CHAIRPERSON: Representative Jonathan Steinberg

SENATORS: Abrams, Cohen, Lesser, Moore, Somers

REPRESENTATIVES: Arnone, Betts, Borer, Candelora, Carpino, Comey, Cook, Demicco, Genga, Hennessy, Kennedy, Klarides-Ditria, McCarty, Michel, Petit, Ryan, Tercyak, Young, Zupkus

REP. STEINBERG (136TH): Welcome to the first public hearing of the session for the Public Health Committee. We have eight bills before us today. For those of you who may not be familiar with our process, the first hour is reserved for elected officials and after that hour elapses, regardless of how many public officials have had a chance to speak, we will start alternating between public officials and the public, so that’s our process. The other key aspect is that we ask that you commit to only using three minutes to testify. If you go beyond three minutes, we will remind you of the fact that three minutes has elapsed. Obviously, the members of the committee can question you at will, but in the interest of all those who have taken time to come up here today to testify, we ask everybody be as expeditious as possible. Without further ado, I am State Representative Jonathan Steinberg, House Chair of the Public Health Committee. I will turn it over to my co-chair, Senator Mary Abrams.
SEN. ABRAMS (13TH): Good morning, thank you for being here. I am State Senator Mary Daugherty Abrams of the 13th District and I’m looking forward to this public hearing. I would just remind people who are going to testify that we have your written testimony and we’ll be reading it, so if you’d like to use your three minutes to summarize and give us an overview of what you think are the important points rather than reading the testimony, that might be the better way to use your time. So I appreciate you being here and let’s get started.

REP. STEINBERG (136TH): Sounds like a good plan. Any comments from our vice-chairs or ranking members?

REP. PETIT (22ND): No, Mr. Chairman, Thank you.

REP. STEINBERG (136TH): All right, so before we start or before we progress in this committee, I will remind you that in the interest of safety, you should note the location of the exits to this hearing room. Those two doors in which you entered are the emergency exits and are marked with exit signs. In an emergency, the two doors behind the legislators can also be used. In the event of an emergency, please walk quickly to the nearest exit. Don’t knock anybody over doing so. After exiting the room, go to your left and exit the building by the main entrance or follow the exit signs to one of the other exits. Please quickly exit the building and follow any instructions provided from the capitol police. Do not delay and do not return unless and until you are advised that it is safe to do so. In the event of a lockdown, please remain in the hearing room, stay away from the exit doors, and seek concealment behind desks and chairs until an
all clear announcement is heard. Thank you. That is the end of that announcement.

So without further ado, we will move to the first person on the list today among legislators, agencies, and municipal registration and that would be Representative Kim Rose. Representative Rose, are you here this morning? We’re off to a -- There she is, perfect timing. Don’t worry, Kim, take your time.

REP. KIM ROSE (118TH): Good morning. I’m Kim Rose, State Representative from the 118th District in Milford. Mr. Chairman, ranking members, I would just like to offer a brief testimony in support of House Bill 6942. The physician assistant plays a significant role in our healthcare system. More often than not these days when we go to a doctor’s office, we see a PA. They are qualified to diagnose and treat illnesses with full prescriptive rights. As a matter of fact, I had a condition for about four years, saw a PA recently, and in one visit she solved my problem, so I’m very, very happy about that.

I think the current statute, we need -- we have needs to be reviewed to determine if it’s unduly restricting the PAs. I have heard that some medical practices, for instance, now prefer to hire an APRN because they can practice individually and independently as opposed to a PA. You will hear testimony today, we do have PAs coming in, that will speak to that part of the issue. A number of states are moving now to redefine the role of PAs from being under the supervision of a physician to one of collaborating with them. I appreciate the fact that you are reviewing this concept today and I hope this
approach can be developed that has the support of the committee members and the members of the healthcare professionals. Just recently, Arkansas and Illinois entered into collaborative agreements and it’s working very well in those states. Thank you again for your interest in PAs and I’m happy to take any questions.

REP. STEINBERG (136TH): Thank you, Representative. We really appreciate you testifying and kicking off our testimony today on this important subject. Are there any members of the committee -- Yes, Representative Petit.

REP. PETIT (22ND): Good morning, Representative. Two quick questions I wonder if you’d answer from a policy point of view and a patient point of view and that is, you know, I think many people practice -- supervise and collaborate with the PAs in their office that they work with. What is your perception of the difference in terms of that, that simple word supervision and collaboration, from a policy point of view and from a patient point of view?

REP. KIM ROSE (118TH): Well, it’s a matter of them having to be physically present at the time. I have really had quite a few experiences with PAs. My daughter is a PA, Quinnipiac graduate, they go through extensive, extensive training and they train -- they go for training every single year. Their knowledge and the diagnosis that I've seen come from the PAs has been terrific and I think that they need to -- especially in this healthcare day and age where you have, you know, physicians that are leaving their practices. A very good friend of mine was a family practitioner and she just recently
closed her practice and she’s doing something else now because of the laws.

REP. PETIT (22ND): So from a functional point of view, you’re seeing it -- you’re pointing out the issue of being physically present versus collaborating say from two separate clinics that are in two physical locations?

REP. KIM ROSE (118TH): Correct?

REP. PETIT (22ND): Thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Representative. Any other comments or questions? If not, thank you for getting us off to a good start, Representative.

REP. KIM ROSE (118TH): Thank you.

REP. STEINBERG (136TH): Next up, we have Linda Cimino. Good morning.

LINDA CIMINO: Good morning, Senator Abrams, Representative Steinberg, Senator Somers, and Representative Petit and distinguished members of the Public Health Committee. My name is Linda Cimino and I’m the director of the judicial branch office of Victim Services and I’m here today to speak in support of Senate Bill 796, An Act Concerning Sexual Assault Forensic Examiners. I appreciate the opportunity to testify before you on this legislation and I would also like to thank our colleagues at the Department of Public Health and the Connecticut Hospital Association for working with us to craft the language that’s before you.

This proposal to seek to expand the current sexual assault forensic examiners training program so that victims of sexual assault have greater access to
trained sexual assault forensic examiners. Under the current law, the office of Victim Services contracts with sexual assault forensic examiners who respond to the eight participating hospitals to provided skilled medical forensic examinations and evidence collection when a victim of sexual assault presents at the hospital. At non-participating hospitals, victims often have to wait for hours for medical forensic examination and the collection of evidence. Also victims of sexual assault who present at these non-participating hospitals will most likely receive care by a non-trained health provider and this results in victims of sexual assault not receiving the trauma informed care that a sexual assault examiner is able to provide, so more specifically, section one of the bill establishes a standing sexual assault forensic examiner committee to recommend policies and procedures regarding the sexual assault forensic examiner training program to the Office of Victims Services with the goal of ensuring statewide consistency in the examination and evidence collection of victims of sexual assault.

The second section adds a definition of sexual assault forensic examiners and a definition of healthcare facility as used in the section of the statute to clarify who may use the term SAFE and where examinations and evidence can be collected. Section three conforms 19A12G of the Connecticut General Statutes to the existing practice of SAFE practitioners being trained by the Office of Victim Services and the Department of Public Health currently does not have a role in that training.

Section four clarifies that the Office of Victim Services may provide training to certain
practitioners in all healthcare facilities to ensure consistency in training statewide. Section five allows the chief court administrator to prescribe policies and procedures to implement this legislation should it be enacted into law. In section six, repeals that statute that established the very first advisory council, the Sexual Assault Advisory Committee, which was disbanded in 2013. Thank you for your time and attention to this matter. I’d be happy to answer any questions.

REP. STEINBERG (136TH): Thank you for your testimony. Let me start with one, how would you describe sort of the state of the state at this point as it relates to our ability to adequately address sexual assault from the context of the forensic process?

LINDA CIMINO: Generally I would say it’s inadequate. As I mentioned in my testimony, there are eight hospitals that we, the judicial branch, have a contract with, a memorandum of agreement, where we respond when a victim of sexual assault responds there. So far this fiscal year, we’ve responded to about 130 cases, but when you go into the other -- the various other 20 hospitals, there’s often -- and we hear the stories at the office, there’s often panic, that people are not trained, they’re ill-equipped to deal with the actual collection of evidence, but they’re even more ill-trained to deal with the traumatic effects that this crime has on the people on front of them, so I really -- from what we’ve heard, the experience -- if you go to a hospital where we respond, victims have a really good experience, as good as they can, and in hospitals we’re not, it’s hours and hours and hours of waiting until they can find someone to
actually do the test and that’s just not appropriate.

REP. STEINBERG (136TH): One could argue that the bill before us is rather modest in its scope in terms of extending the availability of some of the program elements. Would you say the state should be even more aggressive in trying to expand a program such as this statewide very much in the line with the eight hospitals currently participating?

LINDA CIMINO: When this program was initially conceptualized through the Connecticut Alliance Against Sexual Violence, then CONNSACS, the idea was a statewide response system. We -- When this was created or when the initial work was done, we had a lot of inaccurate data. First we were told there would be at least 70 to 80 nurses who would be willing to participate in this program. That is not true and there have been many, many road blocks. What we really believe after running this program for the better part of nine years now is this is the answer, not necessarily a response program, but it’s to have trained individuals in the hospitals taking care of the people who come to their hospitals. If we train hospital-based people, they know the culture of the hospital, they understand the workings of the -- just really the culture of it and we do think it is the better way of doing it is to train the hospital staff.

REP. STEINBERG (136TH): All right, I appreciate your testimony. I’m hopeful that the hospitals and the Hospital Association will embrace the concept behind this legislation and that we will see a much broader application of the SAFE principles in every
hospital across the state of Connecticut. Are there other questions? Yes, Senator.

SEN. ABRAMS (13TH): I just way to say thank you very much for the work that you’re doing and I hope that we can pass this legislation so that every woman in this state, if she should be under those circumstances, receives the great care that you’re trying to provide them, so thank you very much.

LINDA CIMINO: Thank you.

REP. STEINBERG (136TH): Other questions or comments? Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman, and I probably should know the answer to this, but could you just briefly tell us what the length of the certification process and a little bit more about that process?

LINDA CIMINO: Sure. The -- We provide a certificate, it’s not a certification program. When you’re working with medical communities, certification has a whole different standard, but the training program consists of three parts; first there’s a 30-hour -- actually almost 42-hour didactic program where they’re in our -- the Office Victim Services two days a week over three weeks and there are -- like I said, it’s 40 hours of classroom that talks -- it teaches a variety of the medical issues. It also brings in the police department perspective, the prosecutor, the defense perspective, and this is all through and in accordance with the curriculum of the International Association of Forensic Nurses.

Our program is one of five and it’s the only state program in the country that has sort of
certification from the International Association of Forensic Nurses. After they finish that, then there is a mock exam. Then they go to a clinical. We use -- and thankfully there are women who are willing to serve as live models where all of the students go through 15 pelvic exams so that we can ensure competency. After they’ve -- we ensure that competency, then they are out on a case with a preceptor, so it’s a student and a teacher to make sure that there’s competency with the entire exam and that -- it usually takes one or two times and then they’re on their own on the calendar.

REP. MCCARTY (38TH): Thank you very much. That really is very helpful. Thank you.

REP. STEINBERG (136TH): Other questions or comments? Yes, Representative.

REP. PETIT (22ND): Thank you, Mr. Chair. Ms. Cimino, just thank you again for all the good work you do in the Office of Victim Services.

LINDA CIMINO: Thank you.

REP. PETIT (22ND): We have a totally different crowd here than when you’re celebrating 40 years a couple weeks ago, but I’m hopeful, as a co-chair, that this can move forward so that we can bolster up these services available so that folks that are victims of sexual assaults don’t have to be victimized in the process, so I really appreciate all your efforts in this regard.

LINDA CIMINO: Thank you very much.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for your testimony.

LINDA CIMINO: Thank you.
REP. STEINBERG (136TH): The last of the public officials we have indicated today is Representative McGorty.

REP. MCGORTY (122ND): Good morning, chairs and ranking members and committee. Today I’m here with Dr. Randy Trowbridge. He is a great physician from Fairfield County and he’s here to speak on 6843 on my behalf. He knows a little bit more about the bill, if I could give my time to him, please.

REP. STEINBERG (136TH): Go ahead. Thank you, good to see you Dr. Trowbridge.

RANDY TROWBRIDGE: Thank you, Representative McGorty and thank you Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit and the other distinguished members of the Public Health Committee. I consider this a real privilege to have an opportunity to share information with you. I’m really here to provide education from an objective point of view. I think you’ll see that, particularly if you read the entire testimony that I’ve provided you with.

This bill in particular has been in front of us for a number of years in different forms, pretty much the same, but in different forms a little bit, but we’ve been deliberating over this and at one point, it was even passed by the Senate unanimously and so you have to sort of — it should raise our thinking about this a little bit because, you know, this is incredibly important that we get this done this year. I really feel, and I think you’ll see if you look into this, that it is vital to providing the quality healthcare for all of Connecticut’s residents as the pressures continue to mount in our state to provide better access to medical services.
This critical problem has been recognized by the Connecticut SIM Initiative and I happen to be on that practice transformation task force committee for the past four years and was also raised as a key issue last year at the -- at the better health conference here in Hartford in June, which I attended along with Vicki Veltri and some other members of the Office of Health Strategy and what was really interesting at that -- at that meeting, what was brought up, was that the least insured in this state are going to be most affected by these kinds of ideas that we need to have the full team working at its full capacity to provide the care that we have to have for all of our residents.

So the total number of primary care practitioners is declining in Connecticut and is expected to continue. Allowing certified, and the key thing is certified, medical assistants to work at the top of their scope of practice is efficient and safe and it actually acts as a catalyst to allow the other health care providers to work at the top of their scope of practice, including the nurses, so physicians, physician assistants, advanced practice nurses, and nurses can then engage with their highest level of skill in that team environment and this can only enhance the access to and the delivery of quality healthcare.

With certified, and this is the key, with certified medical assistants administrating vaccine, there is no evidence of an increase of adverse effects across the nation and this is after many years and with 48 states already approving certified medical assistants to deliver vaccine across all age groups. Now I spent the time reviewing the last three years of testimony on this particular topic and I just
want to really point out that 90 percent of the testimony is all in favor of this bill. The AMA, Connecticut Hospital Association, the State Society, Fairfield County, Hartford County, the Academy of Family Physicians, American Academy of Pediatrics, and the American Nurses Credentialing Center, the Connecticut Association of Nurse Anesthetists, the Connecticut Coalition of Advanced Practice Nurses, the National Center for Competency Training all support this. Okay.

And furthermore I might add, I have not encountered a single nurse in my area, I've been practicing for 30 years and I know lots of nurses in the Greater Danbury area, I've not found a single nurse, RN, LPN, APRN who objects to this, so I think -- I scratch my head and say what's going on here about this bill when the people in the field working in the offices don’t oppose this at all. So I think it’s incredibly important that we address this fully. So it really comes down to a key thing. I think this is really the key issue, if somebody’s certified to do what they’re supposed to do, here’s from the nurses own American Nurses Credentialing Center, certification validates a nurses’ knowledge skills and abilities in a defined role in a clinical area of practice based on predetermined standards. I have to go through certification, nurses have to go through certification, MAs have to go through certification. If you’re certified to give injections, you’re certified and people being trained in Connecticut to be medical assistants and trained in vaccine are working all across the country delivering vaccine, but we can’t do it here in this state.
So in conclusion, I’d like to say as a physician for more than 30 years, as immediate past president of the FCMA, as the active medical director of Team Rehab for 25 years, and as a former captain of both high school and college athletic teams, I have seen, learned, and experienced teamwork’s inextricable value when engaged in any successful group endeavor and no other present day societal challenge is teamwork more necessary than in the delivery of healthcare. Without all the members of our healthcare delivery team working at their top of skill for practice, we as a state will fail miserably in our goal and responsibility to provide access to high quality medical services. I encourage you all and your colleagues to strongly support H.B. 6943 with the age guideline removed so that they can deliver to all ages. The pediatric practices actually are the most in need and we need to have it delivered there, so I challenge you also, as representative to the centers, to pass it unanimously in both houses as this legislation has no partisan connection and no legitimate facts of opposition. This is all about the betterment of health in Connecticut’s communities.

REP. STEINBERG (136TH): Thank you for your testimony and for your consistent advocacy over the years. As you well noted, I think you made some incredibly salient points. Forty-eight states already allow this relationship to occur and this bill has made it out of the committees several years in a row and we’re all scratching our heads a little bit why we can’t get it over the finish line. I want to also thank you for the thoroughness of your testimony and particularly noting that so many medical associations are in support of this
legislation. One question for you, the nub of the issue if you will, is there a reasonable argument that this particular provider would not be in a position to understand any adverse outcomes related to the administration of vaccines?

RANDY TROWBRIDGE: Well, it’s my understanding that the medical assistants are trained to some extent in adverse outcomes, but it is not really their particular need because they’re in a setting of supervision by other medical professionals, so that’s really the key to this is that medical assistants are working under medical -- under physicians, under APRNs, under nurses, so that if something adverse happens, there’s always another higher level professional there to deal with those consequences.

REP. STEINBERG (136TH): Thank you again, Doctor. Are there other comments or questions? It looks like you covered the entire subject for us.

RANDY TROWBRIDGE: Thank you.

REP. STEINBERG (136TH): I want to thank you, Representative, for bringing the doctor forward and again, thank you for your ongoing efforts on behalf of this important change in our scope of practice.

REP. MCGORTY (122ND): And thank you for your time and consideration to this bill. Thank you.

REP. STEINBERG (136TH): Well, that actually, believe it or not ladies and gentlemen, concludes the elected officials part of our calendar, which is rather unusual for us. I would add that if anybody has come in subsequent to the preparation of the testimony list, you will now need to go to the table over here where our staff is and you want to be
added to the list of any of these bills, so without further ado, we will start in with the first of our eight bills, Senate Bill 16 and with Dr. Daisy Leon-Martinez.

DAISY LEON-MARTINEZ: Good morning, Senator Abrams, Representative Steinberg, and members of the Public Health Committee. My name is Daisy Leon-Martinez. I am a chief resident in obstetrics and gynecology at Yale-New Haven Hospital and I’m here today speaking on behalf of us who have benefitted from being in the process of medical training and specifically also representing the American College of Obstetrics and Gynecology, Connecticut Chapter, and the Connecticut State Medical Society. Thank you in advance for your time and kind consideration. I am here today speaking in opposition to Senate Bill 16, An Act Inhibiting Unauthorized Pelvic Exams of a Woman Who is Under Deep Sedation or anesthesia. I trust that you all have the testimony that was provided, so I will just kind of touch on the salient point that I think are important from the perspective from somebody who in the medical field and taking care of women on a daily basis.

I think the most important distinction that should be made is that this bill specifically needs to talk about the fact that we, as medical professionals, are never in support of having a woman have a pelvic exam be performed by anybody on the team that is purely for education without the woman being told ahead of time that that is being done, so if a woman is going to the operating room and going under general anesthesia and needs a pelvic exam, it should be part of the consent form that is done in the office before she enters the operating room. She should have had a very lengthy discussion with
her providers about every step of the procedure from beginning to end and that always include discussion of a pelvic exam. I think it’s important for all of us to realize that for those of us who practice gynecology and those of us that practice obstetrics, there is almost no procedure that a patient has to undergo that can be done without a pelvic exam under anesthesia. Pelvic exams help us understand the anatomy of every woman, every pelvis is different. They help us to plan what instruments we might need. They help us to understand what approach surgically might be helpful. They also help us anticipate possible complications. It could be that a woman has previous procedures and now has scarring in her cervix that affects the way that we approach that pelvis and those things are important for all of us to understand and that goes from the medical student all the way up to the attending doctor who is in charge of the room.

I think that as a doctor who has taken their responsibility of taking care of people, we all understand that informed consent is a very important part of the process and it is something that we respect highly. I do think that it’s also important to note that all of the bodies that work to put policy together on behalf of our work, including ACOG, who is the main body that kind of gives us our guidelines for our practice, we all say that pelvic exams that are for the purpose of education have to be consented for prior to the patient undergoing any form of sedation or anesthesia.

REP. STEINBERG (136TH): Doctor, if you could conclude shortly.
DAISY LEON-MARTINEZ: Yes. That’s actually the end of my statement. Thank you so much.

REP. STEINBERG (136TH): Well, perfect timing. Thank you.

DAISY LEON-MARTINEZ: Thank you.

REP. STEINBERG (136TH): I really appreciate your testimony to give us the real world perspective of what takes place in both the medical and educational setting. I’m sure you understand how challenging this is for us, how important it is that the patient be able to provide informed consent before such a -- let’s just say a privacy invasive circumstance. You see how our legislation has been written in this case. Is there any sort of compromise that you can foresee that would allow us to honor the importance of informed consent and still allow you enough leeway to perform the critical medical tasks?

DAISY LEON-MARTINEZ: I think that as our current practice currently stands, it respects the autonomy of the woman, so if there is going to be a pelvic exam under anesthesia for the purpose of education, that just has to be discussed with the patient beforehand and we already do that; that is not a change of practice. I think that when we start legislating specifics of medical practice, it puts the woman’s healthcare into a different lens. It starts making us make exceptions about our practice with regards to women’s health specifically and it may actually make people that are already marginalized and already have a hard time accessing care feel even more afraid. I don’t think drawing extra attention to something that is already routine is going to help women access healthcare or feel safe under our care. It think it actually is going
to hinder our ability to take competent care of our patients.

REP. STEINBERG (136TH): Thank you, Doctor. It perhaps is not surprising that at least for you, to say hey, this is not something that takes place and you’re particularly careful about going through the process of education and informed consent. Are you aware of any such problems or abuses at other hospitals in the state of Connecticut?

DAISY LEON-MARTINEZ: Unfortunately I’m new to Connecticut. I've only entered this state for training. I've been here for four years and I have not had the privilege of working outside of the Yale-New Haven system, so I can speak to the hospital of St. Raphael and Yale-New Haven specifically. I have never witnessed a situation that would me as a woman or as a doctor would be concerned that female patients were in some way having their rights violated and I would hope that that is not something that our colleagues are participating in outside of the state, but I cannot speak to that.

REP. STEINBERG (136TH): Well, thank you, Doctor, for your testimony. Other -- Yes, Senator.

SEN. ABRAMS (13TH): If I understood your testimony correctly, this is already a policy at Yale-New Haven and St. Raphael?

DAISY LEON-MARTINEZ: Yes. In fact, ACOG already states that if there is a pelvic exam that is being performed for a woman under anesthesia that is only for education, she is to be introduced to the person that is learning from that exam beforehand and she needs to consent to that beforehand. The
distinction we want to make is that if a pelvic exam is being performed as part of a routine procedure, for example, somebody needs their uterus removed through a hysterectomy in the operating room, that is already implied in the consent process that an exam under anesthesia is part of the process, just like using instruments or placing a Foley to remove the urine from the bladder, all of those things are implied, so the distinction we want to make is that we don’t feel that our workflow needs to be changed in any way. We already ask for permission if we only doing an exam for educational purposes and otherwise any exam under anesthesia that is being performed is already part of our consent process and our consents even say there is a clause in there -- and the patients are provided the consent forms beforehand saying that they are choosing to seek care in a training institution and that there are different members of different levels of training that will be involved in their care.

And I personally, for example, will say for example, our team is comprised of a medical student, a junior resident, a senior resident like myself, and an attending, so all of the patients know that there are different people that are involved in their care and we all introduce ourselves prior to entering the room and prior to the patient going to the operating room.

SEN. ABRAMS (13TH): So my -- One of my questions is, how do you see this as a negative then, to codify it into legislation, something that you’re already doing, but we know that policies can sometimes change without people being aware of it or not extend to other hospitals, so can you explain to
me more what your objection is to having it being codified?

DAISY LEON-MARTINEZ: Yeah, I think that the -- maybe the consideration to made is that once we start singling out particular parts of our practice as needing to have legislation tied to it, it begins to take autonomy away from our ability to take care of our patients and I totally respect the hard work that all of you guys do on behalf of the public, but I think that by singling out this particular part of women’s care and saying that it has to have legislation tied to it, it somehow implies that if that weren’t the case, then women wouldn’t be getting compassionate care from their providers and I just don’t think that’s true.

SEN. ABRAMS (13TH): Thank you very much.

DAISY LEON-MARTINEZ: Thank you.

SEN. SOMERS (18TH): Yes, I have just a few questions. Thank you for your testimony. I reached out and I could not get any hospital, even small, large, to say this is not their practice. First of all, it doesn’t happen in hospitals that are not teaching hospitals, but isn’t there a code of medical ethics that if you are doing something to a patient outside of what they are in there for, that would actually be considered assault on some level?

DAISY LEON-MARTINEZ: Yes, so -- And that is not what we’re saying is happening.

SEN. SOMERS (18TH): No, I’m saying for those -- for those that think there may be this happening outside of what we should be doing. If you’re going in for -- you know, you went in for a, I don't know, a tonsillectomy and ended up having something like
this done to you, that’s covered by medical ethics if that was actually -- could be considered assault?

DAISY LEON-MARTINEZ: Yes.

SEN. SOMERS (18TH): It just does not happen and the standard of practice from the hospitals that I’ve spoken to, small and large, yes, if you’re in a trauma and something happens, you would go in and you may be exposed to an exam if you’re doing a woman’s operation or procedure, but it’s not, you know, something that deviates from the standard protocol of what has come down from the medical world for years and years?

DAISY LEON-MARTINEZ: Yes.

SEN. SOMERS (18TH): But my question is, in a teaching hospital, if you go in for a procedure and you’re asked to consent, what if -- what happens if the woman says no, I don’t. I don’t want to have a resident. I don’t want to have, you know, an intern. I want to have just the doctor, how do you handle that?

DAISY LEON-MARTINEZ: When that happens, then that usually happens in the office in the preoperative visit before they’ve entered the hospital setting or before their procedure has been scheduled. The paperwork at New Haven is, every clause of the consent form is numbered and if they particularly only want the attending involved in their care, which happens a lot when we take care of other attendings in the hospital or other residents or people who are involved in medical education, then they just initial next to that clause that they do not agree with, specifically saying I do not want trainees involved in my care and then the attending
who is consenting for the procedure initials below that and then the trainees are not involved in their care during that hospitalization.

SEN. SOMERS (18TH): I just wanted to make sure that people realized that there is a way for you to say no, I don’t --

DAISY LEON-MARTINEZ: There’s always -- And you know, that applies to many things of our consent form. When I deliver a patient and they want to take their placenta home, there is a part of the consent form where they just have to initial that they don’t want pathology to take the placenta, a specimen, and they would like to take it home, so that applies to any part of a patient's care. It’s always a discussion.

SEN. SOMERS (18TH): Thank you.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. I really appreciate it.

