testimonies that raised mirroring concerns. Specifically, there are two most problematic changes that must be addressed.

- **Delete Section 6, requiring DOH to adopt a sample POLST "Form"**

1. **The POLST is an order for medical treatments.**

a. Physician orders should not be legislated. Physician orders should be based upon best practices, and able to be changed within the professional community, best positioned to keep current.

b. Hawaii has successfully achieved the voluntary universal adoption of the same POLST Order form throughout the state. The Hawaii form has been modeled after national forms that have also been adopted by other states. Grant funding and voluntary grass roots support has spread POLST to every island, hospital, nursing home, home care, hospice and most care homes.

c. The existing statute, 327K-4 allows for voluntary rules creation by the Department of Health.

d. Rules making and mandatory form adoption will delay forward movement.

e. We ask the committee to delete this section.

- **Restore Section 4 (1) (a) (3) (A): "Lacks Capacity"**

1. **Section 4 (1) (a) (3) (A) of HB 2052, HD2 deletes "Lacks capacity", which impedes decision making powers**.

a. The change in HB2052, HD2 effectively eliminates the authority of an individual who was not designated by the patient in an Advance Directive (under section 327E) to create a POLST order.

b. We request that committee to restore the "lack capacity" provision to ensure the authority for ALL legally authorized representatives to make decisions as provided for in the Advance Directive Law (327E).

- **Address Concerns Raised in House Consumer Protection and House Judiciary Committees**

1. **Testimony from two individuals spoke to the "problematic areas with respect to the authority of 'non-designated surrogates' to make certain health care decisions on behalf of incapacitated patients on the POLST form and specifically decisions to withhold or withdraw artificial hydration and nutrition as provided in Chapter 327E."**

a. Both individuals testifying fully support POLST, and the expansion of POLST to include APRN.

b. Both individuals indicate that the concern lies in Chapter 327E, not in the POLST form.

c. Indeed, one individual stated this was ancillary to the [core] POLST discussion.

d. Currently, Chapter 327E-(g) allows for: *"A surrogate who has not been designated by the patient may make all health-care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future."*

e. By only allowing a designated decision maker (that is one who was appointed in writing by the patient through an advance directive) to sign a POLST, the amendment in HD2 effectively contradicts the existing law in 327E-5. Thus, those individuals will be disenfranchised from accessing POLST as a means of establishing a portable treatment plan consistent with the values and best interest of those legally authorized to represent them.

f. How is a non-designated surrogate decision maker appointed? Each hospital must follow the laws as established in 327E-5 for identifying the decision maker. In the event the patient has not designated one, the law allows for a group of interested persons to reach consensus and request that one individual be designated to serve in that role. Further, 327E-5(i) also mandates: *"A supervising health-care provider shall require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority."*

g. Most hospitals have been dealing with this issue for years, since the passage of 327E. We have examples of several hospital forms which require such statement under penalty of false swearing.

h. The concerted effort of the entire state's leadership in hospice and palliative care continues in their efforts to promote advance directives and effective conversations about treatment choices at the end of life.

i. Each health care provider must address their process for obtaining a representative to make decisions for the incapacitated patient who has not designated someone.

j. **Note:** POLST was not designed to be the form or tool that designated a decision maker. When POLST was created, we recognized that it was a complementary tool to the advance directives, and that the POLST orders were completed upon the clinical need of the patient. By contrast, an advance directive can be completed years in advance of a clinical need, and require 2 witnesses or notary to be legal.

- **<u>We understand the intent of those who ask for "safeguards" to be added into the POLST Order form</u>**

1. We respectfully recommend that to modify POLST away from its original design does not fix the problems they have identified.
2. To strengthen language and powers of the so-called "non-designated surrogate" the legislature might consider amending 327E, HRS.
3. The way the POLST legislation is designed is to be consistent with the Advance Directive law and not requiring amendment each time 327E, HRS is changed.

We respectfully request that the committee consider deleted Section 6, in its entirety, and restoring "Lacks Capacity" in Section 4 (1) (a) (3) (A) to ensure the continued effectiveness of POLST. We hope we have satisfactorily outlined our concerns on H.B. 2052, HD2.

