



## TESTIMONY

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Services

The Connecticut Association for Healthcare at Home

Before the Public Health Committee

**March 20, 2018**

### **HB 5417: An Act Concerning End-of-Life Care**

Senator Gerratana, Senator Somers, Representative Steinberg and members of the Public Health Committee, my name is Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with over 35 years' experience in home health, hospice, long term and acute care.

The CT Association for Healthcare at Home is the united voice for 29 of the 32 hospice providers in Connecticut. Our membership includes highly qualified, dedicated hospice provider experts who care for those facing terminal illness.

### **The CT Association for Healthcare at Home opposes HB 5417: An Act Concerning End-of-Life Care.**

Our Association and its hospice providers are committed to the hospice philosophy cherishing life until its natural end while reinforcing dignity, quality and comfort.

According to the most current Medicare claims data from 2016, Connecticut now ranks 2<sup>nd</sup> to last in the country (in front of rural Wyoming) in hospice median length of stay which still translates into "last minute hospice or end-of-life care." Our Association remains diligent in working with the provider continuum to promote hospice and palliative care services and awareness with the goal of having informed consumers who



know what options are available as they approach their end of life. Perhaps this is why some feel a bill on Physician-Assisted Suicide is needed as the public may not be fully informed of the wide array of expert end-of-life services and supports available to them.

First and most importantly, the public and the providers frequently confuse hospice care and palliative care. I have included our flyer that defines both for your review. Essentially, Hospice is a holistic philosophy of care for the terminally ill in their last 6 months of life. Palliative care is also a holistic approach but should be offered early in a serious illness to help a patient and their family cope with side effects and the impact on their quality of life during treatment. In many situations, palliative care is offered once the patient becomes terminal, when in fact, the patient should be offered hospice care at this point.

Our society's emphasis on "cure" and the medical emphasis on intervention are often at the expense of good end-of-life care. Since practitioners and providers have been slow to embrace the practice and principles of palliative care (not offered early enough and often when it should be time for hospice) ultimately leaving hospice referrals for the final days, people think they have no other choice but to request physician-assisted suicide.

In response to this emphasis, Connecticut's healthcare provider collaborative efforts have focused on improving end-of-life care and advanced care planning initiatives through a new collaborative (Care Decisions CT) led by the CT Hospital Association. These efforts include:

- Educational programs on how to have conversations regarding end-of-life care options using The Conversation Project
- The DPH MOLST (Medical Orders for Life Sustaining Treatment) is now statewide via Public Act 17-70 effective October 1, 2017 and encourages consumers to have the conversation with their physician helping to ensure informed decision-making and choice.
- The DPH appointed Palliative Care Advisory Council meets monthly and provides an annual report to DPH Commissioner with recommendations to enhance awareness and standardization of Palliative Care services in CT.



- The Care Decisions CT group uses these recommendations as their guide
- Also in January 2018, the CT Association for Healthcare at Home launched standardized Hospice and Palliative Care training for skilled nursing facilities in CT.

These are all efforts to help the public and the provider understand that there are many options for comfort and quality of life as one approaches the end of life. Instead of considering legalizing Physician-Assisted Suicide, let's instead focus our efforts on the essence of hospice care which is to allow patients to make the most of their remaining time. Hospice values people's lives until their natural end, making their death a true "death with dignity."

**Here are some of the things Hospice and Palliative Care providers can do:**

- Offer expert, compassionate relief of pain and suffering at end of life enhancing the quality of both living and dying.
- Strive to help patients and families deal with important physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears.
- Promote opportunities for meaningful experiences, and personal and spiritual growth so patients may live life to the fullest and die with dignity.
- Assist patients and families cope with loss and grief through best-practice bereavement support for up to 13 months following the death, and
- Support the patient's right to participate in all decisions regarding their care, treatment and services based on knowledge and access to all forms of treatment that have been shown to enhance quality of life and reduce suffering.

Despite our opposition to this bill, we have grave concern for language within the bill itself which, in our minds, leaves much reasonable doubt. We recognize the attention that this bill has assumed in your committee and in the public. As you continue to debate this issue, we ask that you consider



several specific concerns not addressed currently or not defined/outlined in enough detail within the language of the bill.

- Under definitions Section 1.11 “Palliative Care” (A): should read *...throughout the continuum of a patient’s serious (not terminal) illness.*
- Under the same section, hospice care is mentioned briefly yet not defined and not encouraged. Please consider adding a definition for “Hospice Care” understanding that Palliative Care is holistic care throughout the serious illness; whereas hospice care is holistic palliative care once the serious illness becomes a terminal illness (with an anticipated prognosis of less than 6 months).
- Determining terminal prognosis is not an exact science as many people outlive a 6 month prognosis and go on to live several months or years beyond their initial prognosis. However, there are accepted standardized tools/scales used to predict prognosis. We strongly recommend that these tools (e.g, Karnofsky or FAST) be mandated as part of determining prognosis just as they are in determining hospice eligibility.
- To avoid subjectivity in determining the competency (both cognitive and for s/sx’s of depression) of the patient requesting a physician to assist in his/her suicide, we strongly recommend that the physicians determining competency use a standardized validated tool for both cognitive and depression assessment. And, physicians need to be trained in assessing and evaluating based on these tools. The bill doesn’t adequately address this vital issue.
  - Research shows that depression is one of the most underdiagnosed illnesses among the elderly and seriously ill.
  - Left untreated, depression increases risk for morbidity, suicide, decreased cognitive and social functioning, self-neglect, and early death. Despite the devastating consequences, clinicians fail to diagnose up to 50% of depressed patients seen in primary care practices. If they are accurately diagnosed, only 22% receive adequate treatment, partly because practitioners fail to recognize depression’s red flags - See more at: <http://www.pharmacytimes.com/publications/issue/2011/January2011/Counseling-0111#sthash.Nhlnsk5H.dpuf>



- In 2010, only 1 of the 65 patients in Oregon who dies as a result of physician-assisted suicide was referred for psychiatric or psychological counseling.
- A glaring hole in this bill is the issue surrounding the physician being asked to provide the lethal drugs.
  - Because many physicians don't (Oregon and Washington) or won't (reported in other states) prescribe lethal drugs to hasten someone's death, patients are forced to physician shop...they are desperate to find a physician willing to prescribe the lethal drugs.
  - In Oregon, some physicians prescribe lethal drugs for patients whom they have only known as little as one week or less.
  - In Washington in 2010, half of the patients had a "relationship" with the physician prescribing the lethal drugs of only 3-24 weeks.
  - This lack of a long-term relationship challenges the physician's ability to truly understand the patient's emotional and psychological state.
- The cause of the death on the death certificate shouldn't be the underlying disease. As "barbiturate overdose or toxicity" actually caused the death.
  - Putting the underlying disease as the cause is lying and also misinforms state and national statistics that are gathered annually.
  - Given the inexact science of determining a projected prognosis of a disease, a natural death may be for a number of reasons other than the underlying disease itself.
- Finally, any person requesting Physician-Assisted Suicide as outlined in this bill should first be required to have a Hospice and Palliative Care consult.

Thank you for considering our association's testimony. If you have any further questions, please contact me directly at [Wodatch@cthealthcareathome.org](mailto:Wodatch@cthealthcareathome.org) or 203-774- 4940.