DAISY LEON-MARTINEZ: Thank you so much.

SEN. ABRAMS (13TH): Next is Kari Swanson. Welcome.

KARI SWANSON: Hello. I do apologize. I’m going to read from my iPad. Thank you, Senator Abrams and Representative Steinberg, who was here, and distinguished members of the Public Health Committee. My name is Kari Swanson. I’m a resident of North Haven. I’m here to testify in support of S.B. 16 to prevent unauthorized pelvic examinations on women who have been administered deep sedation or anesthesia. Last spring, Forbes published an article “Pelvic Exams Without Consent, a Troubling and Outdated Practice”. The article was shared
numerous times on social media, which is where I saw it. In the article, I learned that only four states in the U.S. prohibit the practice of performing medically unnecessary pelvic examinations on women who were under sedation or anesthesia without their informed consent and I learned that Connecticut is not one of those states.

When I was a child, my mother was a patient at the Dartmouth-Hitchcock Norris Cotton Cancer Center, so I learned at a very young age what it is like to be a patient in a teaching hospital. Since then, I've been a patient in teaching environments, including UConn School of Dental Medicine and Yale-New Haven Hospital. I understand the value of having in-training healthcare providers learn from interactions with real patients; however, in every one of those situations of which I was aware, I was fully informed in advance and I was given a choice, an opportunity to consent or not.

A pelvic exam is a physically invasive procedure. For some women, it is minor discomfort, but for others it is painful and for women, especially who are survivors of sexual abuse and assault, it causes emotional distress. We tolerate them because we’ve been told that they’re a necessary part of preventive healthcare, especially of cancer screening. Women tolerate the discomfort of pain and distress in the interest of health, but it is for our own health. We should not have to tolerate being subjected to medically unnecessary examinations performed without our consent when we’re unconscious or under anesthesia.

Our country has a history of these practices, performing medical procedures on patients without
their informed consent, not for their good, but for the alleged greater good and/or the good of practitioners or researchers. Let’s make the law on the side of what is ethical. Thank you to Senator Winfield for introducing this bill and I ask you to support this bill to ensure that women in Connecticut will not be subjected to unnecessary, invasive physical examinations without their informed consent.

SEN. ABRAMS (13TH): Thank you very much. Are there any questions or comments in the committee? Representative Betts.

REP. BETTS (78TH): Thank you, Madame Chair, and thank you for your testimony. You said you submitted it. Is that correct? Did you submit it to the committee?

KARI SWANSON: This is my testimony today.

REP. BETTS (78TH): No, that’s why -- I was just trying to find it on here and I didn’t see it, so. Okay. I wonder if you can respond to what was said previously where it did not appear to anyone or at least I didn’t hear of any circumstances or policies in which that occurs right now. Do you know personally of any particular sites, locations, or patterns of this problem?

KARI SWANSON: It’s in the literature. There have been articles recently, actually this month, in -- the Journal of the American Association’s forum online has an article about this. There’s a recent bioethics -- a journal article about this. I, as a patient who has had medical procedures at Yale-New Haven Hospital, I think that signing those consent forms doesn’t exactly work the way that I think some
physicians think it does. You’re handed a bunch of papers, you’re told that this is what you need to have done in order for, you know, you need to have whatever procedure is being done to you and you need to sign it and it really isn’t made very clear that there are aspects of that to which you can say no.

In the cases for me personally where I've had interactions with the providers who are in training, for example, my dermatology office, I’m always introduced to the student and I’m always given a choice, but when you’re under anesthesia -- First of all, I've had surgical procedures under general anesthesia at Yale and I don’t recall ever having been introduced to every single person who was involved individually and so I’m not sure that that happens. I do know that the women that I've spoken to about this are horrified because we wouldn’t know. We wouldn’t know if this was done.

REP. BETTS (78TH): Thank you very much.

SEN. ABRAMS (13TH): Thank you, Representative. Any other questions or comments? Thank you very much for your testimony. Thanks for being here today. Next we have Lucy Nolan. Welcome.

LUCY NOLAN: Thank you. Good morning, Senator Abrams, Representative Steinberg, Senator Somers, and Representative Petit and members of the Public Health Committee. Thank you for this opportunity to provide testimony of S.B. 16, An Act Prohibiting an Unauthorized Pelvic Exam of a Woman Who is Under Deep Sedation or Anesthesia and I also would like to briefly mention S.B. 796, An Act Concerning Sexual Assault Forensic Examiners. I am the policy — the director of policy and public relations for the Connecticut Alliance to End Sexual Violence. We are
a statewide coalition of nine community-based sexual assault crisis service centers. Our mission is to create communities free of sexual violence and to provide culturally affirming trauma, informed advocacy, prevention and intervention services centered on the voices of survivors.

So I’m here today in support of S.B. 16. Women who are at the hospital for surgery unrelated for anything that has to do with their pelvis are -- can get pelvic exams and it isn’t -- if it’s a medically therapeutic reason that the doctor is doing an exam, I don’t think there needs to be that informed consent, but if somebody is going in for -- and they’re just under anesthesia and all of a sudden one, two, how many residents or teaching students want to go, you know, feel what their uterus feels like, what their vagina feels like, there should be informed consent. It is -- It’s really -- It’s unrelated to their medical -- why they’re there. There are ways that the hospitals can do these -- do these exams.

We learned today from Linda Cimino that they use models for the SAFE examiners. There are models, there are mannequins that can be used. It’s just not allowing women to give informed consent or women not even really realizing what that informed consent -- what that consent means I think is something very, very outdated, outmoded, particularly in these Me, Too moments. We have -- We may not do it at Yale-New Haven, but many places we don’t know if they’re doing it or not because the women are under deep sedation. I think it’s disrespectful of women. I think it is arrogantly assumed that the medical profession needs are more important than the needs of women, of female patients, especially when these
women are really at the most vulnerable and as we heard before, victims of sexual assault can be re-traumatized by this -- by this kind of thing.

So I just would like to also on S.B. 796, An Act Concerning Sexual Assault Forensic Examiners, the alliance has been longstanding worked with everyone and help build this program and we are fully in support of the changes being made here and because we think it provides uniformity and consistency in the treatment standardization of forensic exams, which are so very important to make sure they’re done correctly to help people with sexual assault and also to bring criminals to -- to have the evidence we need for criminals, so thank you.

SEN. ABRAMS (13TH): Thank you for your testimony today. Are there any questions or comments from members of the committee? Representative?

REP. BETTS (78TH): Thank you and thank you, Lucy, for your testimony and I don’t know anybody on this committee much less the general assembly that doesn’t agree with the premise behind this proposed bill. What I’m struggling trying to understand is, is there a pattern or have their been instances of this occurring? If it is, it seems to me that somebody would be liable for a lawsuit and I don’t know if this is a problem or it’s a possibility, but nobody has been able to document -- I’m literally confused trying to understand has it occurred, where, why. I’m trying to understand the need for this because it’s not that people don’t agree it, but I’m not sure I’ve heard anything and maybe it will happen later on, but I just haven’t heard any examples of it.
LUCY NOLAN: Well, I’m not a doctor, so I wouldn’t know. I don’t go into the ER. It may have been done on me. I would not know. I’ve had several surgeries in my lifetime, but what we do know is in the literature and we’ve heard -- I’ve heard from people anecdotally that in fact it does happen and it has happened and that’s the problem. It’s one of those unseen -- you don’t know it’s happening and some of the doctors, the medical students, who have been asked to participate are being asked by the doctor who is their boss and they don’t -- there’s some very good articles on the Forbes article, there’s some medical journal articles about it, about how it is happening and how they’re -- The reason I think it’s coming up now is that there are more -- some of the students are sort of appalled by it and are beginning to -- it’s becoming more public.

REP. BETTS (78TH): Thank you, and in these articles, is Connecticut cited as a state or has there been a hospital cited in the literature --

LUCY NOLAN: No, not that I've seen.

REP. BETTS (78TH): -- pertaining to Connecticut? Okay, thank you very much.

SEN. ABRAMS (13TH): Thank you. Representative?

REP. KLEARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you for your testimony today. To echo what Representative Betts said, is there a problem? Is Connecticut having a problem with this? Is this happening across the country and if so, is this the first time this has come up? We haven’t heard anything about it and has anybody -- have you checked with area hospitals to see if their informed
consent form has this on this so we can a gauge of which hospitals in Connecticut are or are not doing the informed consent?

LUCY NOLAN: I have not checked with the hospitals, no, and again, I think it’s one of those very difficult things to know whether, in fact, it is happening or not. Connecticut has not been one of the states, but there are -- hospitals can use models, they can use mannequins, it’s been outlawed in four other states. It’s been seen across the country as a problem, so I don’t know Connecticut specifically, but it’s definitely -- it is a problem nationally and there’s no reason why -- I don’t -- I guess I don’t understand the opposition to it because it’s not medically necessary for these women. It’s nothing that’s helping them. It’s not therapeutic. It’s -- They’re just using them because they’re under sedation and this is a great teaching tool.

REP. KLARIDES-DITRIA (105TH): Thank you for your testimony. I don’t necessarily, at least in my opinion, think there’s opposition, it’s just -- if it’s already there, if the consent is already there and you could say yes or no, I’m curious as to why we want to pass a law if it’s already there, so -- but thank you for your testimony. Thank you, Madam Chair.

SEN. ABRAMS (13TH): Senator Somers.

SEN. SOMERS (18TH): Yes, thank you for your testimony. Again, I agree with my colleagues. I don’t think there’s necessarily opposition or a pushback in what has been explained here today, but I do think we’re struggling with the fact that this is a common medical procedure process that is done
at a teaching hospital to sign a consent form. Obviously, it’s informed consent and if we don’t know we have an issue, if we may have an issue, if that were to happen in a Connecticut hospital like we’ve talked about, it’s a medical code of ethics and if a physician were to do something of this nature outside of the informed consent, they could be sued for sexual assault, that’s the law.

The other thing is when you look at OR time now and Dr. Petit can attest to this, everything is so regulated. You have the kit for your appendectomy, you have your kit for this, you would have to be calling in for additional equipment, you know, everything that goes along with a pelvic exam. It’s not like it’s readily available. Everything is in kit form, so I find it even increasingly more difficult to believe that you could go in, no matter what as has been explained, under deep anesthesia to have your appendix out and end up having a pelvic exam happen to you. It just doesn’t happen in the way that hospitals are run. I’m not -- I can’t speak for other states, but again, I think for me, I struggle with codifying something in statute when there’s not an issue that I am known of or that I know of. I’m going to ask the Department of Public Health if they’ve had any complaints as far as this is concerned.

When hospital are currently having procedures to not only make sure they’re following the letter of the law and informing patients that are coming in, but if we go down this road, are we going to have to codify every single thing as far as informed consent of a patient going forward? So I hear what you’re saying, but I think that’s where we’re struggling because as far as I know, there has not been this --
complaints made to the Department of Public Health that something happened to somebody when they were under anesthesia and from, you know, working in healthcare, I just -- I struggle how that could happen other than if you’re in a teaching hospital, you’ve signed your consent form, you’re going in for a female procedure and during that time when you’re under anesthesia, it does allow the residents an opportunity to perform a pelvic exam, but you’ve given that consent at the beginning when you go into the teaching hospital.

That’s what I think we’re struggling with. I just want you to know we thank you for coming and we hear what you’re saying. It’s not struggling on what you’re saying, it’s struggling on how do we deal with it when it may be an issue that we’re experiencing here in Connecticut.

LUCY NOLAN: Thank you, I understand, and I do apologize for saying opposition. That was just a general -- I’m sorry, it was the we of opposition, but Senator Somers, I would like to just correct one thing is that what happens sometimes in other states is that women aren’t being -- going in for female issues. They’re going in for anything and they’re put under deep sedation and this is the time that they’re being used for teaching. I’m just telling you that that’s what the information out there is and so it isn’t -- if it was medically therapeutic, I think we wouldn’t have a problem with it, right, because somebody’s having something, you have to see if everything works right or is there, you know, but this isn’t, this is just being used for teaching and so that’s why we have -- we support this bill. Thank you very much.
SEN. ABRAMS (13TH): Any other questions or comments? Representative.

REP. MCCARTY (38TH): Thank you, Madam Chair. Just for a point of clarification if you would, so if my understanding is that you’re not opposed to an unauthorized pelvic examination if it was for a medical purpose that was discovered at some point or just for educational purposes? I just want to make sure I understand perfectly well your point.

LUCY NOLAN: So I think as the first speaker said, it’s implied when you’re going in for maybe a hysterectomy or, you know, that you may have, right, there may be cone biopsy, I don't know, there could be some kind of -- there has to be an exam because it’s medically necessary to make sure that everything’s working, but yeah, we don’t -- I don’t agree that if somebody is in for something totally unrelated but because they’re put out, this is a good time to say let’s use this time to see what a woman’s vagina feels like.

I mean, one of the articles I read, a woman woke -- went into the ER and they put her into surgery and she absolutely no idea, I mean, into stirrups and she was like why was this because it’s not part of what’s happening, so it does happen in other places and there are other things -- there are other ways that medical students can learn about this and as we already heard today about -- from the SAFE exam that they use models to teach -- to teach the SAFE exam and it just -- So I think it’s important to -- it’s very hard to know whether this is happening or not and that’s why we support putting into legislation because it is akin, I agree with you one hundred percent, Senator Somers, to sexual assault in many
ways when you look at the sexual assault laws except that it’s for medical treatment so it’s not considered that.

REP. MCCARTY (38TH): Thank you.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. I appreciate it.

LUCY NOLAN: Thank you very much.

REP. STEINBERG (136TH): We’re going to do something we do occasionally in this committee which is make an exception. On occasion when we have somebody testifying who comes from some distance or has a particularly unusual time constraint, we do offer them the opportunity to testify so we can get them into the record and they can return to their positions. In this case, we have Dr. William Zempsky who is from the Department of Consumer Protection, physician panel, Doctor, thank you for being here.

WILLIAM ZEMPSKY: Thank you. I appreciate you taking the time to allow me to testify. I’m speaking specifically about the act of adding opioid use disorder and withdrawal as a debilitating medical condition for the palliative use of marijuana. As the legislator mentioned, I’m William Zempsky. I’m a pediatrician. I’m the head of the Division of Pain and Palliative Medicine at Connecticut Children’s Medical Center and professor of pediatrics at the UConn School of Medicine. I am also a member of the Medical Marijuana Program Board of Physicians. It is in this role that I speak with you this morning.
The Medical Marijuana Program Board of Physicians operates within the Department of Consumer Protection. The board is charged with advising the Department of Consumer Protection on which petitions for certifying conditions should be recommended for medical marijuana certification. Our board diligently reviews each petition and makes recommendations considering several factors. First, the evidence-based for cannabis use for the condition being petitioned, second, the existence of other evidence-based therapies, third, the safety of cannabis for the condition in question. You may know the physicians board considered the addition of opioid use disorder and withdrawal as a certifying condition during our 2018 meetings.

In fact, due to the number of individuals giving testimony and our desire to allow addiction specialists to provide written testimony, we initially tabled our vote and then in a subsequent meeting, recommended against certification. The reasons for this decision were as follows; number one, there’s no medical evidence for the use of cannabis for the treatment of opioid use disorder and withdrawal. Number two, there are evidence-based treatments that are strongly supported for treatment of opioid use disorder which include both medication and behavioral health support. Three, there were strong statements by the medical addiction community against certification and finally, allowing treatment of opioid use disorder with cannabis would ignore the importance of medical and behavioral expertise in the treatment of the disorder.

It would be extremely disappointing if the legislature ignored the board of physicians, which
they formed, and allowed the legislation to be passed. It would be a dangerous precedent and diminish the work of our group markedly while putting patients at risk for treatment with an unsubstantiated drug without the appropriate expertise and support. While I personally am in favor of medical cannabis and utilize in the treatment of my patients with pain, I and the board do not support this legislation. Certainly, if evidence becomes available to support cannabis use for opioid use disorder, the board would reconsider its recommendations. Thank you.

REP. STEINBERG (136TH): Well, thank you, Doctor, and I want to thank you first of all for your important work with regard to our, I think, wonderful model of a medical marijuana program. I’m particularly proud of how well our program has rolled out and how deliberate the board has been in adding conditions over the years and I think we all recognize that our intent is certainly such to relieve the crisis that we have in regard to opioid addiction and I will add that while a legislative remedy may be within the legislature’s purview, I for one take very seriously the sensitive nature of superseding the board in their work based upon medical science and I would hope that all members of this committee would keep that in mind when we consider this condition or other conditions for possible legislative action as opposed to working through the current process that I think works very well.

You mentioned, Doctor, that there is an absence or a shortage of relevant research with regard to marijuana as a substitute, for lack of a better
term, for opioids. Could you cut a little bit further on why there is such a lack of research?

WILLIAM ZEMPSKY: So first of all, my comment was that there’s a lack of -- an absence of evidence for cannabis for opioid use disorder. Certainly -- And that’s different than cannabis for a substitute, if you will, for traditionally treated conditions with opioids, which would be pain, would be the primary condition that opioids are used for. I think there’s an emerging evidence that cannabis can be used appropriately either as a substitute for opioids or even in conditions where opioids would not be indicated, but cannabis might provide benefit. That’s very different than opioid use disorder, where, and again, I’m not an addictionologist, but for the treatment of opioid -- the current standard of care for opioid use disorder is medicated assistant treatment, which means a combination of medication plus behavioral health in a supervised environment. If that -- If medical marijuana is approved for this condition, that would not allow or not mandate that that treatment go on in a supervised way. It could be obtained outside of the current paradigm for addiction treatment, which I think has -- may have unintended dangerous consequences for the problems that you are trying to remedy today.

REP. STEINBERG (136TH): So, Doctor, would you feel it’s a worthwhile endeavor to engage in such a study to see if marijuana would be inappropriate?

WILLIAM ZEMPSKY: I do think it would be very appropriate. That was -- We discussed that at our board meeting. In fact, several of the folks giving testimony asked what would be -- how would that
work, how would they go about getting that evidence and I think, you know, the state has been forward thinking in allowing medical marijuana to be used in research studies and I would certainly -- and again, it’s not a study I would probably do, but I would -- I think it would be very appropriate to engage the addiction community. There are excellent addiction facilities in this state that could be engaged to do such a trial or developed an evidence base for the use of cannabis for this disorder.

REP. STEINBERG (136TH): Thank you for your very reasoned response. Senator Abrams.

SEN. ABRAMS (13TH): I just wanted to say that I hope you understand that with the opioid crisis in this state being what it is that we need to be looking at every avenue possible to try to address this and support people and correct what’s happening, so I very much appreciate your testimony and I would never want you to think that there’s in any way a disrespect of the important work that you’re doing on your board and that the board is doing at looking at each of these cases, but I do think that given the state of emergency that we’re in with the opioid crisis, we have to look at every avenue, so thank you very much.

WILLIAM ZEMPSKY: I don’t disagree with you and certainly the board considered the opioid crisis in their -- in our deliberations. I think again, you know, when you do things that aren’t supported by evidence, you run a strong risk of having unintended consequences in actually worsening the care of the patient group you’re intending to help.

SEN. ABRAMS (13TH): So to Representative Steinberg’s point, though, you would be interested
or think the board might be interested in getting that evidence?

WILLIAM ZEMPSKY: I would be very -- We would be very supportive of that, yes.

SEN. ABRAMS (13TH): Thank you.

REP. STEINBERG (136TH): Senator Somers followed by Representative Klarides-Ditria.

SEN. SOMERS (18TH): Good morning and thank you for your testimony. I believe that when you took the vote, it was four to zero, is that correct? There wasn’t anybody who supported this indication?

WILLIAM ZEMPSKY: We have more than four members on the board, I don’t remember exactly, but I believe it was unanimous, but I can’t remember specifically how many members.

SEN. SOMERS (18TH): Okay, I think I looked it up and I thought it said four to zero, but it was unanimously opposed.

WILLIAM ZEMPSKY: Correct.

SEN. SOMERS (18TH): And that was one of the reasons why I was concerned about this coming to Public Health in one respect because I think it’s very important to maintain what we have set up with DCP and the fact that we do have this board of expert examiners or physicians that look at exactly what you’ve discussed, safety, efficacy, evidence and evidence of other therapies that are available and I do know that we have a similar subject coming up on chronic pain. Again, it would go -- I think should go back to you to show the evidence, the safety, etc., and I believe that there is -- there was a pain study authorized. I believe Yale-New
Haven might be doing that right now, but in order for you to get the clinical evidence, we would need to engage addiction physicians in the process and until that time, I’m glad that you brought up that we just don’t have the evidence to support the indication for use and it’s not really a legislative’s body purview necessarily to come up with the indications for use because we could be doing more harm than we intend to, so I really appreciate your testimony and thank you for all you do with DCP and being on that board. It’s a very important board and complicated, so I just wanted to make sure that I was able to say that to you and I, too, would like to see the evidence base on the use of it for opioid disorder and withdrawal, so to speak, and I believe that we actually approved last time through telehealth the use of medical assisted therapy in telehealth, so just imagine if this went through without the evidence and you could even have clinicians engaging in telehealth with writing prescriptions for this, so I just wanted to throw that out there. Thank you for your time.

WILLIAM ZEMPSKY: I agree with your comments and I just want to add that for most of the conditions that have been petitioned to the board we have approved, so this, in my time on the board which goes back about three years, I think there’s only one other condition, again, that had no medically supporting evidence that we have not approved, so I think we’re thoughtful and we look for the evidence where it’s available, and try to make the right decisions.

REP. STEINBERG (136TH): Thank you, Senator. Representative.
REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony today, but my first question, do you know of any other states that have this for opioids?

WILLIAM ZEMPSKY: You know, the states vary very much by what they’ve certified. I think there likely are some states that allow this. I think one of the things I’m proud about our board, but also the medical marijuana in Connecticut, is I think A, we have as your probably know, a pharmaceutical model for medical marijuana. It was the first and probably still maybe the best in the country regarding that and I think we’ve also been very thoughtful and deliberate about how we utilize medical marijuana and who is approved for use based on the medical evidence, so I can’t speak to how that process works in other states, but I’m very proud of the way we’ve done things here.

REP. KLARIDES-DITRIA (105TH): As a followup, do you know of how many times the legislature has superseded the board?

WILLIAM ZEMPSKY: I’m not aware of any time the legislature has superseded the board. I have not been on the board since its initiation. As a pediatrician, I was added to the board when the use of medical marijuana in individuals under 18, so that goes back about three years, but I’m not aware of any.

REP. KLARIDES-DITRIA (105TH): Okay. Thank you for your testimony.

REP. STEINBERG (136TH): Any other questions or comments? Representative Petit.
REP. PETIT (22ND): Thank you. Thank you, Doctor. I may be backtracking in this a little bit, but I've only been up here two years, but a lot of the push I've heard for indications have often been based on anecdote and for the most part, we don't allow medications to be approved in this country without randomized control trials. That's difficult to do with marijuana being a Schedule 1 drug, so the question beyond that is what kind of evidence do you accept? Do you want case control studies, cohort control studies, expert testimony? What kind of things is the board looking for since randomized control trials are tough to come by?

WILLIAM ZEMPSKY: You know, again, I’m not an addictionologist, so I think it’s necessary to gather their input as well, but I would say expert testimony would not be sufficient. I think, you know, randomized control trials are really challenging to accomplish, as you well know, so I think a well-done case control study, some other, you know, even a -- if there was a willingness to do a -- some type of registry underneath the auspices of the addiction community where patients would enter the system and be treated with cannabis would be, in my mind, potentially reasonable and a shorter, you know, route to gaining that data. In fact, I’m doing a registry right now at Connecticut Children’s because there’s no data on children receiving medical marijuana, so we have a registry so any child who is certified for medical marijuana who is under my care or under the care of the hospital, we try to enter in this registry so we can get longitudinal data. I think developing a feasible pilot longitudinal case study would be reasonable as long as it’s done under the right circumstances and
I’d encourage those in the addiction community to step forward and look into this.

REP. PETIT (22ND): Thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Any other comments or questions? If not, Doctor, let me reiterate how much we appreciate you taking time today to come speak to us and equally importantly, the good work you and your colleagues have done on the board on behalf of the state of Connecticut. As I’ve said, I’m particularly proud of Connecticut’s medical marijuana program and we will take very seriously any precedent setting legislation that would change the nature of who gets to make the decisions as to which conditions to add and we would not do that trivially and we may hear from you again because we have one other bill that seeks to do that. Again, thank you for your testimony. Thank you very much.

All right, we’re going to move on to House Bill 5142 and first up is Dorothy Cutter.

DOROTHY CUTTER: Good morning. My thanks to Representative Kurt Vail for introducing this important legislation and also to Representatives Mary Daugherty Abrams, Jonathan Steinberg, Matt Lesser, Philip Young, Heather Somers, William Petit, and the entire Public Health Committee for your thoughtful consideration of Bill 5142, criminalizing FGM. The United States Congress passed our first anti-FGM bill in 1966 and strengthened it in December of 2017. Nevertheless, this federal bill does little to actually protect at-risk girls from this gruesome assault on the most private areas of their bodies, since states cannot prosecute without a state law in place.
At present, 28 states have passed anti-FGM legislation. Connecticut needs to join the ranks. Looking at FGM globally, the World Health Organization reports that over 2 million women and girls have been subjected to FGM in over 30 countries. The UN, WHO, UNESCO, UNICEF, UNIFEM have all recognized FGM, not only as a harmful practice, but actually a violation of human rights. Fifty-nine countries have already criminalized FGM. In the United States, the American Medical Association, the Center for Disease Control, the American Academy of Pediatrics have all condemned the practice and clearly stated there are no medical benefits derived from it. Rather, it consigns girls and women to a host of serious lifelong medical issues, including pain and dysfunction, as well as psychological issues similar to PTSD. With the massive growth of refugees and migrant resettlement, the incidents of FGM have quadrupled since 1990 in the United States and current estimates put those at risk at approximately 513,000. This barbaric practice which operates mainly in secrecy must be stopped for it is torture, cruel, inhuman. It is child abuse at its worse. It is also the antithesis of women’s rights.

Sadly, most people have little or no understanding of what FGM actually entails. First of all, it is not the female equivalent of male circumcision, which does have health benefits, and secondly, it is not just a little nick as some would like to categorize it. Rather, it is the partial or complete removal of the external female genitalia. Usually it includes stitching the vagina and narrowing it so it has to be reopened by a woman’s husband using a razor to consummate the marriage. It is sometimes re-stitched following conception
only to be cut open again for the birth of the baby. Some women endure multiple cuttings and stitchings throughout their lives and this is performed on little girls from the ages of four to 14, sometimes as young as infants, without the benefit of anesthesia. They are held down screaming in pain and terror by mothers, aunts, and grandmothers, all to ensure their virginity until marriage. Is that against -- Oh, okay. I've lost my place, now. So not only --

REP. STEINBERG (136TH): If you could start to conclude at this point. You've had three minutes.