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

55 Merchant Street
Honolulu, Hawai'i 96813-4333

HAWAI'I PACIFIC HEALTH
Kapi'olani • Pali Momi • Straub • Wilcox

808-535-7401
www.hawaiipacifichealth.org

Monday, March 17, 2014 – 1:45 pm
Conference Room 229

The House Committee on Health

To: Senator Josh Green, Chair
Senator Rosalyn Baker, Vice Chair

From: Michelle Cantillo, RN, Advance Care Planning Coordinator

Re: HB 2052 HD2, Relating to Provider Orders For Life Sustaining Treatment Comments

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My name is Michelle Cantillo, and I am the RN, Advance Care Planning Coordinator for Hawai'i Pacific Health (HPH). HPH is a not-for-profit health care system, and the state's largest health care provider and non-government employer. It is committed to providing the highest quality medical care and service to the people of Hawai'i and the Pacific Region through its four hospitals, more than 50 outpatient clinics and service sites, and over 1,600 affiliated physicians. HPH's hospitals are Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Memorial Hospital. The system's leading strategic initiatives include women's health, pediatric care, cardiovascular services, cancer care, and bone and joint services. HPH ranks among the top three percent of hospitals nationwide in the adoption of electronic health records, with system-wide implementation that allows its hospitals and physicians to offer integrated, coordinated care throughout the state.

We support the intent of HB 2051, HD 2, but prefer the Senate version contained in SB 2227. SB 2227 maintains the statutory requirements to allow POLST to continue to be effective in the State of Hawaii, while also expanding access by allowing APRNs to participate in signatory authority.

Unlike SB 2227, HB 2052, HD2 deletes the phrase "Lacks capacity" on page 5, line 18 in Section 4(3)(A). This amendment is significant in that it impedes decision making powers, and effectively eliminates the authority of an individual who was not designated by the patient in an Advance Directive to create a POLST order. Thus, we ask that the phrase be reinserted in to the measure to ensure authority for all legally authorized representatives to make decisions as provided for in the Advance Directive Law.

HB 2051, HD2 at Section 6 on page 8 also contains a provision that requires the Department of Health (DOH) to adopt a sample provider orders for life-sustaining treatment form. We note that the POLST is essentially an order for medical treatment. Physician orders must be given the flexibility to change as best practices evolve. Thus, legislatively requiring the DOH to adopt a sample form may be restrictive and is unnecessary. Hawaii has successfully achieved the voluntary universal adoption of the same POLST Order form throughout the state. The Hawaii form has been modeled after national forms which have been adopted by other states.

POLST have been shown to be nearly 100% effective in preventing unwanted treatments in contrast to other directives, such as living wills, which have not been shown to be effective. POLST have never been a barrier to people receiving the treatments that they do desire. Unfortunately, access to care continues to be an issue, particularly for those with advanced illnesses. Many patients that would wish to complete a POLST to avoid unwanted medical treatment are confined to their beds at home, in a nursing facility, or a hospice. Advanced practice nurses have been critical in providing needed medical care to these patients. The effect of not permitting Advanced Practice Nurses to sign POLST forms means many patients in need will be unable to complete them, leaving these patients vulnerable to unwanted, aggressive treatment, such as electric shocks to the chest or placement on an artificial respirator, at the end of life when most people would prefer to focus on their comfort and dignity.

We urge your Committee to adopt the language in SB 2227. Thank you for the opportunity to provide these comments.

Healthcare Association of Hawaii

Monday – March 17, 2014 – 1:45pm
Conference Room 229

The Senate Committee on Health

To: Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

From: George Greene
President & CEO
Healthcare Association of Hawaii

Re: Testimony in Support
HB 2052, HD 2 — Relating to Provider Orders for Life Sustaining Treatment

The Healthcare Association of Hawaii (HAH) is a 116-member organization that includes all of the acute care hospitals in Hawaii, the majority of long term care facilities, all the Medicare-certified home health agencies, all hospice programs, as well as other healthcare organizations including durable medical equipment, air and ground ambulance, blood bank and respiratory therapy. In addition to providing quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing nearly 20,000 people statewide.

