I really appreciate the changes being made to this bill, I think is imperative for the safety of our incarcerated folks to have all nurses trained in ACLS and that there is no legal loophole to allow community prescribed meds to be discontinued or substituted.

As it reads: 801 c:

(c) **Emergency care. When there is reason to believe an inmate is in need**

19 of medical care, the officers and employees shall render emergency first aid

20 and immediately secure additional medical care for the inmate in accordance

21 with the standards set forth in subsection (a) of this section.

1 facility shall have on staff at all times at least one person trained in ~~emergency~~

2 ~~first aid.~~ ACLS

*I really think this needs to be someone trained in **ACLS at all times**. First aid is vague. Theoretically all nurses working are beyond the first aid ability. First aid, does not imply any form of real heart rythm knowledge, or the ability to recognize a serious decline in a medical condition. The most serious would be heart attack, stroke, or respiratory failure. ACLS teaches how to recognize and treat all 3.*

*If an individual is experiencing chest pain and is put on a cardiac moniter, I believe that there is not anyone in the facilityat all times who has the knowledge to assess if there is a heart problem. I don't know if they have a modern cardiac moniter (**this should be asked**) A cardiac moniter is not the same as an AED. (Automatic External Defibrillator) Additionally if an indivdual is in the infirmary on a heart moniter, if the nurse does not have ACLS or Critical Care nursing experience, the heart moniter is useless.The heart moniter records the beat, a person assesses the beat, the rythm and the appropriate intervention.*

Shortness of breath, and chest pain need the ability of a person to assess lung sounds, 02 saturation, and the heart rythm. A person with first aid is not qualified to do this. (like a life guard trained in first aid)

An AED analizes whether or not to shock a person it does not tell the caregivers what the rythm is. A shock is only advised when the heart rate is above a certain limit, and if the person is not conscious. You would not shock a conscious person. The shock stops the heart in the hope that the next beat will come back as a normal sinus rythm. If the pads are on incorrectly it will not assess the rythm correctly. Therefore a shockable rythm will not be recognized and no shock will be given. These are precious moments to save a life. AND again, it assesses only to shock or not shock. The AED does not diagnose a heart problem a skilled human does.

*This can not be determined by someone trained in "first aid" I really think that the bar needs to be raised that the facilities have **one individual trained in ACLS at all times.** It is not that hard of a certification to get and our incarcerated folks would be much safer with someone there with that knowledge. If a cardiac arrest occurs that person would be able to apply the AED properly, and would*

know all the components of CPR. A witnessed event has a very high degree of success, if an individual with chest pain is ignored, or not placed on a moniter to see what the rythm is, their outcome for survival plummets.

Wellpath nurses have ***CPR it is not a substitute for ACLS*** *as you are not trained on the rythms.*

ACLS drives home high quality resuscitation. We should not have to rely on the CO's to do the CPR, and place pads on our incarcerated folks. They are not ACLS trained, they may be CPR trained, but again, not their job.

Please require ACLS, it is not hard to get and in a situation where the Emergency Medical Services cannot arrive quickly, we could save a person's life, and should know how to do so.

Secondly; *801 e) pre-existing prescriptions*

(2) Notwithstanding subdivision (1) of this subsection**, ~~the Department~~**

~~21 may defer provision of a validly prescribed medication in accordance with this~~

Change to "the department may NOT defer provision of a validly prescribed medication in accordance with this"

BILL AS INTRODUCED H.876

2024 Page 4 of 19

VT LEG #374975 v.1 *Strike the following:*

1 ~~subsection~~ **~~if, in the clinical judgment of a licensed physician, a physician~~**

~~2 assistant, or an advanced practice registered nurse, it is not medically necessary~~

~~3 to continue the medication at that time~~.

I have evaluated many records where the medication is ***prescribed by an endocrinologist*** *and the PA at the Correctional Facility in conjunction with a* ***non specialty prison MD*** *discontinuued the medication. In all instances the individual had a valid prescription and was receiving regular care in the community, and due to the expense of the med, the MD discussed with the admitting PA to discontinue and draw labs in a month to see if it was medically necessary. While the person is* ***abruptly taken off of a medication they had been on for years****.* ***Prison providers are not specialists****, they should* ***not be allowed*** *to discontinue any med that is current from an outside provider.* ***They do not have the expertise, and they do not know the individual.*** *Their clinical judgement is based on saving money. I have seen this over and over again in the records.* ***A person coming in on community provider meds should stay on*** *them It is not the for profit prison healthcare provider to decide "it is not medically necessary" This should simply read:*

The Department may NOT defer provision of validly prescribed medication in accordance with this bill.

Most of the records I review involve medication and it is a lengthy process that wastes everyones time, and our incarcerated folks suffer not just from not having their regular meds, but they feel devalued. The healthcare providers could focus on healthcare and not denial of care and all the paperwork and time that creates.

Every medication case I have reviewed is FDA approved and in the medicaid formulary. The healthcare provider "du jour" should not be able to discontinue community meds. ***Period.***

ALL OF THIS SHOULD GO AWAY (or in bill language, "struck")

*(**3) ~~The licensed practitioner who makes the clinical judgment to~~***

~~5 discontinue a medication shall cause the reason for the discontinuance to be~~

~~6 entered into the inmate's medical record, specifically stating the reason for the~~

~~7 discontinuance. The inmate shall be provided, both orally and in writing, with~~

~~8 a specific explanation of the decision to discontinue the medication and with~~

~~9 notice of the right to have his or her the inmate's community-based prescriber~~

~~10 notified of the decision. If the inmate provides signed authorization, the~~

~~11 Department shall notify the community-based prescriber in writing of the~~

~~12 decision to discontinue the medication~~.

Sending notice to the community provider does nothing as ***the community provider has no say*** *over an incarcerated patient.* ***Case in point****: David Allen who testified to your committee. I actually read the letter from his endocrinologist at DH stating he should have the insulin pump and continuos glucose moniter and the department of corrections NON ENDOCRINOLOGIST MD would not approve it. (Make no mistake here, David Allen is going to have serious future complications from the very bad care he got at the DOC. His care was a throw back in time. For one reason* ***MONEY) Medicaid pays for a CGM and insulin pump, Vitalcore would not.***

IF MEDICAID PAYS FOR A MEDICATION AND TREATMENT SO SHOULD WELLPATH (they have their own formulary based on the cheapest way to provide medication, so if you come in on a prescription that is too expensive they deny it, or substitute it, that should be a NO)

801b

17 (b)(1) If at any time an inmate screens positive as having an opioid use

18 disorder, the inmate may elect to commence buprenorphine-specific

19 medication-assisted treatment medication for opioid use disorder ~~if it is~~

~~20 deemed medically necessary by a provider authorized to prescribe~~

This should be struck. ***Any inmate with a positive urine drug screen for opioids should be placed on buprenorphine****. The DOC uses the TCU-5 assessment criteria, and mild disorder is a score of 2-3. If an individual has opioids in their urine, they already are going to score positive on this test, and will go through withdrawal. Strike line 20. Life will be easier for everyone.* ***If there is opioids in the urine the individual will divert.***

In closing I have reviewed many records involving everything talked about in 801. The defender general's office does not need to receive all these medical records about denied care. It is MOSTLY medication related. Simplify this for everyone and let our incarcerated folks receive the medication they were on in the community, and treat all with opioids in their urine (which is checked when they come in) I can tell you from all the records I have done medication denials are about MONEY, not healthcare.

Thank you for all that you do. If I can be of any assistance at any time reach out.

Leslie M Thorsen RN BBA