DOROTHY CUTTER: What?

REP. STEINBERG (136TH): You've had three minutes, if you could start to conclude at this point.

DOROTHY CUTTER: I will, I will. So Connecticut needs to pass its own comprehensive law and I would ask you to consider this question; if this were my daughter or granddaughter who was at risk for this barbaric practice, would I hesitate for one second to pass a comprehensive piece of legislation to protect her and include severe penalties for perpetrators? I submit to you that you would not, so today I challenge you to please be courageous, be decisive, be proactive of innocent young girls in our state and pass a comprehensive anti-FGM bill that carries stiff penalties and prohibits transporting children across state borders for this atrocity. Thank you.

REP. STEINBERG (136TH): Well, thank you. That was an excellent presentation. I think you made a very compelling case. This is really a serious problem
that we’re asked to consider addressing. Are there -- Yes, Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chair. The -- Are you familiar with the court case that was reported last year or the judge reported as unconstitutional --

DOROTHY CUTTER: In Michigan.

REP. PETIT (22ND): Yeah, in Michigan where -- so states have to create their -- Is that your understanding, because he ruled it as unconstitutional on a federal level that states have to create their own jurisdiction?

DOROTHY CUTTER: That is part of it, even before that ruling came about, it was -- it was understood that states had to have their own laws because a federal law can only be prosecuted by a federal prosecutor and federal prosecutors were not about to come into states and prosecute at the state level, so the federal law really accomplished very little other than to set kind of a foundation for the whole thing, so although there are 28 states that now have states laws, and at the time of that prosecution, Michigan did not have their law, so they tried prosecuting a case that had already taken place before their law was in place.

REP. PETIT (22ND): So if we feel this is critical, we would need to pass a state statute banning the practice?

DOROTHY CUTTER: Yes.

REP. PETIT (22ND): And to follow on that, do you feel that there is a state or states whose current statutes we would like to model ourselves after?
DOROTHY CUTTER: Michigan now does have the strongest laws about this on the books right now. New Hampshire has another very strong law and we submitted one that was drawn up for us that is considered by some groups, like the Ayaan Hirsi Ali Foundation, as to be really the gold standard of what would be an anti-FGM bill and that was presented.

REP. PETIT (22ND): Thank you, and has this -- has this been challenged in any of the states on a religious -- from a religious freedom point of view?

DOROTHY CUTTER: I’m not familiar with whether it’s been challenged on a religious standpoint or not because we don’t approach it from the position of religion. We approach it from the standpoint of health issues, of child abuse, and regardless of what any religion would want to bring into it, the point is in the United States of America, we do not subscribe to abusing children.

REP. PETIT (22ND): Thank you. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, again, thank you for your very compelling testimony and for coming here today. Thank you and next up would be Jane Bate, I believe it is.

JANE BATE: Good morning, I’m Jane Bate from Cheshire speaking of favor of House Bill 5142. I am grateful to the entire Public Health Committee, as well as to sponsors and co-sponsors, Representative Vail, Petit, Fishbein, and Dubitsky, as well as to Senator Kissel for the opportunity to speak on behalf of H.B. 5142 and all legislative efforts to
end the harmful practice of female genital mutilation. I might add, too, that this bill was passed unanimously by the Children’s Committee last year. Not only was the 1996 federal law banning FGM inadequate, but last November Judge Bernard Friedman found it to be unconstitutional in part because he found FGM to be, and this is a quote, “a local criminal activity that must be regulated by the states”, so now, the passage of a law in Connecticut to criminalize FGM is all that will stand in the gap for the thousands of at-risk girls currently in our state and with 28 states having already criminalized FGM, Connecticut could easily become a destination state for cutting and the number of at-risk in Connecticut would skyrocket.

A great number of national and international entities have taken a public stand deeming FGM a human rights abuse. Those organizations and conventions include the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, 1976, the World Health Organization, the Vienna Declaration of the World Conference on Human Rights, the AMA, CDC, AAP, as well as the International Planned Parenthood Federation. Let’s address some misconceptions regarding FGM. First, FGM affects several races and religions around the world, though it has historically been concentrated in certain regions of the globe, (a) with the increasing immigration, that has changed greatly and (b) the regions that have heretofore experienced high rates of FGM are in fact very diverse, while Mali and Sudan, for instance, are majority Muslim
nations, Eritrea and Ethiopia are majority Christian.

Secondly, FGM must not be equated with male circumcision. The AAP states that “the health benefits of newborn male circumcision outweigh the risks” while the WHO states that FGM offers “no health benefits, only harm.” Additionally, there is no safe form of FGM, even type 4 has been known to result in physical and psychological harm. Shouldn’t we in Connecticut respect time-honored oath to first do no harm? Is that my bell? I would ask you why FGM should not be held off until the girl reaches the age of majority and can choose for herself. With so many these days concerned with women’s rights, how dare we not protect young girls from the cruelest form of molestation. To conclude, I’m furnishing you with the contact information of two heroines in this fight. The first is Kadia Doumbia, a victim of FGM who testified for us last year. The second is Zainab Zeb, a human rights activist who works with FGM victims. Both are experts on the horror of FGM and would be delighted to speak with you. Thank you very much.

REP. STEINBERG (136TH): Thank you for your testimony. Are there any questions? Yes, please Representative.

REP. ZUPKUS (89TH): Hi, Jane. Thank you for coming up and I just wanted to say thank you for your advocacy. I know you’re up here. I was on Children’s when we passed it out last year and I have two young girls and I can’t imagine this ever happening to them or to anybody, so I just wanted to say thank you and nice to see you and thank you for your passion regarding this.
JANE BATE: Good to see you, too.

REP. STEINBERG (136TH): Other questions or comments?

JANE BATE: Sorry, if might say I do have a map of all 50 states and the degree of legislation they have passed and have not. Can I leave that up in the Public Health Office perhaps?

REP. STEINBERG (136TH): That would be wonderful if you could share that with us. We’ll make sure all members of the committee have an opportunity to see that documentation.

JANE BATE: Excellent.

REP. STEINBERG (136TH): Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman, and just very quickly, I wondered if you might have an opinion or perspective on adding to the legislation something about educational outreach programs to really educate people about this procedure?

JANE BATE: I personally like that idea a lot. I don’t know what more expert people might have to say about it, but thank you.

REP. MCCARTY (38TH): Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? Again, thank you for taking the time to testify today and for sharing the information that you have.

JANE BATE: Thank you very much.

REP. STEINBERG (136TH): Next up we have Jay Bolton.

JAMES BOLTON: Good morning. First, I want to thank all the legislators who have demonstrated courage to
stand up and to look at the various proposed bills. It’s very excellent and I’m pleased to see that. Unfortunately, the proposed bills do lack elements that will help ensure meaningful return from this atrocity and therefore I’ve attached a supplement to the bill for your consideration to strengthen it such that the child will surely be protected.

REP. STEINBERG (136TH): Is that the conclusion of your testimony, sir?

JAMES BOLTON: Yes, sir.

REP. STEINBERG (136TH): You make reference proposed amendment. Have you submitted that specific documentation?

JAMES BOLTON: Yes, sir. It was submitted with all the documents last night or this morning, so you should have that.

REP. STEINBERG (136TH): So I will refer my colleagues to make sure we all take a look at that. If you wouldn’t mind simply summarizing the import of that amendment so that we all can appreciate that.

JAMES BOLTON: It’s too lengthy to go into right now. It would be 20 minutes, so I would not want to get into the details. What it does is it provides teeth to the law. It’s not half of a lifejacket, it’s a full lifejacket to protect our kids and that’s the essence of it as far as criminal penalties, long-lasting criminal penalties, to those who engage in the practice, so it’s to put the teeth into to have it a meaningful bill as opposed to a window dressing to make it look good.
REP. STEINBERG (136TH): Well, thank you for that brief summary. I’m sure we’ll all take the opportunity to look at it and consider strengthening the bill along those lines. Are there any other questions or comments? If not, thank you for your time and for taking the time to give us something more to think about.

JAMES BOLTON: Thank you, sir.

REP. STEINBERG (136TH): Next we have it looks like Cassandra Slossar.

CASSANDRA SLOSSAR: Thank you for your time. I’m here for Bill 5142 Committee on Public Health

REP. STEINBERG (136TH): If you wouldn’t mind just identifying yourself because I think I might have gotten your name wrong.

CASSANDRA SLOSSAR: Oh, I’m so sorry. My name is Cassandra Slossar and I’m here for an act prohibiting female genital mutilation. Now, before -- Okay, actually, someone -- someone said that Congress and previous legislation does not have the right to regulate the behavior in the first place and that would be true if it were only behavior, but it is not, it is law, it is a foreign law, not American law. Our Congress of the United States, nor has any other -- Our Congress of the United States has not legislated to legislate the observances of other foreign law, therefore I feel as one of the states of America, we would be breaking law if we did allow FGM or freedom of circumcision and as Article I of the Constitution refers, all legislative powers here and granted shall be vested in the Congress of the United States which shall consist of the Senate and the House or
Representatives. To my knowledge, no state has -- no state has actually -- even though states do allow FGM, they haven’t specifically legislated to allow the FGM.

And if I may speak to a previous question asked, someone asked about the education outreach purposes and I personally feel public knowledge is always the best publicity -- or policy, I’m sorry, oh my gosh. While I personally am pretty nauseated to know about the five types of female genital mutilation, I have and you all have a copy of this, the detailed description from Ayaan Hirsi Ali from April 2017 which lists the five types of female genital mutilation performed on young girls, as young as five years old. Four of them are unarguably mutilation and the other is designed to symbolize mutilation.

There is the neck, the female -- and I won’t read all of them; that would go over my three minutes, there’s the neck, the female circumcision, the intermediate infibulation, the total infibulation, and the vaginal fusing. The aim of FGM in all its forms is to control female sexuality. The clitoris is removed to take physical pleasure from sex and reduce libido. Its more severe forms involving some of the genital -- the aim is to assure the girl is a virgin on her wedding night. Many women must be surgically reopened or simply with a penknife or razor blade in order to consummate the marriage. Was that my three minutes? Okay.

REP. STEINBERG (136TH): Thank you for your testimony. You’ve offered some interesting perspectives. Are there any questions or comments?
If not, again thank you for taking the time to testify before us today.

CASSANDRA SLOSSAR: Thank you.

REP. STEINBERG (136TH): Next up is Tom McCormick.

TOM GRIMSHAW: Good morning. Thank you, committee, for hearing us out on this very important issue. My name is Tom Grimshaw and I’m from Cheshire, Connecticut. I’m also here to provide some testimony on female genital mutilation. There are three bills that are passing through this state as we talk, Bills 142 and 536 from the House and there’s a Senate Bill 505. All of these bills call for the prohibition of the practice of female genital mutation in the state of Connecticut. What is it? It’s a range of procedures. You’ll hear that it’s just a little nick and it’s that most times, but it really is done on female genital organs and importantly, there is no medical reason or purpose. It’s a brutal procedure which often follows the removal of part or all of the clitoris and inner and outer labia and then the entire area is sewn up, leaving a tiny hole for urination.

This is barbaric. The procedure is often done without anesthesia by nonmedical people on teenagers, children, and even babies. They are often either captured or lured to a site, held down against their will, and brutally savaged, sometimes by family members and even strangers while hysterically crying and begging for release. There have been 18 major medical complications reported regarding this procedure, traumatic mental health issues to severe infections and yes, even death. There is not one medical benefit provided by this procedure. It is done to prevent women from having
sexual relations and bring under control of men. This is not a world -- a minor problem. You've heard previously over 200 million females from 30 countries are now living with this nightmare, including women in America. I want to stress this is not a religious problem, it is a cultural one.

Imagine coming home and finding your daughter, granddaughter, or sister forever damaged by this savage act. Many states in America have now passed this legislation, including New York, California, Michigan, and many, many others, but it has passed with overwhelming bipartisan support. In Michigan, it was like 102 in favor of it with two against. In many of the other states, it was unanimous, Republican, Democrat, Conservative, Liberal. When people find out what this activity is and it can be corrected, it’s overwhelmingly approved. In fact, we are asking that the state of Michigan be looked at very carefully because it provides up to a 15-year prison term for participating in this. Please, we respectively ask you to pass legislation to abolish FMG. Thank you

REP. STEINBERG (136TH): Thank you for your testimony. Are there any comments or questions? Again, thank you for your time. We had Tom McCormick. Did he have an opportunity to speak? Is he here? If not, that will conclude the testimony on this bill and we will move on to Senate bill 45. First up is -- Well, we’ve heard from Dr. Zempsky, Brian Essenter.

BRIAN ESSENTER: Good afternoon, ladies and gentlemen of the Public Health Committee. I’d like to thank Representative Steinberg and Senator Abrams for listening to us today and trying to find
alternative treatments for the opioid epidemic, as our current options have not been nearly as successful as we had hoped. I’m going to read my testimony. I was having trouble finding someplace to submit it on line, so I apologize. I can submit it again later if you’d like to hear, but my name is Brian Essenter. I’m a pharmacist and former dispensary manager at the Compassionate Care Center in Bethel, Connecticut for three years. I’ll also be the dispensary manager of the newly approved dispensary that will be opening in New Haven in just a few short months. I've seen first-hand the literal death grip that opioids have on those addicted and getting clean is a very long, lonely, and harsh journey.

There’s just a few points I’d like to make today. Number one, no one has ever died from an overdose of cannabis, which leads right into number two which I kind of think is kind of the point of this legislation is harm reduction. We’ve seen that methadone and Suboxone programs are just another opioid addiction. They are -- The patients are not being tracked or tapered off of it properly and usually not at all and it’s almost just a way to maintain their cravings and keep them from getting worse. The overwhelming majority of drug abuse counselors that I have spoken to, they feel -- they feel as though cannabis is a much safer option in helping deal with the withdrawal effects. There’s been a lot of talk regarding the difference between physical and chemical addiction. The bottom line is that patients withdraw from opiates in the same way and they have the same symptoms, pain, anxiety, difficulty sleeping, nausea and vomiting, jitters. We all know what withdrawal looks like.
We here in Connecticut have pharmacists behind the counter in these medical marijuana dispensaries because of their ability to deal with medications and adjusting dosages accordingly and I would like you to lean on them when we speak to these patients and actually help them go through that process. By helping patients decrease their opiate use and abuse, it will help the entire healthcare industry save money and use their resources much more efficiently as well. A couple of other things, one in five prescriptions are written for what is called off-label use. Off-label use means that they have not been tested or any research done for their safety or their efficacy for that. That means 20 percent of prescriptions are being written for off-label use and we’re worried about something that is harm reduction and going to help stem this healthcare crisis that we’re having with the opiate epidemic.

A couple of other things, this is not an option for everybody and it is not the only option. We do have other services out there, depending on what the doctors feel is necessary and what the patients feel is necessary and/or appropriate for any given situation. This is simply just another tool in the toolbox for these clinicians. And one of the other points I wanted to speak to was well, there was a question to overriding the board of physicians and I don’t think that’s really something that we’re looking to do. I think they’re in a great place to provide a lot of support there. The process there can be completely inefficient as well. As we’ve seen, there have been conditions that have taken over 18 months to be added to the approval list so that they can actually be certified. The last thing
I just want to leave you guys with is a quote from a drug abuse counselor that is just “cannabis is the condom for the opioid epidemic. Abstinence did not work with dealing with HIV. Why would be so stubborn to think that it would work with the opioid epidemic, as well.” Representatives of the healthcare committee -- Public Healthcare Committee, sorry, I appreciate your time in listening to us today. I would be happy to take any questions.

REP. STEINBERG (136TH): Thank you for your testimony. I think you’ve put a very interesting perspective on it and I think the points you made give us a lot to think about. I think you get the sense we’re all taking this extremely seriously. We’re all grasping for potential solutions for a real crisis and we’re trying to be very careful about what alternatives we consider, so thank you for that. Did you want --

SEN. ABRAMS (13TH): I had a question.


SEN. ABRAMS (13TH): Hi, thank you for being here.

BRIAN ESSENTER: Thank you.

SEN. ABRAMS (13TH): My question was, when the doctor was speaking about the process that they went through in looking at whether or not to use cannabis for this particular condition, did you or any members of your profession have input in that? Did you get to participate in that in any way?

BRIAN ESSENTER: We did. I actually submitted public testimony for that, as well, along with the -- there’s an Academy of Medical Marijuana Dispensaries, that is all of the dispensaries
participate in. They submitted testimony for that as well as a group and it’s been something that we have all been pushing for. The unfortunate part, I think one of the biggest questions that they had and the debate amongst themselves is the difference between physical addiction and psychological addiction and that they can be treated differently, but as I stated, the withdrawal symptoms are very similar no matter what type of addiction you have and I have helped these patients and have seen this first-hand. I have helped hundreds of patients decrease significant amount of opiates, including methadone and Suboxone which are even harder to get off of at times, so when you deal with these patients one-on-one like we do and you do have pharmacists behind these counters talking to these patients, going through an interview process with them to find out what would be appropriate for them, I think you’re dealing with those situations very specifically as opposed to just a general yes, let’s just use cannabis for opiates.

SEN. ABRAMS (13TH): And are you aware of other states that are doing this?

BRIAN ESSENTER: Absolutely. Illinois actually just started, I believe it was February 1st, allowing any clinician to certify a patient for medical marijuana in place of opiates. Every state in New England has approved either opiate use, opiate use disorder, and/or chronic pain which kind of leads right into that as well for certifying conditions in their states, along with many other states, as well.

SEN. ABRAMS (13TH): Thank you.

BRIAN ESSENTER: Absolutely.
REP. STEINBERG (136TH): If you had the opportunity, you could provide us with any information you have about other states just to simplify our task, that would be great.

BRIAN ESSENTER: I don’t have it on me right this second. I would be happy to provide you guys with any of that information. I don’t bring studies and numbers up here because those get thrown out quite a bit and everybody on every side has studies and numbers, so I really try to speak to my experience rather -- which is very first-hand with these patients rather than just throwing numbers out to get people’s heads spinning, but I would be happy to provide you with any of that information you’d like.

REP. STEINBERG (136TH): We don’t mind having our heads spinning. Other questions or comments? If not, thank you very much for your testimony today.

BRIAN ESSENTER: Thank you very much.

REP. STEINBERG (136TH): Next up would be Lawrence Truman.

LAWRENCE TRUMAN: Good afternoon, ladies and gentlemen. I testified last fall on the marijuana bill and everything on opioids. First of all, it falls under the racketeering law because what happens, children are exposed. You forgot the public safety. Police actions against such people and the legislator who won’t promote safe streets who put opioids on the street, to put disturbance on the police, you have people locked in their house because home invasion -- where I live, there’s opioids and what they say they have rights. They threaten us with knives because we do not smoke. The whole city is under siege by these persons in
yours because you can’t pass legislation for public safety. Dr. Petit, you first-hand understand public safety, but the problem is, there’s so much money going on. I talked to a representative from Newtown and he said there’s a lot of dirty money in this state and I said it’s been here since I’ve been here. It goes right to the governor who is under DSS, could lose his children for exposing neurotoxin poison to -- and drug dens to their children -- into drug dens instead of school. That’s why you have massive dropouts. Thank you. It’s right here.

REP. STEINBERG (136TH): Thank you for that.

LAWRENCE TRUMAN: Don’t be a puppet and there also FBI warrants for children’s safety, which we fail to protect public safety and even with police action, I don’t see no police here, but I don’t see any, any representation for children exposed to this deadly epidemic because it’s ongoing.

REP. STEINBERG (136TH): Thank you for your testimony. You raise a good point. Are there any questions or comments? If not, thank you for your testimony today.

LAWRENCE TRUMAN: You’re welcome. I have all federal --

REP. STEINBERG (136TH): Next up is Christina Capitan. Thank you.

CHRISTINA CAPITAN: Good afternoon, members of -- the highly respected members of the Public Health Committee. I appreciate you having us here and I do understand, you know, the concern of maybe circumventing the oversight of the, you know, the physicians committee for the DCP. While I really do understand that we do need to have those safeguards
in place, I also understand that over regulation can become a hindrance. Unfortunately in Connecticut, while we have about -- over 30,000 patients registered in our program, I believe that we would have many more if we would open up these regulations to be a little bit more lax so that we can have people come on a little bit more quickly and be able to have uninterrupted access. So my name is Christine Capitan. I live in Coventry, Connecticut. I’ve been before many times in the past. I am a Connecticut medical marijuana patient advocate. I do work at a medical marijuana dispensary, Prime Wellness of Connecticut, and I deal with thousands of patients yearly.

So I’m here today to represent that growing number of Connecticut medical marijuana patients. I’m an advocate and I am a child of someone who was addicted to opioids and who did pass away and became a statistic. Thank you for allowing me this time. It’s an understatement to say that the opioid crisis in Connecticut is growing. As we sit here discussing this option again for that growing population, someone is losing their life, not only literally, but figuratively, to these dangerous and deadly drugs. We are looking at an opportunity here to use medical cannabis as a useful tool in alleviating opioid dependence, easing symptoms of opioid withdrawal, and to potentially serve as a substitute to opioids or possibly implemented in harm reduction modeled to decrease the amount of opioids needed by patients to manage their symptoms.

As a Connecticut medical marijuana dispensary employee, I work with a lot of patients closely on the front line of our program. I have witnessed first-hand the effects of cannabis on opioid-
dependent and opioid-addicted patients. I have seen several patients be able to greatly reduce or cease all use of opioid medications and pain killers, including oxycodone, methadone, and for some, it even seems to have helped them cease their use of illicit opioids like heroin. The idea is promising that the same will happen should you decide to approve this viable option when looking for a solution to the problem we have -- that we are facing with opioids in our state. Please consider adding opioid use disorder and opioid withdrawal in giving these folks an additional support system. As I work in the dispensary, I see many patients come in just looking for an additional support. A lot of these people have lost so much, whether they’re addicted to opioid pain killers that were prescribed pharmaceutically and with the new laws that have come into place, they are running out of options as to do once the opioids are reduced or taken away.

We are very much aware that cannabis is a much safer option that prescription opioids, methadone, Suboxone. As we saw the three-year-old who passed away in Stafford was a good friend of mine’s child and they were given a methadone take-home bottle and I do believe if they were given other options, that child may still be alive and those parents may still be out in the world loving that child. I really, really thank you for taking the time to listen to me. I have submitted my testimony electronically, although I wasn’t able to do so prior to the hearing, so it will give you some time to look at it and I’m always available for questions. Thank you.

REP. STEINBERG (136TH): Well, thank you for once again providing us with your testimony and I think it’s a very interesting perspective. You’re sort of
on the front lines in the dispensing area with our medical marijuana program and I’m sure it’s very tough to see people who have very serious addiction problems come there seeking alternatives. I’m sure you also understand how sensitive this is for us to even be contemplating something -- particularly since the board of physicians is not comfortable doing so at this point in time. Are there questions or comments? Representative.

REP. COMEY (102ND): Thank you. Thank you, Ms. Capitan. So you mentioned that as a daughter of someone that was an opioid addict, do you feel, I don’t know how long ago that was, but do you feel that would -- have access to marijuana legally would have made a difference in their recovery?

CHRISTINA CAPITAN: Thank you for asking. So while I’m not sure if there’s an appropriate or right answer for that, I do think that if my mother had been given another option or maybe hadn’t foregone the appropriate services based on her use of cannabis illegally, she may have had a better opportunity at, you know, survival and recovery.

REP. COMEY (102ND): Sorry for your loss. Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Are there other questions, comments? If not, I’m sure we’ll see you again --

CHRISTINA CAPITAN: Yes, you absolutely will.

REP. STEINBERG (136TH): Thank you. Thank you very much.
KATHY FLAHERTY: Good morning, Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee. I’m here to testify in support of H.B. 5145, but I have some concerns about it. I've already submitted my written testimony, so I’m not going to read it. This is really the bottom line from where I’m coming from and I come from this from a perspective as the executive director of Connecticut Legal Rights Project and the co-chair of Keep the Promise and as a person living in recovery from a mental health condition. There are existing statutes that this legislature passed more than 40 years ago that established the regional mental health boards and the regional action councils. Last year, the Department of Mental Health and Addiction Services decided to issue a request for proposals for the creation of these new regional behavioral health action organizations and I am still unconvinced that they had the authority to even do that with new legislation not being passed that repealed those old statutes.

The regional mental health boards and the regional action councils had very distinct missions and very distinct purposes under the law and especially when it came to the regional mental health boards because I’ll be honest, I don’t know that much about the RACs because I've been involved in the mental health service system. The involvement of people with lived experience and their family members was a critical part of the regional mental health board
mission and involving those individuals who were most impacted by the receipt of DMHAS services and the evaluation and oversight of DMHAS and DMHAS funded programs was critical and what scares me about this whole thing with the regional behavioral health action organizations is that the funding that they’re getting now is through the substance abuse block grant and as so many things happen in this state, funding drives function and if this state values the oversight consumer protection type function of the regional mental boards, the amplification of the voices of people with lived experience and their family members in performing that function, this state needs to decide where it’s going to invest its dollars and where it’s going to spend its money on, because if you allow this to be funded solely through the block grants, it’s going to put an over emphasis on the prevention function, not that that’s not valuable, but you’re potentially giving up a lot and that’s it.

REP. STEINBERG (136TH): Thank you for your testimony. I concur with virtually everything you’ve said. I think that we’re all seeking to find the best way out of a very unfortunate circumstance, which I think is reflective of the state of the state, year after year of budget cuts, whereas I did not agree with the agency’s decision. I have some measure of sympathy to the fact that they were cutting both sides budgets year after year and bringing them to the brink of not viability and they thought that by creating a combined entity, they would be able to sustain the functions, but I think to your point, the new entity was created, put emphasis on one end of the spectrum and unfortunately leaves a real gap on the other end. I
think what the committee is trying to do here through this legislation is to help fashion a better solution. I take your point. I’m not sure -- We’ll have to check into the realities of whether or not the agency was within their purview to make such changes with existing statute without statutory changes, but nobody is happy with this circumstance and I think we’re all eager to get some feedback on the even short experience we have with the new entities and whether or not your concerns about gaps in care and oversight are coming to fruition, so we hope you’ll stay involved in that.

KATHY FLAHERTY: Absolutely.

REP. STEINBERG (136TH): Are there questions or comments? If not, thank you very much.

KATHY FLAHERTY: Thank you.

REP. STEINBERG (136TH): Next up, Margaret Watt.