Thank you for the opportunity to testify in support of HB 2052, HD 2, which promotes efficiency in advance care planning. HB 2052, HD 2 modernizes provider orders for life-sustaining treatment by changing references of "physician orders for life-sustaining treatment" in the Hawaii Revised Statutes to "provider orders for life-sustaining treatment," expanding signatory authority to include advanced practice registered nurses. HAH supports the intent and spirit of HB2052, HD 2, which is to improve the quality of life for patients though expanded efficiency and consistency in advance care planning.

HAH supports HB 2052, HD 2, but respectfully requests the committee to adopt the proposed amendments from The Queen's Medical Center and Hospice Hawaii. These amendments strengthen the bill by reinstating language that will ensure the bill works as intended.

Thank you for the opportunity to testify in support of HB 2052, HD 2.

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

Healthcare Association of Hawaii

Monday – March 17, 2014 – 1:45pm
Conference Room 229

The Senate Committee on Health

To: Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

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Thank you for the opportunity to testify in support of HB 2052, HD 2.

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

KŌKUA MAU
"Continuous Care"
Hawai'i Hospice and Palliative Care Organization

March 16, 2014

Dear Chair Green and other members of the committee,

Thank you for the opportunity to speak to HB 2052 which was heard in the Senate as SB2227.

I serve as the Executive Director of Kokua Mau, Hawaii's Hospice and Palliative Care Organization which is the lead agency in Hawaii for POLST. Kokua Mau staffs the statewide multi-sectoral POLST Task Force and our website is the clearing house for information about POLST including the POLST form and other information for download. We have implemented education around the island providing education at facilities and for community groups. Additionally we answer questions on the phone and via email from individuals and professionals alike.

It is because of our very positive experiences with POLST around the state over the last 5 years that we have worked to expand the signing privileges for POLST to include APRNs. We believe that POLST is a crucial document for people facing seriously illness to insure that they get the right care at the right time in the right place and that their wishes are honored. We also believe POLST helps families make sure that loved ones are well cared for throughout their lives.

Unfortunately amendments were made in HB2052 HD2 that substantially change the intent of the legislation and we believe they should be removed. We believe that we should return to **the initial wording of HB 2052, removing amendments made to HB2052 HD2**.

There are two changes that I would like to address in my testimony.

1. Section 4 - The changes made in HD2 have taken away the ability of a non-patient designated surrogate decision maker to complete a POLST. This is a dramatic step that would deny many individuals from having the benefits of a POLST because they did not appoint a Healthcare Power of Attorney ahead of time. Although everyone over 18 is encouraged to complete an Advance Directive, appoint a Healthcare Power of Attorney, and discuss their wishes for end-of-life care with loved ones, most people do not. Some estimates are that 80% of people have not appointed an agent although much effort has been made in Hawaii to encourage people to make these important steps while they are still able. If someone is no longer able to speak for themselves and needs a decision maker, hospitals and other facilities must follow the steps of the law as laid out in 327E-5 for appointing a surrogate.

   Testimony was made that there is not currently a system for designating this surrogate but that is not the case. There is a well-defined process that is currently being effectively used around the state (outlined in 327E-5).

   A surrogate, according to 327E, is a person who is selected through agreement by all interested persons when the patient did not designate anyone. In the vast majority of the cases, family members and other people with an interest in and knowledge of the person

are called together and through a facilitated process, surrogate decision makers are determined. That decision maker is then asked to sign a legally binding form confirming that they are who they say they are, their relationship with the patient, and that they are willing to serve as the surrogate. This process is documented in the patient's medical record. Each facility has their own form but many use the sample form created by UHELP at the University of Hawaii Law School and run by Prof. James Pietsch.

I have attached a copy of the form used by Maui Memorial Medical Center as well as their explanation of Surrogate Decision Making as an example.

If there are issues with the way that non-designated surrogates are appointed or documented in 327E-5, then the legislature could take up that issue at a future time. The expansion of POLST signing privileges should not be the vehicle for changing 327E.

2. Creation of a sample form as proposed in Section 6 of HD2. We view this as an unnecessary step and one that will add extra levels of bureaucracy to a system that is working well. In Hawaii there is only one POLST form which all facilities have voluntarily agreed to use. It was created by the POLST Task Force in 2009, which includes the Department of Health. The form follows formats used in other states and endorsed by the National POLST committee.

   We feel that our current system of voluntary collaboration between key stakeholders has a very positive track record and we do not believe that the proposed changes will improve the situation but would in fact slow down the process.

   Additionally we feel that physician orders should not be legislated. Physician orders should be based upon best practices and able to be changed within the professional community. This is the best way for the forms to keep current.

There were additional language changes in the amendment that we agree with. These are to use the term "legally authorized representative" and to clarify the language about healthcare power of attorney. (These were changes suggested by Professor Jim Pietsch.)

In the past I have testified about the importance of POLST and stand on my testimony about the importance of the expansion of signing privileges to APRNs to remove bottlenecks and increase access to POLST.

As the lead agency for POLST, we have gotten much positive feedback about POLST which is why we have initiated this legislation to expand signing privileges. POLST is working well and therefore we need more access to POLST not less. I welcome the chance to answer any questions about POLST or the other issues raised in this process.

Sincerely,
Jeannette G. Koijane, MPH
Executive Director

Example from Maui Memorial Medical Center

Written Declaration of Surrogate

I, declare myself surrogate

For due to the following

reasons:

A. Surrogate Appointment (check one)

[] According to the physician, I have been designated by the patient to be his/her surrogate decision maker

[X] I am a surrogate decision maker appointed by consensus of interested persons

B. Interested Persons

I am an interested person based on my relationship to the patient as: (check one)

[] spouse, not legally separated or estranged
[] reciprocal beneficiary
[] adult child
[] parent
[] adult sibling
[] adult grandchild
[] an adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values.

C. Additional Facts or Circumstances

The following are additional facts or circumstances as to why I claim to be a surrogate decision maker:

_____

_____

Signature of Surrogate Decision Maker Date

Print Name of Surrogate Decision Maker -- Contact Phone Numbers: Residence / Business / Cell

Lack of Capacity Determination for Surrogate Decision Making

As the primary physician or designee who has undertaken primary responsibility, I certify that _____ (patient's name) **DOES NOT** have the ability to understand the significant benefits, burdens, risks, and alternatives to proposed health care and **DOES NOT** have the ability to make and communicate a health care decision.

Signature of Primary Physician or Designee Date

Print Name of Primary Physician or Designee

*Terminology of patient used within the context of this form is inclusive of residents within a Nursing Facility.

Certification for Withdrawal or Withholding of Artificial Nutrition and Hydration for a Surrogate Appointed through Consensus of Interested Persons

Primary Physician

As primary physician or designee who has undertaken primary responsibility, I certify for _____ (patient's name) the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.

_____ _____

Signature of Primary Physician Date

_____

Name of Primary Physician (print)

Independent Physician

As an independent physician, I certify that for _____ (patient's name) the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.

_____ _____

Signature of Independent Physician Date

_____

Name of Independent Physician (print)

*Terminology of patient used within the context of this form is inclusive of residents within a Nursing Facility.

Example from Maui Memorial Medical Center

INFORMATION ABOUT SURROGATE DECISION MAKING

The following information is provided to help you better understand what a surrogate decision maker is, how he/she is appointed, and what is the scope of their responsibility.

Background Information

- The Uniform Health Care Decisions Act (Modified) was signed into law in July 1999 and addresses the appointment of a surrogate decision-maker for health care decisions. The law also changed and consolidated most of the advance directive laws into one law.
- Prior to the passage of this law, there was no law about surrogate decision making except as a trial project in the nursing facilities. In other settings, surrogate decision making was not provided for under the law even though it was usually accepted as community practice.
- This law applies to all settings, for example inpatients, outpatients, and residents in nursing facilities (e.g. – ICF/SNF). The use of the word patient in this handout is intended to include all of these populations.