MARGARET WATT: Good morning, Senator Abrams or good afternoon, Representative Steinberg and committee members. I’m Margaret Watt, the executive director of the Southwest Regional Health Board. We are in the very final stages of our merger to become the RBHAO for Southwest Connecticut, which will be known as the Hub. I can echo everything Kathy said and that you just said, Representative Steinberg, about the process that led us here and so I won’t repeat some of the background, but I will -- I do want to support the idea that the legislature do some kind of study of the new RBHAO contracts in relation to the statutes that govern both the regional boards and the RACs, including looking at whether the RBHAOs are adequately funded and staffed to meet the expected role, even on the prevention side honestly.
I would like to add that as a group, the RBHAOs have been meeting to work on draft language for a statute that could potentially replace the RMHB and RAC statutes. You can read the current draft in Pam Mautte’s testimony. I think she’s coming up after me. That language represents the consensus that we have around the aspects that we do agree on, but I still feel there is that critical missing component because the RBHAOs, as they’re currently designed, their deliverables, the staffing, and the funding, do focus on the prevention of substance use, which is the traditional RAC mission, and not on that external oversight of the treatment system function that was traditionally the watchdog role of the regional boards and carried out by people and families affected by the system.

As noted, of course it functions on prevention, it’s funded through prevention money, and I value that. I’m a parent, I’m a former teacher. Prevention is really critical. The question now is how and where can we ensure a community oversight role and how does it relate to the RBHAO work. We all know independent oversight is necessary that’s external. People who are -- The people we’re talking about are often entered, even forcibly, into huge systems of care. When they’re ill, when they’re at high risk, they’re highly vulnerable, so they’re at the mercy of these bureaucracies and these systems are well intentioned at the macro level and individuals are well intentioned, but these are subject to neglect and abuse. We saw the case of Bill Shehadi at Whiting Forensic, we saw the pregnant girl who died by suicide at Solnit, the DCF facility, over the summer, and so to me -- to me even the previous
oversight system that we had might not have caught these abuses.

So I think -- and I also think that oversight system is basically a sailed ship right now, honestly, the way the contracts are, so I think you all have the opportunity to look at how do we best as a state assure that there is a new, like redesigned, the consumer watchdog function, so I would envision something that meets like five criteria. It has to involve clients and family members who are served in state programs, both in the design of the new system and the implementation. I think it should look at any state behavioral health service, DCF, DMHAS, TDS, etc., and should focus on the places where abuses -- where people have the least voice, long-term care, residential services, inpatient programs, prison systems. It should conflicts of interest by having its own separate funding stream. It should prevent abuses by being visibly there as an oversight mechanism rather than sort of writing longer reports that identify improvements to services, and -- ten seconds more -- and be flexible to respond to potential issues.

I could see something like that being housed at the RBHAO so that it’s located in the regions, but its own kind of separate entity. I would just add that there are a lot of us out there that would be very willing to serve on a committee to design something like that. I’m here with a couple board members. Others have submitted written testimony. I think it should be a design committee, maybe not a taskforce because we’ve seen the issue with taskforces, and so I thank your and Representative McCarty for bringing this up for considering how best to both make the RBHAOs work and to ensure that the protections that
have been in statute for so long are preserved. Thank you.

REP. STEINBERG (136TH): Thank you, Margaret, for your testimony. I know how wrenching it’s been for both the previous entities to find a way to honor their commitments to their clients and protect everybody in the state of Connecticut. Yes, I think the study is a means by which we can put together a framework and I just want to encourage you to stay in contact. I imagine this particular problem will play out once again in as much as the Appropriations Committee and it will with this committee because of existing budget deficits and how many things are threatened by it. So I want to encourage you to continue to do this work and hopefully the study will be sufficiently timely if we were to pass such legislation to protect that which we still have. Other comments or questions? Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chair. I just really wanted to make a comment to thank you for your thoughtful testimony and really coming here prepared to offer some solutions so that we can all work together to try to find the best method moving forward. Thank you.

MARGARET WATT: Thank you.

REP. STEINBERG (136TH): Next is Pam Mautte.

PAM MAUTTE: Good afternoon, Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit, and members of the Public Health Committee. I’m Pam Mautte. I’m the director of the Alliance for Prevention and Wellness. We’re a program of BHcare in Ansonia and today I’m here in
my capacity as the president of the Connecticut Prevention Network. CPN is the coalition of the five regional behavioral health action organizations who focus on substance abuse and mental health prevention efforts. I’m here to support the bill today and requesting statutory language to define the regional behavioral health action organizations, or hereinafter the RBHAOs. The five RBHAOs have worked together in a unified voice, compromising the leadership of all of us to submit, which I put in with my testimony, new statutory language.

In the last two years, we have seen unprecedented changes for our organizations and together we believe it’s important to clarify our role in the statutory responsibilities. Currently, there are no statutes to govern the RBHAOs. Instead what remains are the attached statutes delineating the responsibilities of the RACs and the regional mental health boards. The attached proposed statutory language seeks to unify our roles in a manner that has not yet been done. Instead what governs our unique prevention organizations with contractual language dictated to the RBHAOs by the Department of Mental Health and Addiction Services. We value our relationship with DMHAS and work with them in a collaborative and constructive manner to promote and implement evidence-based substance abuse and mental health promotion in all of Connecticut’s communities. RACs and regional mental health boards were legislatively enacted bodies with funding appropriated by the legislator. In fact, the legislator funded both the RACs and the regional mental health boards up until fiscal year 2018. The October 2017 bipartisan budget included funding for both and the RACs within the DMHAS budget, however,
Governor Malloy used his authority granted to him by the legislator to eliminate funding for these entities.

DMHAS has moved forward with the request for proposal for 13 RACs and five regional mental health boards to roll into five RBHAOs. This happened in February of 2018. We are awarded through a competitive request for proposal process. The funding each agency receives now is provided through the Substance Abuse Mental Health Services block grant provided through the federal government. All five RBHAOs are made up of former RAC organizations or combinations of RACs and regional health board organizations that consolidated or will be finished consolidated in the next few months. The process was hastily put together and challenging for each of our organizations. Despite this, our agencies continued to serve every community in Connecticut by funding and supporting the local branch and councils.

We implemented the federal state targeted response and state opioid response federally funded initiatives in our region with local community coalitions. We assisted our municipalities and community organizations to obtain additional funding for substance abuse prevention and mental health promotion efforts. We advocate on issues to improve health and reduce substance use and provide data and technical assistance to municipalities. So I don’t have time to finish, but I’m definitely here to answer any questions that you may have regarding what we’ve put in the testimony.

REP. STEINBERG (136TH): Pam, thank you for your testimony. It’s wonderful to see the strong
advocacy from the community that has been working so hard to take care of the people involved here. We’re counting on all of you to be part of the solution to the degree that we can forge one with limited means, so again, as I said with Margaret, I hope you stay actively involved and keep us on the right path as we try to fashion some sort of study that’s going to meet the need. Other comments or questions? Thank you.

PAM MAUTTE: You’re welcome. I also submitted written testimony on behalf of the Alliance for Prevention and Wellness.

REP. STEINBERG (136TH): Thank you. We’ll take a look at that. Next up looks like Marcia DuFore or DuFree, I’m not sure.

MARCIA DUFORE: Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee. My name is Marcia DuFore and I’m testifying as director of the North Central Regional Mental Health Board and member of the Keep the Promise Coalition and the Connecticut Prevention Network. I’m here today to support House Bill 5145, An ACT Concerning a Study of Regional Behavioral Action Organizations for Statutory Language to Define Our Purpose and Scope. North Central Regional Mental Health Board is one of five RBHAOs under contract with the Department of Mental Health and Addiction Services. Last year, the state of Connecticut eliminated all funding for regional mental health boards. Fortunately, DMHAS was able to use some of its federal block grant funding to keep us afloat, but that resulted in the closure of a number of regional mental health boards and a number of regional action councils.
Our contract with DMHAS required regional mental health boards and RACs to consolidate our operations and our statutory functions. RBHAOs then -- Our entity is created through a contract with DMHAS and has replaced the previous regional mental health boards and RACs. Regional mental health boards and RACs were created by the legislature with state statute and funding defining and supporting their respective functions. In our opinion, this was a legislature with vision who wish to make sure that at the very grassroots level, people most impacted by substance abuse and mental health issues would have a key role in identifying needs, recommending policy, carrying out prevention initiatives, and monitoring the services and service system. We wish to ensure that these essential functions are preserved with their purpose and scope accurately described and supported in statute. Some suggested statutory language drafted by the directors of the new RBHAOs is attached. Pam has also attached that to her testimony.

I have to admit the last year and a half has been extremely challenging. The scope of our work has greatly expanded in our new contract with DMHAS. We are now responsible to support and coordinate behavioral health across a continuum of prevention, treatment, and recovery and across the lifespan. This includes children, adults, mental health, substance abuse, and problem gambling. In my region, that’s for 37 towns. We’re -- In spite of that, we’re embracing these new roles as opportunities to better serve our communities and your communities. Our hope is that the core missions and statutory functions of both the regional mental health boards and the RACs can be
sustained and enhanced in our new roles in the RBHAOs. One of our most valued roles from my agency has been working with our community stakeholders, reviewing, especially people with mental health and addiction challenges in their families, to identify local needs, evaluate the delivery of behavioral health services, and provide recommendations for new and improved services.

This involves, among other things, being able to go into state-funded programs and review them from the lens of people who use those services. We’ve maintained that function over the past year, but it has been a challenge and I know that I’m out of time, so I’ll just leave it at that and offer to answer any questions that you have.

REP. STEINBERG (136TH): Marcia, thank you for being here today. I think it’s a testament to how important this issue is that we have. Fortunately, all the heavy hitters who are on the front lines of this are coming to testify before us today. We take that very seriously. We appreciate your struggles over the past year to deal with the ramifications of the agency’s decision, so again as I've said with the others, we encourage you to stay involved with this, to share with us the real consequences of this change as you experience them, and to help us work on ideally a study that will pass as legislation. Questions or comments? Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman, and also thank you always for explaining so well where we are and where we’re going. I really very much appreciate that. Could you just explain for a minute if the regional behavioral health organizations now are still working with DMHAS as
far as looking to do needs assessments so that they can apply for federal grant money? Is that still part of the consolidation piece and if you could speak to that for a moment.

MARCIA DUFORE: Absolutely. That is one of our primary functions. We’ve been asked to conduct an annual priority needs assessment, which will result in a report that they will use for their block grant funding. That includes the review of a great deal of data that’s available to us, as well as focus groups with individuals who receive services and individuals who are children and families who wish they had more services, so we will be producing that report by the end of May.

REP. MCCARTY (38TH): And if I may just clarify, so that work is really enhancing very much the work for DMHAS so that we can bring back those millions and over 20 -- and I don’t know what the amount -- specific amount, but I know that it’s an incredible amount of federal dollars, so that’s in addition to the work that your organization is doing?

MARCIA DUFORE: It’s a core response -- It always has been a core responsibility of our organizations and it does bring in federal money for DMHAS and at this point, that’s all DMHAS has to work with, to fund us, is that federal money from the block grants.

REP. MCCARTY (38TH): Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you for the good work you’re doing and continue to struggle to do and I’m sure we’ll talk more.
MARCIA DUFORSE: We thank you for taking this issue seriously.

REP. STEINBERG (136TH): All right, up next is Janine Sullivan-Wiley.

JANINE SULLIVAN-WILEY: Good afternoon, Senator Abrams, Representative Steinberg, and members of the Public Health Committee. My name is Janine Sullivan-Wiley and I’m the executive director of the Northwest Regional Mental Health Board. Our board, as some of the others you’ve heard, is currently in the process of merging into the Housatonic Valley Coalition Against Substance Abuse, joining the CNB RAC to form the RBHAO, I can use the acronym by now, I figure, in Region 5. I am so glad that this bill was proposed. This bill, as well as the bills proposed by Representative McCarty, these tell me that you are also concerned about the boards and RACs and the CACs in the system that has provided collaborative oversight, as well as the positive influence on behavioral health services for people who need them.

Now the theoretical concept behind the RBHAOs I think is really good, a single organization, both sides of behavioral health across the lifespan, that’s a wonderful goal, but I think the actual implementation that took place is of concern to me in terms of contract deliverables, you’ve heard that. In terms of deliverables, it was supposed to be a merger between the boards and the RACs, which implies inclusion, you know, fair inclusion of kind of both sides of that, but if you look at the deliverables and the funding, and the funding was mentioned it all comes from federal block grant prevention dollars, it really, to some extent has
created five super RACs and really has been very light on issues that impact people with serious mental illness. The work of the boards and the catchment area councils is marginalized in these contracts and deliverables and I want to stress, not in the hearts of the people running the RBHAOs, but in terms of what they are mandated to report on and to deliver. I think that’s where the problem is.

Over 40 years ago, the Connecticut Legislature set up the structure and I think it was excellent. It emphasized the role of people with lived experience, both consumers and family members, regular citizens and providers who all came together at the same table and that stakeholder representative is not assured at all in this new structure. The statutes, which were not changed despite the changes in the DMHAS contracts, established a community-based and transparent process for the evaluation of services. The board and CAC evaluations have always assured that services are high quality and addressed the needs of people who are using them or who might need to use them in the future. Evaluations were not even mentioned in the contract language and are not a deliverable except where required by statute that’s kind of like an off-line piece in here, which makes that, I think, very critical role extremely vulnerable.

Lastly is the funding. Now, I have to say our board has even worked with other organizations in supporting mergers. I think this is a very good approach, but this went from 18 entities down to five and in one region, there wasn’t even a regional board as part of the final merger. Given the state’s fiscal challenges, I can understand that
something maybe needed to be done, but the end game, the end product of the whole thing, is that funding to the surviving organizations is insufficient to enable them to fulfill both their essential RAC prevention efforts, as it’s been stated before, prevention is essential, but it sort of didn’t really address a lot of what I would consider to be some of the essential board and CAC functions. So I support the bill, I support your enthusiasm for looking at this structure, and I would just urge you to ensure that in the final end kind of product, that the evaluation function as well as representation of people with lived experience, and the town representatives are preserved. Thank you.

REP. STEINBERG (136TH): Janine, thank you as always for all the roles you play here on behalf of those with behavioral health issues and I think you gave us a good perspective. You do mention the number of the new entities we have. We’ve actually had bill before us advocating for the creation of a sixth such entity. Do you feel that five as constituted is sufficient to cover the state’s needs?

JANINE SULLIVAN-WILEY: I would say yes, partly because we have had for a long time five regional mental health boards which have covered all of those communities and as I understand it, the bill was to look at Middlesex County, which was traditionally covered very well by the Region 2 Regional Mental Health Board, so I don’t kind of understand why that would need to be different now.

REP. STEINBERG (136TH): Well, thank you for that perspective. As I've said with the other, you collectively represent a great team on behalf of not only the people of the state of Connecticut, but of
this issue and we’re counting on your continued involvement. In your case, I have no doubt that will continue. Any other questions, comments? Yes, Representative Michele.

REP. MICHEL (146TH): Thank you, Mr. Chair, thank you for your testimony and all your good work. I just was looking back at the statutes, the boards were also created sort of as a watchdog to look out for patient abuses, I believe.

JANINE SULLIVAN-WILEY: Yes.

REP. MICHEL (146TH): So I would imagine that you’d be in favor of us sort of reinstating this in the RBHAOs? Sorry, I’m learning my acronyms.

JANINE SULLIVAN-WILEY: Absolutely. I think that I can speak specifically to our region, consumers, family members and townspeople, because we have a structure of town representation, have long valued the fact that the regional boards have had a process -- and I’m going to emphasize it was never a gotcha, never a kind of a negative thing, but in a very much more collaborative and supportive function to help agencies be what they want to be. I have yet to meet an agency that didn’t want to do a good job, so to me, it’s always been our role to help them kind of be the best they want to be.

REP. MICHEL (146TH): Thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Representative. Other questions, comments? If not, thank you, Janine, we’ll see you around.

JANINE SULLIVAN-WILEY: Thank you so much.

REP. STEINBERG (136TH): Next up, Suzi Craig.
SUZI CRAIG: Good afternoon. My name is Suzi Craig. I am the policy lead at Mental Health Connecticut. Thank you, Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee. I am here with support and with recommendations for H.B. 5145. So MHC is statewide, but we also have offices in six cities on the western side of the state. We’re a private non-profit, community-based. We’ve been around for 110 years and so I’m here to offer the perspective of an organization that works with the RACs and the regional mental health boards. I’m not going to read my testimony, you have it, I submitted it electronically, but I do just want to drive home a few points. We’re in full support of ensuring that this amazing grassroots work continues to happen in some way, shape, or form.

From MHC’s perspective and my perspective personally, I’m new-ish to the mental health arena, been working at MHC for over three years now, so the folks that I work with on the boards and the RACS are -- I cannot tell you the depth of expertise, the tireless hours, what they put into ensuring that the people in their backyard, the individuals and families, are actually on the ground receiving services in what theoretically looks like a good idea when it comes to service, how it plays out on the ground, actually happens, is just amazing. So MCH really benefits from the collective voice that a regional board can provide. As consumers of services, individuals and their families can help identify gaps in services, make recommendations about what resources can be allocated and help those of us in the system really identify underserved populations.
So really, our recommendations, I’d like to reiterate what Kathy Flaherty said before which is funding drives function. As you know, in the 1970’s, the boards were created as an external watchdog organization. Other industries have consumer protection agencies, right, the Better Business Bureau, the Federal Trade Commission, I would love to see that idea really -- and the roots of that go back to be revisited and really check into like what would benefit everyone if we’re really revisiting that consumer protection function. So we have that recommendation and obviously ensuring that the voices of individuals and families are part of that decision-making and then also, we recommend that another entity, such as the Office of the Healthcare Advocate, or another entity be the entity that the boards and the RACs, whatever this looks like, report to or appoint to so that you’re now, you know, directing that reporting function to something that’s outside of, you know, DMHAS, so I’ll just leave it at that.

REP. STEINBERG (136TH): Thank you for your testimony and for the role you play in this. I think you -- The recommendations you’ve brought forward are understandable. I think we’re all struggling to figure out how we can provide the same protections that we used to with such limited resources in this case and I’m intrigued by your concept of getting the Office of the Health Advocate involved in some fashion because there is some logic to having them more involved with the oversight function in that regard, so that’s something I think we need to explore further and I think what we’ve heard -- a lot of the testimony with regard to this bill is about how everyone is working as hard as
they can to cover the entire gamut of the previous responsibilities with reduced resources and perhaps if the five entities are successful to some degree in achieving that, that will make an even stronger case for freeing up some of that ability to focus on the oversight side of the equation, so again I would hope that you would stay very much involved in our deliberations, our efforts, to come up with a better solution for this.

SUZI CRAIG: Absolutely.

REP. STEINBERG (136TH): Thank you. Other questions or comments? Yes, Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman, and just I also wanted to thank you for coming forward with some of the solutions and I think part of this goes forward of the study maybe also to look at what kind of funding is coming in and looking to solutions to -- creative solutions to looking at the funding sources and perhaps even expand some of the block grant monies that come in and to look at how those are used, so thank you for your testimony and thank you for being here.

SUZI CRAIG: Thank you so much. Can I just --

REP. STEINBERG (136TH): Go ahead.

SUZI CRAIG: -- mention one thing? I think it was Margaret that mentioned -- Oh, I totally lost my train of thought. I’m done anyways, but --

REP. STEINBERG (136TH): Well, talk for ten seconds. Maybe it will come back to you. You know, we have a couple of bills before this committee in regards to a mental health parody and I think that really underscores our great concern that for whatever
reasons, the mental health side of the equation seems to the victim of budget cuts over and over again, to the point of diminishing effectiveness, so, you know, your points are very much taken to heart by this committee and we hope that through one means or another, we’ll be able to address some of these inadequacies.

SUZI CRAIG: I remember, thank you.

REP. STEINBERG (136TH): There you go.

SUZI CRAIG: Margaret mentioned not moving forward with a taskforce, but actually really putting emphasis on the design of what this could like in the future. I wholeheartedly support that. There are so many taskforces out there and we have so much knowledge and so much data. We know so much about what this work does. I think, you know, what we can do is actually compile all of that and move forward with some actual recommendations and thank you for your comments about parody. I’m the head of the Connecticut Parody Coalition, so I’d love to talk to your further about, you know, your thoughts around that.

REP. STEINBERG (136TH): Well, thank you for that and perhaps you could put all of your intelligent heads together and come back to us with a better idea. It’s not too late to incorporate that into perspective legislation.

SUZI CRAIG: Already working on it.

REP. STEINBERG (136TH): Great.

SUZI CRAIG: Thank you.

REP. STEINBERG (136TH): Thank you. Last up on this bill is Michelle Divine.
MICHELLE DIVINE: Hello, good afternoon Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit, and members of the Public Health Committee. My name is Michelle Divine and I’m the executive director of SEBAC, the regional behavioral health action that serves the 39 towns in eastern Connecticut. I am here to support House Bill 545, An Act Concerning a Study of the RBHAOs, and thank you, Representative McCarty, for putting this bill forward. As you have heard, some of the challenges that we have experienced, I do want to give you a piece of my pie in eastern Connecticut and talk about the some of the successes and then wrap that up, but all of the -- the part of the process is us going through a strategic planning process. We -- Part of that strategic planning process, we engage communities and key stakeholders to identify what they valued most in our work. We have found that many of our small communities do not have the capacity to address concerns in mental health, substance abuse, suicide, gambling among others.

They have welcomed our agencies to come and they support our efforts. We have become the eyes and the ears for the communities and bringing the grassroots up here to you all and to the state and federal government. We have expanded, obviously, to the north area with coalition building, resource alignment, and engaging key stakeholders. We’ve met with numerous, 55, new partners up there, 15 new agencies. We increased our town level funding and actually altogether, our mini grants equals $245,000 dollars. My agency is giving out to my 39 communities. We are getting that funding from both -- how we’re helping the state receive their block
grant funds and we are also getting it from additional funds that we are writing grants for.

We have done over 262 naloxone training, kit trainings, in the last three months alone. We’ve presented in problem gambling at congregations and churches. We’re engaging in a regional needs assessment, of which you’ve heard about, convening engaging voices of individuals with lived experience through CAC meetings, managing all those mini grants that I mentioned. We’re tracking the youth trends. We have 40,000 youth surveys that our agency has done of youth trends in our region and across this state, middle school and high school youth. I know that the other four RBHAOs are doing similar work. Our phones are ringing constantly and people are asking us to go in their communities all of the time for technical assistance, for training, for teacher support, for teaching different things, so we are doing -- we are at our capacity. We are starting to turn people down because we cannot do anymore and to say no to someone is very difficult when they’re calling and they want a QPR and we’re scheduling out right now the rest of the year when they want suicide prevention training, drug trends training, so this is extremely important.

I just want to wrap up and say that the funding needs to be there. The core -- Our core funding, we need to look at taxes for tobacco, E-cigarettes, alcohol, gambling, and the state needs to recognize prevention of a part of that continuum of care and take -- really emphasize that it is a valued part because we can tell you by the calls that we are getting that it is extremely needed. Thank you.
SEN. ABRAMS (13TH): Thank you, Ms. Divine, for your testimony. Are there any questions or comments?

REP. MCCARTY (38TH): Thank you, Madame Chair, and welcome, Michelle, and thank you for your testimony today. I know you’ve been very instrumental in bringing this to the forefront of a lot of the discussion that we’ve had today, but I would just ask if you would, please, to keep all of the data that you’re collecting and all of the information about clients that may be coming forward that we’re not really able to meet all of the needs and bring that forward to whatever we bring forward with this study.

MICHELLE DIVINE: Okay.

REP. MCCARTY (38TH): Okay?

MICHELLE DIVINE: Yes.

REP. MCCARTY (38TH): Thank you.

SEN. ABRAMS (13TH): Representative.

REP. ZUPKUS (89TH): Thank you. Thank you for coming. I’m new to this committee, so how much of your funding comes from the state?

MICHELLE DIVINE: For me -- All of us are different. For me personally, I’m getting about $275,000, so it’s about -- almost 50 percent.

REP. ZUPKUS (89TH): So that’s a good bit. And are you asking for -- how much more money are you asking for or needing? Do you have a number?

MICHELLE DIVINE: Well, I don’t know it’s a number until we really look at -- Well, we really need to look at what we have to complete. If we are really going to look at doing a strong evaluation, which is
not currently funded, the strong evaluation work, then that is going to take another staff person for each region. It’s going to take some considered effort. Each year we’ve been cut in our funds and we were, you know, over a million dollars and I think we have lost, you know, about 35 percent, my agency. In addition to that, though, this year in September we’re losing some additional federal dollars because of we’re at the end of a grant cycle for federal, so across the board, I think if we’re going to pick up an evaluation in there, there needs to be significant funds for evaluation and there also needs to be significant funds to provide all of the TA that the communities are asking for, but I can get a number to you.

We can try to look at some funding, but more importantly instead -- making it consistent through some of those dollars coming in from what we’re -- What we’re working against is, you know, alcohol, tobacco. I know there’s a bill on the table to raise the taxes on E-cigarettes. That would be, you know, a percentage of that. We get a small percentage of gambling. If we’re going to pass marijuana, recreational marijuana, we need to really look at a small percentage of that.

REP. ZUPKUS (89TH): I won’t ask you now, but I was going to ask you your opinion on passing marijuana because you deal with the population that would affect it, so -- but I won’t ask you that question. And then my other point being is, you know, when I sit in these committees and different panels and discussions and I’m not saying this is your organization at all, but I always like to look at is there money because mental health is a huge issue in my opinion and I think a lot of our opinions and is
there something that’s being funded that’s not working and take that money and put it to help you or help whoever, so I would just encourage if maybe there is something that’s being funded that we just keep funding it, it’s not working, and we don’t ever stop funding it, so, you know, is there any money in that area to look at also?

MICHELLE DIVINE: I can’t answer that question right now, but what I can answer is that I know that we have asked to be a part of the decision-making process where funds are being allocated. We’ve asked since we are aware of what’s happening at the community level and we know what the concerns are and sometimes see some of the discrepancies of how the money is being used. We have asked to be at the table to help make some better decisions because we are seeing some discrepancies, you know, at the local level and still the silos of maybe, you know, where money is being used or where agencies that could be working together better, so I think that, you know, just having a voice at those tables would be wonderful for us to share what we’re seeing.

REP. ZUPKUS (89TH): Great, well, hopefully that will happen because, like you, believe that if you bring everybody to the table, then we can get some things accomplished. Thank you.

SEN. ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for coming in today.

MICHELLE DIVINE: Thank you.