Definitions

Agent: Someone designated through a durable power of attorney for health care decisions.

Capacity: An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

Guardian: Someone appointed by a court to make decisions, either for the person or property or both.

Interested persons: The patient's spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or ant adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values.

Surrogate: An individual, other than a patient's guardian or agent, designated to make health care decisions for the patient. Under the Uniform Health Care Decisions Act, there are two types of surrogates: one that is designated by the patient and another who is selected through agreement by all interested persons when the patient did not designate anyone.

What is the process by which a surrogate is appointed?

a. The patient's physician certifies that a patient lacks capacity.
b. In the absence of a guardian or agent, a surrogate decision-maker can be appointed.
c. A patient with capacity can designate an individual to be a surrogate by personally informing the physician. The physician documents the patient's designated surrogate in the medical record.
d. In the absence of a patient designated surrogate, the physician locates "interested persons" who may select a surrogate through consensus (or, if consensus cannot be reached, any individual may petition for legal guardianship).
e. Both designated and "consensus" (or "non-designated") surrogates must provide the physician with signed declaration stating the facts and circumstances through which they were appointed as surrogate.
f. The physician documents the selection of the surrogate in the medical record and provides a copy of the written claim for the medical record.

Is there any limitation on the type of decisions a surrogate can make?

The scope of decisions that a surrogate can make depends on how the surrogate was appointed. A surrogate that was designated by the patient may make health care decisions that the patient would normally make on their behalf. A surrogate who has been designated by consensus of interested persons can make health care decisions that the patient would normally make, however, a decision to withdraw or withhold nutrition and hydration requires that the primary physician and a second independent physician certify in the patient's medical record that the provision or continuation of artificial nutrition and hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.

What should a surrogate consider when making decisions?

A surrogate's decision should be based on what the patient would have wanted. Many times it is based on what the patient expressed to the surrogate in the past, the patient's beliefs and what the patient felt was important. Sometimes the patient gave very explicit instructions to the surrogate and the surrogate was selected based on the patient's belief that this individual was the best choice to carry forth their wishes. Unfortunately, we cannot always predict the future or all situations that will come up. In most situations, what is usually considered is based on the best interests of the patient.

"Best interests" means that the benefits to the patient resulting from a treatment outweigh the burdens to the patient resulting from that treatment and shall include:

1) the effect of the treatment on the physical, emotional, and cognitive function of the patient;
2) the degree of physical pain or discomfort caused to the patient by the treatment, or the withholding or withdrawal of the treatment;
3) the degree to which the patient's medical condition, the treatment, or the withholding or withdrawal of treatment, results in a *severe* and continuing impairment;
4) the effect of treatment on the life expectancy of the patient;
5) the prognosis of the patient recovery, with and without treatment;
6) the risks, side effects, and benefits of the treatment or the withholding of the treatment; and
7) the religious beliefs and basic values of the patient receiving treatment, to the extent that these may assist the surrogate decision maker in determining benefits and burdens.

What if a consensus cannot be reached or someone disagrees with the decisions of the surrogate?

Any of the interested persons may seek guardianship, which is a judicial process. A judge after hearing justifying information from the petitioning party and any objects by the conflicting parties will decide who will become the patient's legal guardian.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

TO:
COMMITTEE ON HEALTH
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

DATE: Monday, March 17, 2014
TIME: 1:45PM
PLACE: Conference Room 229

FROM: Hawaii Medical Association
Dr. Walton Shim, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ron Kienitz, DO, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

RE: HB 2052 HD 2

POSITION: Comments

The HMA respectfully suggests are that the changes that were made during second and third hearings for HB2052 are problematic.

We strongly support the wording of the companion measure, SB2227, as written, as it maintains the statutory requirements to allow POLST to continue to be effective in the State of Hawaii, while also expanding access by allowing APRNs to participate in signatory authority. When it comes to avoiding unwanted medical treatments at the end of life, Physician Orders for Life Sustaining Treatments (POLST) have been shown to be nearly 100% effective in preventing unwanted treatments while other directives, such as living wills, have not been shown effective. POLST have never been shown to be a barrier to people receiving the treatments that they do desire. Unfortunately, access to care continues to be an issue, particularly for those with advanced illness. Many

patients that would wish to complete a POLST to avoid unwanted medical treatment are confined to their beds at home, in a nursing facility, or a hospice. Advanced practice nurses have been critical in providing needed medical care to these patients. Not permitting Advanced Practice Nurses to sign POLST forms means many patients in need cannot complete them, leaving them vulnerable to unwanted, aggressive treatment, such as electric shocks to the chest or placement on an artificial respirator, at the end of life when most people would prefer to focus on their comfort and dignity.

Turning the committee's attention now to HB2052, HD2, we would like to take this opportunity to address substantive changes made to HB2052 HD2, by the House Judiciary committee, in response to two testimonies, which raised mirroring concerns.

- **<u>Delete Section 6, requiring DOH to adopt a sample POLST "Form"</u>**

1. **The POLST is an order for medical treatments.**

a. Physician orders should not be legislated. Physician orders should be based upon best practices, and able to be changed within the professional community, best positioned to keep current.

b. Hawaii has successfully achieved the voluntary universal adoption of the same POLST Order form throughout the state. The Hawaii form has been modeled after national forms which has also been adopted by other states. Grant funding and voluntary grass roots support has spread POLST to every island, hospital, nursing home, home care, hospice and most care homes.

c. The existing statute, 327K-4 allows for voluntary rules creation by the Department of Health.

d. Rules making and mandatory form adoption will delay forward movement.

- **<u>Restore Section 4 (3) (A): "Lacks Capacity"</u>**

1. **Section 4 (3) (A) of HB 2052, HD2 deletes "Lacks capacity", which impedes decision making powers**.

a. The change in HB2052, HD2 effectively eliminates the authority of an individual who was not designated by the patient in an Advance Directive (under section 327E) to create a POLST order.

b. We request that SB2227 retain the "lack capacity" provision to ensure the authority for ALL legally authorized representatives to make decisions as provided for in the Advance Directive Law (327E).

- **<u>Address Concerns Raised in House Consumer Protection and House Judiciary Committees</u>**

1. **Testimony from two individuals spoke to the "problematic areas with respect to the authority of 'non-designated surrogates' to make certain health care decisions on behalf of incapacitated patients on the POLST form and specifically decisions to withhold or withdraw artificial hydration and nutrition as provided in Chapter 327E."**

a. Both individuals testifying fully support POLST, and the expansion of POLST to include APRN.

b. Both individuals indicate that the concern lies in Chapter 327E, not in the POLST form.

c. Indeed, one individual stated this was ancillary to the [core] POLST discussion.

d. Currently, Chapter 327E-(g) allows for: "*A surrogate who has not been designated by the patient <u>may make all health-care decisions for the patient that the patient could make on the patient's own behalf, except</u> that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.*"

e. <u>By only allowing a designated decision maker(that is one who was appointed in writing by the patient through an advance directive) to sign a POLST the amendment in HD2 effectively contradicts the existing law in 327E-5. Thus, those individuals will be</u>

<u>disenfranchised from accessing POLST as a means of establishing a portable treatment plan consistent with the values and best interest of those legally authorized to represent them.</u>

f. How is a non-designated surrogate decision maker appointed? Each hospital must follow the laws as established in 327E-5 for identifying the decision maker. In the event the patient has not designated one, the law allows for a group of interested persons to reach consensus and request that one individual be designated to serve in that role. Further, 327E-5(i) also mandates: *"A supervising health-care provider shall require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority."*

g. Most hospitals have been dealing with this issue for years, since the passage of 327E. We have examples of several hospital forms which require such statement under penalty of false swearing.

h. The concerted effort of the entire state's leadership in hospice and palliative care continues in their efforts to promote advance directives and effective conversations about treatment choices at the end of life.

i. Each health care provider must address their process for obtaining a representative to make decisions for the incapacitated patient who has not designated someone.

j. **<u>Note:</u>** POLST was not designed to be the form or tool that designated a decision maker. When POLST was created, we recognized that it was a complementary tool to the advance directives, and that the POLST orders were completed upon the clinical need of the patient. By contrast, an advance directive can be completed years in advance of a clinical need, and require 2 witnesses or notary to be legal.