SEN. ABRAMS (13TH): So with that, we’re going to move on to Senate Bill 795 and if Dr. Bruce Gould is here? Welcome. Thank you, please begin.
BRUCE GOULD: Thank you. Chairman Abrams, Chairman Steinberg, Representative, excuse me, Petit, as well as Senator Somers and the rest of the committee. I want to thank you for the opportunity to testify in support in changes in the Good Samaritan Law around AED use in medical offices, S.B. 795. My name is Bruce Gould. I’m an internist and a primary care physician and serve as the associate dean for primary care at the University of Connecticut School of Medicine and director of the Connecticut Area Health Education Center program. Some of you will know that as AHEC. As part of my UConn duties, I also serve as medical director of the Hartford Department of Health and Human Services, for the past three years as medical director of the Community Health Center Association of Connecticut, the Primary Care Association federally designated for the community health centers in this state. I’m also chair of the Community Health Committee for the Hartford County Medical Association, and today I’m also testifying on behalf of the Connecticut State Medical Society.

Brief story, in 2005, a good friend of mine, age 60, retired. He was in the gym in a treadmill and he dropped dead and for want of an AED, there was none at that time in the gym. The fire department right next door, their ambulance was out on a call and so it was their AED and so that began for me a little bit of a journey toward looking at and then trying to increase the number of AED out there. As chair of the health committee for the Hartford county, it was clear that most physician offices don’t have an AED and so what we tried to do was look into as a county medical association to provide and encouraged doctors to get them. The council for the County
Medical Association then informed us that actually for liability concerns, it was better that a physician did not have an AED in their office, but just call 9-1-1. Several attempts have been done this around us, worked with the State Medical Society, similarly issues around liability came up as a huge barrier.

As I read the Good Samaritan statute, it does bestow immunity from my ability for the use of AEDs and includes a person -- in quotes, “a person licensed to practice medicine and surgery, dentistry, registered nurses, and others who voluntarily and gratuitously and other than in the ordinary course of such a person’s employment and practice”, that’s a quote, “renders emergency medical and professional assistance to a person in need.” The way this statute is presently written, with that phrase in it, still acts as a barrier to clinicians acquiring and having an AED in their practice. As a public health official, I believe that AEDs do work, I think most of us do realize that, and that within a community as a public health official, the more that are out there -- The Community Health Center Association, we have one and there’s a big sign out front that says AED here so that if someone should arrest in anywhere in the industrial park they’re located, they can come and we can come help them with our AED.

In a similar way, having more AEDs in physician offices not only would help folks that arrest in the waiting room, but also potentially in that vicinity and I’m getting older, I know you are all immortal, but we all, you know, heart disease is still the major cause of death in this state and across the country and you know that getting that AED in there
probably within three minutes is critical to avoiding both increasing survival, but also avoiding brain damage and so when I get my arrest, this is all very selfish, I really want one right there. The other piece of this is that by having them in clinicians’ offices, you know, voluntarily, but they would then train their staff and so when I have my arrest, not only would there potentially be an AED there, but someone who actually knows how to use it. And so all that in mind, I fully support and hope that you and implore you actually to support a tweaking of the Good Samaritan Law to include AEDs in medical offices. Thank you

SEN. ABRAMS (13TH): Thank you so much for your testimony. Your credentials are obviously impressive and also your personal experience means a lot to hear about that and I think that we are very interested in helping protect people and this is a good way to do it, so are there any other questions or comments? Thank you very much for your time. I appreciate it.

BRUCE GOULD: Thank you.

SEN. ABRAMS (13TH): According to my sheet, we don’t have anyone testifying for Senate Bill 796. If that’s correct, we’ll move on to House Bill 6942 and Dr. Stacy Taylor.

STACY TAYLOR: Good afternoon, Senator Abrams and Representatives Steinberg and Young, and members of the Public Health Committee. Thank you very humbly for allowing me to be here today. I am Stacy Taylor and I am past president of the Connecticut Academy of Family Physicians, a member of the Connecticut State Medical Society, and chair of the Academy of Family Physicians Legislative Committee. I am here
today on behalf of the members of the Connecticut Academy of Family Physicians and the Connecticut State Medical Society in opposition to House Bill 6942. In 2012 and 2018, the Connecticut State Medical Society and the Connecticut Academy of Family Physicians gladly participated in the DPH scope of review process requested by the physician assistants with the 2018 proposal of allowing a level of independent that is unprecedented. The Connecticut Academy of Family Physicians believe that high-performing inter-professional teams consisting of nurse practitioners, physician assistants and others are best at performing high quality patient care to all and in fact, the majority of family physicians include physician assistants and nurse practitioners in their practices.

Clearly, teamwork has been identified as an important component of improving patient care, with each team member contributing to the best of their ability, but there’s no doubt there are benefits in working together, however, there continues to be tension on who’s the top dog, who’s the leader. The overriding principle, however, shouldn’t be that. It should be the patient, not the provider. The patient should be the center of our efforts. Because the patient is the center of our concern, we believe that the scope of practice should not be modified for physician assistants. They are already an essential and respected part of our healthcare team and it does not increase the quality of patient care in terms of this proposal and in fact, it may create unintentional harm by allowing an overly confident, less educated, less experienced physician assistant to not seek assistance when warranted.
Their educational differences are vastly different between a physician assistant and a physician. A PA has a four-year BA or BS, a two to two-and-half year Masters program, and there’s no residency training program. An MD has a four-year BA or BS and much more training, including 15,000 to 16,000 hours of clinical training compared to 2,000 hours for a physician assistant and therefore given that there is so much more training, we do believe physician assistants should be supervised, just like I am supervised by my more experienced MD boss. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony, Doctor. Is your concern explicitly with regard to the private practice setting? Would there be differences, for example, in a hospital setting as opposed to a private practice?

STACY TAYLOR: I don’t believe there are any differences. I’m actually part of a hospital system. I am an outpatient -- I am in an outpatient setting, but supervision is supervision. My boss supervises me and in turn, I supervise others in my practice.

REP. STEINBERG (136TH): In the past, we’ve had these exact same conversations about scope with regard to other practitioners in the continuum of care that were initially controversial, but are now generally accepted and have not resulted in untoward outcomes to the degree that you alluded. Why is this situation different?

STACY TAYLOR: I think because the physician assistant’s training, by just the name physician assistant, the training reflects the fact that they are physician assistants, not physician -- some
other name I can’t even describe, but the training of physician assistants means that they are to assist physicians, they are to be there to be an assistant to physicians and therefore they should be supervised by physicians, just like -- frankly, I supervise the nurse practitioners even though the scope has changed, the nurse practitioners in my system are supervised by me at the request of my hospital system and in fact, I've had to have a conversation with one of them regarding a bad outcome. The physician assistant that works in the practice also needs to be overseen. I also need to be overseen. I think that’s part of a work environment and I think if we don’t have any supervision, then we can do almost anything we want without any oversight and supervision in medicine is crucial for patient safety.

REP. STEINBERG (136TH): I’m not sure I totally concur with your opinion that it’s all about the name. We could change the name from physician assistant to something else and I’m not sure necessarily that would necessarily describe the current practice on the ground of what a physician assistant does. Full disclosure, for a long time I was pretty much a doctor snob. I’m the son of an MD, I only went to MDs for my care, and thanks to concierge medicine, my physician has moved on and I’m seeing a PA now and he’s doing a very good job. Yes, under the current circumstances, but there’s not a physician immediately present. It took some getting used to, but this is the world as it’s going forward.

I would submit that perhaps a physician assistant spends more time actually practicing medicine than the MD gets to do these days with all the other
responsibilities that are going on, so I’m not sure I’m in the exact same place because I think that we’ve also demonstrated the effectiveness of the collaborative relationship and what I alluded to earlier, you know, to your point, we had the same arguments about nurses and there were a lot of concerns about nurses and I understand them. I had some sympathy for them, but I think you’d be -- have a hard time convincing me today that a nurse practitioner can’t serve in a lot of the roles that a physician used to, so the question is now, not necessarily one purely of a name, it is now, to your point, training and experience for specific functions and I think that’s really where the conversation is now.

I think it’s reflective of not simply trying to control costs, so that’s a significant factor in the conversation, but this is also more broadly about who is actually providing care in a variety of settings with adequate protections to the safety of the patient, but I think that this process we’re going through in looking at this legislation is important because there is a changing landscape and I think we need to be open-minded about how we can best take care of a patient regardless of the title of the person providing that care. Please.

STACY TAYLOR: I agree with you actually and in fact, in some countries there are tiered levels of care where -- and I don’t see that necessarily going on here, where the more complex care is taken care of by the physician and less complex cases are given to people with less training and experience. I don’t know that our system is structured as such and if we’re going to be looking in that direction, I think we also have to figure out how do we ensure
the safety of patients so that we don’t place a provider in over their heads.

REP. STEINBERG (136TH): I’m sure we all share your concern and it’s very important and thank you for your testimony today because that’s really our ultimate responsibility. Other questions or comments? Representative Comey.

REP. COMEY (102ND): Sure. I heard from one of my constituents, I’m down in the New Haven area, and he was saying that in 1967 when the PAs were first graduating, the profession relied on the concept differently than it would now in the 21st Century. In relation to optimal team practice, is that something that -- what do you think about that sort of structure?

STACY TAYLOR: Well, optimal team practice really allows the patients the ability to see a nurse practitioner or a PA or a physician and optimally as I was mentioning, and I don’t think the structure is there today, having a tiered system based on complexity, but also I have the responsibility in my practice and the physician assistants and nurse practitioners know it, to be the final person, so if they have a difficult problem, they know they should come to me and I know I need to be there for them. To me, that’s optimal. I’m not so much -- I’m collaborating with them, but more than not, I’m supervising them, too, and I have that level of responsibility, and take it very seriously, that I need to be there for them and they also know that I cannot shut my door, regardless of how many patients I see, they are as important as any patient.

Ideally, I've thought about this for many years, we'd be divvying up the patients based on what was
coming in and the complexity and maybe I should be seeing a certain type of patient and they shouldn’t, but it has -- it’s very difficult to predict that.

REP. COMEY (102ND): Thank you.

REP. COOK (65TH): Thank you. Thank you, Dr. Taylor. So in the conversation of this piece of legislation, is there anything that you would -- so I’m going through to look at obviously the scope and what they’re asking for and the changes that were made, is there anything that you could agree to? I know that puts you on the spot and you’re speaking, obviously, for a larger group, in this legislation as far as a move forward, so maybe everybody gets a little bit?

STACY TAYLOR: Well, I guess what annoys me about the bill is I don’t see that it changes patient care at all. I don’t understand why people shouldn’t be supervised as I am. I’m supervised. To me, that’s a workplace requirement, maybe. I don’t quite -- I understand in a sense where the bill is coming from and I think it is coming from the nurse practitioner background and what happened with the nurse practitioners. I understand and I -- it’s got to be frustrating because the hours of training are very similar and having worked with PA students and I precept PA students and precept nurse practitioner students, I don’t see a huge level of difference, however, I look at the bill and say where is -- where is the patient in all of this? What’s enhancing in terms of the patient and I don’t see it.

I see people saying I’m better, I want something different, but I don’t see patient outcomes being any different, I don’t see more accessibility with
that. I see maybe perhaps a better working environment, perhaps maybe PAs being treated better, but maybe not because healthcare systems are going to still set up supervisors and just like my healthcare system has me supervising no matter -- I supervise nurse practitioners regardless of what the legal system says in terms of them being independent, so I’m not sure what substantive changes this will create.

REP. COOK (65TH): So could there be the argument that this would allow more coverage, I guess if you will. I’m not weighing one side or the other, I’m just trying to play devil’s advocate on both sides to try to understand where we go from here. I know that I can take my children into their pediatrician’s office and never see the doctor and only see the PA and the doctor’s not in the office, so -- and that’s on the same campus of where you are, so I’m trying to understand, so you hold your bar and your responsibilities here. Are other practices holding their bar at a totally different level and maybe they’re teetering on what’s necessarily not legal or ethical? I’m just trying to kind of wrap my hands around personal experiences and then what you are citing what either should be the bar or that is legal or not legal in the whole ramification of things.

STACY TAYLOR: I think it does end up being a personal choice. I’m not -- Obviously, I’m the only physician at my practice and I’m here. My PA is in Torrington, however, they also know they can text me at any time and I will be on the phone with them or I will text them back and get back to them. I’m not sure other physicians would necessarily say do this for me, I don’t know. I think my PAs in the
practice as the same way as the NPs. However, I take the supervisory role seriously and I think the open door policy should be there seriously and I’m not sure all practices would have that regardless of this bill or not having this bill or, you know, I just don’t -- I don’t understand what’s going to change with this bill.

REP. COOK (65TH): Thank you. Thank you for everything that you do and your time, as you always do, come up and advocate for what you believe is right and for what you do for your patients. Thank you, Mr. Chair. Thank you.

STACY TAYLOR: Thank you.

REP. STEINBERG (136TH): Representative Zupkus.

REP. ZUPKUS (89TH): I actually see both, like I go and I normally see my PA, but then my kids, they always see their doctor, so I have kind of a mixed bag of who I see all the time. With that being said, though, just again so I’m understanding, with this, would this make a PA and an MD equal? So when you talk about supervisory and collaboration, what would this bill do? What do you see this as?

STACY TAYLOR: In terms of Webster’s dictionary, yes. In terms of who do you -- When I collaborate with someone, I am doing something with an -- who I consider an equal. When someone supervises me, they’re responsible for me. That doesn’t mean they’re breathing down my neck, it doesn’t mean they’re there every day, it doesn’t mean -- but it does mean ultimately they are responsible for how I do or don’t do. It -- So yes, I think we collaborate with our peers and we’re supervised by our bosses.
REP. ZUPKUS (89TH): I understand. So if this goes into effect, who would -- so an MD, you said you report somebody, you have a supervisor, who would be the supervisor of the PA if it was collaborative?

STACY TAYLOR: I have -- It would depend on the healthcare system. I have no idea. I don't know.

REP. ZUPKUS (89TH): Okay. And my last question if I may, so if you collaborate, okay, who is responsible for the malpractice insurance? How does all of that piece, how would that work or not work?

STACY TAYLOR: That did come up during the scope of review and I think it was at that point tabled because I thought -- it was thought it was way -- it was too far beyond the discussion, but one of the things we did -- what we know is that in any kind of a lawsuit, everyone is sued, from the MD to the PA to, you know, everyone gets a slice of the suit.

REP. ZUPKUS (89TH): Right, and I understand that, too, but who carries the insurance? So if people are equal, right, then does the PA have to have it or is the MD responsible for --

STACY TAYLOR: Most likely if people were considered equal, there would be a higher burden on the PA. For instance, if I was an independent nurse practitioner now, I would have to carry my own malpractice insurance, for sure.

REP. ZUPKUS (89TH): Okay, thank you.

REP. STEINBERG (136TH): Thank you. I just want to comment that I find some of this recent conversation a little concerning. I would agree with the doctor that in the generic definition of supervisory, everybody’s got a boss. If you go way up the line,
you answer to someone and I understand that, in the generic sense, collaborative from a definition standpoint suggests equality, but there both demonstrated protocol and experience in the state of Connecticut what those two definitions mean in the context of medical care and they’re not a generic definition. They are fairly well defined what they really mean and don’t mean and I think it’s important for the committee members to understand the genuine differences in the medical setting of a supervisory relationship and a collaborative relationship and I’m not quite sure it’s quite a simple as the doctor has stated in this context and I think we need to discuss that further. Any other comments or questions? If not, thank you, Doctor, for your time.

STACY TAYLOR: Thank you so much.

REP. STEINBERG (136TH): Next up is Mick DeVanney.

MICK DEVANNEY: Good afternoon, chairs and Public Health Committee members. My name is Mick DeVanney. I’m a full-time practicing physician assistant and the current president of the Connecticut Academy of Physician Assistants. I reside in Glastonbury with my wife who wanted me to say that she is also a practicing physician assistant. I’m here to speak to today regarding modernization of the Connecticut statutes regarding physician assistants. The PA profession is now more than 50 years old and in that time, the landscape of healthcare delivery has drastically changed and that change will continue going forward. It is imperative that we in Connecticut be able to adapt to these changes. PAs have proven their value on the healthcare team by helping to increase access to quality, cost-
effective healthcare. The current supervisory language was written at a time when healthcare delivery was vastly different.

There are fewer and fewer physician-owned practices and now corporations and large hospital systems, in which both the physician and the PA are employees of that practice, own most practices in Connecticut. As a result, employers feel they must impose a wide range of limitations on patient care, care that should be appropriately provided by a PA based upon education, training, and the skill set. The scope of services provided by PAs does not change with a shift to collaboration, but it was requested that we submit for a scope of practice review with the Department of Public Health. ConnAPA submitted a request for review both in 2016 and in 2017 prior to being chosen for review in 2018. We felt the scope meetings were a respectful discussion of the importance such a change may have on various colleagues.

Many within the meeting failed to see the distinction between collaboration and independent practice. There is a clear delineation, as our colleague nurse practitioners, have had collaborative agreements for more than 20 years before recently adding the ability to practice independently. In addition, the current need for nurse practitioners to separately apply for the ability to practice independently clearly shows there’s a contrast between collaboration and independent practice.

Since the passage of independent practice for nurse practitioners, PAs have seen an increase in restrictions applied to PA practice in Connecticut.
We have heard from PAs and we’ll hear testimony today who were qualified for positions who were not considered due to the restricted supervisory language that’s currently in statute. This is not limited, however, to practicing PAs as it also has affected PA programs in Connecticut, having trouble placing students for clinical rotations. To be very clear, PAs are not seeking independent practice. One of the main -- I’ll be done very quickly -- modernization of the practice act is critically important to keep pace with the changing healthcare landscape. The word supervision no longer accurately depicts the professional relationship between PAs and physicians and diminishes the role PAs play in healthcare delivery. Thank you. I’m sorry I went over a little bit.

REP. STEINBERG (136TH): Compared to many, yeah, it was very timely and speaking of timely, I want to thank you for your testimony. It’s seems to be very timely in the context of the testimony that immediately preceded yours. I think it’s an important distinction for the members of this committee to recognize, that there is a continuum which the furthest extreme is independent practice and this is not what they’re asking for in this context and as we deliberate this bill, I think we’re going to need you to drill down and make sure we’re very clear on supervisory versus collaborative and independent so we understand what that means and what it doesn’t mean and I think it’s particularly important for us to understand the collaborative process well so we can be reassured that patient needs and safety are being addressed. We need to be reassured. Maybe we will move forward this legislation, but I thought your testimony was
particularly helpful in that regard and I want to thank you and your wife who couldn’t be here for your testimony. I agree with you. I think we’re all concerned about the pace of change in healthcare. We’re concerned about the cost of healthcare. We’re trying to balance needs. For us, quality and safety are always paramount, but this is an important conversation we’re having. Thank you. Other comments or questions? Yes, Senator.

SEN. SOMERS (18TH): Thank you for being here and thank you for your testimony. You know, I did -- we just received a copy of the scope review this morning and, you know, reading through it, it appears that there was opposition to what you want to do and I just wanted to ask you a couple questions and some of the language of the bill. It talks about that the PA may perform and surgical functions in a setting in collaboration with one or more collaborating physicians and then it talks about a written agreement between the PA and the physician that would have to be signed and then it talks about it would list the services that the physician assistant could provide and then it says -- it talks specifically as to what needs to be into this agreement as far as the PA being able to sign all the forms that a physician can sign, obtain informed consent, prescribe and administer durable medical equipment, drugs including but not limited to controlled substances, Schedule 1 and 2, the ability of the PA to request, sign for, receive, and dispense drugs, and in the form of professional samples, blah, blah, blah, it goes on, so how is that different, I’m asking this, I know the answer, but how is that different than what you can do now and is it possible if you were given this authority,
that you will not get a physician to sign off and that wants to collaborate with you because ultimately, in other states that I've looked at that allow a collaboration, still the doctor’s ultimately responsible. They call them collaborating with supervision, so.

MICK DEVANNEY: We have those six states. They’re all a little different.

SEN. SOMERS (18TH): Yes.

MICK DEVANNEY: I’m sure you’ve read through all of them. Maybe New Mexico is the one you’re referencing.

SEN. SOMERS (18TH): Tennessee.

MICK DEVANNEY: Oh, Tennessee and New Mexico are very similar where they have the collaboration/supervisory collaboration which was discussed at the scope meeting. Personally I think it would be confusing to have both words in the statute, but we, and I speak for ConnAPA, are open to discussing language if people would like to discuss language, we are more than open. Do I think we’d have a hard time finding a physician to sign a written agreement? They sell delegation agreements now. They’re very similar to what a written agreement is -- would be if this was passed, so I don’t think we’d have a hard time.

SEN. SOMERS (18TH): So right now, can you write for the -- can you write a script without a doctor’s signature for controlled substances on Schedule 2?

MICK DEVANNEY: Yes, they have to --
SEN. SOMERS (18TH): But that’s signed off by a physician. It’s under the physician’s DEA license. Correct?

MICK DEVANNEY: No, the physician has to sign off that they approve with the use of a Category 2, but the physician’s license does not have to be on the actual prescription as of right now. We have full prescriptive authority in Connecticut.

SEN. SOMERS (18TH): Okay. So do you carry -- Would you carry the same medical malpractice as a physician because you’re going to have to really hone in on what you consider collaboration to be.

MICK DEVANNEY: Agree. So --

SEN. SOMERS (18TH): Because collaboration among equals is collaboration, but you’re -- in here, you have to -- it specifically says you would be collaborating with a physician, so that to me mentally means I’m collaborating with somebody who has more knowledge than me, so I would be really being supervised, so that’s the part I think many of us are struggling with, what specifically is that you want? You don’t want to be independent. You want to continue to do what you are doing now, but with -- without having to have the doctor sign off on forms which they say are not burdensome, according to the scope of practice -- your review, they say those are not an issue, and I guess I’m just struggling with what, you know, what is it that you want other than -- Did you see the language for -- CHA gave some language. I don’t know if you’d be willing to accept that where they say we could add you to many of the statutes we’ve added APRNs. There are some that we’re not comfortable with, so if you don’t want to practice independently, what do
you want specifically now that you can’t do versus what you’re doing now? Like, that’s the part that many of us are struggling with.

MICK DEVANNEY: And it’s very close. The six states that have -- I won’t say collaborative because one of them is participating so they’re not non-supervisory as opposed to collaborative, but what we’re looking for, as I’m sure you read, is adaptive collaborative, where it also gets rid of the new graduate who has not been practicing very long shouldn’t be collaborative where there’s not someone with them, so, you know, someone who -- I've been practicing for ten years, someone else has been practicing for 40 years, they would each be able to adapt their agreement, their written agreement, to what the physician is comfortable with for that particular PA.

SEN. SOMERS (18TH): You didn’t answer my question. I want to know what you specifically want as collaborative versus what you have now. Are you telling me that every practice with a physician is going to be -- you’re going to have a different thing in your contract? You know, I want to know what you can do now versus what you can do if we pass this collaboration. How is it different?

MICK DEVANNEY: Increase access care. Right now we’re struggling and I’m -- forgive me, Dr. Taylor I think her name was, said we’re struggling with nurse practitioners, which is a fact; we’re beginning to have a hard time. We’re having a hard time where hospital systems are saying a PA can’t do that because it specifically says that and a nurse practitioner can; it doesn’t specifically say a PA can. We have over 80 instances and I’m going to
defer to someone who will be testifying later today, that can answer that better than I could, where there’s somewhere between 80 and 100 instances where a PA has been told they can’t do something because of the supervisory language that we currently have. So we have someone who could answer that question that I could that will be testifying very soon. I’m sorry. It’s very similar to what we have right now.

SEN. SOMERS (18TH): What I’m struggling with is we don’t -- I understand, doctors’ offices many times will choose an APRN over a PA for various reasons and is this request because you feel like you’re being shut out of the market because APRNs are -- is that really what this is about?

MICK DEVANNEY: It’s certainly part of it is job loss. There have been job losses in Connecticut.

SEN. SOMERS (18TH): I will -- I will tell you that the physicians that I have spoken to about this specifically have said this to me, whether it’s, you know, how you view it or not, but a PA goes to school and it’s very much like going to med school, but it’s not med school. It’s the same type of curriculum, where an APRN goes to school and gets a nursing degree, but it’s much more clinically based versus, you know, what it is in med school for the first couple of years when you study the anatomy. It’s not as clinically based as an APRN, so they really see a distinction between the two and they, the ones I’ve talked to and I’ve tested the waters in many different specialties, feel that PAs are a very important part of the system and part of a collaborative team effort, but they still don’t feel that they should be on their own doing prescription writing, etc., all this being able to sign off on
all these forms when it’s not an issue without having -- they’re just not comfortable with it, I’m just going to be honest.

MICK DEVANNEY: I appreciate your honesty.

SEN. SOMERS (18TH): So I’m just -- I’m trying to figure out specifically maybe whoever that is that can cite those things specifically. Are those 80 areas, the areas that have been listed and what CHA has required as language or submitted as language, that could be fixed in the statute where we include PAs and APRNs -- where APRNs are listed without having to change the supervisory role?

MICK DEVANNEY: I think adding PAs to where those 80 -- I mean, obviously all 80 is not going to happen, I totally understand that, but -- I’m sorry. I think adding them would be helpful, yes, but I think, you know, further describing what exactly it is that we provide, which is no longer supervisory, it was in 1968, it’s not now.

REP. STEINBERG (136TH): You know, I’m very pleased with the Senator’s line of questioning because I think it does reflect that there’s going to be some perspective on where the line should be drawn if we make changes at all and I’m going to recommend, since we’ve only seen DPH’s scope of practice report since this morning, we need a little time to assimilate that and perhaps opposite legislative research can help us actually chart the differences, the sort of before and after picture, so we have a little better understanding of some of those aspects and I think that’s where the conversation is going to take place on this committee is, is there a point in which we feel comfortable establishing a collaborative relationship, on what basis, and that
may not be either what’s proposed in the bill or even is recommended in DPH’s report. We need to have that conversation. Next will be Representative Zupkus followed by Representative Klarides-Ditria.

REP. ZUPKUS (89TH): Senator Somers really asked my questions because I would like to know what you want, I don’t know. I can’t understand what you have now and what’s the difference, what do you want, so I guess we’ll wait to hear unless you can tell me.

MICK DEVANNEY: A level playing field is a big part of it.

REP. ZUPKUS (89TH): As an MD or as an APRN?

MICK DEVANNEY: No, no, as a nurse practitioner. We, PAs, totally agree physicians are far better trained. Their education far exceeds that of a PA. I think were you will see more similarities is that of an education of a nurse practitioner is independent and a physician assistant who is supervisory.

REP. ZUPKUS (89TH): So -- And pardon my ignorance --

MICK DEVANNEY: No, please.