- **<u>We understand the intent of those who ask for "safeguards" to be added into the POLST Order form</u>**

1. We respectfully recommend that to modify POLST away from its original design does not fix the problems they have identified.

2. To strengthen language and powers of the so-called “non-designated surrogate” the legislature might consider amending 327E, HRS.
3. The way the POLST legislation is designed is to be consistent with the Advance Directive law and not requiring amendment each time 327E, HRS is changed.

We respectfully request that the committee consider and advance the language in S.B. 2227 to ensure the continued effectiveness, as well as expanded access to POLST. We hope we have satisfactorily outlined our concerns on H.B. 2052, HD2. We welcome continued dialog with interested parties on re-examining Chapter 327E, HRS during the interim.

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

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	kzeri@hospicehawaii.org
Subject:	Submitted testimony for HB2052 on Mar 17, 2014 13:45PM
Date:	Sunday, March 16, 2014 12:59:23 PM
Attachments:	HB 2052 HD2 Senate Health March 17 Support with Amendments

HB2052
Submitted on: 3/16/2014
Testimony for HTH on Mar 17, 2014 13:45PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Kenneth Zeri	Hospice Hawaii	Support	Yes

Comments: Proposing amendments

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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HAWAI'I STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Written Testimony Presented Before the
Senate Committee on Health
March 17, 2014 1:45 p.m.
Conference Room 229
.
by
Dale Allison, PhD, WHNP-BC, FNP, APRN-Rx, FAAN
Member, HSCN Advisory Board
Hawaii State Center for Nurisng
University of Hawai'i at Manoa

HB 2052, HD1 RELATING TO PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.

Chair Green, Vice Chair Baker, and members of the Sentee Committee on Health, thank you for this opportunity to provide testimony in strong support of this bill, HB 2052, HD1, except for the effective date.

The Hawaii State Center for Nursing supports increasing access to POLST by updating references from "physician orders for life-sustaining treatment" to "provider orders for life-sustaining treatment" throughout chapter 327K, HRS; particularly, expanding health care provider signatory authority to include advanced practice registered nurses (APRNs); and correcting inconsistencies over terms used to describe who may sign a POLST form on behalf of a patient. POLST is a tool to help ensure that patients make informed decisions and that their wishes are honored across health care settings. POLST requires a meaningful dialog between patients and their physicians or APRNs (especially in rural, medically underserved areas of Hawai'i.

HB 2052, HD1 is consistent with barrier-breaking legislation made between 2009-2011, when the Legislature authorized[1] APRNs to function independently as primary care providers to help relieve the oncoming shortage of primary care physicians[2].

[1] **Act 169, SLH 2009** required insurers/HMOs/benefit societies to recognize APRNs as PCPs; authorized APRNs to sign, certify, or endorse all documents relating to health care within their scope of practice provided for their patients including workers' compensation, verification documents,

However, the Hawaii State Center for Nursing is strongly opposed to the change in the effective date of July 1, **2112** and requests that the language in HB 2052 “This Act shall take effect pon its approval” be restored.

Therefore, the Hawaii State Center for Nursing respectfully requests passage of this measure. We appreciate your continuing support of nursing and education in Hawai'i.

Thank you for the opportunity to testify.

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verification and evaluation forms the DHS and DOE, verification and authorization forms of the DOH and physical examination forms.

Act 57, SLH 2010 the adoption of the National Council of State Boards of Nursing’s Model Nurse Practice Act and Model Nursing Administrative Rules.