REP. ZUPKUS (89TH): So a nurse practitioner right now can be on their own?

MICK DEVANNEY: They have -- I’m not a nurse practitioner, but I believe they have to be collaborative for two years, then the ability to apply for independence.

REP. ZUPKUS (89TH): Right, which is not want you want?

MICK DEVANNEY: Correct.
REP. ZUPKUS (89TH): So then what’s the difference of education, clinical from a nurse practitioner and a PA?

MICK DEVANNEY: So PAs are trained more in the medical model, whereas nurse practitioners are trained in the nursing model. I’d be happy to get you -- We have information comparing the two programs in Connecticut and nationally. They’re both around 28 months. PAs generally in Connecticut will have more clinical training than will a nurse practitioner. Many nurse practitioner programs are moving to more of an on-line kind of a venue, but I’d be happy to get you that information. We have comparisons I’d be happy to get you, even by the end of the day.

REP. ZUPKUS (89TH): That would be great. Representative, you were kind of going to do the say thing if I understood you correctly, so I think for me especially, that would be very helpful to understand, you know, what level, why we have two, where does the APRN fit it, all of that, so thank you.

MICK DEVANNEY: Yes, I will get it to you before the end of the day.

REP. STEINBERG (136TH): I think we will be soliciting a number of ways to look at the different constructs. As you heard the gentleman say, there are aspects of the medical model, there are aspects of ours, there are aspects of the clinical versus the classroom. I think we need to understand all those things a lot better. Representative.

REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony. It’s a point of
clarification that I think you spoke about before, as a PA, are you -- does the physician, your supervisory physician, have to sign off on everything you do or are there blanket things you can that’s a standing order type model?

MICK DEVANNEY: They do not have to sign off on everything that we do. Schedule 2 medications, they need to -- there needs to be a record -- I don’t know the exact wording, there has to be a record in the chart of their agreement for our use of narcotics in that patient.

REP. KLARIDES-DITRIA (105TH): So for another example, if you did a physical for a child or an adult, is that -- you’re able to sign off on that on your own without a second signature?

MICK DEVANNEY: Correct, that’s among those 80 things that we’re having a hard time is that often some hospital systems won’t allow a PA to sign off on a physical. They will allow an MD or an NP, they will not allow a PA.

REP. KLARIDES-DITRIA (105TH): But that’s their policy, it’s not your scope of practice?

MICK DEVANNEY: Correct, correct.

REP. KLARIDES-DITRIA (105TH): So per your scope of practice, you can do that?

MICK DEVANNEY: That’s right, yeah.

REP. KLARIDES-DITRIA (105TH): So one would say you’d just take your scope of practice and give it to the hospital and say you have legal ability to do to sign those?
MICK DEVANNEY: It’s one of the things we’ve seen that have changed in the five years since the NPs got independence. It’s one of the things that we -- some places will no longer allow us to do.

REP. KLARIDES-DITRIA (105TH): Okay, thank you.

MICK DEVANNEY: Thank you.

REP. STEINBERG (136TH): Any other questions or comments? If not, thank you for your time.

MICK DEVANNEY: Thank you very much for your time, everyone. I appreciate it.

REP. STEINBERG (136TH): Next up, Gabriella Smith.

GABRIELLA SMITH: Good afternoon, everybody. My name is Gabriella Smith. I am a physician assistant. I've been practicing at St. Francis Hospital for the last 22 years. I practice in the field of cardiology, generally inpatient, but I have about ten years of experience of outpatient PA experience at UConn Health and also at a large cardiology practice in Bloomfield. I came here today to speak of favor of the Public Health Bill Number 6942, which I’m just going to call the collaboration bill. In order to help my oldest to cover the cost of private college, I've been looking for a side hustle as they might say. It’s never really been a problem in the past for PAs to find a second job, but what I've been finding recently is that when I go to apply for a position, I will be called by the human resources folks and say, you know, I look at your experience. I see that you’re a top talent, but I can’t hire you and I’ll ask why and they’ll say because of the supervisory language in the State of Connecticut statute. Now, even with your level of experience, up against a nurse practitioner, the
nurse practitioner needs less direct supervision according to the law and that’s really the way that we’ve been practicing and we’ve been practicing at St. Francis and the way we’ve been practicing in the outpatient, our positions are mirror images of each other and there should not be any language in our contracts that limits our depth or scopes of practice.

You may also be aware that medicine is changing quickly and sort of going back to the good old days of homecare. I've had several instances with homecare companies where, again, they would prefer to work with an advanced practice nurse because they do not need to have that same level of supervision. Some of these companies have very specific numbers. Like one physician can only provide supervision to six or eight physician assistants and it’s really up to them to decide that number because that number, it doesn’t exist in the law, but that limits the number of people -- of PAs they can hire, whereas they could hire 30 APRNs and have on doctor loosely supervising or collaborating with them, whereas in PA law, because of this word supervision, it’s seen as more strict and there should actually be one -- At St. Francis there’s -- I have one supervisory physician and there are seven of us that are listed underneath that position.

I just wanted to say that the language is antiquated and it needs to start to reflect what we actually do in practice every day and that’s all we’re really here to do. To answer your question as to what is that we want, we want the language to be updated to reflect the practice that we do every single day and that would be -- for me, that would be collaborative. I do not operate independently. If
I have a question that I don’t think I understand -- I don’t understand what to do next or I have several things to do, I’m going to go to my physician to collaborate, that’s what I’m going to do. I got well off track of my letter, but I just wanted to put out what the answer to the question is, is that we want to be able to compete with our colleagues who are APRNs and I’m not asking for independent practice. None of us practice without collaborating with one another and that’s really we want reflected in the law. Thanks so much.

REP. STEINBERG (136TH): Thank you for your testimony and your willingness to detour a little bit to respond to the real questions we have here. I assume you submitted your testimony as well?

GABRIELLA SMITH: Indeed, it has been.

REP. STEINBERG (136TH): Okay. Thank you for also clarifying some of the other real world economic aspects of this as well. It’s always a conundrum for the committee to balance trying to control costs without getting sort of in the middle of some of the tour de force between different practitioners. You know, we have to be very careful about that. Our job is to improve the healthcare for the people of the State of Connecticut, but I don’t think we can blind to the aspects of job opportunities and how care is provided, so that is an important distinction. Are there any other comments or questions? If not, thank you for your testimony.

GABRIELLA SMITH: Thank you so much.

REP. STEINBERG (136TH): Anne Hulick. Nice to see you’re wearing your nursing hat for a change.
ANNE HULICK: So good afternoon, everyone, Chair Steinberg, Chair Adams, ranking members, distinguished members of this committee. My name is Anne Hulick and for those of you who don’t know me, I am -- I've been a nurse for almost 30 years. My primary focus over the last several years has been really in environmental health, but I am a member of the Connecticut Nurses Association, have been since I graduated from nursing, and I am currently assisting them on the GRC committee and I’m here on their behalf today as Dr. Mary Jane Williams is unable to be here, so just to clarify that for those of you who may have seen me in a little bit different light. So I’m sharing Dr. Williams’ testimony which she had submitted previously and I assume you have in front of you.

I know this is a complex issue and you all are asking really great questions and I know a lot of work has been put into this issue and there are many important considerations to consider going forward. We are aware of the scope of review of meetings that happened and actually support the questions and the position of that group of professionals in their concerns about this particular bill and as Mary Jane pointed out in her testimony, that no way reflects in any way a feeling of not valuing the very important work that PAs provide to the healthcare team.

Physician assistants practice under the supervision of physicians and surgeons. They’re formerly trained to provide diagnostic, therapeutic, and preventative healthcare services as delegated by the physician. Their education, they -- many people spoke to this before, they start off with a Bachelor’s degree that may or may not be in a
healthcare or medical profession and then go on to take a very rigorous two-year program. They, you know, clearly have a lot of expertise that they bring and a lot of skills that they bring to the healthcare team, but from CNAs perspective, our organization feels strongly that the supervisory role is critical and necessary. So I’ll quickly, I know I’m running out of time, CNA believes that the presence of the supervising physician is essential to the professional relationship, evaluation, and ongoing development of the PA in the work environment and while they serve as an integral member of the healthcare team, there is an important role and value of the extensiveness of that medical professionals, the physician’s, education that he or she brings to the complexity of healthcare delivery today.

There were some really good points and questions that came out of those meetings that I think as Representative Steinberg alluded to are worth further discussion and CNA would be happy to participate in that, so I think I’ll close with that.

REP. STEINBERG (136TH): Well, thank you, Anne. It’s interesting that we’re hearing from the entire continuum of practitioners on their perspective in relationship to everybody’s primary goal of providing good care. So we’ll be very interested to review your testimony and the testimony of who you represent today and we hope you’ll be part of further conversations on this subject. I wouldn’t want to represent by any stretch of the imagination that the legislation as proposed is the end product that we’re all going to end up with for a vote if we have a vote on it, but it would benefit from further
dialog from all the parties involved and we expect that to be the case. Other questions or comments? If not, Anne, thank you. We’ll probably see you in your environmental role more often going forward.

ANNE HULICK: Thank you for your very thoughtful questions and considerations.

REP. STEINBERG (136TH): Next we have Dr. Mariam Hakim-Zargar, I believe.

MARIAM HAKIM-ZARGAR: Good afternoon, Representative Steinberg and distinguished members of the healthcare committee. My name is Mariam Hakim-Zargar. I’m chair of orthopedic surgery at Charlotte Hungerford Hospital and I’m president of the Connecticut Orthopedic Society and I welcome this opportunity to oppose this -- provide testimony to oppose this bill on behalf of the 230 orthopedic surgeons who practice in the state of Connecticut. Orthopedic surgeons in general, we utilize physician assistants tremendously. They are our right-hand men and gals in provision of healthcare to patients. When we talk about supervision, what happens in the PA scope of practice, the physician assistant comes out of their training and they have some two years of course work and 2,000 hours of training and then they come to us green. They don’t know anything about doing any orthopedics and we train them, we supervise them, we train them.

The word doctor comes from Latin “docere”, which means to teach, that’s our job, so we teach them, we supervise them, and based on their ability, and each PA is different, just like every person is different, based on what they learn and what they’re capable of doing, we give them graduated responsibility. Ultimately, the responsibility of
the patient is with us. When there’s a malpractice, when there’s a bad outcome, the physician is responsible for that. If a PA is doing things all out on their own without physician responsibility or supervision, that patient, if they have a bad outcome, in a court of law, the PA is going to be held to the standard of their care and their training, not to the higher standard that the physician has, so from a patient perspective, it is a bad idea to take that physician supervisory and responsibility level away.

When you use the word collaboration, again we’ve heard that over and over, what it’s doing basically is taking the responsibility away from the shoulder of the doctor and putting it on the PA and that is bad for the citizens of Connecticut, that is bad for the people. You want that responsibility to be with the physician, so I’m sitting here today -- I would just give you an anecdote if you’d like me to.

REP. STEINBERG (136TH): Please.

MARIAM HAKIM-ZARGAR: Yeah, so I’m sitting here today. I’m not in my office. I got a call from the ER about a patient with an ankle dislocation, it’s broken and dislocated. The PA in the ER sends me a picture and I test him as I’m sitting here, can you reduce that, meaning can you put that back together, can you just manipulate and put it in a splint and he did and he texted me a picture and it looked great. If it didn’t look great, I would get in my car and leave this hearing and go there and take care of that patient, but I’m supervising him, he did a great job, so I’m here because of the service that he provided and the patient is going to have a great outcome because what that PA was perfect and
competent. I know this PA well, I know what he can and can’t do. When John has been working with me for ten years, I know what I can delegate to him to do. When Jack has only worked for two years and is not very good with his hands, I’m not going to delegate that job to that PA, so that is where the supervision comes in and that’s how it basically assures patient safety.

This collaboration thing really doesn’t do anything. When it comes -- Some people were talking about the hospitals, no matter what law you pass, St. Francis is always going to have the same stringent regulations that they want to do, that their medical exec committee has decided what they are going to and not going to allow to do. You gave podiatrists authority to do certain procedures that we as a medical community didn’t think was a good idea, many surgical centers still don’t allow them to do that, so just because it’s state law doesn’t mean somebody is going to allow you to do it, so just because you pass a law saying you can collaborate or whatever you want to call it, which I’m again to Representative Somers’ point, I’m not sure exactly what the difference is and what the details are going to be because right now the American Academy of Physician Assistants has laid out six points that they consider to modernize the practice of physician assistants and Connecticut, guess what? You guys have done a great job. We get six stars. We have met all of those and that was just reviewed in June of 2018, so we’ve done everything. We’ve done everything that we were supposed to do to modernize the practice of physician assistants and really, what we should not do is take away the supervisory
role that would allow us to ensure patient safety and I’m happy to answer anymore questions.

REP. STEINBERG (136TH): Thank you for your testimony. You know, with each successive testifier today, we’re getting a little bit more of a layered perspective and recognizing how complex are the circumstances and I think you hit one of the point I tried to make earlier, I’m less concerned about the hospital context because of the rigor that virtually every hospital in the state already provides in that case. To my mind, the real action is going to place in the non-hospital setting where there are real differences in the nature of practices, the distribution of different types of practitioners, within that the number of physicians, the number of nurses, number of PAs, and that has a big impact, but I think the other point you make in terms of years of experience and knowledge of a PA’s talents is also very relevant, though I guess I could argue that all physicians aren’t created equal either and some are better at some things than others.

MARIAM HAKIM-ZARGAR: And that’s why residency programs are held to certain standards and you have to pass those standards and there are residents who get held back for an extra year of training, sometimes two extra years of training. They don’t - - They’re not going to be let loose on the public to practice medicine if the people in charge of the residency programs don’t feel that they’re ready to do so, so we have lots of lots of checks and balances and what the proposal that is here, is going to get rid of all these checks and balances and it’s not appropriate.
REP. STEINBERG (136TH): Doctor, if you wouldn’t mind sharing with us the -- You know, it’s really rare that Connecticut gets six points to the good for anything these days, so if you could share with us that document that refers to the things we’ve been doing well, I think that would also help us understand this challenging bill.

MARIAM HAKIM-ZARGAR: Yep. These key elements that they highlight are licensure as a regulatory term, which we have, full prescription authority, which you just heard from one of our PA colleagues that they said they just -- they have, scope determined at practice site and that’s what I just mentioned. So a physician has a PA that works for them, they’ve been with them for so many years, they know they can do X, Y, and Z and we delegate based on what we think they can do and we can -- we know they can do without generating a lawsuit for us because we’re responsible, so that’s determined at the practice level; it’s graduated relegation of responsibility and Connecticut law allows that, adaptive supervision requirements, which is again the same sort of thing, chart co-signature determined at the practice level and that’s again, in the beginning, when you get a PA, you may -- you may want to read through every note and co-sign every chart and as they get more competent and you’re not as worried about them anymore, you let them fly on their own and that’s -- the state law allows physicians at the practice decide, do they want to co-sign every note or do they not want to co-sign, do they need to or do they not need to.

You might do it for one PA, but not do it for another PA, based on their level of experience and Connecticut law already allows that. And then --
And physicians may practice with an unlimited number of physician assistants and that’s already allowed, probably not a good idea, but it’s already allowed in the state of Connecticut.

REP. STEINBERG (136TH): If you wouldn’t mind forwarding that to us electronically, that would be great as well, any document you have that relates to that.

MARIAM HAKIM-ZARGAR: Will do.

REP. STEINBERG (136TH): Thank you.

MARIAM HAKIM-ZARGAR: My pleasure.

REP. STEINBERG (136TH): Yes, Representative Klarides-Ditia.

REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony. I think one thing I took out of your testimony that I thought was very important was just because it’s the state law doesn’t mean they have to accept it.

MARIAM HAKIM-ZARGAR: A hospital, yeah.

REP. KLARIDES-DITRIA (105TH): Right, a hospital. Now, besides a hospital, does that continue on to a surgical center?

MARIAM HAKIM-ZARGAR: Right, anybody who is charge of a practice or what have you can set their own limits of how stringent they want --

REP. KLARIDES-DITRIA (105TH): So a surgical center could say if I want -- if I got a physical for my -- for my surgery that was coming up and I had the PA do it, the surgical center could say we’re not accepting it?
MARIAM HAKIM-ZARGAR: Right, because the anesthesiologist at the surgery center may not be comfortable with the level of assessment that can by law --

REP. KLARIDES-DITRIA (105TH): But that surgical center can decide?

MARIAM HAKIM-ZARGAR: Right, so that may not be acceptable to someone.

REP. KLARIDES-DITRIA (105TH): Certainly for a patient, that would be a huge hassle. Imagine showing up on the day of your surgery and some anesthesiologist saying well, we’re going to have to cancel you because you didn’t see an MD?

MARIAM HAKIM-ZARGAR: Right.

REP. KLARIDES-DITRIA (105TH): Well, hopefully you’ll have that done before the surgical day.

MARIAM HAKIM-ZARGAR: Yeah, hopefully.

REP. KLARIDES-DITRIA (105TH): Your preop. Thank you very much for your testimony.

MARIAM HAKIM-ZARGAR: You’re welcome.

REP. STEINBERG (136TH): Just a point for clarification, Representative, I don’t think you’re espousing that they ignore state law as much as -- in this instance, state law is not preemptive of stronger safeguards. We don’t want to set the precedent that we’re recommending people ignore us going forward.

MARIAM HAKIM-ZARGAR: No, no, they’d be more stringent than state law.

REP. STEINBERG (136TH): Exactly.
MARIAM HAKIM-ZARGAR: Yeah, more stringent, not less. They can’t be less stringent, right.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for your testimony. We really appreciate it.

MARIAM HAKIM-ZARGAR: My pleasure. Thank you. It’s an honor.

REP. STEINBERG (136TH): Next up looks like Jason -- I’m having a tough time. Jason, come on up.

JASON PREVELIGE: Good afternoon, esteemed members of the Public Health Committee. My name is Jason Prevelige. I’m a PA. I live in Fairfield. I practice emergency medicine and pediatrics in Waterbury. I’m past president of the Connecticut Academy of PAs and I’m the current chair of legislative affairs. Over the last 50 years or so, our education and role in healthcare has continued to evolve and advance. We’re educated at a Master’s level. We work in all specialties, evaluating, diagnosing, and treating patients. PAs work in all settings ranging from urban hospitals to rural farmlands. PAs may work side by side with physicians, nurses, and other healthcare team members or may work completely alone with resources available to them via electronic means.

Fifty years ago as a new profession, for patient safety there is absolutely a need to ensure PAs were closely supervised. As PA education has evolved and advanced, the PA role has become clear on the healthcare landscape has also evolved that the relationship that we have with the physicians is one of a collaborative nature. This language simply helps reflect that. I work side by side every day
with an amazing group of emergency-trained physicians. With a decade of experience behind me, they trust me to evaluate, diagnose, treat and disposition all the patients that come my way. Sometimes sicker patients come in and we work together on those patients, all the while running plans and thoughts by one another. Sometimes a patient comes in that I’m seeing personally that perhaps I don’t have as much expertise on and then I approach one of the physicians with whom I’m working to discuss the patient. When a patient comes in, such as a pediatric patient, the physician perhaps will ask me questions.

*Merriam-Webster Dictionary* defines collaboration as “to work jointly with others or together, especially in an intellectual endeavor.” I think that well describes the example I just exhibited. Ultimately as we are all employees of some hospital and practice and we’re all regulated by the Department of Public Health, we are all accountable to someone, we all have supervision. In December, we had our scope of practice review session, as was mentioned our third year asking for the session to occur, and we are grateful for the opportunity to discuss our proposal with the other groups. We have tried to meet with some of the other groups that have expressed concern, but unfortunately almost none have taken up on the offer to meet and discuss solutions. It was an interesting session. There was affirmation of some other, primarily physician groups in the room, that indeed we work collaboratively with one another every day, as well as affirm that we all have supervision and we’re all accountable to something, whether it be a direct supervisor, a medical staff office, Department of
Health, etc. However, as we’ve heard, there is significant concern over the word collaboration. For some reason, it’s equated as independence. It will remain in statute that PAs are not independent. It’s not seen on the bill proposed today. It’s actually the subsection after that because it’s not going to change. In fact, as we’ve heard, APRNs have used the word collaboration for decades and only recently added a separate independence status.

Collaboration is a term accepted by our national organization and in fact, over the last few years, several states have gone away from the term supervision. I’ll quickly wrap up. As we’ve heard, APRNs have had legislation approved granting independent practice for some of their professionals. There have been several unintended consequences for PAs, placing us at a disadvantage. In a market where often PAs and APRNs typically fulfill the same roles, increasingly we’re reports of PAs that are turned down for positions because APRNs are seen as easier to manage, despite them being independent or not. They’ve worked hard to update their statutes to be inclusive of their profession, the ability to perform a multitude of functions, and we as PAs have repeatedly been told that since we are supervised and have delegation agreements allowing us to perform nearly any task, the statutes don’t need to be updated.

In fact, there’s a bill to be heard after this one today where that’s exactly the case. However, the real-world consequence of this has been that increasingly, PAs are told at the local level that because they’re not listed in the statute, they must not be able to perform the function. Ultimately, that leads to delayed care and services, potentially
increased cost of care for the patient because either the physician needs to take time to perform those tasks or the patient needs to have a new appointment.

REP. STEINBERG (136TH): So you’ll wrap now?

JASON PREVELIGE: Yes.

REP. STEINBERG (136TH): Okay.

JASON PREVELIGE: So there’s no doubt that PAs are crucial to address the primary care shortage in Connecticut. Increasingly across the country, we’re finding that PAs are at a disadvantage and I thank you for hearing all of our testimony and considerations today.

REP. STEINBERG (136TH): Well, thank you for your testimony and I share your disappointment that other parties have not engaged to the degree that you’d like. I would encourage you to continue to reach out. Hopefully, you know, if we’re going to find a path to consider this, all parties, all stakeholders will have an opportunity to weigh in and share their concerns and their expectations. Yes, Representative Betts.

REP. BETTS (78TH): Thank you very much and nice to your voice again. Glad you’re feeling better. Thank you for your testimony. I apologize I came in late, but I’m curious, and maybe this has been asked before, how many other states allow for this arrangement and if so, do you -- I haven’t had a chance to read your testimony. Is it in there or?

JASON PREVELIGE: It is. It’s actually in a couple of ours. There’s six at the moment that no longer have supervisory language. They perform in a
collaborative or a participating relationship with plenty more on the way. I know that there are at least several states, including, I believe, North Dakota, Washington State, and several others that are doing the same efforts as us.

REP. BETTS (78TH): And since that’s been passed, has there been any adverse outcomes from the adoption of that law?

JASON PREVELIGE: Not to my knowledge and in fact, the state of Alaska has used collaboration for 20 plus years.

REP. BETTS (78TH): Okay. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): And to your point, Representative, there has been some previous testimony on the number of states and I’m sure we’re going to collate some of that information so we understand some of those fine distinctions. Any other questions or comments? Yes, Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chair. The issue seems to be coming down to the economic issue of hiring APRN versus PAs, but it sounds like from previous testimony that people can collaborate or supervise from afar, don’t have to be in the exact spot to do so, don’t have to co-sign every chart, so what is the reason that employers give? Does it have to do with the letter of delegation/supervision the specific letter that people don’t want to do that puts the PAs at a disadvantage?

JASON PREVELIGE: I don’t believe so. I think it’s more the interpretation of the language that they see. APRNs have a collaboration agreement as well, at least until the point that they’re independent,
so I don’t believe that having an actual paper is the problem. I think it’s just the way it’s interpreted. The way our language currently is, the delegation agreement can be a bit cumbersome. In some of my testimony, I didn’t get a chance to get to it, but I work in a group with, you know, 20 plus physicians. I’m one of 14 PAs. It’s not necessarily clear who exactly is supervising us sometimes. You know, I have a supervising physician that’s listed, but I may not work with them once or twice, you know, a month or so if even that, so who is really supervising us in that case. It’s really the people who are working with us from day to day, so I don’t think it’s the paperwork that’s the issue because we all have our jobs, but certainly the wording of it can be confusing and potentially -- not necessarily prohibitive, but discouraging from people wanting to take it on.

REP. PETIT (22ND): So do you think there’s a real issue there or do you think it’s confusion on the part of prospective employers as to what you’re -- what you’re capable of and I’m coming from the perspective when I was in full time, I actually had one PA and one APRN, so I had one of each and it worked great with both.

JASON PREVELIGE: Sure, I mean, I think its both. I think there’s definitely some cumbersome nature to the agreements. You know, in my pediatric practice that I do per diem, there’s eight of us. There’s ten groups that we cover for. That’s at least 80 agreements a year that we’re signing. That in itself is pretty cumbersome. If you go a larger surgical practice where you may have 40 PAs in the practice and another 40 surgeons in the larger hospitals, that’s a lot more agreements and with
supervision, the way it’s written currently -- the way the current language is written for the delegation agreement, you know, you have a supervising physician, you may have a backup physician in there, but you’d be working with the whole or a multitude of physicians, so the way that the language proposed today is written, it’s with one or more physicians. I think it takes some of that confusion away and doesn’t necessarily require as many of the written agreements that can just be a burden administratively.

REP. BETTS (78TH): Thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you for your testimony.

JASON PREVELIGE: Thank you.

REP. STEINBERG (136TH): Next is Sue Schaffman.

SUE SCHAFFMAN: Hi. Thank you so much today. I’m here representing Dr. Aronow, who’s our vice-president of the Connecticut Orthopedic Society. Unfortunately, he had an added surgical case, so he’s not able to attend so he asked me to come to provide testimony for him. So I wanted to thank Senator Abrams and Representative Steinberg and the members of the committee of public health for this opportunity to provide testimony in opposition to House Bill 6942, An Act Concerning a Collaborative Relationship Between Physician Assistants and Physicians. As I stated earlier, my name is Susan Schaffman and I’m here to provide the testimony for Dr. Aronow.
The scope change proposed in House Bill 6942 has been most recently reviewed by the Department of Public Health’s scope review committee, with the committee’s 129-page report being released this past Friday. I have two concerns with this scope review and what was being focused on and the first one is the term supervision and why it should be replaced with collaboration, regardless of the potential of the potential consequences, and also the other aspect of it, they claim the physicians don’t want the responsibility and administrative burden of supervising physician assistants.

With respect to the first, supervision is a good thing. Physicians are supervised during their training as medical students and residents and in practice, administrators and department chairs are supervisors, so supervision typically leads to better physician and patient outcomes. Physician assistants in Connecticut currently collaborate with the supervising physicians to improve patient care, however, the amount of autonomy and direct hands on supervision depends upon the individual physician assistant’s education, training, experience, and performance as satisfactorily demonstrated to the supervising physician. This determination based on supervision is more preferable to the proposed bill, which on lines 188 to 189, would allow a physician assistant to engage in an appropriate level of consultation with a physician with the term appropriate not being defined.