Act 110, SLH 2011 required each hospital in the State licensed under Hawai`i Revised Statutes (HRS), § 321-14.5 is required to allow[1] APRNs [1] and qualified APRNs granted prescriptive authority to practice within the full scope of practice including as a primary care provider. APRNs granted prescriptive authority to prescribe controlled drugs (Schedule II-V) within formulary appropriate to the APRN’s specialty. Able to prescribe drugs without working relationship agreement with a licensed physician

[2] A 2010 study by the John A. Burns School of Medicine reported a current shortage of 600 physicians (more than 20% of the current supply) and an impending shortage of 1,600 by 2020. "Because physician shortages of the magnitude described will directly impact the health and well-being of virtually all residents of Hawai‘i, something must be done. Unfortunately, there is no easy fix to the problem. The problem is most acute on the island of Hawai‘i, but people everywhere, including urban O‘ahu are also starting to feel the effects in a variety of specialties… If Hawai‘i’s utilization of physician services were to match the average mainland usage, our current demand for physicians would be about 3,500. If Hawai‘i’s population grows as anticipated without change being made in the system of care or current utilization patterns, our state will need over 4,000 doctors by the year 2020. It is expected that even with active recruitment Hawai‘i will probably suffer a net loss of approximately 50 physicians every year in the face of dramatically rising demand. If the delivery system remains the same as today, many Hawai‘i residents will not have timely access to care. The indigent and elderly will feel it first. As the shortage deepens, we’ll all experience the effects". The ten top solutions identified by the working groups to be addressed most urgently include the use of non-physician clinicians (*Report to the 2011 Hawaii State Legislature: Report on Findings from the Hawaii Physician Workforce Assessment Project.* Withy, K. and Sakamoto, D.T. John A. Burns School of Medicine, December, 2010).

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: psgegen@hotmail.com
Subject: Submitted testimony for HB2052 on Mar 17, 2014 13:45PM
Date: Friday, March 14, 2014 2:52:31 PM

HB2052
Submitted on: 3/14/2014
Testimony for HTH on Mar 17, 2014 13:45PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
pat gegen	Individual	Support	No

Comments: Many patients rely on APRN's as primary providers - APRN's need to have this ability to provide good care.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: bishopmattj@gmail.com
Subject: *Submitted testimony for HB2052 on Mar 17, 2014 13:45PM*
Date: Sunday, March 16, 2014 5:49:42 AM

HB2052
Submitted on: 3/16/2014
Testimony for HTH on Mar 17, 2014 13:45PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Matt Bishop	Individual	Support	No

Comments:

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HAWAII ISLAND
Family Medicine Residency

Kristine I McCoy, MD, MPH
Program Director
45 Mohouli Street
Hilo, HI 96720
(808) 932-4215
FAX (808) 933-9291

THE SENATE
THE TWENTY-SEVENTH LEGISLATURE
REGULAR SESSION OF 2014

COMMITTEE ON HEALTH
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

NOTICE OF HEARING

DATE: Monday, March 17, 2014
TIME: 1:45PM
PLACE: Conference Room 229
State Capitol
415 South Beretania Street

Dear Chair Green and members of the Committee:

I am pleased to write to you in support of HB 2052 HD2. As an active faculty member for the advanced practice nursing programs of both University of Hawaii School's of Nursing, and the University of New Mexico and Saint Francis University in prior years, I have extensive experience in both training and working with advanced practice nurses. Hawaii, like the rest of the country is experiencing a deepening shortage of primary care providers and will increasingly depend on care teams that include advanced practice nurses to provide high quality care to ourselves, our families, and our neighbors. While ideally, we will all work in teams, there are times when advanced practice nurses will be operating independently as allowed by state law. As such, they need to have the capacity to provide all of the care needed, including signing orders for patients to receive home care, medical equipment such as hospital beds, and signing off on orders promoting or limiting end of life care in emergency situations. When they cannot, this "busywork" of signatures gets passed off to physician colleagues or friends who do not know the patient well or these critical items simply do not get completed, depriving patients of care.

I urge you to pass HB2052-HD2 to allow patients whose primary care providers are advanced practice nurses to have their trusted provider complete the POLST form documenting their end of life wishes.

Sincerely,

Kristine I McCoy, MD, MPH