Furthermore, in lines 308 and 309 of the proposed bill, it would allow physician assistants to perform medical and surgical functions in all settings in collaboration with one or more collaborating physicians. We do not agree that it is appropriate
to have the option for physician assistants and determine and then perform surgery in all settings without any supervision. The replacement of supervision with collaboration is part of a national effort by the American Academy of Physician Assistants toward independent practice, which they call optimal team practice, or OTP, it’s important to note that in an article from the Physician Assistant Education Association cites 90 percent of responding past presidents, program directors, and medical directors do not believe that the current physician assistant education prepares graduates for the OTP model.

With respect to the second justification, our members dispute the implication that ensuring our patients get appropriate care by providing supervision is a burden we are trying to shed. Physicians, with their extensive education, training, clinical experience, and patient advocacy are well qualified for this responsibility which is accepted without reservation by the orthopedic community. In summary, there is no demonstrated need for this bill. Physician assistants are well respected in Connecticut. They are able to provide patient care and collaborate to the full extent of their education and training and neither they or their patients are harmed by the safety net we call supervision. We respectfully ask you to vote no on this bill and the maintain the safeguard of supervision and the current scope statute. Thank you and I’m happy to answer any questions.

REP. STEINBERG (136TH): Thank you for your testimony. We appreciate you being specific to the parts of the proposed legislation that you’re concerned about which led you to your conclusion,
which we’ll look at very seriously. I assume that’s part and parcel of the testimony you presented?

SUE SCHAFFMAN: That’s correct.

REP. STEINBERG (136TH): Okay, comments, questions? If not, thank you for your time.

SUE SCHAFFMAN: Thank you.

REP. STEINBERG (136TH): Last up, this Jim Martone. I think it says Jim.

JIM MARTONE: Good afternoon. Thank you for asking me to testify. My name is Jim Martone. I am presently -- I’m a board-certified ophthalmologist. I’m presently the president of the Connecticut Society of Eye Physicians and I’m here representing that group, plus the urologists, ENT, and the dermatologists. As I've sat here, I've listened to everything that you’ve been listening to, so I won’t belabor a lot of those points. If you would like to know how I feel, I listened to the doctor who came from the orthopedic society. I agreed with 100 percent of everything she said. I couldn’t have said it any differently for myself and so I think in listening to this, what this boils down to is this issue of supervision versus collaboration and when you’re supervising someone, which I do now, I’m working at the West Haven VA and I supervise the Yale ophthalmology residents, so I’m in this position a lot where I have to decide who’s good, who’s competent, who can I let go, who can I watch carefully and I think that’s true of all professionals, so the idea of supervision is one thing.

I think the word collaboration you can interpret a lot of ways, but I think it was said before,
supervision means I’m watching, I’m responsible, I know who you are, I have a relationship, I’m on top of it. Collaboration sounds a little bit like okay, we’re on the same level, you’re over here, you’re going to tell me what you’re doing and I’ll try to make the best assessment. The point she brought up today about the ankle broken and can you reset it and, you know, collaboration is okay, reset it and things hopefully will go well, but she supervised it, she got a picture, she looked at it, she said you know what, I’m comfortable with that, I’m responsible. And I do that with the residents. Some are good, some are great, and some are terrific, you know, and I have to make that judgement based on my close relationship with them.

So I think it’s been recognized here today that that’s at the heart of this, is this idea of supervision versus collaboration. Supervision is clear. Collaboration is a little looser and as we loosen that arrangement, does that end up having negative consequences for the people of Connecticut, so I think that that has to be defined and I think that we have to be careful with that and I agree with what was said that in a hospital setting, there’s probably a structure in place. In a private practice, as you said, you know, that’s where things can get a little bit loose, so I think that we have to be careful in loosening these relationships. So I won’t go on too much, but that’s --

REP. STEINBERG (136TH): Thank you for your testimony. It does come at a good time to sort of wrap this, to a large degree. I think the point you make is that we’re all very clear what a supervisor is and has been and the whole collaborative relationship aspect is where things may be trending,
but does create, for lack of a better term, more wiggle room in terms of how it’s applied in an individual practice setting. That’s really what we’re going to struggle to figure out if there’s some common ground which we could all agree on and which will, you know -- we get into the most trouble as a legislature when we come up with prescriptive one size fits all, top down solutions, so we have to be very careful how it will actually play out in the real world if we’re going to protect patients, so thank you for your testimony and I hope you stay involved as we try to struggle our way through this and I want to suggest, and it happens to me at least once in every meeting, I made a mistake and I forgot about Dan Musse, who is also to testify in this. I hope I didn’t strike fear into his heart for suggesting that we were going to continue without him, but thank you for testifying.

DAN MUSSEN: Good afternoon, members of the Public Health Committee. Linda Orange is joining me here. Thank you very much. So good to see you, Representative.

REP. ORANGE (48TH): Oh, it’s good to see you always. For the record, my name is Linda Orange. I am the state representative from the 48th Assembly District and I appreciate the fact that you raised this bill and hosting a public hearing on this bill. I submitted written testimony, but we needn’t go through all of that. I’m sure that you will read it. The basic reason to bring this forward is the laws seem to be more antiquated at this point as far as the medical community goes and the amount of care that so many people need out there, healthcare. I mean, you could call your doctor’s office and say I got this, this, and this and they’ll say go to the
ER and we want to keep people out of the ER, so I think that anything that we can do to help deserves looking at and I certainly am grateful that you are taking this. The APRNs were once supervised. They are no longer supervised and that kind of -- this kind of evens the playing field. Why aren’t they supervised and that’s a big question on my mind, why aren’t they supervised if the PAs have to be supervised, so I appreciate you taking the time to thoroughly investigate this matter and come up with your own conclusions as to whether this -- we proceed with this or we don’t proceed with this, but if we don’t maybe we should take another look at the APRNs because if they’re out --

REP. STEINBERG (136TH): Be careful about reopening old scope of practice. I might take you up on that someday. But Representative, perhaps you, without getting into all of Dan’s time, you’ll afford him a little?

REP. ORANGE (48TH): No, no, I’m on my own time.

REP. STEINBERG (136TH): Oh, you are, are you?

REP. ORANGE (48TH): Yes. I’m actually going to give Dan like a couple of my minutes, too.

REP. STEINBERG (136TH): I was just suggesting that, if I could. Okay, I got it.

DAN MUSSEN: My name is Dan Mussen and I’ve been providing primary care in Connecticut now for over 40 years and I do thank you for the opportunity to testify in favor of House Bill 6942. I do want to address, to begin this, the concepts of supervision, collaboration, and independent practice. In state statute, there is very specific wording used for supervision and it’s something that states that
there must be control, there must be oversight, there must be significant physician interaction, which creates somewhat of a glass ceiling and I think the APRNs came up against that glass ceiling over two decades ago. They said over two decades ago, patient care is being reduced and we are seeing this. You are seeing a gradual reduction in the care the PAs can provide because of this glass ceiling, this wording that’s being used.

So I want to say that some people determine the fact that since supervision is dependent practice that therefore, if you remove supervision and must be therefore independent practice, you only see it in black and white. I submit that there’s actually a middle ground which is the best of both worlds which is intra-dependent care. Intra-dependence means that you are not leaving the team. PAs, there has been a suggestion that PAs are running amok and that we are -- without supervision, we are therefore running amok and I’m not saying that someone used that word, so I apologize for paraphrasing, but on the other hand, I think intra-dependence means that you stay within the team. PAs are not leaving the team.

As a matter of fact, it’s just redefining the way we actually practice after 50 years where some situations in some locations in some settings with some practitioners, there should be some ability to move beyond that very strict wording of supervision. And there’s going to be practices, there’s going to be specialties where practices say you know, I have an APRN and I have a PA and I supervise both of them and I don’t -- I’m not going to go beyond that. That’s perfectly fine because as was said, you can be more strict than what the law allows, but I would
love to sit down with the physician groups and the PAs have tried. We’ve tried to sit with them, we’ve tried to come to terms with what terminology might be acceptable with APRNs. We’d love to come together on this and come up with great terminology because in fact, if you’re a physician that hires both an APRN and a PA, why is it you feel comfortable hiring an APRN and working with a an APRN who is collaborate and not with a PA who is collaborative. Why is that? You know, what is the -- what it is that is so good about the collaboration for one provider that’s not good for another provider in this situation?

We’re documenting that in fact, because we have the supervisory wording, that we are being excluded from bills, bills that are being placed before you to say that now an APRN can provide a service, PAs are not going to. The very next bill that you’re going to hear is a perfect example, that in fact medical assistants can potentially be supervised by APRNs and physicians, PAs are not in that bill? Why? Because we are their -- We are supervised, so therefore we shouldn’t be then working with medical assistants? It just doesn’t make sense and we’re excluded from a variety of --

REP. STEINBERG (136TH): I’m going to ask you to wrap up, please.

DAN MUSSEN: So the locations, we can certainly discuss with you, but we’re not even asking for those locations in statute to be including PAs this session. We think that if we get the collaborative agreement in place that these other places in statute will fall -- will fall in place because we
are directly labeled as working collaboratively with physicians. Thank you.

REP. STEINBERG (136TH): Thank you. I mean, I think I can speak on behalf of many of my colleagues. Scope of practice conversations can be a headache, not only because they’re complicated and there’s so much at stake, but because things so rapidly as well and it’s very difficult for us to put certain things in statute that need to be reconsidered so frequently, but this is an important conversation and I want to thank you both for testifying today. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Just one question, so I don’t believe PAs are running amok. I don’t, you know, I’m taking your word and other words that you don’t want to become independent and practice, I forget the word, alone or by yourselves or whatever, so it sounds like in listening, though, to you and I could be wrong, are you saying -- because you were comparing PAs and APRNs, so are you saying that they’re equal? And I don’t know, I’m asking. Again, I can’t wait to get the education and all that, so is that what you’re saying?

DAN MUSSEN: PAs and APRNs are not the same. We have different educational models and I think that APRNs come from a nursing background, which is an independent professional. They come from a background that became -- was independent to begin with and then moved into an APRN and it was sort of a natural progression for them to move into independence. PAs, though, we are trained in PA school to never think of yourself as a physician. If you want to be a physician, go to medical school, but when you take a look at the anatomy, physiology,
all of the education, and you compare them side-by-side, like you will be seeing hopefully by the end of the day as promised, you’ll see that the PA education and training compares extremely favorably when it comes to the APRN training and education.

REP. ZUPKUS (89TH): Favorably meaning close, the same, is that what you’re saying?

DAN MUSSEN: I could say better in some ways.

REP. ZUPKUS (89TH): Okay. Thank you. That’s what I thought you were saying in your testimony. Thank you.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for your patience and your testimony and with that now, I can say we are moving on to our final bill for today’s public hearing. I want to thank all those who have hung on this long. We’re going to give you an extra second to testify to having hung on so long. First up is Edith Duellet.

EDITH DUELLET: Good afternoon, Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit, and members of the Public Health Committee. My name is Edith Duellet and I’m a registered nurse. I’m also the division director of Nursing and Allied Health at Three Rivers Community College. Thank you so much for giving the opportunity to testify on Bill 6943. I've testified on this bill or similar bills year after year and what I can say is that I've actually learned a lot over the years, so I’m going to summarize some very key points.

First of all, I’d like to bring on the floor that we agree about medical assistants. They are a very,
very important part of the healthcare team. I also would like the committee to recognize that I oversee both RN and medical assistant programs. Our medical assistant programs at the college are both degree and non-degree programs and I think that’s where I’d like to focus my testimony on today. You have my written and you can read it, but the concern that I have still about medical assistants administering meds is the fact that the education is so varied, even in our own state and across the country and I can tell you that in a non-credit program, there’s absolutely no course that goes over any kind of medication administration and they are certified medical assistants when they’re done through the National Health Careers Association.

In our associate degree program, they have one three-credit course and that goes over basic medication knowledge, okay, so I’m not -- I’m not completely saying that we shouldn’t engage in this kind of practice because I recognize how vastly healthcare is changing, how the landscape is changing. We’re sitting here talking about many different scopes of practice and I know that it gives you a headache, but these are critical conversations that we have to have because we want the public to remain safe and so in summary, I think that if we’re going to look at medical assistants administering any kind of medication, I believe that there are four critical things that we have to take a look at and that is education, scope, data collection, regulation oversight, and supervision.

When we say that the physician is going to supervise or an APRN or a nurse is going to supervise, what exactly does that mean? I know that all of you have used a physician’s office or a community walk-in
center. The medical assistant as all by themselves with you. They don’t know what they don’t know and I heard and I agree with Senator Abrams when she said she believes best practices in legislation include considering the evidence and when other states includes this practice, the evidence of safe outcomes is lacking and with the development of this evidence, in an upcoming testimony, you will hear about some data that was collected in California about medical assistant medication errors that is very concerning.

REP. STEINBERG (136TH): We’ll get a chance to hear that. I will ask you to wrap up, though, because you had three minutes.

EDITH DUELLET: I’m all done. I really would encourage you to please reach out to me and ask me questions. I oversee both of these programs.

REP. STEINBERG (136TH): Well, thank you for that and I will ask you a question. In the context of this specific legislation, we recognize that there — it is not ramification free, but we’re talking exclusively about vaccines to start with. Would you say that the training with regard to the administration of vaccines and the ability to assess adverse reactions is inconsistent in training MAs in this country?

EDITH DUELLET: I think that the training of any kind of medications, whether they’re vaccinations or inhalation therapy or anything else that medical assistants are administering, I would say that it is inconsistent across the country.

REP. STEINBERG (136TH): If we were to couple such legislation with a requirement for some specific
additional training in vaccines, is that something that would especially ameliorate your concerns?

EDITH DUELLET: I think if we standardized it across the state in every single program. I actually recommend that we get rid of the non-credit programs.

REP. STEINBERG (136TH): Very interesting points. Other comments or questions? I will take you at your word that we do want to continue to engage with you as we think very carefully about this bill. As you say, you bring a unique and very relevant perspective to the training and the applied aspects as well, so thank you for your testimony.

EDITH DUELLET: Thank you very much.

REP. STEINBERG (136TH): Next we have Dr. Jim Martone again.

JIM MARTONE: Thank you. So I guess in looking at this, the first thing that comes to mind is why a certain bill introduced. We have one of the highest vaccination rates in the country. We have also delegated this to pharmacists. There’s access to vaccinations and so I think, as you said earlier, all these things boil down to does this help with access of care, does this help with quality of care for the people of Connecticut, what is it doing to improve the lot of the patients and the people? So the question of quality and supervision let’s say, for example, I have seasonal allergies and for 20 years, I've been getting injections once a month, it’s helped me tremendously. When I go to the physician’s office, I get the injection from the nurse or from the doctor. They ask me to take an antihistamine first and they insist that I stay
around for at least 20 minutes afterwards to make sure that I don’t get an anaphylactic reaction, even though I've been doing it for all this time. So these are kind of random events and so there can be serious consequences to vaccinations, so you have to put that in perspective in terms of what the potential is. So under direct care, maybe that’s one thing, in any setting that is not supervised directly, that would be of concern.

So we think that the best care is given in the medical home, you know, strong physician-led team and this is what’s come up today is what’s the structure of all this, you know, there’s a difference in education and physician-led teams are going to give the best care. We’re used to being in the position of the buck stops with us. We’re trained for it, we’ve dealt with it our entire careers, and when we start to loosen that and let things get out of that team, that would concern us. So in terms of the medical home and continuity of care, we would say we would oppose allowing this to happen.

REP. STEINBERG (136TH): Well, thank you, Doctor, for your perspective. I think the point you make, which is a physician centric practice approach is what I think everyone is sort of talking about to a large degree and I think some of the things we’re talking about is a combination of sufficient education and appropriate in-practice protocols just along the lines of what you describe, building, sort of hardwiring, standardizing the importance, for example, of keeping your patient in the practice setting for a period of time to monitor adverse reactions is something that perhaps we could consider, but I guess the nub of it, bear with me,
we’ve heard in some cases that in some physician practices, the ability to, and I know this is a loaded term, to delegate responsibility for administering vaccines to MAs would be something of a relief on the sort of day-to-day operations of a specific practice. We would want to presume that that practice would be adhering to good standards, good practices, good protocols and there would be always the fallback of the appropriate physician in a supervisory role should something happen.

But playing devil’s advocate, if we put the safeguards in place, why wouldn’t an MA be able to administer vaccines in that kind of practice setting?

JIM MARTONE: In that kind of practice setting, you have the protections in place.

REP. STEINBERG (136TH): Perhaps there’s room for conversation about whether or not we could assure ourselves that every practice setting could emulate that basic good standard?

JIM MARTONE: If there are safeguards in place to make sure that that was going to happen.


REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chairman. Thank you for your testimony. I have a question, pharmacists can administer vaccines and what’s their training?

JIM MARTONE: Oh, I agree wholeheartedly. I was surprised to find out that they were given that ability.
REP. KLARIDES-DITRIA (105TH): I believe they’ve been doing that for a very long time with no supervision at all.

JIM MARTONE: I know. I agree. I agree with you.

REP. KLARIDES-DITRIA (105TH): So we’re looking for something that’s giving complete supervision in a doctor’s office in a setting versus that, but thank you very much.

JIM MARTONE: Yeah, I think that, you know, as we go along, the need for care is there. How do we -- How do we delegate that in a way that’s good for the patients and safe for the patients.

REP. STEINBERG (136TH): Thank you, Doctor. Anybody else? If not, thank you. Next up, Anne Hulick.

ANNE HULICK: Thank you again for the opportunity to speak today. Again, I’m representing Dr. Mary Jane Williams’ testimony that she submitted on behalf of the Connecticut Nurses Association. CNA does oppose House Bill 6943 for the reasons of concerns about education, licensure, regulation, the lack of safeguards that are not in place in the current language. As the previous speaker pointed out, Connecticut has the highest rate of vaccinations, which is terrific, so there’s a question about why we would need this. We are concerned about the educational training of a medical assistant, which generally consists of, as you heard there’s varying levels, but generally consist of 900 hours which comprise lectures, laboratory, and also about 225 hours of externship in different settings.

Much of those -- Some of those classes also include office management, billing, customer service, things like that. The focus of the three -- the modules is
to teach the trainees to perform both the tasks as well as the administrative responsibilities efficiently and the concern really is that administering vaccines is not a simple task at all. It requires skill, knowledge, judgement. The individual who is responsible for administering the vaccine needs to be able to, as the physician alluded to, assess the patient, even things like assessing where that injection should be placed, am I going to put it in the deltoid muscle or the thigh muscle, is the patient frail or am I going to hit a bone, am I going to hit a vessel? What happens if I do, what are the concerns about that? Those are some things that took hours and hours of education in my training as nurse and not only that, but hours and hours of people standing over me watching me do that to make sure that I knew exactly which muscle I was aiming for and using the right needle length to assure that I wasn’t hitting a nerve or an artery or a vein.

So I think just the way this is currently written is what’s driving the concerns from the Connecticut Nurses Association and as the previous physician also alluded to is that ability to assess the patient after a medication -- after a vaccine is given. There really is no assessment in their scope of practice, in their education, so that’s the primary concern for this bill.

REP. STEINBERG (136TH): Well, thank you, Anne. You know, I think you’re one of the most fair-minded people I know, so I’m sure the irony is not lost on you that it wasn’t all that many years ago when nurses were making the same argument and physicians were directly opposed because the nurses didn’t have the education or the practical training and I’m not
trying to say it’s a perfect equivalence, because it isn’t, but this is, I don’t even want to call it a sliding scale, it’s different and when we’re talking about an APRN or a PRN or MA, they’re all different, they have a different mix of things, but I think there’s an argument that we need to be at least cognizant of the facts on the ground and on how practices are operating in this day and age, so I’m going to challenge you a little bit on this. This legislation might not be where it needs to be yet. I’m open to the prospect, and this may not be easily accomplished, whereby we require further education, further classroom and clinical training, in the very specific and narrow application of vaccines before we allow an MA to perform them. Is that beyond the realm of reason, Anne? Isn’t that something we could fashion?

ANNE HULICK: You know, certainly I want to defer to Dr. Williams and Kim Sandor, but I do believe that they are very open to talking further about what kinds of procedures and policies and education would need to be implemented to make this worthy of consideration. You know, I think fully we understand the changing nature of healthcare delivery and the need to be very thorough, efficient, fast and also cost effective to meet the goals — the needs of all the patients coming in, so I think CNA would be very willing to talk about those. There’s not a lot of data, unfortunately. I think you know that we always, as nurses are trained, to look at the research and the evidence-based practice, there’s not a lot about, as we’ve been able to find, that really speaks to the pros and cons of this. There was one study that I’ll share with you electronically that wasn’t really a
study, it was more of kind of a report, out of California where they did look at this, and I’m happy to forward that, where there was an acknowledge that MAs giving medications, not just vaccines, may represent an underappreciated source of risk for the practice, I’m quoting there. That’s only one report. You know, I do some of those things that might make it a safer situation should be definitely part of the conversation and I believe strongly that CNA would be willing to participate in that.

REP. STEINBERG (136TH): That’s very important for us to hear and again, I don’t intend to really put you on the spot as much as just say we’re all working towards the same goal of trying to serve patients well within the context of a very challenging medical delivery landscape. Representative Betts.

REP. BETTS (78TH): Thank you, Mr. Chairman, and thank you for the testimony. A couple of thoughts have run through my mind as I’ve been listening to this, but first I’d like to get your reaction, if you would, to the previous comments that were made about vaccinations can be given at pharmacies.

ANNE HULICK: Right.

REP. BETTS (78TH): And it’s unclear how much training or what kind of training they have and yet people can get that and it’s frequently marketed and advertised. If they’re able to do that, why would you be opposed to the MAs doing it and I’m going to make an assumption, but I think they’re probably going to be more likely to be as much, if not more, knowledgeable about doing it.
ANNE HULICK: The MAs? Yeah, it’s a good question. Pharmacists actually have a minimum amount of six years of education required, so they are at the PhD level to get a pharmacy license. They’re highly regulated, they study for years to learn biology, anatomy and physiology, you know, all of those kinds of things, never mind they are far more expert than most of us in terms of knowing medications, drug interactions, all of those kinds of things, so they -- pharmacists are highly educated whereas, you know, MAs don’t even have an associate’s degree to be a medical assistant in some programs.

REP. BETTS (78TH): And I don’t want to misrepresent or misunderstand what you’re saying, but are you suggesting that MAs don’t have the capacity to understand --

ANNE HULICK: No, no, no.

REP. BETTS (78TH): -- how to be able to give the --

ANNE HULICK: No, not at all. I don’t think they’re given the training, yeah, not at all. I think they can be, you know, I’m sure they’re very smart and they have very tough jobs, frankly. No, I just think it’s a level of what they’re provided in their program, yeah.

REP. BETTS (78TH): Thank you very much, Anne. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. I just have one question and I hate needles, so talking about this makes me crazy.

ANNE HULICK: I do, too.
REP. ZUPKUS (89TH): I cry still, but anyway, so we talked about pharmacists giving vaccinations and all, but -- so an MA, again, I’m not familiar a lot with that, but when I've taken my kids to get vaccinated or anything, I’m not sure they’re an MA -- Well, probably not at this point, but somebody else besides the doctor has given them a shot before, but if I’m taking my child or me to get the shingles vaccination or whatever and I go into the doctor’s office and an MA would give it, somebody -- the MA just wouldn’t say here take this. It seems to me that somebody would give them the direction to give them that vaccination, so it’s not up to the MA’s discretion to give it or not, am I correct? Or maybe the doctor would say we need to vaccinate this child with measles or mumps, I don't know, whatever, and then the MA would just give it to them. So I agree that understanding and knowledge is always better and best, but to me, I wouldn’t go into a doctor’s office and get a vaccination without the doctor or somebody saying yes, give this shot to Leslie and then they would just deliver the shot, right?

ANNE HULICK: Yes. No healthcare provider other than a -- you know, somebody who’s licensed to prescribe can prescribe medicine, so yes, you’re absolutely right. A physician or an APRN would have to prescribe, you know, give Leslie the flu shot. The concern is -- I think where the gap is for MAs right now is that they can follow that direction and give the shot. They don’t have the training or the education to know, you know, my deltoid muscle may not be suitable on my right arm because of I've had breast cancer, so you know, use my left arm. They may not know that a dialysis patient has a shunt,
you know, and so they should use another site. They may not know, you know, to think about I’m an elderly person that weighs 80 pounds and that one and a half inch long needle is going to hit the bone so I need to address the needle size, so it’s things like that. It’s not in any way reflective of their intellect, it’s the process of their education that may not provide them with all of the right things that they may need to that in a safe manner.

REP. ZUPKUS (89TH): And one more if I might, and if at this point, what level of education, whether it’s a PA, an APRN, what level do they get that right now?

ANNE HULICK: So nurses get that, so LPNs can administer some medicines. They can’t do intravenous push injections, so that’s, you know, infusing something directly into a vein. Registered nurses on up can -- are trained to deliver intravenous or intramuscular or subcutaneous medications.

REP. ZUPKUS (89TH): Thank you.

ANNE HULICK: Does that?

REP. ZUPKUS (89TH): Yes, you answered by question.

REP. TERCYAK (26TH): Thank you very much, Mr. Chairman. Thank you very much for coming before us. Personally as a nurse, I hope the CNA fights this tooth and nail forever. The idea that we can apart of jobs and identify this part and that part and train somebody well enough so that you don’t have to deal with -- you don’t have to pay a professional is madness and short of the tax in the oil change place, it’s not something we do with a whole lot of professions to divide it up that way.
Do you have any information on the decrease in LPNs working in physicians practices, because I’m aware that should every physician keep a nurse on staff when they’re open -- like it was not too many years ago in which would include LPNs, some of whom are coming out of school that are state schools where we’re paying for it, that we want to be talking about can a medical assistant give an injection because the appropriate licensed staff is there. Does a CNA have any stats on that?

ANNE HULICK: I don't know and I will check and get back to you.

REP. TERCYAK (26TH): Thank you very much, but in general, it’s not a question, it’s a comment, I can’t stand stuff like this, I really can’t stand it and I don’t believe I've ever seen anybody attack a male-dominated profession the way I've seen this legislator happy to go after the pockets and the earnings of their nurses, never, not for anything. Thank you very much, Mr. Chairman. I appreciate this opportunity, Madam Chair. Thank you, Ma’am.

REP. STEINBERG (136TH): That you for that dramatic juxtaposition there. Other questions or comments? Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman, and I believe we absolutely know where Representative Tercyak stands on this issue. I have a daughter’s that’s a nurse, so I understand and she would probably feel the same way. I do have a question, though, you made a comment just a second ago about a vaccination or injection couldn’t happen without the directive of a physician. Did I quote you right?

ANNE HULICK: I think so, yeah.
REP. COOK (65TH): So how is it that I can walk into a Walgreen’s or CVS or anywhere else and get a flu shot without the doctor telling me or giving that direction? Can you just clarify that?

ANNE HULICK: So that is a good question and I’ll get back to you on that. I don’t want to give you wrong information. I know when I've gone in, I've had a doctor’s -- my doctor has ordered it, so -- but that’s --

REP. COOK (65TH): I can walk in without a doctor’s order and we advertise that very clearly.

ANNE HULICK: Yeah, you’re right.

REP. COOK (65TH): Anyone can walk in and get a flu shot. If you’re above a certain age, you can get the shot for shingles, you can get the shot for pneumonia.

ANNE HULICK: Yep.

REP. COOK (65TH): So that’s clearly without a doctor’s order or directive.

ANNE HULICK: Yeah.

REP. COOK (65TH): So if we are allowing that, I’m just -- I’m just for consistency. I’m trying to understand how we allow that for certain things, but you’re saying that things had to be done with a doctor’s order, because I know my doctor doesn’t prescribe that. I can just simply walk in.

ANNE HULICK: No, you’re right, and I’ll double check on that. So what I was referring to was anyone has prescriptive authority to write -- to write orders for medications and I think I was responding to your question, so any, you know, I
can’t just go in and get penicillin, for example, but you’re right, I mean, the flu shot is different, so whether that was statutorily a public policy initiative, I will double check and get back to you, but what I was referring to is just a very general statement that like a medical assistant or me as a nurse, unless I’m an advanced practice nurse, I’m not licensed to prescribe medications. That’s what I was referring to.

REP. COOK (65TH): And I understand that, so at any pharmacy that I go get any of these medications because we have actually kind of forced the hand in theory, my general practitioner does not carry the flu shots.

ANNE HULICK: Right.

REP. COOK (65TH): He’ll send me out to a pharmacy. Who is administering that at the pharmacy? Do you know?

ANNE HULICK: The pharmacist is my understanding.

REP. COOK (65TH): And are they a licensed and certified person that can give that injection?

ANNE HULICK: Yes.

REP. COOK (65TH): Or are they given a different training?

ANNE HULICK: A different training than a nurse or -

REP. COOK (65TH): Well, a pharmacist is different than a nurse.

ANNE HULICK: Yes.

REP. COOK (65TH): And so their training and education is totally different.
ANNE HULICK: Yes.

REP. COOK (65TH): So what allows a pharmacist to give an injection in my arm?

ANNE HULICK: So as I understand it, when we were asked about the difference in level of education, pharmacists have a minimum of, you know, Bachelor’s, Master’s, and beyond, so they go through a whole program of, you know, learning about anatomy and physiology, medication administration, medications themselves, drug interactions, you know, assessment of patients, they have a lot more education than what this current proposal for medical assistants is.

REP. COOK (65TH): But during that education, are they trained to do --

ANNE HULICK: As I understand it, yes.

REP. COOK (65TH): -- vaccinations or injections?

ANNE HULICK: As I understand it, yes.

REP. COOK (65TH): Thank you.

SEN. ABRAMS (13TH): Thank you. Any other questions or -- Representative.

REP. MCCARTY (38TH): Thank you, Madame Chair. Just again for a point of clarification, what we’re talking about here today is actually the administration by medical assistants of a vaccine ordered by the physician?

ANNE HULICK: Right.

REP. MCCARTY (38TH): And as the discussion has gone on to say that there are inoculations being given by pharmacists in other areas, so in the bill, it does
specifically state that the medical assistant will receive eight hours of training in exactly that, giving the vaccination, so if I may go back for a moment, I believe the chair earlier said would you be open to looking at what are the educational requirements and what type of training is necessary, but I think going through the discussion here, we’re not looking to open up a new scope of practice --

ANNE HULICK: Right.

REP. MCCARTY (38TH): -- or anything of that order. We’re just saying that the vaccination by order of the physician should be allowed through the medical assistants, so I’m struggling. I heard Representative Tercyak and what he stated earlier and I’m just trying to find where we have common ground. I think we’re all here for public safety. We want the best possible care for our patients, but when we’re hearing repeatedly that a vaccination -- I know when a family member was discharged from the hospital, I was given an inoculation right away, you’re given certain B12 shots or diabetic, so I’m just struggling trying to find out what we’re really -- the struggle that we have here today.

ANNE HULICK: So if I’m answering your question appropriately or if I’m not, please let me know, but I think it’s really that from CAN’s perspective, from what you learn as a licensed nurse, whether it’s a licensed practical nurse or a registered nurse and up from that, APRN, PA, etc., you have a whole scope of education that goes into your professional judgement, your ability to assess, not only the patient, but what other medications they’re on that may be, you know, something important to think about, what’s their current status, you know,
a whole host of things that go into delivering -- it’s not just kind of popping a pill down somebody’s mouth, you know, it sounds easy, but there’s a whole five rights of medication delivery, there’s a lot that goes into thinking about what, you know, what medications somebody is taking, what are the potential concerns about administering that, what could happen after that, so you know, there’s just a lot that goes into that kind of training. It’s not just the task of drawing up a medication and, you know, inserting it into a muscle. There’s a lot more thinking that goes into that, frankly.

REP. MCCARTY (38TH): Okay. Thank you for our explanation.

ANNE HULICK: I don’t know if I sufficiently.

REP. MCCARTY (38TH): Well, I’m just struggling with the concept because I don’t see it as expanding the scope. I just see it under a doctor’s order allowing the medical assistant to give the vaccine on a specific order of a specific vaccine, that’s all. Thank you.

REP. STEINBERG (136TH): Are there any other questions or comments? Well, Anne, you got more than you bargained for on this one.

ANNE HULICK: I’m going back to environmental health.

REP. STEINBERG (136TH): Sometimes it seems more simple. Thank you. Moving along, Mary Blankson, please.

MARY BLANKSON: Good afternoon, Representative Steinberg, Senator Abrams, and members of the Public Health Committee. Thank you so much for allowing us
to testify today and I’m very excited to testify in favor of H.B. 6943. I’m a family nurse practitioner by training and the chief nursing officer for Community Health Center, Incorporated, your largest federally qualified health center here in the state of Connecticut. We serve approximately 100,000 patients every single year and I employ about 100 medical assistants, 50 registered nurses, and about 12 to 13 LPNs, as well, on our team. I mean, really part of why, you know, I testify in favor of this bill is really about the fact that, you know, we are in an every changing healthcare environment. You know, we’re in -- we’re working on payment reform, we’re embracing value-based care with PCMH Plus and some of the other demonstration projects going on here in the state of Connecticut and because of this, we have to increasingly embrace team-based models of care, which is extremely, extremely important.

And I will say that given that we are the only state that doesn’t allow any amount of medication administration and simply what we’re asking for in this particular bill is adult vaccinations. You know, it seems we are the furthest behind in this area, so I’m happy to see that this committee is continuing to consider this type of information. You’ve heard testimony before talking about sort of the training of medical assistants and I will say that the majority of the written testimony that’s been submitted to you, as well as some of the oral testimony that you’ve already heard, really doesn’t take into account the responsibility of the providers who will be supervising this, as well as the responsibility of the organizations.
So here already in the state of Connecticut, medical assistants are able to deliver Clearwave tests. So I’ll give you three particular examples with in-house INRs for the management of Coumadin. Actually I’ll only give you one other, a hemoglobin A1C and your in-house glucose for the management of diabetes. Both of these, insulin and Coumadin, are by definition high-risk medications, yet you have medical assistants that support the quality assurance, the delivery of this point of care tests, and providers make decisions about these high risk medications based on those results, yet, you know, the task or the intervention of doing an intramuscular or a subcutaneous immunization is seen as more complex, but I am here to tell you it, in fact, is not.

You’ve also heard about the report from California and again, I ask you to look into that. The reality is that in the state of California, the majority of immunizations are delivered by medical assistants, so of course you will see that any type of, you know, issue that has happened related to vaccinations are going to come from MAs, just in the same way that if you demonstrated this similar type of study here in the state of Connecticut, it would be nurses. Why? Because nurses are the only ones allowed to deliver vaccines or licensed providers as well, of course, are able to deliver them. So I really ask what is the continued cost to the system to not allow MAs to participate in this when again, our patients continue to go to the ER for uncontrolled diabetes, uncontrolled hypertension, and other types of chronic illness management, that I really need my registered nurses to take that 30 percent of immunization time to focus on getting our
patients to control and really reducing ER utilization, as well as hospital readmissions. Thank you.

REP. STEINBERG (136TH): Well, thank you, Mary, for your pragmatic and important perspective sort of from the front lines of the practice. So much of what we’ve heard with regard to this bill has to do the team approach, how critical it is, how that’s the model for delivery going forward in the practice setting. The issue seems to be with regard to being confident that that model is being emulated effectively in a standardized fashion for virtually every practice in the state of Connecticut. How far away are we from that? Do we -- Are there ways in which we can work on this legislation to assure that the appropriate protocols and best practices are in place such that the concerns we have about risk can be minimized?

MARY BLANKSON: Absolutely, and I don’t think we’re actually as far away as you would think because again, with all the work that we’ve been doing in Connecticut with the payment reform council and others, we have already been moving in this direction and really, the safety protocols are in place because again, nurses need these safety protocols as well, right? Patients should be, you know, watched for at least 15 minutes post immunization, my nurses do that right now, but an MA could also be a part of that process as well. So again, you know, this is I think very easy to embrace because these protocols are in place.

I would also welcome any one of you, actually, to come visit the Community Health Center at our 675 Main Street site, bring you up to see our team-based
model of care and show you what our policies and procedures look like and what this can actually be. I think it’s important to, you know, even potentially think about a demonstration project or something to really look into this. Really, unfortunately, in prior years, the legislation has just shut down without anybody really considering the fact that there are places where this could work very well today without this becoming an issue of RN jobs and more really around how do we activate and make sure that everybody is practicing at the top of their licensed training and education.

REP. STEINBERG (136TH): I’m intrigued by your concept of doing some sort of demonstration project, maybe as a way to give us more confidence or perhaps we can be very explicit as to the types of practice settings where this would be allowed and perhaps if you could not meet those standards in terms of staffing and supervision and things of that nature, we would limit it for the near term, so it seems like there’s more conversation to be had.

MARY BLANKSON: Absolutely, and I’m more than happy to be a part of that in any way.

REP. STEINBERG (136TH): Thank you. Other questions? Yes, Representative.

REP. PETIT (22ND): Thank you. Thank you for your testimony. I wonder if you could just comment from your experience at the health center how people would respond to some of the issues that were brought -- the issue of upper extremity lymphedema was brought up, which we almost never see because those surgeries are not done very frequently and usually the patients are well aware they don’t need injections there or someone who is extremely frail,
how do people in your clinic tend to approach those situations?

MARY BLANKSON: So we have two particular situations, so the first thing I would focus on is that every new employee who is able to administer vaccinations actually attends a course at New Hire, where they actually are trained about all of the issues related to immunizations from start to finish for the various different age groups, needle size, which was brought up in a prior testimony, as well as sort of what are the very few contraindications for not giving a particular vaccine. The other thing we have is a standing order, so our nurses are able to utilize that standing order to be able to decide who may get what and again, as much as, you know, the prior member of the Public Health Committee and I apologize for not remembering your name off the top of my head, but you had brought up kind of parsing out the pieces of medication -- thank you, Tercyak, Representative Tercyak, parsing of the parts of medication administration, but certainly, a medical assistant will never be able to order the vaccine and again, those things must be considered at the point of placing the order.

REP. PETIT (22ND): Thank you.

REP. STEINBERG (136TH): Other questions or comments? Representative Tercyak.

REP. TERCYAK (26TH): Thank you. Thank you very much. You mentioned Coumadin and some other tests, but we were talking about tests there, not medicine administration. Correct?
MARY BLANKSON: Correct, yes, but they’re multistep procedures that do involve finger-sticks and pipetting and other types of complicated procedure.

REP. TERCYAK (26TH): So the answer then would be that those are tests, not administering --

MARY BLANKSON: Correct.

REP. TERCYAK (26TH): -- entering a new medication into somebody’s body?

MARY BLANKSON: Correct.

REP. TERCYAK (26TH): Okay. You spoke about needing your RNs to take back the time that’s presently spent on vaccinations and that makes perfect sense. I again don’t understand why the answer would be to start training medical assistants of using LPNs more wisely and having them do that. I’m pleased that you do employ LPNs, that’s good.

MARY BLANKSON: Absolutely. There are many of them who actually really love it and enjoy primary care. I think the reality is is that unfortunately, even LPNs in a lot of their training and experience are not, you know, really aren’t familiar with primary care and really aren’t familiar with what we do. We are beginning to integrate them more, but again, medical assistants are a large workforce. They tend to look just like the communities that we serve and really support our patients in a lot of different ways. I’m not even sure that using an LPN to give an intramuscular injection, such as the flu vaccine, is the best use of even their time because again, you know, we have out of a panel of 1,200 to 1,500 patients, probably close to about 400 to 500 of them are actually eligible for complex care management because of their high year utilization, because of
their readmissions, because of their uncontrolled hypertension, diabetes, asthma, because of their substance use and their engagement in our MAP programs, because of the complexity that is their social determinants of health, and again, these are the realities of today’s primary care health delivery.

I would also say that, again, as much as you want to parse out sort of the tests from the actual immunization administration, you know, we are also in the age of prefilled syringes where again, there is no measurement involved, there is no sort of drawing up from a bottle, none of that in virtually the majority of all vaccines, particularly the ones that adults will be receiving, so again that is not necessary as part of sort of the administration process.

REP. TERCYAK (26TH): Thank you very much. I was struck by the importance of this issue being the cost to the system and as we speak about PNs again, how they’re being used is interesting and good, but we’re not talking about a shortage of PNs, that we couldn’t get them if we decided that we wanted to, we’re just talking about how there are people we can pay less instead of having to pay them to do that and for public health, when people we can pay less are able to do something, for some reason we decide that is the gold standard of quality.

MARY BLANKSON: I don’t think it’s about paying them less. I think -- I have a workforce of 100 medical assistants that I could leverage to support my existing nursing team and I would like permission to be able to do that.
REP. TERCYAK (26TH): When I hear I would like leverage to support my nursing team, I think to myself, leverage in this case I won’t pay as much. I don’t agree that having people that don’t earn as much do something is progress or is radically upending an industry in a good way. It just keeps coming.

MARY BLANKSON: With all due respect, my definition of leveraging was not to pay less. I am currently paying all of my medical assistants, all of my LPNs, and all of my nurses, we are paying them fair -- actually, our minimum wage is $18.50 dollars an hour, which is actually $3 dollars more an hour than any other medical assistant in the state average for what they get, so again, I’m not trying to pay less. I’m going to be paying the same amount --

REP. TERCYAK (26TH): I’m saying only job --

MARY BLANKSON: -- by being able to support my medical assistants to be able to give some of the vaccines, thereby better utilizing my registered nurses and my LPNs to be able to engage in complex care management so that instead of only being able to manage a much smaller population of patients, we can actually take on more of those patients and hopefully reduce the cost of care, which again if you look at ACG risk scores and other things for our Medicaid population, the patients that are hugely spending the majority of the money and really where our lot of our cost savings is going to be found is in chronic disease management and we need to focus more on that.

REP. TERCYAK (26TH): Having spent my whole nursing career working with people with chronic diseases exclusively, I agree that that’s important. I
haven’t felt the need to be identifying people who could do part of my job for less with the belief that it must be exactly the same. Thank you very much, Mr. Chair and Madame Chair. I appreciate it. Thank you, Ma’am.

MARY BLANKSON: Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Other questions or comments? I’m sure we’ll carry on this conversation going forward. Thank you.

MARY BLANKSON: Thank you, Representative Steinberg.

REP. STEINBERG (136TH): Next up, Dr. Debra Brandt.

DEBRA BRANDT: Hi, Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee. I am speaking on behalf of the physicians and the physicians in training at the Connecticut State Medical Society and all the other societies listed above and would like to take this opportunity to offer our support in the House Bill 6943, An Act Allowing Medical Assistants to Administer Vaccines. I am a medical oncologist. I practice hematology and oncology in Torrington. We have a number of medical assistants who assist in our practice. They are very well trained, they are supervised by us. CMS supports the ability to delegate the administration of the vaccines to the medical assistants who are appropriately trained. Those are the medical assistants who have taken the extra courses, have the extra hours, and are certified to do this procedure.

It does not allow them to decide who gets the vaccine, it does not allow them to act differently than they would act if there’s a complication with the vaccine. There would be a provider, a physician
or a nurse practitioner in the office at the time that the vaccines are being administered to oversee any problems that they may have in terms of is the arm okay, can you come in, can you evaluate, or if there’s a complication from the vaccines. Vaccines do cause complications. They don’t always come with no complications and you do have to assess somebody to see if they are appropriate for vaccines. We have personally seen in our office people faint during vaccines, we have seen -- I have seen skin reactions and cellulitis from the vaccines and I have actually seen allergic reactions from vaccines. Unfortunately, with some of the vaccines leaving the physician’s office, I have also seen vaccines being administered in appropriately. I had a number of patients who are immunocompromised receive the live shingles vaccine when that is a contraindication to their receiving this vaccine.

I've also found since the vaccines have left the physicians’ offices that we can no longer get the vaccines. If you would like the new Shingrix vaccine, you have to go to the big box pharmacies. Both physician offices cannot get them because they’re in back order and I would argue that there is a lack of oversight as to giving the neediest patients that vaccine earlier because it is not in the hands of those who are -- the physicians who can appropriately evaluate those patients. Having said that, I do think the medical assistants with the appropriate training and the appropriate supervision should be able to safely administer these vaccines in an office setting and those medical assistants are very helpful for the care of our patients and our office can’t work without them and they don’t do what nurses do, they do something very different.
REP. STEINBERG (136TH): Well, thank you, Doctor. I think the point you made and this seems to be really what we’re focused on is assuring the safety of the patient by making sure that the MA has the requisite education and training and certification, as you bring up. It seems like these are things we want to make sure we’re hardwiring into any legislation, so that -- We have work before us and we hope that you’ll contribute to that dialog as well. Are there others who comments or questions? If not, thank you Dr. Brandt for your patience today and again, we hope that you’ll stay involved as we see if we can get it right.

DEBRA BRANDT: Great. Thank you so much.

REP. STEINBERG (136TH): Thank you. Dr. Leslie Miller.

LESLIE MILLER: I also think that the pharmacy issues are a problem and I don’t see the -- any issues with this being a woman thing. Actually, most medical students are women, last I heard. This is a testimony of H.B. 6943, which allows, obviously, a physician, APRN, or PA to authorize a medical assistant to vaccinate a mutual patient under whose care both are charged. Any trained, certified medical assistant deemed competent should be allowed to give a vaccine under the orders of a doctor. This would allow the lead clinician to continue work of diagnosing, treating, and documenting. Connecticut remains only one of two states that does not allow its medical assistants to inject.

Forty-eight states allow certified medical assistants to vaccinate babies, children, adults, and the elderly. We have not been able to identify
a single liability case against medical assistants. The Public Health Committee has wisely supported this legislation in the past and we thank them for it. The vast majority of Connecticut legislators have been positive about it. Politics itself has prevented this bill from obtaining a proper vote and that has been to the detriment of people like me who work -- who is an office-based provider. Medical assistants have been specifically trained to be a physician’s third hand. Their function is to implement the busy work of medical evaluation at the direction of the physician they represent. They receive hours of training to properly administer injections. Currently, they’re already readying the vaccine for me and for other providers, documenting it in the electronic medical record.

While they’re not allowed to vaccine, they perform a much more difficult and painful task called phlebotomy. They have to palpate a vein underneath the skin, not even seeing it many times. They have to insert a needle, kind of figuring out where that vein might be, and then they have to draw blood all while juggling three Vacutainers, a 2 x 2, and a Band-Aid for the patient and they do this very well. And sometimes things do happen and if they do happen, a physician is always there to take care of things. In 2019, the prior speaker, who did a terrific job, immunization is uncomplicated. While certified medical physicians complete hours of formal training and practice, individuals of every social economic bracket, every level of education, self-administered all kinds of injectable medications. Patients inject themselves with biologics for psoriatic arthritis and rheumatoid arthritis, insulin for diabetes, hormones for
fertility, chemotherapy for multiple sclerosis, vitamins for bariatric surgery, and some people even inject themselves with blood thinners.

Unlike other sanctioned improvements in healthcare, having a certified medical assistant vaccinate does not add any additional cost to the healthcare system. The patient already recognizes the MA as adept with a needle, therefore vaccinating is an obvious and natural progression. The personal attention that the MA provides actually encourages patient compliance. Conversely, disallowing medical assistants to vaccinate encourages MAs to leave Connecticut for more respectful communities elsewhere, essentially dumbing down the pool of professionals available to Connecticut doctors. As the burden of practicing medicine increases with close to 50 percent of physicians in a burnout rate, it is a priority for doctors to capture any aspect of time efficiency that we can. Certified medical assistants are a valued member of our practices. It is better for medicine if they are allowed to contribute the full breadth of their training.

Fairfield County Medical Association requests that you not only support Bill 6943, but also decrease the patient age requirement so pediatrics can make sure of this improvement to Connecticut medical practices. Finally, we hope you will encourage your colleagues to allow this bill to be allowed to come forward for a vote. Thank you.

REP. STEINBERG (136TH): Thank you, Dr. Miller. Could you quickly describe your practice circumstances? You have MAs in your practice?

LESLIE MILLER: I do.
REP. STEINBERG (136TH): And then what are their number and currently what do you have them doing?

LESLIE MILLER: I always have one to two MAs. I predominantly use one MA. She is my second -- she is my third hand. She does everything and she’s very bright and years ago, I felt she could this.

REP. STEINBERG (136TH): You also employ APRNs or LPNs?

LESLIE MILLER: No, I don’t. actually, that’s not true. I do have -- I do have an RN in my practice that works part time.

REP. STEINBERG (136TH): Thank you. Other questions or comments? If not, thank you, Doctor, for your patience. We hope that we’ll be able to continue talking about this and everybody will -- stakeholders will have an input. Next up is Joann Rodriguez.

JOANN RODRIGUES: Good afternoon, Representative Steinberg, Senator Abrams, and members of the committee. I have been a certified medical assistant for over 25 years through the AAMA. I am also an MA instructor for the past ten years and I come before you once again to ask that you please allow us to perform the tasks for which we have been fully trained and proven by testing in competency skills that we are more than capable of doing. Any student that’s graduating from a technical program here in Connecticut has received classroom training between 45 and 90 hours in pharmacology alone. That includes clinical simulation of the administration of all types of medication, oral, subq, and IM. At my school in particular, we have 45 hours of classroom principle and theory, where they learn
things like contraindications, things like lymphedema, along with 75 hours of a lab simulation where injections are practiced on special training equipment.

Students are also tasked with doing drug carts, so if they don’t know about a specific drug, they absolutely know how and where to look it up to get the information they need. Students are tested and trained, not only on the seven rights of administration, but also about the importance of observation of the patient and reporting such to the provider for a possible anaphylactic response and adverse reactions. We and New York are the last two states where MAs cannot practice to their level of training. In the other 48 states, licensure is not included. According to the California Medical Board, MAs can give medications after only ten hours of training. That includes narcotics, which also might account for some of their med errors since it’s only ten hours of training. In Florida, according to the Florida.gov website under their licensing and regulations, MAs can fully perform IV and fusion therapy since 2009. We are allowed to stick a needle in a patient's vein for the purpose of drawing blood, where if done incorrectly can have serious side effects.

We are also allowed to set up a sterile field prior to many invasive procedures and as any doctor here knows, that’s not an easy task. Don’t turn your back on it, don’t reach over it, so many rules to keeping that sterile field, yet if it is broken, the consequences to the patient can range from infection to many more serious ill effects. Again, we’re trained to do these skills, just as we are for injections. Please allow us to pull a chair up to
the table in the medical field and perform to our level of training. Thank you.

REP. STEINBERG (136TH): Thank you, Joann. Quickly, since you can offer the perspective of somebody who has been in this situation for some time, tell me, you’ve heard some testimony about assuring that the MA has not only the requisite training, but sufficient experience. Would you be in favor of a graduated or some sort of staggered approach to affording an MA the opportunity to administer vaccines based upon experience?

JOANN RODRIGUES: Absolutely, and I’m also -- I’m a firm -- I’m very much for this bill, I've testified for it, I think, for the past five years, but I’m also a very firm believer in that we have to verify the education of the medical assistant and therefor -- and have the doctor supervise, maybe the doctor verifying their ability to perform the task. I don’t think it should be assigned to, you know, carte blanche that every MA can do this. I think it does have to be monitored by the providers that will be delegating this. Also, like when we talked about, or it has been talked about, that pharmacists giving the injections, as an instructor, I teach the students if you were to give these injections, you observe the patient; 20 minutes is the standard time. I've recently had two injections at a pharmacy. I got the shot, they put on the Band-Aid, and I was out the door, never observed at all, which I think is a much more dangerous situation for our patients and it has been stated there are some vaccines that are available only at a pharmacy, so I think we’re actually putting our patients more at risk in those kind of situations.
REP. STEINBERG (136TH): We may have to look at pharmacists again. Maybe we’ll have to take it away from them. Could you describe your -- the practice setting in which you operate?

JOANN RODRIGUES: Right now, I am strictly teaching, but I have worked in the past recent three or four years, I was in a cardiology practice in Middlebury and in a primary care setting in Watertown.

REP. STEINBERG (136TH): What was the sort of configuration of nurses and MAs in those two settings?

JOANN RODRIGUES: In the cardiology practice, there was one nurse who was just a graduate. She was attending school while there prior to her graduation. There were no nurses at all. The doctors did any administration of medications themselves.

REP. STEINBERG (136TH): Thank you. Any questions or comments? If not, thank you.

JOANN RODRIGUES: Thank you, and I’d be happy to be part of any discussion or questions going forward as well. Thank you.

REP. STEINBERG (136TH): Thank you for that. We’ll take you up on that. I do not see Randy Trowbridge. I believe he probably left earlier -- what’s that? Okay, so Mark, you have the last word.

MARK: Actually, everything’s been set.

REP. STEINBERG (136TH): Wow, I wish legislators would follow that. Unless there’s anybody else that we’ve missed, this concludes testimony on this bill and the public hearing, which I will summarily adjourn. I want to thank you all for your patience.
I will advise the new members of the committee this is the shortest public hearing we will have, so buckle down.